MARYLAND MEDICAID
CMS-1500
PAPER
BILLING INSTRUCTIONS

A Comprehensive Guide Focusing on Maryland Medicaid Billing Procedures and Other Useful Information

Effective August 10, 2017:
Only ICD-10-CM codes for claims with **dates of service**
on or after October 1, 2015 can be reported.

Dept. of Health and Mental Hygiene
Office of Systems, Operations & Pharmacy
Medical Care Programs

Revised 9/2015

TABLE OF CONTENTS

			PAGE
I.	**GENERAL INFORMATION**		
	A.	Introduction	1
	B.	HIPAA	1
	C.	NPI	1
II.	**HEALTHCHOICE**		
	A.	Health Choice (MCO)	2
	B.	Payments to Managed Care Organizations	3
	C.	MCO Excluded Services	4
	D.	Self-Referral Services	5
III.	**BILLING INFORMATION**		
	A.	General Instructions	6
	B.	Timely Filing Statutes	6
	C.	Paper Submission & Claims Address	6
	D.	Electronic Submission	7
IV.	**EVS**		8
V.	**CMS-1500 BILLING INSTRUCTION**		
	A.	CMS-1500 Billing Instructions	10
	B.	Third Party Billing	19
	C	Medicare/Medical Assistance Crossover Claims	21
	D.	Claims Troubleshooting	24
	E.	How to File an Adjustment Request	28
	F.	Medical Assistance Payments	27
VI.	**FRAUD AND ABUSE**		30
VII.	**MARYLAND MEDICAID PROGRAM SERVICES INFORMATION**		
	A.	Emergency Service Transporter	33
VIII.	**EPSDT/HEALTHY KIDS**		
	A.	EPSDT/Newborn Billing	34/35
	B.	Audiology	36
	C.	IEP/IFSP Health Related Services	37
	D.	PT, OT, Speech & Chiropractic Services	38
	E.	Substance Abuse Services	39
	F.	Therapeutic Behavioral Service	42
	G.	Vaccine for Children Program	43
	H.	Vision Care Services	44
IX.	**HEALTHY START PROGRAM FOR PREGNANT WOMEN**		45

X. DMS/DME
A. DMS/DME 46
B. Oxygen and Related Respiratory Equipment Services 47

XI. LABORATORY AND PATHOLOGY 48

XII. MEDICAL DAY CARE 49

XIII. PHYSICIANS' SERVICES
A. Physicians' Services 50
B. Modifiers 51
C. Podiatry 54
D. Radiology 55
E. Abortion 57
F. Hysterectomy 58
G. Sterilization and Tubal Ligation 59
H. Trauma Billing 61

XIV. PRIVATE DUTY NURSING 64

XV. IMPORTANT TELEPHONE NUMBERS AND ADDRESSES
A. Websites, Important Telephone Numbers and Addresses 65
B. Directory of Local Department of Social Services 68

XVI. FREQUENTLY ASKED QUESTIONS 70

XVII APPENDIX – DHMH FORMS
A. CMS-1500 Form 72
B. Adjustment Form - DHMH 4518A 73
C. Abortion Form - DHMH 521 74
D. Hysterectomy Form – DHMH 2990 75
E. Sterilization and Tubal Ligation Consent Form – DHMH 2989 76

INTRODUCTION

This manual was prepared to provide proper billing procedures and instructions for Maryland Medicaid providers who bill using the CMS-1500 form. This includes Certified Nurse Midwives, Certified Nurse Practitioners, Certified Registered Nurse, Anesthetists, Free-Standing Clinics, Physicians, Podiatrists and DME/DMS providers.

The Medical Assistance Program has made numerous revisions to the billing procedures for all Medicaid Programs in order to adhere to the standards created under the Health Insurance Portability and Accountability Act (HIPAA). As a result of the requirement for standardization of code sets and forms, Maryland Medicaid has replaced all local procedure codes to nationally accepted codes. This includes standardization in the way providers transmit claims electronically.

HIPAA

The Administrative Simplification provisions of HIPAA require that health plans, including private, commercial, Medicaid and Medicare, healthcare clearinghouses and healthcare providers use standard electronic health transactions. A major intent of the law is to allow providers to meet the data needs of every insurer electronically with one billing format using health care industry standard sets of data and codes. HCPCS is the specified code set for procedures and services. Additional information on HIPAA can be obtained from the CMS website at:

http://www.hhs.gov/ocr/hipaa
dhmh.maryland.gov/hipaa/SitePages/Home.aspx

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI is a HIPAA mandate requiring a standard unique identifier for health care providers. Providers must use this unique 10-digit identifier on all electronic transactions. When billing on paper, this unique number and the provider's 9-digit Medicaid provider number will be required in order to be reimbursed appropriately. Details about placement of the NPI and the Medicaid provider number are contained within the block-to-block information beginning on page 10. Additional information on NPI can be obtained from the CMS website at:

http://www.cms.hhs.gov/NationalProvIdentStand/
http://mmcp.dhmh.maryland.gov/SitePages/NPI%20New%20Billing%20Instructions.aspx

Health Choice

In June 1997, Maryland Medical Assistance began "*Health Choice"* the Medicaid Managed Care Waiver Program. Medical Assistance capitates Managed Care Organizations (MCOs) to provide care for most Medical Assistance recipients. This care includes provision and coordination of healthcare, and fiscal management of Medical Assistance benefits for these recipients. Some Medicaid recipients are excluded from *Health Choice* and will continue with fee-for-service Medicaid. Those recipients are:

- Those recipients who are dually eligible for *Medicare and Medicaid*
- Those recipients who are *institutionalized* in nursing homes, Chronic Hospitals, Institutions for Mental Diseases (IMDs) or Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
- Individuals who are eligible for Medical Assistance for a *short period of time*
- Those recipients in the *Model Waiver* program for children who are medically fragile; and
- Persons receiving family planning services through the *Family Planning Waiver.*

Recipients who are part of the MCO program will receive information regarding changing their MCO, one time per year, on the anniversary date of their MCO linkage. Information regarding recipient eligibility or MCO linkages should be obtained using the Eligibility Verification System (EVS) at **1-866-710-1447**. In order to use this system, you must have an active Medical Assistance provider number.

Providers wishing to participate with the MCO program must contact the MCOs directly. If you are having problems with any of the MCOs, please contact the MCO Provider Hotline at 1-800-766-8692.

Recipient Protection

DHMH understands the importance of protecting the recipient's choice of MCOs under this program. Providers who want to provide Medicaid services may notify their Medicaid patients of the MCO's which they have joined or intend to join. *However, providers must disclose the names of all MCO's in which they expect to participate under Health Choice and may not steer a recipient to a particular MCO by furnishing opinions or unbalanced information about networks.*

In order to communicate Health Choice information, it is imperative that DHMH has current addresses of recipients. As providers, you are in a unique position to inform recipients of the importance to pass on any new address information to DHMH. When possible, please inform recipients that they *must* give their correct address to their Department of Social Services. If recipients receive SSI, they will need to change their address with the Social Security office.

Payments to Managed Care Organizations

Recipients are linked by their MCO to a primary care physician or clinic. All MCO-enrolled recipients are provided an identification card by their respective MCO. As a result, recipients must obtain all services except services excluded (see page 4 for a list of excluded services) through their MCO. The recipient's primary care physician or clinic will give referrals for specialty care.

If you are not part of an MCO and a recipient identified by EVS as an MCO recipient seeks services from you for which an MCO is responsible, you may contact that MCO to determine if it will approve payment for rendered services. Otherwise, the MCO has no obligation to reimburse you except in the case of providing routine family planning services, or in some instances reimbursement for pregnancy related services.

NOTE: If the recipient-required services are emergency services, you may provide the appropriate services and expect to be reimbursed by the MCO upon billing the MCO directly. If you provide non-emergency services without MCO authorization, Medical Assistance will not reimburse you.

MCO Excluded Services

(Fee-For-Service)

The MCO's are responsible for providing all Medicaid covered services **excluding the following,** which are paid fee-for-service by Medicaid:

- ***Abortion Services*** – MCO's are responsible for related services performed as part of a medical evaluation prior to the actual abortion.
- ***Aids Drug Therapies*** - Limited to Protease Inhibitors, Non-nucleoside Reverse Transcriptase Inhibitors and viral load testing.
- ***Healthy Start Case Management Services***
- ***IEP/IFSP*** - Individual Education Plan (IEP) or Individual Family Services Plan (IFSP). Medically necessary services that are documented on the IEP or IFSP when delivered in schools or by Children's Medical Services community based providers.
- ***Medical Day Care Services***
- ***Nursing Home/Long Term Care Facility Services*** - After the first 30 consecutive days of care.
- ***Personal Care Services***
- ***Rare & Expensive Case Management Services (REM)*** - Recipients are eligible based on one of the diagnoses listed in COMAR 10.09.69. Recipients receive all State Plan Medicaid services on a fee-for-service basis.
- ***Specialty Mental Health Services*** - Including inpatient admissions to Institutions for Mental Disease (IMD). These services are payable through the *Value Options Maryland. For information, call* ***1-800-888-1965***.
- ***Stop Loss Case Management (SLM)*** - A recipient participating in a MCO which does not self insure becomes eligible for the Stop Loss Case Management Program when his or her paid inpatient hospital services exceed $35,000.00. At that point, the Program pays 90% of inpatient charges, while the MCO pays the remainder. Once SLM eligibility is in effect, the recipient is also eligible to receive case management and additional services available through the REM Program.
- ***Transportation Services*** – MCO's may, be responsible for transportation services that are not covered by fee-for-service Medicaid.

Self-Referral Services

Self-referral services are defined in the HealthChoice regulations as "health care services for which under specified circumstances the MCO is required to pay without any requirement of referral or authorization by the primary care provider (PCP) or MCO when the enrollee accesses the services through a provider other than the enrollee's PCP."

The following services must be reimbursed by the MCO without a referral:

- Child With Pre-Existing Medical Condition - Medical Services
- Child In State-Supervised Care - Initial Medical Exam
- Emergency Services
- Family Planning Services
- HIV/AIDS Annual Diagnostic and Evaluation Service Visit
- Newborn's Initial Medical Examination In A Hospital
- Pregnancy-Related Services Initiated Prior To MCO Enrollment
- Renal Dialysis Services Provided In A Medicare Certified Facility
- School-Based Health Center Services
- Substance Abuse Assessment

For additional information regarding the above self-referral services contact the Division of Outreach Care and Coordination at 410-767-6750/6859.

Billing

Providers should also contact the MCO's for billing regulations and instructions related to self-referral services. Claims for excluded services and fee-for-service should be submitted to:

Maryland Medical Assistance
Office of Systems, Operations, and Pharmacy
P.O. Box 1935
Baltimore, MD 21203.

GENERAL INSTRUCTIONS

Before providing services to a Maryland Medicaid recipient make sure that:

- Your enrollment as a Medical Assistance provider is effective on the date of service;
- Your patient is eligible on date of service. **Always** verify recipient's eligibility using EVS (*See instructions on page 8)*
- You determine if the recipient is an MCO. If so, bill the MCO for services rendered;
- You determine if the recipient has other insurance; and
- You have obtained preauthorization, if required.

BILLING INFORMATION

Providers must bill on the CMS-1500. Claims can be submitted in any quantity and at any time within the filing limitation.

Filing Statutes: Claims ***must*** be received within 12 months of the date of service. The following statutes are in addition to the initial claim submission.

- 12 months from the date of the IMA-81 (Notice of Retro-eligibility)
- 120 days from the date of the Medicare EOB
- 60 days from the date of Third Party Liability EOB
- 60 days from the date of Maryland Medicaid Remittance Advice

The Program **will not** accept computer-generated reports from the provider's office as proof of timely filing. The **only** documentation that will be accepted is a remittance advice, Medicare/Third-party EOB, IMA-81 (letter of retro-eligibility) and/or a returned date stamped claim from the Program.

Paper Claims Submission: Once a claim has been received, it may take 30 business days to process your claim. Invoices are processed on a weekly basis. Payments are issued weekly and mailed to provider's pay-to address. Medicaid will accept paper claims only on the revised Form 1500, version 02/12. Providers cannot report both ICD-9-CM and ICD-10-CM codes on the same claim form.

All claims should be mailed to the following address:

Claims Processing
Department of Health and Mental Hygiene
P.O Box 1935
Baltimore, MD 21203

Electronic Claims Submission: Providers must submit claims in the ANSI ASC X12N 837P format, version 5010A. A signed Submitter Identification Form and Trading Partner Agreement must be submitted, as well as testing before transmitting such claims. Testing information can be found on the DHMH website:

http://dhmh.state.maryland.gov/hipaa/SitePages/testinstruct.aspx

If you have any questions regarding HIPAA testing, please send an email to:

dhmh.hipaaeditest@maryland.gov

Companion guides to assist providers for electronic transactions can be found on the DHMH website:

http://dhmh.maryland.gov/hipaa/SitePages/transandcodessets.aspx

eClaims: Direct billing is available through our eMedicaid website. This service will enable certain provider types, that bill on the CMS 1500, to submit their single claims electronically. Claims that require attachments cannot be submitted through this new feature. Claims will be processed the same week it is keyed and payment to follow the next week.

To become an eClaim user, the administrator from the provider's office must register users by going to the eMedicaid website: www.emdhealthchoice.org

If you have questions regarding this new feature, how to register, or to determine if your provider type can submit eClaim, please email your questions to: dhmh.emedicaidmd@maryland.gov .

ELIGIBILITY VERIFICATION SYSTEM (EVS)

It is the provider's responsibility to check EVS prior to rendering services to ensure recipient eligibility for a specific date of service.

Before providing services, you should request the recipient's Medical Care Program identification card. If the recipient does not have the card, you should request a Social Security number, which may be used to verify eligibility.

EVS is a telephone-inquiry system that enables health care providers to quickly and efficiently verify a Medicaid recipient's current eligibility status. It will tell you if the recipient is enrolled with a Managed Care Organization (MCO) or if they have third party insurance.

