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SPECIAL HIPAA 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 address www.dss.mo.gov/dms. 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.

PROVIDER ALERT – HIPAA CONTINGENCY PLAN UPDATE

The Missouri Medicaid grace period is subject to end in the near future. Providers are encouraged to continue working towards HIPAA compliance and testing with Verizon.

Missouri Medicaid's original plan for HIPAA implementation was to start accepting the X12N 837 electronic claims and at the same time, turn off the old non-HIPAA compliant electronic formats and media. To make allowances for providers not yet ready to bill an 837 transaction, a contingency plan was implemented which allows for continued use of the old formats listed below during a grace period:

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

No changes to these old formats or media will be made to accommodate HIPAA changes since the old formats will be discontinued. Therefore, the following code set information for use with the old formats is being provided.

ALL PROVIDER CLAIMS

Providers who continue to submit claims using a non-HIPAA compliant electronic format or media, must continue to submit the appropriate **Type of Service** with all procedure codes identified in the program-specific provider bulletins. For specific information, reference Special (HIPAA) Bulletin, Volume. 26, No. 2, dated September 30, 2003.

OUTPATIENT HOSPITAL CLAIMS

Per HIPAA regulations, Hospital providers were instructed to use **Revenue Codes** instead of Level III procedure codes for outpatient facility charges for dates of service October 16, 2003, and after. If hospitals continue to submit outpatient claims using a non-HIPAA compliant electronic format, providers must submit Level III procedure codes for outpatient facility charges/services instead of the specified revenue codes. The non-HIPAA compliant formats are not programmed to accept revenue codes for outpatient hospital claims. If submitted, the revenue codes will be dropped from the transaction and claims will be denied. For specific information, reference Hospital Bulletin, Volume. 26, No. 1, dated October 8, 2003.

INPATIENT HOSPITAL CLAIMS

Per HIPAA regulations, Hospital providers were instructed to use **ICD-9-CM procedure codes** instead of CPT procedure codes to report surgical procedures for inpatient stays for dates of service October 16, 2003 and after. For claims submitted on the HIPAA compliant X12N 837 Institutional layout, MO Medicaid made allowances for the valid 3 or 4 digit procedure codes. However, non-HIPAA compliant electronic formats (UB92) logic was not modified. Under the contingency plan, providers will have two options for submitting the surgical procedures for inpatient stays. The options are:

1. If submitting ICD-9-CM procedure codes, codes must be right justified in the 5-digit field, without a decimal. For example, code 12.3 should be sent with two spaces in front and no decimal; and code 12.34 should be sent with one space in front and no decimal. Providers must modify their software to allow users to enter the 3 and 4 digit codes with space or spaces in front; or
2. Providers may choose to continue use of CPT procedure codes on the non-HIPAA compliant electronic format.

For specific information, reference Hospital Bulletin, Volume. 26, No. 1, dated October 8, 2003.

HOSPICE CLAIMS

Per HIPAA regulations, Hospice providers were instructed to use **Revenue Codes** instead of Level III procedure codes for hospice services for dates of service October 16, 2003, and after. If hospice providers continue to submit claims using a non-HIPAA compliant electronic format, providers must continue to submit Level III procedure codes instead of the specified revenue codes. The non-HIPAA compliant formats are not programmed to accept revenue codes for hospice claims. If submitted, the revenue codes will be dropped from the transaction and claims will be denied. For specific information, reference Hospice Bulletin, Volume. 26, No. 1, dated August 29, 2003.

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