



MISSOURI
DIVISION OF MEDICAL SERVICES

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PHYSICIAN AND HOSPITAL 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.

2004 CPT AND HCPCS UPDATES

February 1, 2004, Missouri Medicaid will begin accepting the 2004 versions of the Current Procedural Terminology (CPT) and the Health Care Procedure Coding System (HCPCS). Providers may begin billing the 2004 CPT or HCPCS codes with appropriate modifier(s) for dates of service February 1, 2004 and after. Claims for dates of service prior to

February 1, 2004 must be submitted using the old procedure code(s) and/or appropriate modifier(s). Discontinued procedure codes will close on February 1, 2004.

Changes, which occurred as a result of the updates, include additions, revisions and discontinued procedures. Please reference the 2004 CPT and HCPCS for the updates.

**THE FOLLOWING 2004 ADDITIONS ARE NOT COVERED IN THE MISSOURI MEDICAID PHYSICIAN/HOSPITAL PROGRAMS:**

0001F	37765	A9532	Q4055	S3822
0002F	37766	A9533	Q4075	S3823
0003F	65781	A9534	Q4076	S3828
0004F	68371	G0296	Q4077	S3829
0005F	89268	G0297	S0115	S3833
0006F	89272	G0298	S0136	S3834
0007F	89280	G0299	S0137	S3840
0008F	89281	G0300	S0138	S3841
0009F	89290	G0302	S0139	S3842
0010F	89291	G0303	S0140	S3843
0011F	89335	G0304	S0141	S3844
0045T	89342	G0305	S0317	S3845
0046T	89343	G3001	S2070	S3846
0047T	89344	H2011	S2085	S3847
0048T	89346	P9051	S2090	S3848
0049T	89352	P9052	S2091	S3849
0050T	89353	P9053	S2095	S3850
0051T	89354	P9054	S2113	S3851
0052T	89356	P9055	S2135	S3852
0053T	A4216	P9056	S2213	S3853
0054T	A4217	P9057	S2225	S5550
0055T	A4248	P9058	S2230	S5551
0056T	A9525	P9059	S2235	S5552
0057T	A9526	P9060	S2362	S5553
0058T	A9528	Q0137	S2363	S8075
0059T	A9529	Q0182	S3000	S8948
0060T	A9530	Q3031	S3625	S8990
0061T	A9531	Q4054	S3820	

**THE FOLLOWING 2004 ADDITIONS REQUIRE PRIOR AUTHORIZATION:**

65780                      65782

**THE FOLLOWING 2004 ADDITIONS REQUIRE A TRANSPLANT PRIOR AUTHORIZATION:**

47140                      47141                      47142

Copies of the 2004 versions of the CPT and HCPCS books may be purchased from your local medical bookstore.

**BILLING FOR PROFESSIONAL AND TECHNICAL COMPONENTS (MODIFIERS 26 & TC)**

Missouri Medicaid follows Medicare guidelines for billing of professional and technical components. Please reference Medicare's Newsletter for Indicators/Global Surgery Percentages/Endoscopies at <http://www.medicare.com/>.

Diagnostic tests or radiology services – These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes.

Professional component only codes – Modifiers 26 and TC cannot be used with these codes.

Technical component only codes – Modifiers 26 and TC cannot be used with these codes.

Global test only codes - Modifiers 26 and TC cannot be used with these codes.

**GLOBAL PRENATAL/DELIVERY TRANSITION FROM FEE-FOR-SERVICE TO MANAGED CARE MC+**

When the obstetrical care begins under a fee-for-service setting and continues into an MC+ health plan, and the MC+ health plan reimburses the provider a global fee, the provider must not bill any visits to Medicaid fee-for-service. If a global fee is not received from the MC+ health plan, the provider may bill Medicaid fee-for-service for each visit provided.

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