EVS also allows a provider to verify past dates of eligibility for services rendered up to one year ago. Also, if the Medical Assistance identification number is not available, you may search current eligibility and optionally past eligibility up to one year by using a recipient's Social Security Number and name code.

EVS is an invaluable tool to Medical Assistance providers for ensuring accurate and timely eligibility information for claim submissions. If you need additional information, please call the Provider Relations Unit at 410-767-5503 or 1-800-445-1159.

HOW TO USE EVS:

STEP 1: Call the EVS access telephone number by dialing the number for your area. EVS Telephone Number:

1-866-710-1447

EVS answers with the following prompt:

"Medicaid Eligibility Verification System. Attention: For past eligibility status checks, you must enter month, date and 4-position year. To end, press the pound (#) key. Please enter provider number."

STEP 2: Enter your 9-digit provider number and press pound (#).

EXAMPLE: 0 1 2 3 4 5 6 7 8 #

STEP 3: ***For Current Eligibility:*** Enter the 11-digit recipient number and the 2-digit name code (the first two letters of the last name converted into numeric touchtone numbers) and press pound (#).

EXAMPLE: For recipient Mary Stern, you would enter:

1 1 2 2 3 3 4 4 5 5 6 78#

Recipient Number Last Name Code*

**Last Name Code – where 7 is for the S in Stern and 8 is for the T in Stern*

NOTE: *Since the characters Q and Z are not available on all touchtone phones, enter the digit 7 for the letter Q and digit 9 for the letter Z.*

For Past Eligibility: Enter a date of up to one-year prior using format MMDDYYYY.

EXAMPLE: For recipient Mary Stern, where the date of service was January 1, 2005, you would enter:

1 1 2 2 3 3 4 4 5 5 6	**78**	**0 1 0 1 2 0 0 5 #**
Recipient Number	**Last Name Code**	**Service Date**

NOTE: Use a zero for space if recipient has only one letter in the last name. Example: Malcolm X; Name Code X0

If the Recipient Number is Not Available: Press zero, pound, pound (0##) at the recipient number prompt and the system prompts you for a Social Security search. EVS will then prompt you with the following:

"Enter Social Security Number and Name Code"

Enter the recipient's 9-digit Social Security Number and 2-digit name code:

EXAMPLE:

1 1 1 2 2 3 3 3 3	**78#**
Social Security Number	**Last Name Code**

NOTE: Social Security Numbers are not on file for all recipients. Eligibility cannot be verified until the Medical Assistance number is obtained. If you have entered a valid Social Security Number and the recipient is currently eligible for Medical Assistance, EVS will provide you with a valid recipient number, which you should record with the current eligibility status.

STEP 4: Enter another recipient number or immediately press the pound button **twice** (# #) to end the call.

WebEVS

For providers enrolled in eMedicaid, WebEVS, a new web-based eligibility application is now available at *http://www.emdhealthchoice.org*. Providers must be enrolled in eMedicaid in order to access Web-EVS. To enroll, go to the URL above and select 'Services for Medical Care Providers' and follow the login instructions. If you need information, please visit the website or for provider application support call
410-767-5340.

CMS-1500 BILLING INSTRUCTIONS

Providers must use the CMS-1500 form to bill the Program. The CMS-1500 forms are available from the Government Printing Office, the American Medical Association; major medical oriented printing firm, or contact the US Government Printing Office at 202-512-1800 to place an order.

Instructions for the completion of each block of the CMS-1500 are provided in this section. See Section XVI - Appendix, page 72 for a reproduction of a CMS-1500 showing the reference numbers of Blocks. Blocks that refer to third party payers must be completed only if there is a third party payer **other than** Medicare or Medicaid.

The Medical Assistance Program is by law the **"payer of last resort"**. If a recipient is covered by other insurance or third party benefits such as Worker's Compensation, CHAMPUS or Blue Cross/Blue Shield, the provider must first bill the other insurance company before Medical Assistance will pay the claim.

NOTE: ***Effective October 1, 2015:*** *only ICD-10-CM codes for claims with dates of service on or after October 1, 2015 can be reported.*

****** *All* ***rebilling of claims*** *should use the revised CMS-1500 form (02-12) version*

**Providers cannot report both ICD-9-CM and ICD-10-CM codes on the same claim form.*

If there are services you wish to report/bill that occurred on dates when ICD-9-CM codes were in effect (Prior to October 1, 2015) and others that occurred on dates when ICD-10-CM codes (After October 1, 2015).* ***Providers must bill on separate claims,* *you can only report ICD-9-CM codes on a claim and only ICD-10-CM codes on a claim,* ***they cannot be combined****.*

PROPER COMPLETION OF CMS-1500

For Medical Assistance processing, **THE TOP RIGHT SIDE OF THE CMS-1500 MUST BE BLANK**. Notes, comments, addresses or any other notations in this area of the form will result in the claim being returned unprocessed.

Block 1 Show all type(s) of health insurance applicable to this claim by checking the appropriate box(es).

Block 1a INSURED'S ID NUMBER – Enter the patient's Medicare number if applicable. The patient's (recipient's) 11-digit Maryland Medical Assistance number is required in Block 9a. – **Situational.**

Block 2 PATIENT'S NAME (Last Name, First Name, Middle Initial) – Enter the patient's (recipient's) name as it appears on the Medical Assistance card.

Block 3	PATIENT'S BIRTH DATE/SEX – Enter the patient's (recipient's) date of birth and sex. – **Optional.**
Block 4	INSURED'S NAME (Last Name, First Name, Middle Initial) – Enter the name of the person in whose name the third party coverage is listed, only when applicable. – **Optional.**
Block 5	PATIENT'S ADDRESS – Enter the patient's (recipient's) complete mailing address with zip code and telephone number. – **Optional.**
Block 6	PATIENT'S RELATIONSHIP TO INSURED – Enter the appropriate relationship only when there is third party health insurance besides Medicare and Medicaid. – **Optional.**
Block 7	INSURED'S ADDRESS – When there is third party health insurance coverage besides Medicare and Medicaid, enter the insured's address and telephone number. – **Optional.**
Block 8	RESERVED FOR NUCC USE – **No entry required.**
Block 9	OTHER INSURED'S NAME – **No entry required.**
Block 9a	OTHER INSURED'S POLICY OR GROUP NUMBER – Enter the patient's (recipient's) 11-digit Maryland Medical Assistance number exactly as it appears on the MA card. The MA number **must** appear in this Block regardless of whether or not a recipient has other insurance. Medical Assistance eligibility should be verified on each date of service by calling EVS. EVS is operational 24 hours a day, 365 days a year at the following number: 1-866-710-1447- **Required**
Block 9b	RESERVED FOR NUCC USE – **No entry required.**
Block 9c	RESERVED FOR NUCC USE – **No entry required.**
Block 9d	INSURANCE PLAN OR PROGRAM NAME – Enter the insured's group name and group number only when there is third party health insurance coverage besides Medicare and Medicaid. – **Optional.**
Block 10a thru 10c	IS PATIENT'S CONDITION RELATED TO - Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Item 24, if this information is known. If not known, leave blank. – **Optional.**
Block 10d	CLAIM CODES – When billing for abortions or abortion related service, enter the appropriate two-alpha character (AA-AH) condition code from the table below. This field should **ONLY BE USED for abortions and abortion related services, otherwise leave blank.**

AA[(a)]	Abortion Performed due to Rape	Code indicates abortion performed due to a rape.
AB[(a)]	Abortion Performed due to Incest	Code indicates abortion performed due to an incident of incest.
AC[(a)]	Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality	Code indicates abortion performed due to a genetic defect, a deformity, or abnormality to the fetus.
AD[(a)]	Abortion Performed due to a Life Endangering Physical Condition	Code indicates abortion performed due to a life endangering physical condition caused by, arising from, or exacerbated by, the pregnancy itself.
AE[(a)]	Abortion Performed due to Physical Health of Mother that is not Life Endangering	Code indicates abortion performed due to physical health of mother that is not life endangering.
AF[(a)]	Abortion Performed due to Emotional/Psychological Health of the Mother	Code indicates abortion performed due to emotional/psychological health of the mother.
AG[(b)]	Abortion Performed due to Social or Economic Reasons	Code indicates abortion performed due to social or economic reasons.
AH[(b)]	Elective Abortion	Elective abortion.

(a) CMS1500 claims reporting abortion codes AA-AF are covered by the Medicaid Program and do not require attachment of the DHMH 521 form. These claims may be billed electronically to Maryland Medicaid for payment. **The DHMH 521-Certification for Abortion form must be completed and kept in the patient's Medical Record.**

(b) CMS1500 claims reporting abortion condition code AG and AH are not covered by the Medicaid Program.

Block 11 INSURED'S POLICY GROUP OR FECA NUMBER – If the recipient has other third party health insurance and the claim has been rejected by that insurance, enter the appropriate rejection code listed below: For information regarding recipient's coverage, contact Third Party Liability Unit at 410-767-1765. – **Required**

CODE	**REJECTION REASONS**
K	Services Not Covered
L	Coverage Lapsed
M	Coverage Not in Effect on Service Date
N	Individual Not Covered

Q	Claim Not Filed Timely (Requires documentation, e.g., a copy of rejection from the insurance company.)
R	No Response from Carrier Within 120 Days of Claim Submission (Requires documentation e.g., a statement indicating a claim submission but no response.)
S	Other Rejection Reason Not Defined Above (Requires documentation, e.g., a statement on the claim indicating that payment was applied to the deductible.)

Block 11a INSURED'S DATE OF BIRTH – **No entry required.**

Block 11b OTHER CLAIM ID – **No entry required.**

Block 11c INSURANCE PLAN OR PROGRAM NAME – **No entry required.**

Block 11d IS THERE ANOTHER BENEFIT PLAN? **- No entry required.**

Block 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – **No entry required.**

Block 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – **No entry required.**

Block 14 DATE OF CURRENT ILLNESS, INJURY, PREGNANCY – **No entry required.**

Block 15 OTHER DATE – **No entry required.**

Block 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION – **No entry required.**

Block 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE –
Note: Completion of 17-17b is only required for Lab and Other Diagnostic Services.
Completion is optional if a valid Medical Assistance individual practitioner identification number is entered in Block #17a. To complete, enter the full name of the ordering practitioner. Do not submit an invoice unless there is an order on file that verifies the identity of the ordering practitioner. – **Situational**

Block 17a (gray shaded area) ID NUMBER OF REFERRING PHYSICIAN – Enter the ID Qualifier – **1D (Medicaid Provider Number)** followed by the provider's 9-digit Medicaid Provider Number. – **Required**

Block 17b Enter the NPI of the referring, ordering, or supervising provider listed in Block 17. – **Required**

Block 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES – **No entry required.**

Block 19 ADDITIONAL CLAIM INFORMATION – **No entry required**

Block 20 OUTSIDE LAB – **Optional.**

Block 21 DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY - Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.

- 9 ICD-9-CM
- 0 ICD-10-CM

Enter the 3-5 alpha/numeric character code from the ICD-9 related to the procedures, services, or supplies listed in Block #24e. List the primary diagnosis on Line A, with any subsequent codes to be entered on Lines B thru H (the highest level of specificity in priority order). Additional diagnoses are optional and may be listed on Lines I thru L. – **Required**

NOTE: *Do not report ICD-10 codes for claims with dates of service prior to October 1, 2015. The Program will accept either ICD-9 or ICD-10 codes depending upon the dates of service on the revised form.* REMINDER: *ICD-9 and ICD-10 codes cannot be reported on the same claim form,* ***providers must bill on separate claims and they cannot be combined****.*

Block 22 MEDICAID RESUBMISSION – **No entry required.**

Block 23 PRIOR AUTHORIZATION NUMBER – For those services that require preauthorization, a preauthorization number **must** be obtained and entered in this Block. – **Required**

Block 24 A-G **(gray shaded area)** NATIONAL DRUG CODE (NDC) – Report the NDC/quantity when billing for drugs using the J-code HCPCS. Allow for the entry of 61 characters from the beginning of 24A to the end of 24G. Begin by entering the qualifier **N4** and then the 11-digit NDC number. It may be necessary to pad NDC numbers with left-adjusted zeroes in order to report eleven digits (5-4-2). Without skipping a space or adding hyphens, enter the unit of measurement qualifier followed by the numeric quantity administered to the patient. Below are the measurement qualifiers when reporting NDC units:

<u>Measurement Qualifiers</u>
F2 International Unit
GR Gram
ML Milliliter
UN Units (EA/Each)
ME Milligram

Example: NDC/Quantity Reporting

24A DATE(S) OF SERVICE			D. PROCEDURES, SERVICES	G. DAYS OR UNITS
FROM:		TO:	CPT/HCPCS	
MM DD YY		MM DD YY		
N400009737604ML1 (SHADED AREA)				
01 01 08		01 01 08	J1055	1

More than one NDC can be reported in the shaded lines of Box 24. Skip three spaces after the first NDC/Quantity has been reported and enter the next NDC qualifier, NDC number, unit qualifier and quantity. This may be necessary when multiple vials of the same drug are administered with different dosages and NDC's. – **Required**

NOTE: *These instructions detail only those data elements for Medical Assistance (MA) paper claim billing. For electronic billing, please refer to the Maryland Medicaid 837-P Electronic Companion Guide which can be found on our website: dhmh.maryland.gov/hipaa/SitePages/transandcodesets.aspx*

Block 24A DATE(S) OF SERVICE – Enter each separate date of service as a 6-digit numeric date (e.g. June 1, 2005 would be 06/01/05) under the **FROM** heading. Leave the space under the **TO** heading blank. Each date of service on which a service was rendered must be listed on a separate line. Ranges of dates **are not** accepted on this form. – **Required**

Block 24B PLACE OF SERVICE – For each date of service, enter the appropriate 2-digit place of service code listed below to describe the site. – **Required**

Code	Location	Code	Location
03	School	42	Ambulance – Air or Water
11	Office	50	Federally Qualified Health Ctr.
12	Patient's Residence	51	Inpatient Psychiatric Facility
20	Urgent Care	52	Psychiatric Facility Partial Hospitalization
21	Inpatient Hospital	53	Community Mental Health Ctr.
22	Outpatient Hospital	56	Psychiatric Residential Treatment Ctr.
23	Emergency Room – Hospital	57	Non-Residential Substance Abuse Facility
24	Ambulatory Surgical Ctr.	61	Comprehensive Inpatient Rehabilitation Ctr.
25	Birthing Ctr	62	Comprehensive Outpatient Rehab. Ctr
26	Military Treatment Ctr	65	End-Stage Renal Disease Treatment Facility
31	Skilled Nursing Facility	71	State or Local Public Health Clinic
32	Nursing Home	72	Rural Health Clinic
33	Custodial Care	81	Independent Laboratory
34	Hospice	99	Other Unlisted Facility
41	Ambulance – Land		

Block 24C EMG – **Leave Blank**.

