MARYLAND MEDICAID SCHOOL-BASED HEALTH CENTER PROVIDER MANUAL

A Comprehensive Guide on CMS-1500 Billing Procedures for School-Based Health Centers

MARYLAND
Department of Health

Revised August 1, 2017

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POLICY CHANGE HIGHLIGHTS

August 2017

The following items are changes from previous School-Based Health Center (SBHC) billing instructions:

- **Rendering Providers:** Federally Qualified Health Centers (FQHC) must include the National Provider Identifier (NPI) of an individual rendering provider when billing Medicaid for services. This requirement applies to services rendered in school-based settings in the same way as services rendered at other FQHC practice locations. **All FQHC-sponsored SBHCs must list the individual rendering provider on the CMS-1500 form (in Block 24J). The rendering provider must be enrolled in the Maryland Medicaid program.** Medicaid is not permitted to reimburse for services where the rendering provider is not an enrolled Medicaid provider.

- **Referring Providers:** In accordance with federal regulations, any services requiring a provider referral must list the referring provider's NPI on the CMS-1500 form (Block 17). **The referring provider must be enrolled in the Maryland Medicaid program.** Medicaid is not permitted to reimburse for services where the referring provider is not an enrolled Medicaid provider.

- **"Free Care Rule":** SBHCs may bill the Medicaid program or HealthChoice MCOs for SBHC covered services provided free of charge to students without Medicaid coverage. Previously this was prohibited under the federal "Free Care Rule."

  CMS issued guidance in mid-December 2014 repealing the "Free Care Rule" and permitting state Medicaid programs to pay for services available free of charge to the general public. The guidance primarily impacts public health providers who provide services to those without any insurance or undocumented individuals free of charge and previously were unable to bill Medicaid for the covered services that was provided free of charge.

  The new policy does not override existing Local Health Department (LHD) regulations related to the Department's Non-Chargeable List (COMAR 10.02.01). LHD providers may only bill services excluded from the Non-Chargeable List regardless of whether non-Medicaid individuals receive services for free.

- **ICD-10:** As of October 1, 2015, **all claims must include IDC-10 diagnostic codes.** All diagnoses must be coded to the highest level of specificity available. Medicaid and HealthChoice MCOs will deny claims submitted using codes from outdated ICD versions.

- **Family Planning Code:** In accordance with ICD-10, claims for family planning services must now use the diagnosis code "Z30." To indicate an Evaluation and Management code relates to a Family Planning service, include Z30 on claims to HealthChoice MCOs.

- **Updated CMS-1500 Form**: CMS updated the CMS 1500 form due to ICD-10 implementation on October 1, 2015. **Medicaid will accept only the updated ICD-10 compliant version of the CMS 1500 form - Version 02/12.** For more information about ICD-10 conversion and changes to the CMS 1500 form, please visit: https://mmcp.health.maryland.gov/Pages/ICD-10-Conversion.aspx.

I. GENERAL INFORMATION

A. INTRODUCTION

This manual provides School-Based Health Center (SBHC) administrators and clinicians with the information necessary to bill using the CMS-1500 Claim Form or 837P electronic format. SBHCs should use this manual when billing for services rendered to students who have Medical Assistance (MA)/MCHP, whether they are enrolled in a HealthChoice Managed Care Organization (MCO), or are enrolled as fee-for-service (FFS) participants. Most students are enrolled in a HealthChoice MCO. If the student is not in an MCO then directly bill the Medicaid Program on a FFS basis.

Although this manual provides resource information on relevant MCO billing instructions, it is not intended to supplant the MCOs' Billing Instructions. MCO-specific billing instructions are available on each MCO's website or in its manual. SBHCs must follow the billing and reporting instructions under the Self-Referred provisions outlined in COMAR 10.09.76 – School-Based Health Centers.

CHANGE TO FEDERAL FREE CARE POLICY

SBHCs may bill the Medicaid program or HealthChoice MCOs for covered services provided free of charge to students without Medicaid coverage.

