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FEDERALLY QUALIFIED HEALTH CENTER (FQHC)/RURAL HEALTH CLINIC (RHC) BULLETIN

Provider Bulletin News: Due to budget constraints, paper copies of bulletins will no longer be distributed by DMS. Bulletins are now available only at the DMS Website http://www.dss.mo.gov/dms/pages/bulletins.htm. Please note new website address.

Bulletins will remain on this site only until incorporated into the provider manuals as appropriate, then deleted.

Missouri Medicaid News: Missouri Medicaid providers may sign-up to receive automatic notifications of all bulletins and other official Missouri Medicaid communications via e-mail. Providers and other interested parties are urged to go to the DMS website to subscribe to the e-mail list.

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MC+ MANAGED CARE

The information contained in this bulletin applies to coverage by the MC+ fee-for-service and Medicaid fee-for-service programs. The MC+ fee-for-service and Medicaid fee-for-service programs also provide coverage for those services carved out of the MC+ Managed Care benefit for MC+ Managed Care enrollees. Questions regarding services included in the MC+ Managed Care benefit should be directed to the enrollee's MC+ Managed Care health plan. Please check the patient's eligibility status prior to delivering a service.

HIPAA

To prepare for the October 16, 2003 mandatory implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) national standards, Missouri Medicaid has analyzed how providers must bill for services in order to be in compliance with the implementation of national transaction and code sets.

HIPAA mandates the use of standard Health Care Procedure Coding System (HCPCS) code sets; however, it does *not* require states to add coverage for services that it does *not* currently cover.

Billing providers wishing to exchange electronic transactions with Missouri Medicaid may now view the X12N Version 4010A1 Companion Guide on Missouri Medicaid's web page <http://www.medicaid.state.mo.us/>. To access the Companion Guide, select Missouri Medicaid Electronic Billing Layout Manuals; select System Manuals; select Electronic Claims Layout Manuals; select X12N Version 4010A1 Companion Guide. For information on Missouri Medicaid's Trading Partner Agreement, select Section 1 - Getting Started; select Trading Partner Registration. All questions concerning Trading Partner Agreements or provider testing schedules should be directed to the Verizon Help Desk at 573-635-3559.

Billing providers wishing to exchange electronic pharmacy transactions with Missouri Medicaid may now view the NCPDP Telecommunication V.5.1 and Batch Transaction Standard V.1.1 Companion Guide on Missouri Medicaid's web page at <http://www.medicaid.state.mo.us/>. To access the Companion Guide select Missouri Medicaid Electronic Billing Layout Manuals; select Systems Manuals; select Electronic Claims Layout Manuals; select NCPDP Telecommunication V.5.1 and Batch Transaction Standard V.1.1 Companion Guide. For information on Missouri Medicaid's Trading Partner Agreement, select Section 1 - Getting Started; select Trading Partner Registration. All questions concerning Trading Partner Agreements or provider testing schedules should be directed to the Verizon Help Desk at 573-635-3559.

With the implementation of HIPAA national standards by Missouri Medicaid, the following non-HIPAA compliant methods of electronic claims submission will be phased out:

- Accelerated Submission and Processing (ASAP) System
- Bulletin Board System (BBS)
- Direct Electronic File Transfer (DEFT)
- Direct Electronic Medicaid Information (DEMI)
- Magnetic Tape Billing (MTB)

The existing formats and media will be available during a short grace period for providers unable to produce a HIPAA-compliant 837 professional transaction starting October 16, 2003. Providers may continue to bill current Missouri Medicaid formats and media during this grace period.

All providers wishing to bill Missouri Medicaid in paper format should refer to Section 15 – Billing Instructions Physicians for paper claim filing instructions.

TYPE OF SERVICE

With the implementation of HIPAA national standards on October 16, 2003, type of service will no longer be a valid code set. Type of service *must not* be included on any type of claim submission (other than the non-HIPAA compliant formats and media as defined above) on or after October 16, 2003, regardless of the date of service being billed. In order to make up for the loss of type of service, claims submitted to Missouri Medicaid must reflect an appropriate modifier with a procedure code when billing for the services defined below. For example, prior to October 16, 2003, when billing for laboratory services, a procedure code is submitted with types of service I (technical component) and R (professional component). Effective on or after

October 16, 2003, laboratory services must be billed with modifiers TC (technical component) and 26 (professional component). Failure to use the appropriate modifier will result in claim denial.

Modifier	Definition
26	Professional Component
54	Surgical Care Only
55	Postoperative Management Only
80	Assistant Surgeon
AA	Anesthesia service performed personally by anesthesiologist
NU	New Equipment (required for DME service)
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals
QX	CRNA service; with medical direction by a physician
QZ	CRNA service; without medical direction by a physician
RP	Replacement and Repair (required for DME service)
RR	Rental (required for DME service)
SE	State and/or federally funded programs/services
SG	Ambulatory Surgical Center (ASC) facility services
TC	Technical Component
UC	EPSDT Referral for Follow-up Care (required if EPSDT referral made)

Providers who continue to bill claims to Missouri Medicaid using one of the non-HIPAA compliant electronic formats or media during the grace period, as stated under the HIPAA section of this bulletin, should continue to bill using the appropriate type of service with the new procedure codes identified in this bulletin.

INJECTION CODES

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, all Missouri Medicaid-specific injection procedure codes, including codes beginning with the letter "J" that are billed with local modifiers YA, YB, YC, and YD and codes beginning with the letters "W" and "Z" will no longer be valid. Injections must be billed with valid "J" codes without the modifiers for dates of service October 16, 2003 and after.

INDEPENDENT RHC ENCOUNTER CODE

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service October 16, 2003 and after, procedure codes Z7000 and Z7000YG will no longer be valid codes for billing the RHC all-inclusive encounter rate. Please refer to the table below for replacement codes.

Procedure Code	Replacement Code
Z7000	T1015
Z7000YG	T1015EP

FQHC HCY CASE MANAGEMENT CODE

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service October 16, 2003 and after, procedure code Y9600 will no longer be a valid code for billing HCY case management services. Please refer to the table below for the replacement code.

Procedure Code	Replacement Code
Y9600	T1016EP

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Provider Communications

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or
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