Block 24D PROCEDURES, SERVICES OR SUPPLIES – Enter the five-character procedure code that describes the service provided and two-character modifier, if required. See pages 7-9 in Physicians' Fee Manual for use of modifiers. Physician Fee Schedule can be found at: https://www.mmcp.dhmh.maryland.gov/SitePages/Pages/Provider%20Information.aspx – **Required**

Block 24E DIAGNOSIS POINTER – Enter a single or combination of diagnosis items (A thru H) from Block #21 above for each line on the invoice. – **Required**

NOTE: *The Program only recognizes up to eight (8) pointers A-H.*

Block 24F CHARGES – Enter the usual and customary charges. **Do not** enter the Maryland Medicaid maximum fee unless that is your usual and customary charge. If there is more then one unit of service on a line, the charge for that line should be the total of all units. – **Required**

Block 24G DAYS OR UNITS – Enter the total number of units of service for each procedure. The number of units must be for a single visit or day. Multiple, identical services rendered on different days should be billed on separate lines. – **Required**

NOTE: *Multiple, identical services for medical, radiological, or pathological services, within the CPT code range of 70000-89999, rendered on the same day, must be combined and entered on one line.*

Block 24H EPSDT FAMILY PLAN – **Leave Blank.**

Block 24I ID. QUAL. – Enter the ID Qualifier **1D (Medicaid Provider Number)** – **Required**

NOTE: *This two-digit qualifier identifies the non-NPI number followed by the ID number. When required to indicate the provider's 9-digit MA provider number, the ID Qualifier **1D** must precede this number.*

Block 24J (gray shaded area) RENDERING PROVIDER ID # – Enter the 9-digit MA provider number of the practitioner rendering the service. In some instances, the rendering number may be the same as the payee provider number in Block #33. Enter the rendering provider's **NPI** in the **unshaded area.** – **Required**

Block 25 FEDERAL TAX ID NUMBER – **Optional.**

Block 26 PATIENT'S ACCOUNT NUMBER – An alphabetic, alpha-numeric, or numeric patient account identifier (up to 13 characters) used by the provider's office can be entered. If recipient's MA number is incorrect, this number will be recorded on the Remittance Advice. – **Optional.**

Block 27 ACCEPT ASSIGNMENT? – For payment of Medicare coinsurance and/or deductibles, this Block must be checked "Yes". Providers agree to accept Medicare and/or Medicaid assignment as a condition of participation. – **Required**

NOTE: *Regulations state that providers shall accept payment by the Program as payment in full for covered services rendered and make no additional charge to any recipient for covered services.*

Block 28 TOTAL CHARGE – Enter the sum of the charges shown on all lines of Block #24F of the invoice. – **Required**

Block 29 AMOUNT PAID – Enter the amount of any collections received from any third party payer, **EXCEPT Medicare**. If the recipient has third party insurance and the claim has been rejected, the appropriate rejection code shall be placed in Block # 11. – **Situational**

NOTE: *The Program does not consider Medicare as a third party payer***.**

Block 30 RESERVED FOR NUCC USE – **No entry required.**

Block 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS – **Optional.**

NOTE: *The date of submission must be entered here in order for the claim to be reimbursed.*

Block 32 SERVICE FACILITY LOCATION INFORMATION – Complete only if billing for medical laboratory services referred to another laboratory or the facility where trauma services were rendered. Enter the name and address of facility. – **Situational**

Block 32a NPI – Enter facility's NPI number. – **Required**

Block 32b (gray shaded area) Enter the ID Qualifier **1D (Medicaid Provider Number)** followed by the facility's 9-digit Maryland Medicaid provider number. **– Required**

NOTE: *The Program will not pay a referring laboratory for medical laboratory services referred to a reference laboratory that is not enrolled. The referring laboratory also agrees not to bill the recipient for medical laboratory services referred to a nonparticipating reference laboratory.*

Block 33	BILLING PROVIDER INFO & PH# - Enter the name, complete street address, city, state, and zip code of the provider. This should be the address to which claims may be returned. – Required
Block 33a	NPI - Enter the NPI number of the billing provider in Block # 33. Errors or omissions of this number will result in non-payment of claims. – **Required**
Block 33b (gray shaded area)	Enter the ID Qualifier **1D (Medicaid Provider Number)** followed by the 9-digit MA provider number of the provider in Block #33. Errors or omissions of this number will result in non-payment of claims. – **Required**

NOTE: *It is the provider's responsibility to promptly report all changes of name, pay to address, correspondence address, practice locations, tax identification number, or certification to the Provider Enrollment Unit at 410-767-5340.*

Third Party Billing

The Medical Assistance Program is by law the "payer of last resort". Therefore, if a recipient is covered by insurance or other third-party benefits **(such as Worker's Compensation, CHAMPUS or Blue Cross/Blue Shield)**, the provider must seek payment from that source. Before Medical Assistance can pay, you must bill all third parties which might help to pay for the services you provided. If the third party insurance makes a payment, we will pay the provider up to Medicaid's allowed amount. If the third party insurance pays more than Medicaid's allowed amount, we will make no additional payment to the claim.

If Medical Assistance has a record of other coverage for your patient and if you have not billed the other insurance carrier, you must bill or contact the other carrier first except for ***prenatal care, well child care, and immunization services.*** If you do not bill the other carrier first, the Medical Assistance Program will deny your claim.

Step **Action**

1. Locate the potential payer's address and telephone number in the supplemental third carrier listing. If your Medical Assistance claim was denied because of other insurance, the address will also appear on the remittance advice.

2. Contact the insurance carrier or other payer by telephone, if possible

    - If the coverage has expired or is not applicable, ask the company to send you a denial letter and ask that a cancellation date be provided if in fact the coverage is canceled. If they refuse, write down the contact person's name.

    - If the coverage does apply, ask if preauthorization is required

3. Submit the claim to Medical Assistance. Attach the appropriate supporting documentation, If necessary, i.e., copy of the other carrier's remittance or denial or a summary of your collection efforts

    - If payment is made by the other payer, indicate the other payment on block 29 of the claim form

    - If you have not received payment or a rejection of liability from the health insurance carrier within 120 days of submission of the claim to the carrier, You may submit the claim to the Medical Assistance Program for payment. Follow the block by block billing instructions on page 10 to complete the claim for the appropriate rejection code in block 12.

4. Notify the Division of Medical Assistance Recoveries when you receive a denial of third party responsibility due to policy coverage termination by calling 410-767-1762.

If payment of a claim is made by both the Medical Assistance Program and a third party source, the provider must refund to the Medical Assistance Program either the amount paid by the Medical Assistance Program or the third party, whichever is less. This refund is due within 60 days of receipt of payment.

All refund checks should be payable to the Division of Medical Assistance Recoveries and mailed to:

Division of Medical Assistance Recoveries
P.O. Box 13045
Baltimore, MD 21203

MEDICARE CROSSOVER CLAIMS

The Maryland Medicaid Program will no longer pay Part B Medicare coinsurance or copayments for dates of service beginning August 1, 2010, on claims where the Medicare payment exceeds the Medicaid fee schedule. Therefore, if Medicare pays the claim equal to or greater than the Medicaid fee schedule, Medicaid will make no additional payment. The remittance advice will show a $0.00 dollar payment under the **"paid "**column reflecting that Medicare paid more on the claim than the allowed amount on Medicaid's fee schedule. If Medicare pays the claim at an amount less than the Medicaid fee schedule, Medicaid will pay all or part of the coinsurance to bring the total payment to the provider equal to the Medicaid fee schedule. See examples below or refer to Transmittal 79, which can be found on: http://mmcp.dhmh.maryland.gov/docs/PT%2001-2011_rev.pdf

Example 1:
Medicaid Allow: $103.55
Medicare Paid: $108.91
Reimbursement Amt to the Provider: $0.00
(Medicare paid more on the claim than the allowed amount in the Maryland Medicaid fee schedule. Medicaid will not make any additional payments)

Example 2:
Medicaid Allow: $108.91
Medicare Paid: $103.55
Reimbursement Amt to the Provider: $5.36
(Medicaid allowed more than what Medicare paid, which results in the Provider receiving the difference to meet the amount in the Medicaid fee schedule)

This methodology will ***not*** *be applied when:*

- The amount submitted to Medicaid is for the deductible
- The service is not covered by Medicaid
- The service is a mental heath service (applies to specific codes)
- The service is billed using a HCPCS beginning with a letter from A to W
- CPT codes priced by report
- The service is billed using CPT codes 00100 to 01999

Please remember that Medicaid providers are prohibited from balance billing recipients. In order for claims to be accurately paid, your NPI number must be on our Medicaid system. To verify your NPI number, contact Provider Enrollment at 410-767-5340.

PROCEDURES FOR SUBMITTING HARDCOPY MEDICARE CLAIMS
Billing a CMS-1500 with a Medicare EOMB:

On the Medicare EOMB, ***each individual claim*** is generally designated by two horizontal lines. Therefore, you should complete ***one*** CMS-1500 form per set of horizontal lines.

- When billing Medical Assistance, the information on the CMS-1500 must be identical to the information that is ***between the two horizontal lines*** on the Medicare EOMB.
    - Dates of service ***must*** match
    - Procedure codes ***must*** match
    - Amount(s) on line #24F of the CMS-1500 ***must*** match the "amount billed" on the EOMB.

- Claims that have ***more*** then six lines, write ***"con't"*** in Block #28 of each CMS-1500 claim and total all the lines on the ***last*** CMS-1500 claim.

- When submitting your Medicare claims for payment, the writing should be legible. In addition, when attaching a copy of the Medicare EOMB make sure it is clear and that the entire EOMB, including the information on the top and the glossary is included on the copy. Write in bold letters **"Medicare EOMB"** on each claim. In order for MA to make the necessary payments, the CMS-1500 and the Medicare EOMB must be submitted. Claims should be sent to the original claims address:

Maryland Medical Assistance
P.O. Box 1935
Baltimore, MD 21203

CLAIM SUBMISSION

Claims submitted via electronic media are processed more quickly and accurately. For further information on how to bill electronically, please contact the Electronic Billing Unit at 410-767-4682 or send questions to hipaaedittest@maryland.gov. If you have problems with your electronic claims submission, please send inquiries to dhmh.ediops@maryland.gov.

If you choose to submit paper claims, please use the following checklist before submitting your claims to the Medical Assistance Program for reimbursement.

CHECKLIST

- ❑ Is your copy legible? Did you ***type or print*** your form? Although not required, typing the form will speed up the process.
- ❑ Did you follow the ***Billing Instructions****?*
- ❑ Did you enter your ***provider name and number***? Without this information payment will not be made correctly.
- ❑ Are ***attachments*** required? Claims cannot be paid without required attachments.
- ❑ Did you enter your ***preauthorization number*** for services, which require prior approval? Without this number payment will be denied.
- ❑ Do you have the correct P.O. Box Number for submitting your claims? Correct address for submission is listed on page 6 of this manual.
- ❑ Do you have any questions not answered in this handout? If so, please contact the Provider Relations Unit at 410-767-5503 or 800-445-1159 and select option 2 for assistance.

CLAIM TROUBLESHOOTING

This section provides information about the most common billing errors encountered when providers submit claims to the Medical Assistance Program. Preventing errors on the claim is the most efficient way to ensure that your claims are paid in a timely manner.

Each rejected claim will be listed on your remittance advice along with an Explanation of Benefits (EOB) code that provides the precise reason a specific claim was denied. EOB codes are very specific to individual claims and provide you with detailed information about the claim. The information provided below is intended to supplement those descriptions and provide you with a summary description of reasons your claim may have been denied.

Claims commonly reject for the following reasons:

1. ***The appropriate provider and/or recipient identification is missing or inaccurate.***

   - ✓ Verify that your NPI and 9-digit Medical Assistance provider numbers are entered in Blocks #33a/b. The ID Qualifier **1D** must precede the 9-digit Medial Assistance provider number. **Do not** use your PIN or tax identification number.

   - ✓ Verify that a valid NPI and 9-digit Medical Assistance provider number for the requesting, referring or attending provider are entered in the Blocks #17a/b and each provider is correctly identified. The ID Qualifier 1D must precede the 9-digit Medical Assistance provider number in block 17a.

     Note: Completion of 17-17b is only required for Lab and Other Diagnostic Services.

   - ✓ Verify that the NPI and 9-digit rendering Medical Assistance provider number you entered in Block #24j. is in fact, a rendering provider. The ID Qualifier **1D** must precede the 9-digit Medial Assistance provider number. If you enter a group NPI and provider number in the block for the rendering provider, the claim will deny because group provider numbers cannot be used as rendering provider numbers.

   - ✓ When billing for preauthorized procedures, verify that the 9-digit provider number entered on the claim form is the same 9-digit provider number that was authorized to provide the services.

   - ✓ Verify that the recipient's 11-digit Medical Assistance identification number is entered in the Block #9a.

   - ✓ Verify that the recipient's name is entered in Block #2, last name first.