CMS issued guidance in mid-December 2014 permitting state Medicaid programs to pay for services available free of charge to the general public. The guidance primarily impacts public health providers who may have previously wanted to bill Medicaid for certain services provided free of charge to those without any insurance or to undocumented individuals, but could not, under the Federal Free Care Policy.

The new policy does not override existing Local Health Department (LHD) regulations related to the Department's Non-Chargeable List (COMAR 10.02.01). LHD providers may only bill services excluded from the Non-Chargeable List regardless of whether non-Medicaid individuals receive services for free. See Attachment B for guidance on billing requirements for LHDs.

Non-covered services and service limitations are described in COMAR 10.09.76 – School-Based Health Centers, COMAR 10.09.08 – Freestanding Clinics, and COMAR 10.09.23 – EPSDT Services. While this manual provides commonly used billing codes, LHD SBHCs can only bill Program Cost and Analysis approved CPT codes.

Note that these billing instructions do not apply to the following services:

- **Behavioral Health (including Mental Health and Substance Abuse)**
- **Dental (including the application of fluoride varnish)**

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

With only two exceptions, these billing instructions **do not affect** the billing procedures for Federally Qualified Health Centers (FQHCs). FQHCs should continue to use their existing billing codes rather than those included in this manual. The only two billing requirements that apply to FQHCs are related to filling in the CMS-1500 form:

Change #1: Block 24B – All SBHCs must enter "03" as the "Place of Service Code"

Change #2: Block 32 – All SBHCs must enter the Name and Address of the SBHC

FQHCs must list an individual rendering provider who is enrolled with Maryland Medicaid on all claims. Medicaid will deny FQHC claims that do not include an individual rendering provider.

B. GETTING STARTED

In order to bill the Medicaid program or HealthChoice MCOs for self-referred services, SBHCs must take the following steps:

STEP 1: APPLY TO BECOME AN SBHC THROUGH THE MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE)

Please use the following MSDE link to access the Maryland SBHC Application:

www.marylandsbhc.org

In addition to general SBHC information, the site provides the application instructions and materials necessary for MSDE approval.

- **Local jurisdictions must apply for new SBHC locations through MSDE first. Upon approval, MSDE will return the application to the applicant for use in the following steps.**
- **MSDE approved SBHC should attach its MSDE approval notice to its Medical Assistance application in Step 3 below.**
- **Applicants should attach their MSDE approval notification to their Medicaid Application in Step 3 below.**

MSDE Contact Information:
Phone: 410-767-0353 or 410-767-0278
Fax: 410-333-8148
Email: sbhcentprog.msde@maryland.gov

STEP 2: APPLY FOR A NATIONAL PROVIDER IDENTIFIER (NPI)

The National Provider Identifier (NPI) is a Health Information Portability and Accountability Act (HIPAA) mandate requiring a standard unique identifier for health care providers. SBHCs and their sponsoring organizations must obtain a unique 10-digit NPI and use it on all electronic transactions. When billing on paper, this unique NPI number and the provider's 9-digit Medicaid provider number will be required for reimbursement. Additional NPI information can be found on the Centers for Medicare and Medicaid Services (CMS) website:

https://nppes.cms.hhs.gov/

For NPI assistance, call **1-800-465-3203** or email **customerservice@npienumerator.com**.

STEP 3: SUBMIT A MARYLAND MEDICAL ASSISTANCE PROVIDER APPLICATION

In order for SBHCs to participate in the MA Program, a sponsoring agency such as a LHD or an FQHC must apply for the SBHC using the sponsor's federal tax identification number. **Only provider type 34 (FQHC), 35 (LHD Clinic) or 38 (general clinic) are eligible to apply to become SBHCs.** SBHC Medicaid applicants should **not write in "SBHC"** on the provider application as a provider type.

Be sure to attach the SBHC approval from MSDE to the Medical Assistance application.