   - ✓ When billing for preauthorized procedures, verify that the 11-digit recipient number entered on the claim form is the same 11-digit recipient number that was authorized to receive the services.

- ✓ Verify that you did not use the mother's 11-digit number if you are billing for services provided to a child. Age and procedure codes will ensure that such claims are automatically rejected.

2. ***Provider and/or recipient eligibility was not established on the dates of services covered by the claim.***

   - ✓ Verify that you did not bill for services provided prior to or after your provider enrollment dates.

   - ✓ Verify that you entered the correct dates of service in the Block #24a of the claim form. You **must** call EVS on the day you render service to determine if the recipient is eligible on that date. If you have done this and your claim is denied because the recipient is ineligible, double-check that you entered the correct dates of service.

   - ✓ Verify that the recipient is not part of the Medical Assistance HealthChoice Program. If you determine that the recipient is in HealthChoice, contact the appropriate Managed Care Organization (MCO).

   - ✓ Verify that the recipient is not covered by Medicare. If you determine that the recipient is covered by Medicare, bill the appropriate Medicare carrier.

3. ***Preauthorization is required.***

   - ✓ Certain procedures require preauthorization. If you obtain preauthorization, verify that you entered the number correctly in Block #23 on the claim. If you did not obtain preauthorization, remove the unauthorized procedure from the claim and resubmit the claim to receive payment for the procedures that do not require preauthorization.

   - ✓ When billing for preauthorized procedures, verify that the dates of service entered on the claim are the same dates of service that were authorized.

4. ***The medical services are not covered or authorized for the provider and/or recipient.***

   - ✓ There are limits to the number of units that can be billed for certain services. Verify that you entered the correct number of units on the claim form.

   - ✓ A valid 2-digit place of service code is required. Please refer to the Place of Service List on page 15 in this manual.

   - ✓ When billing for preauthorized procedures, verify that the units entered on the claim form are not more units then were authorized.

- ✓ If you receive a 110 denial code, some tests are frequently performed as groups or combinations and must be billed as such. Verify the procedure codes and modifiers that were entered on the claim form and determine if they should have been billed as a group.

- ✓ Claims will be denied if the procedure cannot be performed on the recipient indicated because of gender, age, prior procedure or other medical criteria conflicts. Verify that you entered the correct 11-digit recipient identification number, procedure code and modifier on the claim form.

- ✓ Verify that the billed services are covered for the recipient's coverage type. Covered services vary by program type. For example, some recipients have coverage only for family planning services. If you bill the Program for procedures that are not for family planning, these are considered non-covered services and the Program **will not** pay you. Refer to regulations for each program type to determine the covered services for that program.

- ✓ Some procedures cannot be billed with certain place of service codes. Verify that you entered the correct procedure and place of service codes in the appropriate block on the claim form.

5. ***The claim is a duplicate, has previously been paid or should be paid by another party.***

- ✓ MMIS-II edits all claims to search for duplications and overlaps by providers. Verify that you have not previously submitted the claim.

- ✓ If the Program has determined that a recipient has third party coverage that will pay for medical services, the claim will be denied. Submit the claim to the third-party payer first.

- ✓ If a recipient is enrolled in an MCO, you must bill that organization for services rendered. Verify that the recipient's 11-digit MA number is entered correctly on the claim form.

6. ***Required attachments are not included.***

- ✓ If you bill for a hysterectomy or sterilization, the appropriate form must be attached and completed **accurately.** Verify that this has been done.

- ✓ For some procedures there is no established fee and the claim must be manually priced. These claims require that a report be attached. Verify that you have completed such a report, attach it to the claim form and then resubmit the claim.

Lastly, some errors occur simply because the data entry operators have incorrectly keyed or were unable to read data on the claim. In order to avoid errors when a claim is scanned, please ensure that this information is either typed or printed clearly. When a claim is denied, always compare data from the remittance advice with the file copy of your claim. If the claim denied because of a keying or scanning error, resubmit the claim.

HOW TO FILE AN ADJUSTMENT REQUEST

If you have been paid, but paid incorrectly for a claim **or** received payment from a third party after Medical Assistance has made payment, you **must** complete and submit an Adjustment Request Form (DHMH 4518A) to correct the payment. See Section XVIII- Appendix, page 73 for an example of the DHMH 4518A.

If an incorrect payment was due to a keying error made by Medical Assistance, or you billed the incorrect number of units, you must complete an Adjustment Request Form following the directions on the back of the form.

When completing the Adjustment Form, do not bill only for remaining unpaid amounts or units, bill for entire amount(s).

> **Example:** You submitted and received payment for three units, but you should have billed for five units. **Do not** bill for the remaining two units; bill for the full five units.
>
> **Total Refunds –** If you receive an incorrect payment, return the check issued by the Medical Assistance Program only when every claim payment listed on the remittance advice is incorrect, i.e., none of the recipients listed are your patients. When this occurs, return with a copy of the remittance advice and the check with a complete Adjustment Request Form to the address on the bottom of the form.
>
> **Partial Refunds –** If you receive a remittance advice, which lists some correct payments and some incorrect payments do not return the Medical Assistance Program check. Deposit the check and file an Adjustment Request Form for each individual claim paid incorrectly.
>
> **NOTE:** For overpayments or refunds, the provider may issue and submit one check to cover more than one Adjustment Request Form.
>
> Before mailing Adjustment Request Forms, be sure to attach any supporting documentation such as remittance advices and CMS-1500 claim forms. Adjustment Request Forms should be mailed to:

Medical Assistance Adjustment Unit
P.O. Box 13045
Baltimore, MD 21203

If you have any questions or concerns, please contact the Adjustment Unit at 410-767-5346.

Medical Assistance Payments

You must accept payment from Medical Assistance as *payment in full* for a covered service.

You ***cannot*** bill a Medical Assistance recipient under the following circumstances:

1. For a covered service for which you have billed Medical Assistance;
2. When you bill Medical Assistance for a covered service and the claim denies because of a billing error(s) on your part such as:

- wrong procedure and diagnosis codes,
- lack of preauthorization
- invalid consent forms,
- unattached necessary documentation,
- incorrectly completed claim form,
- filing after the time limitations, or
- other provider errors.

3. When Medical Assistance denies your claim and Medicare or another third party has paid up to or exceeded what Medical Assistance would have paid;
4. For the difference in your charges and the amount Medical Assistance has paid;
5. For transferring the recipient's medical records to another health care provider or
6. When services were determined to not be medically necessary.

You ***can*** only bill the recipient under the following circumstances:

1. If the service provided is not covered by Medical Assistance and you have notified the recipient prior to providing the service that the service is not covered; or
2. If the recipient is not eligible for Medical Assistance on the date you provided the service(s)

Fraud and Abuse

It is illegal to submit reimbursement requests for the following:

- Amounts greater than your usual and customary charge for the service. If you have more than one charge for a service, the amount billed to the Maryland Medical Assistance Program should be the lowest amount billed to any person, insurer, health alliance or other payer
- If a service is not provided, or is not provided in the manner described on the claim. . *You must accurately describe the service performed, correctly define the time and place where the service was provided and identify the professional status of the person providing the service.*
- Any procedures other than the ones you actually provided to an eligible recipient.
- Multiple, individually described or coded procedures if there is a comprehensive procedure that could be used to describe the group of services provided.
- Unnecessary, inappropriate, non-covered or harmful services, whether or not you actually provided the service.
- Items or services that are performed without the required referrals or pre-authorizations.
- Services for which you have received full payment by another insurer or third party.

You are required to refund all overpayments received from the Medical Assistance Program within 30 days. Providers must not rely on Department requests for any repayment of such overpayments. Retention of any overpayments is also illegal.

Sanctions Against Providers – General

If the Program determines that a provider, any agent or employee of the provider or any person with an ownership interest in the provider or related party of the provider has failed to comply with applicable federal or State laws or regulations, the Program may initiate one or more of the following actions against the responsible party:

1. Suspension from the Program
2. Withholding of payment by the Program
3. Removal from the Program
4. Disqualification from future participation in the Program, either as a provider or as a person providing services for which Program payment will be claimed
5. Referral to the Medicaid Fraud Control Unit for investigation and possible prosecution. The Medical Assistance Program will give reasonable written notice of its intention to impose any of the previously noted sanctions against a provider. The notice will state the effective date and the reasons for the action and will advise the provider of any right to appeal.

If the U.S. Department of Health and Human Services suspends or removes a provider from Medicare enrollment, the Medical Assistance Program will take similar action against the provider.

A provider who is suspended or removed from the Medical Assistance Program or who voluntarily withdraws from the Program must inform recipients *before* rendering services that he/she is no longer a Medical Assistance provider, and the recipient is therefore financially responsible for the services.

Sanctions Against Providers – Specific

In addition to penalties arising from any criminal prosecution which may be brought against a provider, Medical Assistance may impose administrative sanctions on a provider should the provider defraud or abuse the Program.

Administrative sanctions include termination from the Medical Assistance Program, suspension from the Program or required participation in provider education. Examples of instances in which Medical Assistance may take administrative action are when a provider:

- Refuses to allow authorized auditors or investigators reasonably immediate access to records substantiating the provider's Medical Assistance billings
- Is not in compliance with the following:
    1. Maryland Statutes
    2. Federal and State rules and regulations
    3. Medical Assistance policy handbooks
    4. Medical Assistance provider agreement
    5. Maryland Administrative Code

- Furnishes a recipient goods or services that are determined to be:
    1. In excess of the recipient's needs
    2. Harmful to the recipient
    3. Of inferior quality
    4. Insufficient to meet the recipient's needs

- Fails to provide necessary access to medical care for recipients who are bound to the provider through MCOs, including:

    1. Not providing necessary preventive care and treatment in a reasonably timely manner,
    2. Failing to provide reasonable accessible and adequate 24-hour coverage for evaluation of emergency complaints,
    3. Discouraging a recipient from seeking medically necessary care,
    4. Failing to provide a timely referral to an accessible provider for medically necessary care and/or ancillary services, or
    5. Making a misleading statement of a material fact as to the recipient's medical condition or need for referred or emergency care, either to the Program or to another provider.

- Provides misleading or false information to the Medical Assistance Program, or to its authorized representatives or delegates;
- Demands, bills or accepts payments from recipients or others for services covered by Medical Assistance;
- Has been indicted for, convicted of, or pled guilty to Program related offenses, or is suspended or terminated from the Medicare Program; or
- Does not have all required professional licensure and certifications necessary for the services he/she is performing.

APPEAL PROCEDURE

Appeals that are authorized by Medical Assistance regulations are conducted under the authority of COMAR 10.09.36.09 and in accordance with State Government, Sections 10-201 et seq. And Health-General, Sections 2-201 through 2-207 of the Annotated Code of Maryland and COMAR 10.01.03 and 28.02.01.

To initiate an appeal, follow the procedures described in the Annotated Code and COMAR. Appeals must be filed within 30 days of receipt of a notice of administrative decisions.

EMERGENCY SERVICE TRANSPORTERS

Effective October 16, 2003, Maryland Medical Assistance has changed its procedure code for Emergency Services Transportation. When billing for Emergency Transport Services, use procedure code **A0427**.

Additional Instructions

Block #24B – Place of Service Code: 41
Block #24G – Units of Service: 1 (per trip)

If you have any questions concerning this Program, please contact the Transportation Policy Specialist at 410-767-1739.

EPSDT/HEALTHY KIDS

The Maryland Healthy Kids/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a comprehensive pediatric program to be billed only by those physicians, nurse practitioners and free-standing clinics who have been certified by the Program as Healthy Kids/EPSDT providers. These services are available to Medicaid recipients from birth through 20 years of age on a fee-for-service basis including children enrolled in a Managed Care Organization (MCO).

Effective October 1, 2010, EPSDT providers must use modifier "32" (Mandated Services) for initial examination visits and any other procedures provided during this visit, of a child entering State-supervised care. When this modifier is used, MCOs will be obligated to pay for all portions of the EPSDT examination. Providers should use modifier "32" for initial visits only. Refer to the list below to bill for age appropriate preventative CPT codes in conjunction with modifier "32" (Mandated Services).

Comprehensive Preventive Medicine (New Patient)

CPT Code	Modifier	Description
99381	32	Infant (age under 1 year)
99382	32	Early childhood (age 1 through 4 years)
99383	32	Late childhood (age 5 through 11 years)
99384	32	Adolescent 9 (age 12 through 17 years)

Comprehensive Preventive Medicine (Established Patient)

CPT Code	Modifier	Description
99391	32	Infant (age under 1 year)
99392	32	Early childhood (age 1 through 4 years)
99393	32	Late childhood (age 5 through 11 years)
99394	32	Adolescent 9 (age 12 through 17 years)

The EPSDT/Healthy Kids Program also offers additional expanded services that include:

- ✓ Case Management
- ✓ Durable Medical Equipment & Supplies not normally covered under Medicaid
- ✓ Speech/Language Therapy
- ✓ Chiropractic Care
- ✓ Occupational Therapy
- ✓ Health-Related Services in Schools such as psychological testing and mental health
- ✓ Inpatient and Outpatient Alcohol-Drug Treatment
- ✓ Medical Day Care for Medically Fragile Children
- ✓ Nutrition Counseling

If you have any questions about EPDST services, call the Healthy Kids Program Staff Specialist at 410-767-1683 or 410-767-1722 for expanded EPSDT services.

NEWBORN BILLING INSTRUCTIONS

Medical Assistance will automatically cover all infants born to women with MA coverage on the date of delivery through their first birthday; however, the Program cannot issue the newborn's card until the hospital or DSS worker notifies the Department. The Department will enroll the newborn upon receipt of the Hospital Report of Newborn form (DHMH-1184). Effective April 2012, DHMH will begin the online enrollment of newborns (1184 process) via the Programs eMedicaid application on the internet. To download the new 1184 Process instructions, please visit: http://mmcp.dhmh.maryland.gov/docs/1184%20E-Medicaid%20Manual%20New%20Born%20Processing.PDF

The newborn will be enrolled in the same MCO as the mother at the time of delivery. To assure continuity and coordination of care, a newborn coordinator is assigned to each MCO to handle newborn assignment in the MCOs. For a list of these newborn coordinators and an information grid on how to handle newborn problems, please visit our website at *www.dhmh.state.md.us/mma/healthchoice*.