Access provider application forms at: http://health.maryland.gov/providerinfo.

STEP 4: EPSDT CERTIFICATION

Each SBHC location **must** become an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) certified provider.

When Medicaid approves the SBHC application, an EPSDT nurse will be in contact to schedule a site visit.

EPSDT/Healthy Kids Program information, including provider application and MDH EPDST staff contact information is available at: https://mmcp.health.maryland.gov/epsdt.

STEP 5: VERIFY ENROLLMENT WITH MA AS AN MCO BILLABLE PROVIDER

SBHCs are not required to contract with MCOs; however, before receiving payment from MCOs, SBHCs must be added to a list of non-contracted SBHC providers. The Department will only add SBHCs that have followed the above steps to the list.

The Department will add SBHCs to the MCO billable list if the SBHC followed the steps above for MSDE approval and Medicaid enrollment. SBHCs should contact the **Staff Specialist at**: **410-767-1737** and verify that the application is complete and that the SBHC is an MCO billable provider. Please be prepared to provide the following information:

- Full name of school-based health center
    - Address
    - Telephone number
    - NPI number for SBHC
    - SBHC-specific Medical Assistance number, if applicable
        - *If sponsoring agency (e.g., FQHC or LHD) does not have a specific NPI and Medical Assistance number for each SBHC, information of sponsoring agency needs to be provided instead.*
- Age or gender restrictions
- Billing entity if applicable
    - Tax ID number for sponsoring agency
    - "Pay to" address
    - NPI number of sponsoring agency (e.g., LHD or FQHC)
    - 9-digit Medical Assistance (MA) number
- Copy of SBHC approval from MSDE (if not sent previously)

STEP 6: FOLLOW HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PROTOCOL

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. Additional information on HIPAA can be obtained from the following websites:

https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/PrivacyandSecurityInformation.html

https://health.maryland.gov/hipaa/

STEP 7: BILL APPROPRIATE PARTY FOR SERVICES RENDERED

To ensure payment and before providing services to a Maryland Medicaid participant, SBHCs must verify:

- The SBHC's Medical Assistance provider number is effective on the date of service;

- The student is eligible for MA on the date of service. Because eligibility can change after an MA card is issued, **always** verify the student's eligibility using the Eligibility Verification System (EVS) (see ELIGIBILITY VERIFICATION SYSTEM (EVS) section for details);

- If EVS indicates that the student is an MCO enrollee, bill the MCO for services rendered (see Attachment 1: MCO Contact Information for MCO addresses);

- If the student with Medical Assistance coverage has other insurance (e.g., TriCare, Carefirst, etc.), bill the other insurance for services rendered. Exceptions include claims for well-child care and immunization, which can be billed without first billing the third-party insurer (see page 23 regarding specific CPT codes that are exempt from third party billing).

- If the student with Medical Assistance coverage is not enrolled in an MCO, bill Medical Assistance fee-for-service.

- The service rendered is billable under self-referral regulations for SBHCs. This manual does not cover billing guidelines for the he following services:
  - Mental Health;
  - Substance Use Disorder Services;
  - Dental, including fluoride varnish;
  - Services covered by an IEP/IFSP; and
  - Services typically covered by a school nurse.

For more details on how to become a provider for the above services, please visit http://health.maryland.gov/providerinfo.

II. ELIGIBILITY VERIFICATION SYSTEM (EVS)

It is the SBHC's responsibility to check EVS on the date of service provision to ensure the student's eligibility and Medicaid reimbursement.

Before providing services, or at the time of enrollment, request the student's Medical Assistance (Medicaid) program identification card to obtain the member number for use on the EVS. The EVS enables providers to verify a Medical Assistance participant's current eligibility status. If applicable, the EVS will also provide information regarding a participant's MCO or third party insurance. The EVS also allows a provider to verify past dates of eligibility for up to one year.

If the student does not have the Medicaid card, request a Social Security number, which may also be used to verify eligibility via EVS. If the Social Security number is on file, SBHCs may search current eligibility and/or past eligibility up to one year by using a participant's Social Security number and first two initials of the last name.

If additional information is needed, please call MDH's **Provider Relations Unit** at **410-767-5503** or **800-445-1159**.

A. HOW TO USE WEB EVS

For providers enrolled in eMedicaid, Web EVS is 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 additional information is needed, please visit the web site.

If additional information is needed, please call MDH's **Provider Relations Unit** at **410-767-5503** or **800-445-1159**.

B. HOW TO USE PHONE EVS

For instructions on using the phone EVS system to verify a recipient's eligibility, visit:

https://mmcp.health.maryland.gov/docs/EVS_Brochure_June2016.pdf

III. BILLING INFORMATION

A. FILING STATUTES

Please bill promptly. Claims received after the timely filing rules deadline will be denied. If the student is enrolled in an MCO on the date of service, bill the MCO directly. The following statutes must be followed for timely billing:

- MCOs must receive claims within 180 days from the date of service;
- Medicaid must receive Fee-For-Service (FFS) claims within 12 months of the date of service;
    - A Remittance Advice, Medicare/Third-party Explanation of Benefits (EOB), IMA-81 (letter of retro-eligibility) and/or a returned date-stamped claim from the program are the **only** documents that will be accepted as proof of timely filing.

Please find MCO contact information in Attachment 1.

B. PAPER CLAIMS

If a provider is submitting paper claims, the provider must use a CMS-1500 form. Claims can be submitted in any quantity and at any time within the filing time limitation. Once Medical Assistance receives a claim, it may take 30 business days to process. Invoices are processed on a weekly basis. Payments are issued weekly and mailed to provider's "pay-to" address. For those services rendered to students **not** enrolled in an MCO, mail FFS claims to the following address:

Claims Processing
Maryland Department of Health
P.O Box 1935
Baltimore, MD 21203-1935

Reminder: CMS has updated the CMS 1500 form due to ICD-10 implementation on October 1, 2015. Medicaid will accept only the updated ICD-10 compliant version of the CMS 1500 form.

For MCO Claims: Paper claims for students enrolled in HealthChoice must be submitted to the appropriate MCO. Once an MCO receives a claim, they are required to process claims within 30 calendar days (or pay interest). For MCO billing addresses and contact information, please see Attachment 1.

C. ELECTRONIC CLAIMS

If a provider chooses to submit claims electronically, HIPAA regulations require providers to complete electronic transactions using ANSI ASC X12N 837P, version 5010A. **Before** submitting electronic claims directly or through a billing service, a provider must have a signed *Submitter Identification Form* and *Trading Partner Agreement* on file. Providers must also undergo testing before transmitting such claims. Electronic claims are generally paid within two weeks of submission.

Testing information and companion guides to assist providers for electronic transactions can be found at: https://health.maryland.gov/HIPAA

For MCO Claims: SBHCs should contact individual MCOs if interested in billing electronically. MCOs are not required to accept electronic claims. Each MCO may require separate testing. For MCO billing contact information, please see Attachment 1.

IV. CMS-1500 BILLING INSTRUCTIONS

When filing a paper claim, providers must use original CMS-1500 forms available from the **Government Printing Office** at **202-512-1800**, the American Medical Association, and major medical-oriented printing firms. See the following website for more information: **https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html**

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 patient 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. Exceptions include claims for well child care and immunization, which can be billed without first billing the other third party insurer (see page 23 regarding the specific CPT codes that may be billed to Medical Assistance without first billing the other third party insurer).

NOTE: CHANGES TO THE CMS 1500 FORM

Effective April 1, 2014, Maryland Medicaid accepts only the revised CMS 1500 form – Version 02/12.

Changes to the CMS 1500 form were made to accommodate the implementation of ICD-10 diagnostic coding format. Changes are reflected in the CMS-1500 form billing instructions below.