When billing for a newborn, always call EVS to verify that the mother was eligible on the baby's date of birth. If the mother was eligible, use the temporary newborn MA number that has been assigned. This number can be derived by replacing the last two numbers of the mother's MA number with 01 (first child) or 02 (second child), etc., following the order of sequential births. It takes two to four weeks for the mother to receive the newborn's Medicaid card. For assistance with newborn eligibility, have the mother call 1-800-456-8900.

Providers should bill MA directly for children who are not enrolled with an MCO. If you provide any health care services to a recipient enrolled in an MCO, you must seek reimbursement from the MCO. Verify the recipient's enrollment with the MCO through EVS.

AUDIOLOGY

In accordance with HIPAA standards and beginning with dates of service July 1, 2003, Maryland Medicaid's EPSDT Audiology Services Program revised its procedure code schedule for audiology and hearing aid services. The provider is required to specify the procedure code that describes the type of aid(s) (i.e. monaural, binaural, digital etc.) on all claims and preauthorization requests that are submitted to the Program. Bill one unit of service when using the procedure code describing "binaural" hearings aids. A copy of the EPSDT: Audiology Services Procedure Code schedule can be viewed by visiting the Program's website at: *http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx*. Bill the dispensing codes V5160, V5200, V5240 or V5241 only when directly dispensing the aid(s) to the Maryland Medicaid recipient. Use procedure code 92592 or 92593 if filling a hearing aid order for an ordering audiologist outside of your office who will be conducting the actual dispensing directly to the recipient. Code 92592 or 92593 is also used as the professional fee for handling repaired hearing aids.

If a service requires preauthorization, enter the preauthorization approval number in Block #23 of the CMS-1500 form as described in the instructions. It is important that you review the preauthorization letter for the correct authorization number, authorized procedure code(s) and authorized units of service. Information entered on the claim must correspond to the information on the approved preauthorization letter. The preauthorization facilitates payment of your claim. Claims for preauthorized services should be submitted separately for services not requiring preauthorization. Claims **will reject** if a preauthorization number is entered in Block #23 for procedure codes not requiring preauthorization.

The provider must bill the actual acquisition cost for hearing aids, accessories and other related costs. In addition, the provider must itemize all charges, i.e. insurance, repair, shipping/handling and accessory/supply charges should be billed by using the assigned code for the service and the actual acquisition cost. Do not combine these charges with the hearing aid or repair charge. When required, attach a copy of the manufacturer's invoice to the claim. The provider should continue to bill the usual and customary charge for professional services.

Providers, who are enrolled solely as a hearing aid dispenser, are limited to billing for hearing aids and hearing aid related services. Dispensers who are also interested in providing audiology professional services should contact the Provider Enrollment Office at (410) 767-5340 to obtain an enrollment application for audiology services.

NOTE: *Audiologists are not considered physician extenders under the Medicaid Program. These providers must be enrolled in the Program via an enrollment application and be assigned a provider number for billing purposes. Contact the Program's Provider Enrollment Office at (410) 767-5340 for an application.*

If you have any questions regarding the coverage, policy or regulations for EPSDT: Audiology Services please contact Stephanie Hood at (410) 767-3998.

IEP/IFSP HEALTH RELATED SERVICES

The procedure codes for IEP/IFSP Health Related Services have been changed. When billing the Program for Case Management and Health Related Services, refer to the chart below for the new procedure codes.

Current Code	Code Description
T1023 - TG	Initial IEP or IFSP Assessment
T2022	On-going service coordination
T1023	Periodic IEP/IFSP review
90801	Psychiatric Diagnostic Interview
90804	Individual Psychotherapy (20-30 minutes)
90806	Individual Psychotherapy (45-50 minutes)
90808	Individual Psychotherapy (75-80 minutes)
90847	Family Psychotherapy
90853	Group Psychotherapy
92506	Speech Evaluation
92507	Individual Speech Therapy
92508	Group Speech Therapy
92557	Comprehensive Audiology Evaluation
96101	Psychological Testing
96152	Therapeutic Behavior Aide
97001	Physical Therapy Evaluation
97002	Physical Therapy Re-evaluation
97110	Physical Therapy Service
97003	Occupational Therapy Evaluation
97004	Occupational Therapy Re-evaluation
97150	Group Occupational Therapy Evaluation
97530	Occupational Therapy Service
T1000	Nursing Service
97802	Nutrition Assessment and Intervention
97803	Nutrition Re-assessment and Intervention
T2003	Non-Emergency Transportation Services

If you have any questions regarding these procedure codes, policy, or a list of covered services, please call the Staff Specialist at 410-767-1903.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH LANGUAGE-PATHOLOGY AND CHIROPRACTIC SERVICES

Under Maryland Medicaid, payment for these services is made on a per visit basis rather then on a per treatment basis regardless of the number of treatments rendered to the patient during a single visit.

Providers should visit the DHMH website: ***http:mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx*** to view the procedure codes and fee schedules for these services. Coverage for EPSDT Speech, Occupational and Chiropractic Services are limited to recipients under the age of 21.

NOTE: *Physical therapists, occupational therapists, speech-language pathologists and chiropractors are not considered physician extenders under the Medicaid Program. These providers must be enrolled in the Program via an enrollment application and be assigned a provider number for billing purposes. Contact the Program's Provider Enrollment Office at (410) 767-5340 for an application.*

NOTE: *EPSDT Chiropractic Services are coverable through the MCO. Contact the MCO for coverage procedures.*

If you have any questions concerning these Program services, contact Stephanie Hood at (410) 767-3998.

SUBSTANCE ABUSE SERVICES UNDER THE EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT PROGRAM

Outpatient Addiction Services

Effective October 1, 2004, the following procedure codes for substance abuse services are required. Substance abuse services under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program cover assessment and treatment benefits for Medicaid children less than 21 years of age. In addition, Medicaid covers substance abuse benefits for pregnant and postpartum women. Licensed providers rendering fee-for-service outpatient addiction services must use the following procedure codes when billing on or after October 1, 2004. Pregnant and postpartum women are identified by the use of a modifier following the appropriate 5-digit procedure code for assessment and/or treatment. Mental health providers should use the appropriate substance abuse "H" codes when rendering substance abuse services on or after October 1, 2004. **Please refer to page 38 & 39 for procedure code information.**

If you have any questions concerning this Program, please contact Alexis Moss at (410) 767-1687.

PROCEDURE CODE CHANGES FOR BILLING FOR OUTPATIENT ADDICTION SERVICES UNDER THE EPSDT PROGRAM

HIPAA CODE	CODE DESCRIPTION	MAXIMUM UNITS
H0001	Alcohol and Drug Abuse Assessment	Up to one service per day (one assessment per day, per client)
H0005	Group Counseling – Alcohol and/or Drug Services	Up to two units per day (one unit = 1 hour)
H0015	*Group Intensive Outpatient Program – Alcohol and/or Drug Services	Up to five units per day (one unit = 1 hour)
H2035	Individual – Alcohol and/or Drug Treatment	Up to one service per day (one service = 1 hour)

Note: To receive reimbursement for Intensive Outpatient Program-Alcohol and/or Drug Services, you must be certified as an Intensive Outpatient Program through the Drug Abuse Administration.

Procedure Code Changes for Billing for Outpatient Addiction Services – Pregnant and Post-Partum Women

NOTE: *"TH" Modifier* ***must*** *be used for all Pregnant and Post-Partum Women.*

HIPAA CODE	CODE DESCRIPTION	MAXIMUM UNITS
H0001-TH	Alcohol and Drug Abuse Assessment	Up to one service per day (one assessment per day, per client)
H0005-TH	Group Counseling – Alcohol and/or Drug Services	Up to two units per day (one unit = 1 hour)
H0015-TH	*Group Intensive Outpatient Program – Alcohol and/or Drug Services	Up to five units per day (one unit = 1 hour)
H2035-TH	Individual – Alcohol and/or Drug Treatment	Up to one service per day (one service = 1 hour)

Note: To receive reimbursement for Intensive Outpatient Program-Alcohol and/or Drug Services, you must be certified as an Intensive Outpatient Program through the Drug Abuse Administration.

PROCEDURE CODE CHANGES FOR PRIMARY MENTAL HEALTH SERVICES

Current Code	Code Description	Maximum Units
H2017	Psychosocial Rehabilitation Services	Up to four units per day (one unit = 15 minutes)

Licensed professional counselors, nurse psychotherapists, psychologists, and social workers delivering outpatient addiction services must use the "H" procedure codes for outpatient addiction services. Providers will continue to receive their current Medicaid reimbursement.

Procedure Codes for EPSDT Outpatient Addiction Services for Children less than 21 Years of Age

Current Code	Code Description	Maximum Units
H0001	Alcohol and Drug Abuse Assessment	Up to one assessment per day, per client
H0005	Group Counseling – Alcohol and/or Drug Services	Up to two units per day (one unit = 1 hour)
H2035	Individual – Alcohol and /or Drug Treatment	Up to one service per day (one service = 1 hour)

THERAPEUTIC BEHAVIORAL SERVICE

The Therapeutic Behavioral Service (TBS) Program is an intensive, one-to-one, rehabilitative service **for children under 21 years of age** who have been assessed as having behaviors related to a mental health diagnosis that places their current living arrangement at risk for a more restrictive placement or prevents their transition to a less restrictive placement. The service is intended to provide the recipient with behavioral management skills and is designed to restore the recipient's previously acquired behavior skills.

TBS providers must be a licensed Developmental Disabilities Administration (DDA) provider, an outpatient mental health clinic, a mental health mobile treatment unit, or a psychiatric rehabilitation program (PRP).

Effective April 1, 2006 all TBS services require preauthorization through the Administrative Service Organization (ASO), Value Options Maryland prior to the initiation of services. Please contact the Value Options Maryland care manager for TBS at 1-800-888-1965, option 2, ext 4805 for preauthorization.

Claims for all TBS services must be submitted Value Options for processing and payment. The phone number of claims information is: 1-800-888-1965. The claims address is:

Value Options Maryland
P.O. Box 1950
Latham, NY 12110

Current Code	**Code Description**	**Maximum Units**
96150	Initial assessment and development of behavioral plan	One unit = 15 minutes, maximum units 4
96151	Re-assessment and development of new behavioral plan	One unit = 15 minutes, maximum units 4
96152	Therapeutic Behavioral Service	One unit = 15 minutes

If you have any questions concerning this Program, please contact a DHMH Staff Specialist at 410-767-1903 or the Value Options Maryland care manager for TBS at 1-800-888-1965, option 2, ext 4805.

VACCINE ADMINISTRATION/VACCINES FOR CHILDREN PROGRAM

Eligible providers should bill for administering childhood vaccines received free from the federal Vaccines for Children Program (VFC) by using the appropriate CPT code for the vaccine/toxoid or immune globulin in conjunction with the modifier – SF (State and/or Federally-funded programs/services). The maximum reimbursement is **$15.49** per administration. Providers will not be reimbursed for vaccine administration unless the modifier – SE is appended to the appropriate CPT vaccine code. (The modifier – 26 is no longer used for VFC vaccine administration.)

VFC immunization administration codes are as follows:

VACCINE	CPT-MOD
Hepatitis B Immune Globulin (HBIG)	90371 – SE
Hemophilus influenza b, HbOC conjugate (Hib)	90645 – SE
Hemophilus influenza b, PRP-D conjugate (Hib)	90646 – SE
Hemophilus influenza b, PRP-OMP conjugate (Hib)	90647 – SE
Hemophilus influenza b, PRP-T conjugate (Hib)	90648 – SE
Influenza virus, split virus, 6-35 months	90657 – SE
Influenza virus, split virus, 3 years/above	90658 – SE
Pneumococcal conjugate, polyvalent, under 5	90669 – SE
Diphtheria, tetanus toxoids and acellular Pertussis (DTaP)	90700 – SE
Diphtheria and tetanus toxoids (DT, 0-6)	90702 – SE
Measles, mumps and rubella virus (MMR)	90707 – SE
Poliovirus, live, oral (OPV)	90712 – SE
Poliovirus, inactivated (IPV)	90713 – SE
Varicella virus, live	90716 – SE
Tetanus toxoid and diphtheria (Td, 7-18)	90718 – SE
Diphtheria, tetanus toxoids, whole cell pertussis and Hemophilus influenza b (DTP-Hib)	90720 – SE
Diphtheria, tetanus, toxoids, acellular pertussis and Hemophilus influenza b (DtaP-Hib)	90721 – SE
Diphtheria, tetanus toxoids, acellular pertussis and Hepatitis B and poliovirus (DtaP-HepB-IPV)	90723 – SE
Hepatitis B, adolescent (2 dose schedule)	90743 – SE
Hepatitis B, pediatric/adolescent (3 dose)	90744 – SE
Hepatitis B and Hemophilus influenza b (HepB-Hib)	90748 – SE

If you have any questions regarding these procedure codes or a list of covered services, please contact the Staff Specialist at 410-767-1683.

VISION CARE SERVICES

The Medical Assistance Program covers the following vision care services:

Eyeglasses

Use the following procedure codes when billing for frames:

V2020 – child/adult ZYL frame.

V2025 – metal or combination frame when required for a proper fit.

V2799 – special or custom frame when necessary and appropriate (preauthorization required).

92390 – single vision integrated glasses.

92340 – 92342 – fitting of spectacles.

Contact Lenses

Contact lens services require preauthorization and include the prescription of contact lenses (specification of optical and physical characteristics), the proper fitting of contact lenses (including the instruction and training of the wearer, incidental revision of the lens and adaptation), the supply of contact lenses, and the follow-up of successfully fitted extended wear lenses. Use the following procedure codes when billing for these services:

92310-26 – professional services of prescription, fitting, training and adaption.