For more information about ICD-10 conversion and changes to the CMS 1500 form, please visit: https://mmcp.health.maryland.gov/Pages/ICD-10-Conversion.aspx.

A. HOW TO PROPERLY COMPLETE THE CMS-1500 FORM

The following table provides information on how to complete the **required** blocks on the CMS-1500 form. All blocks not listed in this table may be left blank. For help completing the CMS-1500 form, please see the mock claims in Attachments 2 and 3.

Please note that for Medical Assistance claims 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	Check all appropriate box(es) for all type(s) of health insurance applicable to this claim.
Block 1a	**INSURED'S ID NUMBER** **1. When billing an MCO**, enter the participant's unique MCO enrollee

	number. Please note that not all MCOs have unique MCO numbers for their clients. If there is no unique MCO number for a particular participant, enter the participant's MA number in this box. At this point in time, MedStar Family Choice, UnitedHealthcare, and Priority Partners are the only MCOs that have unique numbers. If you do not have the student's unique number, call the MCO and get that number at the same time that you are calling to get information on the student's PCP. All other MCOs accept the students MA number in this block. **2. When billing MDH for a FFS client**, no number is required in this box.
Block 2	**PATIENT'S NAME** (Last Name, First Name, Middle Initial) – Enter the patient's name as it appears on the Medical Assistance card.
Block 3	**PATIENT'S BIRTH DATE/SEX** – Enter the patient's date of birth and sex.
Block 4	**INSURED'S NAME** (Last Name, First Name, Middle Initial) – If the student has other third party insurance, enter the name of the person in whose name the third party coverage is listed. ***(No entry required when billing for a student without third-party insurance)***
Block 5	**PATIENT'S ADDRESS** – Enter the patient's complete mailing address with zip code and telephone number.
Block 6	**PATIENT'S RELATIONSHIP TO INSURED** – If the student has other third party insurance, aside from Medicare, enter the appropriate relationship to the insured. ***(No entry required when billing for a student without third party insurance).***
Block 7	**INSURED'S ADDRESS** – When the student has third party health insurance coverage aside from Medicare, enter the insured's address and telephone number. ***(No entry required when billing for a student without third party insurance).***
Block 8	**RESERVED FOR NUCC USE**
Block 9a (Blocks 9b and 9c reserved for NUCC use)	**OTHER INSURED'S POLICY OR GROUP NUMBER** – Enter the patient's 11-digit Maryland Medical Assistance number. The MA number **must** appear in this Block regardless of whether or not a patient has other insurance. Medical Assistance eligibility should be verified on each date of service by web or phone EVS. EVS is operational 24 hours a day, 365 days a year at the following number: 1-866-710-1447 or online at http://www.emdhealthchoice.org
Block 10a through 10c (Block 10d only for abortion-related billing)	**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.
Block 11	**INSURED'S POLICY GROUP OR FECA NUMBER** – If the patient has third party health insurance and the claim has been rejected by that insurance, enter the appropriate rejection code listed below: **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) For information regarding patient's coverage, contact MDH's Third Party Liability Unit at 410-767-1771.
Block 11a	**INSURED'S DATE OF BIRTH** – ***(No entry required when billing for a student without third party insurance).***
Block 11b	**EMPLOYER'S NAME OR SCHOOL NAME** – ***(No entry required when billing for a student without third party insurance).***
Block 11c	**INSURANCE PLAN OR PROGRAM NAME** – ***(No entry required when billing for a student without third party insurance).***
Block 11d	**IS THERE ANOTHER BENEFIT PLAN?** – ***(No entry required when billing for a student that doesn't have another third party insurance in addition to the one already described in 11 above).***
Block 12	**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE** – If the school already has an authorized signature on file for the student, this section should read, "Signature on File" and include the billing date.
Block 13	**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE** – ***No entry required when billing for a FFS client or a client without third party insurance.*** If the school already has an authorized signature on file for the student, this section should read, "Signature on File"
Block 14	**DATE OF CURRENT ILLNESS, or INJURY, or PREGNANCY**
Block 15	**IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (OTHER DATE)**
Block 17	**NAME OF REFERRING PHYSICIAN OR OTHER SOURCE** – Block 17 should be completed in cases where there is a referring provider and the services rendered require provider referral. **For services that require a referral the referring provider must be actively enrolled with Maryland Medicaid.**
Block 18	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES – No entry required.**
Block 19	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**
Block 20	**OUTSIDE LAB –*No entry required***
Block 21	**DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY** – Enter the 3, 4, 5, 6, or 7 character code from the ICD-10-CM manual 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 through H. Additional diagnoses are optional and may be listed on Lines I through L. All diagnoses must be coded to the highest level of specificity available. All letters must be upper-case.
Block 23	**PRIOR AUTHORIZATION NUMBER** – For those services that require preauthorization, a preauthorization number **must** be obtained and entered in this Block.
Block 24 A-G (shaded area)	**NATIONAL DRUG CODE (NDC)** – Report the NDC/quantity when billing for drugs using HCPCS J-codes. Allow for the entry of 61 characters from the beginning of 24A to the end of 24G. Begin by entering the qualifier **N4,** followed by the 11-digit NDC number. It may be necessary to pad NDC numbers with left-adjusted zeroes in order to report eleven digits. 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: **Measurement Qualifiers** **F2 International Unit, GR Gram, ML Milliliter, UN Units, ME Milligram** 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 NDCs.
Block 24A	**DATE(S) OF SERVICE** – Enter each separate date of service as a 6-digit numeric date (e.g. June 1, 2016 would be 06/01/16) 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.
Block 24B (Block 24C leave blank)	**PLACE OF SERVICE** – For each date of service, enter the code to describe the site. **Note: SBHCs must use Place of Service code "03"- School**
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 6-8 in Physicians' Fee Schedule for use of modifiers.
Block 24E	**DIAGNOSIS POINTER** – Enter a single diagnosis or combination of diagnoses from Block #21 above for each line on the invoice. *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 than one unit of service on a line, the charge for that line should be the total of all units.
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.
Block 24J (shaded area)	**RENDERING PROVIDER ID # –** **<u>For FQHCs:</u>** Enter the NPI number of the individual provider rendering care (required for FQHCs). **<u>All FQHCs must report an individual rendering provider, and the provider MUST be actively enrolled with Maryland Medicaid with a valid Provider ID.</u>** **<u>For Other Sponsoring Entities:</u>** – Enter the NPI number of the SBHC. Note: Use the NPI number of sponsoring agency (e.g., LHD) when there is no specific NPI number for each SBHC site.
Block 25	**FEDERAL TAX I.D. NUMBER** – This block requires the Federal Tax I.D. number for the Billing Provider entered in Box 33.
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 patient's MA number is incorrect, the patient account number will be recorded on the Remittance Advice (RA).
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.
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 participant for covered services.	
Block 28	**TOTAL CHARGE –** Enter the sum of the charges shown on all lines of Block #24F of the invoice.
Block 29	**AMOUNT PAID** – Enter the amount of any collections received from any third party payer, except Medicare. If the patient has third party insurance and the claim has been rejected, the appropriate rejection code should be placed in Block # 11.
Block 30	**RESERVED FOR NUCC USE**
Block 31	**SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS –** **<u>For students enrolled in MedStar Family Choice:</u>** Please give the full name of the rendering provider (nurse practitioner). **<u>For all other MCOs/FFS</u>:** Please write "Signature on File." In both cases, please include the date of submission.
NOTE: The date of submission must be in Block 31 in order for the claim to be reimbursed.	
Block 32	**SERVICE FACILITY LOCATION INFORMATION** – Enter complete name and address of the SBHC.
Block 32a	**NPI** – Enter SBHC's NPI number. Note: Use the NPI number of sponsoring agency (e.g., LHD or FQHC) when there is no specific NPI number for SBHC