V2500 – V2599 – contact lenses.

92012 – follow-up subsequent to a proper fitting.

Services that require preauthorization must be requested in writing. A Preauthorization Request Form for Vision Care Services (DHMH 4526) must be completed and submitted to:

Office of Systems, Operations & Pharmacy
Division of Claims Processing
P.O. Box 17058
Baltimore, MD 21203

A copy of the Vision Care Services Procedure Code and Fee Schedule can be viewed by visiting the DHMH website:
http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx . If you have any questions concerning this Program, contact Stephanie Hood at 410-767-3998.

HEALTHY START SERVICES FOR PREGNANT AND POSTPARTUM WOMEN

Effective July 1, 2003, the Medical Assistance Program changed two procedure codes for the Healthy Start Program for pregnant women. For services rendered on or after the effective date, providers must bill using these codes for Medicaid reimbursement:

- W9090 is changed to H1000 Prenatal Care, At-Risk Assessment.
- W9091 is changed to H1003 Prenatal and Postpartum Care, and At-Risk Enhanced Service/Education.

There have been no changes to the fees and limitations. If you have questions concerning the Program, please call the Nurse Consultant at 410-767-6750.

DURABLE MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT

Maryland Medicaid updates the DMS/DME Approved List of Items on the same schedule as Medicare. The items on the Approved List of Items are covered as long as the items requested are deemed medically necessary. It is important that you review the current list to ensure that you are using the correct procedure code when requesting prepayment authorization (form DHMH-4527) and direct billing DMS/DME items. Before requesting prepayment authorization, ensure that the procedure codes require prepayment authorization by referring to the "PA" column on the Approved List of Items. It is also important to make sure that miscellaneous procedure codes are not used when there is an available code for that item. Additionally, DMS items should be requested on different prepayment authorization forms. These errors will cause a delay in processing your request.

If the request has been approved, place the prepayment authorization number in Block #23 of the CMS-1500 form. All the information entered on the claim must correspond to the information on the approved prepayment authorization. Separate claims based on items that require authorization. Submit items that do not require authorization on a different CMS-1500 form.

When billing for disposable medical supplies, indicate the number of units in Block #24G based on the pricing units stipulated in the Approved List of Items.

Use of Modifiers: When billing for rentals, use modifier **"RR"**. Any rentals beyond three (3) months require prepayment authorization. When billing for new equipment, use **"NU".** When billing for used equipment use **"UE"**, which requires prepayment authorization.

NOTE: *The column referred to as "Medicare Coverage" indicates whether Medicare covers that particular item. A block that is blank indicates that Medicare either covers the item with special coverage instruction or it is up to the MME Regional Carrier's (DMERC) discretion.*

Please visit http://mmcp.dhmh.maryland.gov/communitysupport/SitePages/Home.aspx if you have questions or concerns about these policies, or would like a copy of the Approved List of Items. Also available is the prepayment authorization form (DHMH-4527), provider memos/transmittals, and access to the DMS/DME regulations (COMAR 10.09.12). If you prefer to speak with a Staff Specialist, call 410-767-1739.

OXYGEN AND RELATED RESPIRATORY EQUIPMENT SERVICES

Maryland Medicaid's DMS/DME Approved List of Items also include oxygen and related oxygen services. The items on the Approved List of Items are covered as long as the items requested are deemed medically necessary. It is important that you review the current list to ensure that you are using the correct procedure code when requesting prepayment authorization (form DHMH-4527) and direct billing oxygen items. Before requesting prepayment authorization, ensure that the procedure codes require prepayment authorization by referring to the "PA" column on the Approved List of Items. It is also important to make sure that miscellaneous procedure codes are not used when there is an available code for that item. Additionally, DMS and DME items should be requested on different prepayment authorization forms. These errors will cause a delay in processing your request.

If the prepayment authorization has been approved for covered oxygen, oxygen equipment, related respiratory equipment, component replacements, equipment repairs and/or tracheostomy items, place the approved prepayment authorized number in Block #23 of the CMS-1500 form. All the information entered on the claim must correspond to the information on the prepayment preauthorization. Separate claims based on items that require authorization. Submit items that do not require authorization on a different CMS-1500 form.

Use of Modifiers: When billing for rentals, use modifier **"RR"**. Any rentals beyond three (3) months require prepayment authorization, unless item is only rented. When billing for new equipment, use **"NU".** When billing for used equipment use **"UE"**, which requires prepayment authorization

NOTE: *The column referred to as "Medicare Coverage" indicates whether Medicare covers the particular item. A block that is blank indicates that Medicare either covers the item with special coverage instruction or it is up to the MME Regional Carrier's (DMERC) discretion.*

Please visit http://mmcp.dhmh.maryland.gov/communitysupport/SitePages/Home.aspx if you have questions or concerns about these policies, or would like a copy of the Approved List of Items. Also available is the prepayment authorization form (DHMH-4527), provider memos/transmittals, and access to the oxygen and related services regulations (COMAR 10.09.18). If you prefer to speak with a Staff Specialist, call 410-767-1739.

LABORATORY SERVICES

When billing for laboratory services, enter the name of the ordering practitioner in Block #17. In Block #17a, the ID Qualifier 1D must precede the ordering practitioner's 9-digit MA provider number. In Block #17b, enter the ordering practitioner's NPI number.

Medical laboratories **must** use "81" as the place of service for all services that are actually performed in the laboratory, regardless of where the specimen was collected. Use the appropriate place of service for the site of collection and immediately performed tests, such as bleeding time.

When billing for medical laboratory services referred to other enrolled and certified laboratories, use the modifier "90" for the procedure that was performed. The referring laboratory's charge is limited to the amount actually paid to the reference laboratory. Payment to the referring laboratory will be the lower of the referring laboratory's charge or the Maryland Medicaid maximum rate of reimbursement for that service. The reference laboratory must be enrolled with Maryland Medicaid, and its 9-digit MA provider number and NPI number must be entered in Block #32. If services were referred to more than one reference laboratory, use a separate invoice for each different reference laboratory. The referring laboratory is prohibited form billing Medical Assistance recipients for services referred to non-participating reference laboratories.

Laboratories with Waived or Provider Performed Microscopy CLIA certificates are required to use the "QW" modifier on all laboratory codes. These claims must be submitted on paper, as they are processed manually. Claims that are sent to the original processing address or submitted electronically will result in denial of the claim. To avoid a delay in reimbursement, **please send all claims using the modifier "QW" to**:

Provider Relations Unit
201 W. Preston Street, Room LL-3
Baltimore, MD 21201

NOTE: *Medical Laboratory Providers must supply a copy of their CLIA certificate and a Maryland Lab permit, if located in Maryland and/or receiving specimens originating in Maryland for each site where services are performed. If a laboratory does not receive specimens originating in Maryland, a statement declaring they do not receive specimens originating in Maryland is needed.*

If you have any policy questions or any program changes, please contact Tenesha Lynch at 410-767-3074.

MEDICAL DAY CARE

Effective January 3, 2004, Maryland Medical Assistance has changed its procedure code for Medical Day Care Services. When billing for Medical Day Care Services, use procedure code **S5102**.

Medical Day Care providers are only required to complete 11 fields on the CMS-1500. The required fields are: 2, 9A, 11, 24A, 24B, 24D, 24F, 24G, 28, 31, and 33.

Additional Instructions

Block #11: Enter "K". This indicates that medical day care is not covered by any other insurance.

Block #24B: Enter place of service code "99".

Block #31: A signature and date are required for this field.

If you have any questions regarding the Program, please contact the Medical Day Care staff specialist at 410-767-1444.

PHYSICIAN SERVICES

Providers should refer to the fee schedule provided to obtain a list of approved CPT and national HCPCS codes used by the Program and the maximum fee paid for each procedure code. A provider using CPT terminology and coding, selects the procedure or service that most accurately identifies the service performed.

Some physician services within the fee schedule require preauthorization. The Program will preauthorize services when the provider submits adequate documentation demonstrating that the service is both necessary and appropriate. Preauthorization for these services must be requested in writing. A Preauthorization Request Form for Physician Services (DHMH-4523) must be completed and submitted to:

HealthChoice and Acute Care Administration
Division of Hospital and Physician Services
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201

Effective January 1, 2008, the Maryland Medical Assistance Program will require that a valid 11-digit National Drug Code (NDC) number and quantity administered be reported on the CMS-1500 in order to be reimbursed for drugs. Details about placement of the NDC/Quantity are contained within the block-to-block information on page 10.

If you have any questions regarding the Program or to request a copy of the fee schedule, please contact the Staff Specialist at 410-767-1762. A copy of the fee schedule can be viewed by visiting the DHMH website
http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx

MODIFIERS

A modifier provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. When applicable, the modifying circumstance would be identified by the appropriate modifier(s), which is a two-character code appended to the procedure code in Block #24D of the CMS-1500. Up to four modifiers can be reported on one service line.

NOTE: *Up to four modifiers can be used in the HIPAA complaint electronic format.*

The modifiers listed below must be reported when applicable and affect the processing and/or reimbursement of claims billed to the Program. Generally, only those modifiers that effect payment should be reported. The payment rate for each modifier is a percentage of the listed fee. Payment rates for multiple modifiers are multiplied together to determine the reimbursement amount.

Anesthesia

Anesthesia procedure codes 00100 – 01999 billed without an appropriate modifier will be **rejected**. Modifiers – AD (Medical supervision by physician: more then four procedures) and –47 (Anesthesia by surgeon) **are not** used/payable by the Program. Modifiers –G8, -G9 and –QS are informational and do not effect payment.

Modifier	Description	% Payment
AA	Anesthesia performed personally by anesthesiologist	100
QK	Medical direction of 2-4 concurrent anesthesia procedures	50
QX	CRNA service with medical direction by a physician	50
QY	Medical direction of 1 CRNA by an anesthesiologist	50
QZ	CRNA service w/o medical direction by a physician	100
23	Unusual anesthesia	B.R.

COMPONENT BILLING

Certain procedures (e.g., radiology, electrocardiograms, specific diagnostic procedures) are a combination of a professional component and a technical component and must be reported in order to receive reimbursement. When the physician component is billed separately, the service must be identified by adding the modifier –26 to the usual procedure code. Modifier –TC (Technical Component) is not used/payable by the Physicians' Services Program.

Modifier	Description	% Payment
26	Professional Component	28-100
Medicine		
26	Professional Component	50-100

SE	State or Federally funded service (VFC)	($10)

Radiological Services

26	Professional Component	28-50
50	Procedures performed on left **and** right side of body	200

Surgical Services

50	Bilateral procedure	150
51	Multiple procedures	50
52	Reduced services	B.R.
53	Discontinued procedure	B.R.
54	Surgical care only	80
55	Postoperative management only	20

NOTE: *Modifier –56 (Preoperative management only) and –66 (Surgical team) are not used/payable.*

Surgical Assistance

Modifier	**Description**	**% of Payment**
80	Assisted surgeon	20
82	Assistant surgeon (when qualified resident not available)	20

NOTE: *Modifier –81 (Minimum assistant surgeon) is not used/payable*

Trauma Services

Trauma services rendered by trauma physicians to trauma patients on the State Trauma Registry are reimbursed at 100% of the Medicare rate.

Modifier	**Description**	**% of Payment**
U1	Trauma Services	NA

Multiple and Bilateral Surgical Procedures

If multiple procedures are performed on the same day or at the same operative sessions, the procedure code must be followed by the two-positions modifier “51” for all procedures following the first procedure. The major procedure should be reported without a modifier. The modifier “51” should be used for the second and subsequent procedures.

When a procedure has a code for both a single procedure and for each additional procedure, use the modifier “51” for the second and subsequent procedures. When only one procedure is available, regardless of the number of procedures performed, use the same procedure code with

the modifier “51” to report the second and subsequent procedures and report the additional procedures in Block #24D.

When there is no procedure code to identify bilateral procedures, use the procedure code for the unilateral procedure without a modifier and use the same procedure code with a modifier “51” to identify that the procedure was performed bilaterally.

“50” for Bilateral procedures: If a bilateral procedure is performed, report the bilateral procedure if available. When there is no code describing bilateral services, report the bilateral service on one line with the modifier –50.

If you have any questions regarding this program or to request a copy of the fee schedule, please contact the Staff Specialist at 410-767-1462.

PODIATRY

Routine Podiatric Care

Maryland Medicaid coverage for routine foot care, the cutting and removal of corns or calluses, and the trimming, cutting, clipping or debriding of toenails (procedures 11055-11057, 11719) is limited to one visit every 60 days for recipients who have diabetes or peripheral vascular diseases that affect the lower extremities, when rendered in the podiatrist's office, the recipient's home, a nursing facility or domiciliary.

When billing Medicare for routine care rendered to a Medicaid recipient, the appropriate diagnosis code related to the diabetes or peripheral vascular disease must be entered as the primary diagnosis in Block #21 on the CMS-1500.

RADIOLOGY

Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound and other imaging procedures. The nuclear medicine codes (78000-79999) are to be used for in-vitro testing only. In-vitro tests are described in the Pathology and Laboratory section of CPT (80049 – 89399).

Providers **can** bill for the global service in a non-hospital setting or professional only component service in any setting. Providers **cannot** bill for the technical component only. The global service includes all resources necessary to perform the procedure and the professional physician services to interpret the output. The professional component includes the specialized interpretation or reading of the test results and preparation of a detailed written report of the findings for the referring/attending physician. Interpretation of radiology services are payable to any physician trained in the interpretation of the study. The provider who bills for the interpretation must be the provider who evaluates the study and prepares and signs the written report for the medical record and is subject to post-payment review. Review of results and explanation to the patient is part of the attending physician's E & M service and cannot be billed as an interpretation of the study.