	sites.
Block 32b (shaded area)	Enter the ID Qualifier "**1D" (Medicaid Provider Number)** followed by the SBHC's 9-digit Maryland Medicaid (legacy) provider number. Note: Use the Medicaid Provider Number of sponsoring agency (e.g., LHD or FQHC) when there is no specific provider number for SBHC sites.
Block 33	**BILLING PROVIDER INFO & PH#** - Enter the name and complete address to which payment and/or incomplete claims should be sent. The billing provider should match the federal Tax I.D. number entered in Block 25.
Block 33a	**NPI** - Enter SBHC's NPI number. Note: Use the NPI number of sponsoring agency (e.g., LHD or FQHC) when there is no specific NPI number for SBHC sites. Errors or omissions of this number will result in non-payment of claims.
Block 33b (shaded area)	Enter the ID Qualifier **1D (Medicaid Provider Number)** followed by the 9-digit MA (legacy) provider number of the pay-to provider in Block #33. Errors or omissions of this number will result in non-payment of claims.
NOTE: It is the provider's responsibility to promptly report all name changes, "pay to" addresses, correspondence addresses, practice locations, tax identification numbers, or certifications to the MDH's Provider Master File via Provider Relations at 410-767-5340. SBHCs should also contact Earl Tucker at 410-767-4078 with any changes.	

To ensure proper completion of a claim, please follow the guidelines below:

1. Enter the appropriate rendering and pay-to provider information in Blocks 24J, 25, 32 and 33

- ✓ Block 24J should contain information for the individual rendering provider (required for FQHCs).
- ✓ Blocks 25, 32, and 33 should contain information for the SBHC sponsoring entity.

2. **Establish provider and/or participant eligibility on the dates of services**

- ✓ Verify that provider is enrolled prior to rendering services; and
- ✓ Verify that Block 24a of the claim includes the correct dates of service. Providers must verify participant eligibility via EVS on the date of services rendered. If EVS verifies eligibility and the claim is denied due to participant ineligibility, double-check that the claim includes correct dates of service.

3. Make sure the medical services are covered/authorized for the provider and/or participant

- ✓ A valid 2-digit place of service code is required. SBHCs must use Place of Service "03" – School;
- ✓ Claims will deny if the procedure cannot be performed on the participant because of gender, age, prior procedure or other medical criteria conflicts. Verify the 11-digit enrollee MA number, procedure code and modifier on the claim form; and
- ✓ Verify that the services are covered for the participant's coverage group. Covered services vary by population and program. For example, some participants have coverage only for family planning services. If you bill the Program for procedures other than family planning, these are considered non-covered services and the claim **will not** be

paid. Refer to regulations for each program type to determine the covered services for that program.

B. REJECTED CLAIMS

Rejected claims will be listed on the Remittance Advice (RA) 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 detailed information about the claim. There are several reasons a claim may be rejected:

1. Data was incorrectly keyed or was unreadable on the claim

- Typing or printing clearly will help to avoid errors when a claim is scanned. When a claim is denied, always compare data from the RA with the file copy of your claim. If the claim denied because of a keying or scanning error, resubmit the claim with the corrected data.

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

- Verify the claim was not previously submitted;
- If the program determines that an enrollee has third party coverage that should be billed first, the claim will be denied. Submit the claim to the third party payer first (see exceptions on page 20); and
- If an enrollee has coverage through a HealthChoice MCO, the provider must bill that organization for services rendered.

For MCO Rejected Claims: The information above is true for claims submitted to Medical Assistance; each MCO sets its own rules for rejection of claims and provides varying information on the EOB (see MCO manuals for further information).