When performing radiology service using hospital equipment and/or staff, bill only for the professional component by adding the modifier **–26** to the procedure code. Payment for the professional component shall be a percentage of the total fee as follows:

CPT-4	**% of Total Fee**
70010-76488	42
Computerized Tomography	28
76506 – 79999	50

***NOTE**: Computerized tomography CT's PET's and SPECT's.*

Bilateral services are studies done on the same body area, once on the left side and once on the right side. Providers should use the "bilateral" CPT code to bill the service when available. If a bilateral code is not available, report bilateral radiological studies on one claim line with the modifier –50. Do not use modifier –51 to report multiple radiology studies of the same area on the same day.

If the same x-ray is repeated on the same patient on the same day, report two units in Block #24G on the claim form. Generally, the maximum two units are allowed for radiology procedures.

CAT scans and MRI's do not require preauthorization. Use procedure codes 76090 (unilateral) or 76091 (bilateral) for diagnostic mammography when the patient is referred by a physician. Use procedure code 76092 for walk-in mammography screening. A physician referral is not required for walk-in mammography screening; however, the patient must be age 35 or older.

NOTE: *Radiology services billed with a place of service code of 21 or 22 will be denied without a modifier –26.*

If you have any questions regarding this program or to request a copy of the fee schedule, please contact the Staff Specialist at 410-767-1722.

ABORTION

The Program will cover an abortion for only the following five medical reasons:

1. Life of the mother.
2. Mother's current or future health
3. Mother's current or future mental health
4. Fetus is probably deformed
5. Mother was a victim of rape or incest.

A document submitted by an official law enforcement agency or public health service where the rape or incest of the mother was reported must include the following information:

- Name and address of victim.
- Name and address of person making report (if different from victim)
- Date of the rape or incest incident.
- Date of the report.
- Statement that the person making it signed the report.
- Name and signature of the person at the law enforcement agency or public health service.

Abortion and abortion related services can be billed electronically. The **"Certification of Abortion"** (DHMH-521), **must be completed and kept in the patient's medical record. If you choose to bill electronically, the DHMH 521 is not required; however, you must indicate the appropriate 2-alpha character condition code in Block 10d. See Pages 11 and 12 for these codes.**

NOTE: *See physician's provider manual for information about Mifeprex – medical termination of early intrauterine pregnancy through administration of mifeprestone.*

See Section XVI – Appendix, page 74 for a reproduction of DHMH 521.

If you have any questions regarding the Program or to request a copy of the fee schedule, please contact the Staff Specialist at 410-767-6750 or 410-767-1462. The fee schedules are also available on line at the DHMH website
http://mmcp.dhmh.maryland.gov/SitePages/Provider%20INformation.aspx

HYSTERECTOMY

The Program **will not** reimburse for a hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing, or if there was more than one purpose to the procedure, and it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

The Program **will** reimburse for a hysterectomy only if the following conditions are met:

1. The physician who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing, and

2. The individual or her representative, if any, has signed a written acknowledgement of receipt of that information, or

3. The individual was already sterile before the hysterectomy, or

4. The individual requires a hysterectomy due to a life-threatening emergency situation and the physician determines that prior informing and acknowledgement are not possible, and

5. The physician who performs the hysterectomy:

    a. Certifies in writing, that the individual was already sterile at the time of the hysterectomy and states the cause of the sterility.

    b. Certifies in writing, that the hysterectomy was performed under a life-threatening emergency situation in which the physician determines that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

Regulations require the physician who performs the hysterectomy (not a secondary provider such as an assisting surgeon or anesthesiologist) to certify that the woman met one of the specified exemptions. The **"Document for Hysterectomy"** (DHMH-2990) **must be completed and kept in the patient's medical record** for a hysterectomy (51925, 58150-58294, 58550-58554, 58951, 58953-58954, 59135, 59525). **Do not** bill other services on the same claim form with this procedure. Patient's signature **is not** required if the patient is over age 55.

See Section XVI - Appendix, page 75 for a reproduction of DHMH 2990.

If you have any questions regarding the Program or to request a copy of the fee schedule, please contact the Staff Specialist at 410-767-6750 or 410-767-1462. The fee schedules are also available on line at the DHMH website
http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx

STERILIZATION AND TUBAL LIGATION

Sterilizations have special conditions that **must** be met in order for them to be covered by the Medical Assistance Program. The Program will reimburse for the sterilization of an individual, including a tubal ligation, only if **all** of the following conditions are met:

1. The individual is at least 21 years of age at the time consent is obtained.

2. The individual is not mentally incompetent.

3. The individual is not institutionalized.

4. The individual has voluntarily given informed consent as described in Part I of the consent document, **"Sterilization Consent Form"** (DHMH-2989), **and**

5. At least **30** days, but not more than **180** days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

The "**Sterilization Consent Form"** (DHMH-2989) **must be completed and kept in the patient's medical record** for sterilizations (55250, 55450, 58670-58671, 58600-58615, 58670-58671, 58700). A sterilization/tubal ligation procedure must be billed on a separate CMS-1500 claim form. If the procedure was performed on the same date of service as another procedure, a modifier –51 is required in Block #24D for the second or subsequent procedure.

The sterilization form consists of four parts:

Part I - Consent to Sterilization – This section must be completed for all sterilizations and must be signed and dated by the individual being sterilized.

Part II - Interpreter's Statement – This section must be completed only when an interpreter is provided to assist the individual to be sterilized to understand the consent statement.

Part III - Statement of Person Obtaining Consent – This section must be completed. For all sterilizations and must be signed and dated by the person who counseled the individuals to be sterilized.

Part IV - Physician's Statement – This section must be completed for <u>all</u> sterilizations by the physician. One of the final paragraphs, the one that is not used, must be crossed out. This section is worded so that the physician is required to sign this form on or after the date of sterilization. This section **may not** be signed or dated by the physician **prior** to the date of sterilization.

***NOTE**: The individual is not eligible for the sterilization procedure until the 32nd day after giving consent (signature date).*

***NOTE**: Use procedure codes 58565 and 58340 to bill for Essure. Essure is a permanent birth control that occludes both fallopian tubes. Use procedure code 58565 – hysteroscopy, surgical; bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants. Three months after the procedure, women must undergo hysterosalpingogram testing. Use procedure code 58340 for the testing that is completed. Use diagnosis code V25.40 to indicate the proof from the test of tubal occlusion.*

See Section XVI - Appendix, page 76 for a reproduction of the DHMH 2989.

If you have any questions regarding the Program or to request a copy of the fee schedule, please contact the Staff Specialist at 410-767-6750 or 410-767-1462. The fee schedules are also available on line at the DHMH website *http://mmcp.dhmh.maryland.gov/SitePages/Provider%20INformation.aspx*

TRAUMA SERVICES BILLING

A trauma physician is defined as a trauma surgeon, an emergency room physician, an orthopedic surgeon, a neurosurgeon, a critical care physician or an anesthesiologist who provides care in a trauma center to trauma patients on the State Trauma Registry.

NOTE: *Claims for trauma services by emergency room physicians will be denied.*

The following billing instructions for CMS-1500 must be followed by trauma physicians in order to be reimbursed for trauma services at the higher Medicare rate:

1. A primary, secondary or additional diagnosis code listed in Block #21 (diagnosis or nature of illness or injury field) must be from **800.00 – 959.9**, or if not, a supplementary classification of external causes and injury and poisoning code from **E800-E999** must appear as a subsequent supplementary classification code in Block #21.

2. A primary, secondary or additional diagnosis code listed in Block #24E (diagnosis pointer field) for **each** line item on the invoice, must be from **800.00 – 959.9**, if not, a supplementary classification of external causes and injury and poisoning code from **E800-E999** must appear as a subsequent supplementary classification code in Block #24E.

3. The last 2-digits of the trauma center identification number **and** the 6-digit trauma registry (patient identification) number must be reported in Block #23 (prior authorization number field) as an eight position number. The trauma registry number is less than 6-digits, place zeros in front of the trauma registry number until you have a 6-digit number. For example, if there is only a 4-digit trauma registry patient number, fill in the first two positions with zeros. Please refer to the list on page 62 for Trauma Facility I.D. numbers.

4. Only the place of service codes **21** (hospital-inpatient), **22** (hospital-outpatient) and **23** (emergency room) can be reported in Block #24B (place of service field) for trauma services.

5. The modifier –**U1** must be reported in one of the modifier positions for the trauma service in Block #24D (modifier field). This modifier is being used to reimburse trauma providers for trauma services at the Medicare rate instead of the current Medicaid rate.

6. The 9-digit Medicaid provider number of the hospital where the trauma center is located must be reported in Block #32b (Service Facility Location Information). The number must be proceeded with the ID Qualifier, 1D. In Block #32a, indicate the trauma center's NPI number.

NOTE: *The increased fees are only applied to the trauma services rendered during the initial admission or trauma center visit and the resulting acute care stay, not for subsequent follow-up services.* ***All*** *reporting of the modifier –U1 will be subject to post-payment audit.*

If you have any questions regarding this Program or would like to request a copy of the fee schedule, contact the Staff Specialist at 410-767-1722.

TRAUMA FACILITIES NAMES AND NUMBERS

FACILITY NAME	TRAUMA CENTER ID (Last two digits of the MIEMSS Facility ID # + Trauma Registry Number)
Primary Adult Resource Center	
R. Adams Cowley, Shock Trauma Center, Baltimore	34 + six digit Trauma Registry Patient Number
Level I Trauma Center	
Johns Hopkins Medical System Adult Trauma Center, Baltimore	04 + six digit Trauma Registry Patient Number
Level II Trauma Centers	
Johns Hopkins Bayview Medical Center, Adult Trauma Center, Cheverly	01 + six digit Trauma Registry Patient Number
Prince George's Hospital Center, Adult Trauma Center, Cheverly	32 + six digit Trauma Registry Patient Number
Sinai Hospital of Baltimore, Adult Trauma Center	10 + six digit Trauma Registry Patient Number
Suburban Hospital, Adult Trauma Center, Bethesda	49 + six digit Trauma Registry Patient Number
Level III Centers	
Western Maryland Health System, Cumberland Memorial Trauma Center	20 + six digit Trauma Registry Patient Number
Peninsula Regional Medical Center, Adult Trauma Center, Salisbury	08 + six digit Trauma Registry Patient Number
Washington County Hospital,	89 + six digit Trauma Registry Patient Number
Pediatric Trauma Centers	
Johns Hopkins Medical System, Pediatric Trauma Center, Baltimore	05 + six digit Trauma Registry Patient Number
Children's National Medical Center, Pediatric Trauma Center, Wash., D.C.	17 + six digit Trauma Registry Patient Number

PRIVATE DUTY NURSING (PDN)

Effective January 3, 2004, procedure codes for Private Duty Nursing services have changed due to HIPAA. When billing for these service, providers are required to use the revised **T-codes**. In addition, providers **must** use the **"TT"** modifier in all instances in which clients share nursing or aide services.

SERVICE	PROCEDURE CODE	DESCRIPTION OF CODE
Assessment	T1001	RN up to 15 minutes
1 nurse/1 recipient 1 nurse/1 recipient	T1002 T1003	RN up to 15 minutes LPN up to 15 minutes
1 nurse/2recipients 1 nurse/2 recipients	T1002 T1003	RN up to 15 minutes LPN up to 15 minutes
1 aide/1 recipient 1 aide/2 recipients	T1004	Aide up to 15 minutes

Information on preauthorizing T-codes for private duty nursing and shift home health aide services can be requested by contacting:

Division of Nursing Services
Office of Health Services
Room 130
201 West Preston Street
Baltimore, MD 21201

If you have any questions regarding these procedure codes or would like to request a list of covered services, please contact the Staff Specialist at 410-767-1448.

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

The Department's website will contain up-to-date information relative to Maryland Medicaid Programs, physician's fee schedule and program transmittals. Providers can access the website via the following address:
http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx

The Department of Health and Mental Hygiene (DHMH) has developed a new website called eMedicaid www.emdhealthchoice.org. This website is an interactive site that allows providers to:

- Enroll as a Medicaid Provider
- Add new providers to their practice
- Obtain payment information by downloading copies the remittance advices for up 2 years
- Access EVS to verify recipient eligibility
- Submit claims electronically for faster payment
- Check the status of claims

It is recommended that the office administrator register all users for this site.

Claims – Originals
P.O. Box 1935
Baltimore, MD 21203 410-767-5347

Claims – Adjustments
P.O. Box 13045
Baltimore, MD 21298 410-767-5346

Eligibility Verification System (EVS) 1-866-710-1447

Forms – How to Order Forms
Office of Systems, Operations & Pharmacy
201 West Preston Street, Room SS-12
Baltimore, MD 21201 410-767-6857

Provider Enrollment Unit
(formally Provider Master File Unit)
P.O. Box 17030
Baltimore, MD 21203 410-767-5340

Provider Relations

P.O. Box 22811	Baltimore Area	410-767-5503
Baltimore, MD 21203	Outside Baltimore Area	800-445-1159

Third Party Recovery

Office of Systems, Operations & Pharmacy
Division of Recoveries & Financial Services
P.O. Box 13045 410-767-1762
Baltimore, MD 21298

MEDICAID PROGRAM TELEPHONE NUMBERS

EPSDT Audiology Services		410-767-3998
EPSDT Therapy Services		410-767-3998
Electronic Billing		410-767-4682
Disposable Medical Supplies/ Durable Medical Equipment		410-767-1739
Emergency Service Transporters		410-767-1739
EPSDT Unit		410-767-1683
Health Choice Enrollment Line	Recipient	1-800-284-4510
	Provider	1-800-766-8692
Private Duty Nursing		410-767-1448
Family Planning Program		410-767-6750
Free-Standing Clinics		410-767-5706
Healthy Start Program		410-767-6750
Home Health Services		410-767-1448
Managed Care Organizations MCO Provider Hotline		1-800-766-8692
Maryland Children's Health Program (MCHP)		1-800-456-8900
Maryland Pharmacy Assistance		410-767-1455
Medical Day Care Services – Adult		410-767-1444

Medical Laboratories		410-767-1426
Model Waiver for Medically Fragile Children		410-767-1448
Department on Aging/Senior Assisted Housing Waiver		410-767-1102
Oxygen and Related Respiratory Equipment Services		410-767-1739
Personal Care Services		410-767-1444
Pharmacy Services		410-767-1455
Physicians' Services		410-767-1462
Podiatry Services		410-767-1462
Pregnant Women and Children Medical Assistance		410-767-6750
Primary Adult Care (PAC)	Enrollment Hotline	1-888-754-0095
	Provider Hotline	1-800-766-8692
Rare and Expensive Case Management (REM)		1-800-565-8190
Targeted Case Management for HIV Infected Individuals		410-767-5220
Waiver Programs		410-767-5220

DIRECTORY OF LOCAL DEPARTMENTS OF SOCIAL SERVICES

Allegany County DSS
1 Frederick Street
Cumberland, MD 21502
Mail – P.O. Box 1420
Cumberland, MD 21502-1420
301-784-7000

Anne Arundel County, DSS
80 West Street, 2nd Floor Deck
Annapolis, MD 21401
410-269-4500

Baltimore City DSS
2000 North Broadway
Baltimore, MD 21213-1447
443-423-6300

Baltimore County DSS
Investment Building
6401 York Road
Towson, MD 21212
410-853-3000

Calvert County DSS
Goldstein Building
200 Duke Street
Prince Frederick, MD 20678
Mail – P.O. Box 100
Prince Frederick, MD 20678-0100
443-550-6900

Caroline County, DSS
207 S. 3rd Street
Denton, MD 21629
Mail – P.O. Box 100
Denton, MD 21629-0100
410-819-4500

Carroll County DSS
10 Distillery Drive
Westminster, MD 21157-4045

Cecil County DSS
Multi-Service Building
170 E. Main Street
Elkton, MD 21921-5941
Mail-P.O. Box 1160
Elkton, MD 21922
410-996-0100

Charles County DSS
Southern MD Trade Center
200 Kent Avenue
LaPlata, MD 20646
Mail P.O. Box 1010
LaPlata, MD 20646-1010
301-392-6400

Dorchester County DSS
627 Race Street
Cambridge, MD 21613
Mail-P.O. Box 217
Cambridge, MD 21613-0217
410-901-4100

Frederick County DSS
100 E. All Saints Street
Frederick, MD 21705
Mail – P.O. Box 237
Frederick, MD 21701-0237
301-600-4555

Garrett County DSS
12578 Garrett Highway
Oakland, MD 21550-1159
301-533-3000

Harford County DSS
2 South Bond Street, 3rd Floor
Bel Air, MD 21014
410-836-4700

410-386-3300

Howard County DSS
7121 Columbia Gateway Drive
Columbia, MD 21046-2151
410-872-8700

Kent County DSS
350 High Street
Chestertown, MD 21620
Mail – P.O. Box 670
Chestertown, MD 21620-0670
410-810-7600

Montgomery County DSS
1301 Piccard Drive, 2nd Floor
Rockville, MD 20850
240-777-4600
Germantown
240-777-3420
Silver Spring
240-777-3100

Prince George's County DSS
6505 Belcrest Road
Hyattsville, MD 20782
Mail – Centre Pointe
805 Brightseat Road
Landover, MD 20785-4723
301-909-2000

Queen Anne's County DSS
125 Comet Street
Centreville, MD 21617-1089
410-758-8000

St. Mary's County DSS
Carter Bldg. 23110 Leonard Hall Dr.
Leonardtown, MD 20650
Mail – P.O. Box 509
Leonardtown, MD 20650
240-895-7000

Somerset County DSS
30397 Mt. Vernon Road
Princess Anne, MD 21853
Mail – P.O. Box 369
Princess Anne, MD 21853-0369
410-677-4200

Talbot County DSS
301 Bay Street
Easton, MD 21601
Mail – P.O. Box 1479
Easton, MD 21601-1479
410-770-4848

Washington County DSS
122 N. Potomac Street
Hagerstown, MD 21740
Mail – P.O. Box 1419
Hagerstown, MD 21741-1419
240-420-2100

Wicomico County DSS
31901 Tri-County Way, Ste 101
Salisbury, MD 21802-4966
Mail – P.O. Box 2298
Salisbury, MD 21802-2298
410-713-3900

Worcester County DSS
299 Commerce Street
Snow Hill, MD 21863
Mail – P.O. Box 39
Snow Hill, MD 21863-0039
410-677-6800

FREQUENTLY ASKED QUESTIONS

1. When can a provider bill a recipient?

You can bill the recipient only under the following circumstances:

- If the service provided is not covered by Medical Assistance and you have notified the recipient prior to providing the care that the service is not covered; or

- If the EVS reported a message that the recipient is not eligible for Medical Assistance on the date you provided services.

2. Can a provider bill Maryland Medicaid recipients for missed appointment?

No. Federal policy prohibits providers from billing Medicaid recipients for any missed appointments. To obtain a copy of the transmittal (MCO #52) that explains this policy, visit ***http://mmcp.dhmh.maryland.gov/SitePages?Provider%20Information.aspx*.**

3. Where can a provider call to check the status of claims?

Provider Relations is available Monday-Friday to assist providers with questions regarding the status of claims. To reach a representative, call 410-767-5503 or 1-800-445-1159 between 8:00 am – 5:00 pm and select option #2. Providers can now check the status of claims on the eMedicaid website by adding the claim lookup feature. The site administrator has to add this feature to all users.

4. Where can a provider obtain a copy of a Remittance Advice (RA)?

Copies of RAs are available for up to two years by accessing the Program's website at ***www.emdhealthchoice.org*,** eMedicaid registration must be completed by an Administrator.

5. How can a provider request a check tracer?

You may call Provider Relations (410) 767-5503 between the hours of 8:00 am to 4:30 pm.

6. Can you check EVS for future dates?

No, however you can check EVS for past eligibility up to one year.

7. How long does a provider have to file a claim?

A provider has twelve months from the date of service to submit a claim for payment. For other time statutes, see page two.

8. Claims should be mailed to what address?

Claims Processing
P.O. Box 1935
Baltimore, MD 21203

9. How long should I wait before I check claim status?

Under normal conditions, if you have sent a paper claim, wait four to six weeks before calling Provider Relations. When billing electronically, please allow two weeks.

Sample

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

OMB APPROVAL PENDING

OMB APPROVAL PENDING

MARYLAND MEDICAL ASSISTANCE PROGRAM
ADJUSTMENT REQUEST FORM

Page ____ of ____

Remittance Advice **MUST** Be Attached

1. Provider Name **Provider #** Provider Address (Street or Box No.) (City, State, ZIP Code)	**2. Check One:** ◯ Initial Request ◯ Follow-up Request **5. Number of Claims:** _____ (this form) **Total Number of Claims:** _____	**3. If One Check Enclosed** Check No. _____ Check Amt. _____ ◯ More Than One (1) Check Enclosed **6. Check One:** ◯ Medicaid ◯ Medicare Crossover	**4. Claim Type** ◯ Home Health ◯ HCFA 1500 ◯ Pharmacy ◯ Vision ◯ Dental ◯ Nursing Home ◯ UB92 ◯ Other _____

7.A. Invoice Control #	**B. Date of Service**	**C. Check One:** If Provider Underpaid _____ If Provider Overpaid _____	**D. Adjust Reason Code:**	**E. Complete One:** Amount Due Prov. _____ Amount Due State _____	**F. Enter the Corrected Proc. Code, Units, Modifier, $ Amt., TPL $ Amt., Recipient #, Resource $ Amt., or Prov. #:**
G. Recipient Name (Last, First)	**H. Recipient I.D. #**	**I. Prior Authorization #:** (If applicable)	**J. Check Amount $** _____	**K. Check #:** (if enclosed)	

8.A. Invoice Control #	**B. Date of Service**	**C. Check One:** If Provider Underpaid _____ If Provider Overpaid _____	**D. Adjust Reason Code:**	**E. Complete One:** Amount Due Prov. _____ Amount Due State _____	**F. Enter the Corrected Proc. Code, Units, Modifier, $ Amt., TPL $ Amt., Recipient #, Resource $ Amt., or Prov. #:**
G. Recipient Name (Last, First)	**H. Recipient I.D. #**	**I. Prior Authorization #:** (If applicable)	**J. Check Amount $** _____	**K. Check #:** (if enclosed)	

Adjustment Reason Codes *	
01 Incorrect Procedure	08 Outpatient Adm. Hospital
02 Incorrect Units of Service	79 TPL Payment Wrong **
03 Incorrect Modifier	80 Recip Did Not Receive Service
04 Incorrect $ Amount Charged	83 Change in Recip Eligibility
05 Wrong Provider Paid	87 Change in Patient Resource **
06 Duplicate Payment	BN Pt. Assess. Unbilled Verified **
07 Other Insurance Paid **	CG Incorrect Date Of Service

* **If uncertain, leave Section D Blank**
** **Additional Documentation Required** (See Instructions on Back)

REMARKS:

Name of MCOA Representative/Section: **Telephone No:** **Date:**

STATE COPY DHMH 4518A (7/98) DISTRIBUTION: The Original and Green copies are to be sent to the Adjustment Section, Medical Care Programs Administration, P.O. Box 13045, Baltimore, MD 21203 (410) 767-5346

MARYLAND MEDICAL ASSISTANCE PROGRAM

CERTIFICATION FOR ABORTION

A COPY OF THIS FORM MUST BE ATTACHED TO ALL INVOICES FOR ABORTION SERVICES.

Please Print or Type

PATIENT'S NAME	PHYSICIAN COMPLETING FORM
PATIENT'S ADDRESS	PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER
PATIENT'S ADDRESS	PLACE OF SERVICE
PATIENT'S MEDICAL ASSISTANCE NUMBER	DATE OF SERVICE

PART I - Check one of the blocks if applicable and sign the certification.

☐ G. I certify that this abortion is necessary because the life of the mother would be endangered if the fetus were carried to term.

DATE PHYSICIAN'S SIGNATURE

☐ I. Attached is a document submitted by an official of a law enforcement agency or public health service where the rape or incest was reported. The document includes the following information:

1. Name and address of victim;
2. Name and address of person making the report (if different from the victim);
3. Date of the rape or incest incident;
4. Date of the report (may not exceed 60 days after the incident);
5. Statement that the report was signed by the person making it;
6. Name and signature of person at law enforcement agency or public health service who took the rape or incest report.

DATE PHYSICIAN'S SIGNATURE

PART II - You must check one of the following blocks and sign the certificate, unless you have checked "I" in Part I, above.

☐ R. I certify that this abortion is necessary because, based on my professional judgement, continuation of the pregnancy is likely to result in the death of the woman.

DATE PHYSICIAN'S SIGNATURE

☐ S. I certify that, within a reasonable degree of medical certainty, based on my professional judgement, termination of pregnancy is medically necessary because there is substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.

DATE PHYSICIAN'S SIGNATURE

☐ T. I certify that, in my professional judgement, there exists medical evidence that continuation of the pregnancy is creating a serious effect on the woman's present mental health and, if carried to term, there is substantial risk of a serious or long lasting effect on the woman's future mental health.

DATE PHYSICIAN'S SIGNATURE

☐ V. I certify that, within a reasonable degree of medical certainty, based on my professional judgement, this abortion is necessary because the fetus is affected by genetic defect or serious deformity or abnormality.

DATE PHYSICIAN'S SIGNATURE

☐ W. I certify that this procedure is necessary for a victim of rape, sexual offense, or incest, and the incident has been reported to a law enforcement agency or to a public health or social agency.

DATE PHYSICIAN'S SIGNATURE

DHMH 521 (9/80/25,000)

MARYLAND MEDICAL ASSISTANCE PROGRAM

DOCUMENT FOR HYSTERECTOMY

A COPY OF THIS FORM MUST BE ATTACHED TO ALL INVOICES FOR HYSTERECTOMIES.

Please Print or Type

PATIENT'S NAME

PATIENT'S ADDRESS

PATIENT'S MEDICAL ASSISTANCE NUMBER

PHYSICIAN COMPLETING FORM

PHYSICIAN'S MEDICAL ASSISTANCE NUMBER

PLACE OF SERVICE

DATE OF SERVICE

SECTION I - To be signed by physician and patient or patient's representative when patient has been informed of the service.

A. I have performed a hysterectomy on _____ (NAME OF PATIENT). I hereby certify that the following conditions do not apply to this hysterectomy.

1. It was performed solely for the purpose of rendering the individual permanently incapable of reproducing; or
2. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

I have informed the patient and her representative, if any, orally and in writing, that the hysterectomy will make the patient permanently incapable of reproducing.

DATE

SIGNATURE OF PHYSICIAN

B. Receipt of Hysterectomy Information

I, _____ (NAME OF PATIENT) have been informed by _____ (NAME OF PHYSICIAN), that the hysterectomy to be performed will render me permanently incapable of reproducing.

DATE

SIGNATURE OF PATIENT OR REPRESENTATIVE

SECTION II - To be signed by physician. No patient signature is needed because the individual:

A. Was already sterile before the hysterectomy due to _____ (CAUSE OF STERILITY); or

B. Required a hysterectomy performed under a life-threatening emergency situation in which prior acknowledgement was not possible. (Describe the nature of the emergency.)

_____

_____

_____

DATE

SIGNATURE OF PHYSICIAN

DHMH 2990 (Rev. 10/82)
(10/82/10,000)

MARYLAND MEDICAL ASSISTANCE PROGRAM

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____, hereby consent of my own free will to be sterilized by _____ (doctor) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Signature Date: _____ (Month Day Year)

You are requested to supply the following information, but it is not required.

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ Interpreter Date

DHMH-2989

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____ the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ Signature of person obtaining consent Date

_____ Facility

_____ Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization), I explained to him/her the nature of the operation sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- [ ] Premature delivery
- [ ] Individual's expected date of delivery:
- [ ] Emergency abdominal surgery:

(describe circumstances):

_____ Physician

Date _____