C. HOW TO FILE AN ADJUSTMENT REQUEST

To submit an adjustment request for an inaccurate payment, please refer to Section V part F (How to File and Adjustment Request) in the Maryland Medicaid CMS-1500 Paper Billing Instructions:

https://mmcp.health.maryland.gov/docs/dhmh_cms_1500_billing_instructions_092315.pdf.

For MCO Adjustment Requests: The information above only applies to claims submitted to Medical Assistance; the Adjustment Request Form (DHMH 4518A) is not valid for an MCO. SBHCs will have to submit corrected claims or appeals directly to the MCO. For information on how to file an adjustment with an MCO, see the contact information provided in Attachment 1.

V. SCHOOL-BASED HEALTH CENTER SERVICES

The following list of covered services is not exhaustive, but provides a listing of the most commonly used services within SBHCs. While this manual provides commonly used billing codes, LHD SBHCs can only bill for MDH's Program Cost and Analysis approved CPT codes.

FOR CURRENT FEE SCHEDULES, SEE THE MEDICAID PROVIDER INFORMATION PAGE: http://health.maryland.gov/providerinfo

A. PRIMARY CARE SERVICES

SBHCs may diagnose and treat all illnesses and injuries that can be effectively managed in a primary care setting. Follow the General Billing Practices noted in the Professional Services Billing Manual: **http://health.maryland.gov/providerinfo**

Providers should refer to the fee schedule to obtain a complete 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 code that most accurately identifies the service performed. For example:

Evaluation and Management Office Visit Codes

Procedure	CPT Code
Office visit, New patient, minimal (10 minutes)	99201
Office visit, New patient, moderate (20 minutes)	99202
Office visit, New patient, extended (30 minutes)	99203
Office visit, New patient, comprehensive (45 minutes)	99204
Office visit, New patient, complicated (60 minutes)	99205
Office visit, Established patient, minimal (5 minutes)	99211
Office visit, Established patient, moderate (10 minutes)	99212
Office visit, Established patient, extended (15 minutes)	99213
Office visit, Established patient, comprehensive (25 minutes)	99214
Office visit, Established patient, complicated (40 minutes)	99215

B. HEALTHY KIDS/EPSDT

For complete information regarding Healthy Kids/EPSDT, please refer to: https://mmcp.health.maryland.gov/epsdt.

The Maryland Healthy Kids/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services is a comprehensive pediatric program to be billed only by those physicians, nurse practitioners and free-standing clinics that are certified by the Program as Healthy Kids/EPSDT providers. These services are available to Medicaid participants from birth through 20 years of age.

It is recommended that SBHCs use the Age-Specific Encounter Forms to document Healthy Kids/EPSDT preventive health care screens. These forms are available at: **https://mmcp.health.maryland.gov/epsdt/healthykids/Pages/providerforms.aspx**

To bill for EPSDT services, SBHCs must:

- Be certified to provide Healthy Kids/EPSDT services; (access the EPSDT Provider Application for Certification & Participation at: **https://mmcp.health.maryland.gov/epsdt**);
- Render preventive care services according to Healthy Kids/EPSDT standards as described in the Healthy Kids Manual published at: **https://mmcp.health.maryland.gov/epsdt/healthykids/Pages/Provider-Manual.aspx**
- Provide follow-up of positive or suspect EPSDT screening components, without approval of the student's Primary Care Provider, except where referral for specialty care is indicated; and
- Use the age appropriate CPT preventive medicine codes for billing Healthy Kids services.

1. Preventive Medicine Service Codes

Procedure	CPT Code
New patient 1 – 4 years	99382
New patient 5 – 11 years	99383
New patient 12 – 17 years	99384
New patient 18 – 39 years	99385
Established patient 1 – 4 years	99392
Established patient 5 – 11 years	99393
Established patient 12 – 17 years	99394
Established patient 18 – 39 years	99395

If a student presents for a problem-oriented visit and the student is due for a preventive visit, it is recommended that the SBHC complete the Healthy Kids screen, in addition to rendering care for the presenting problem, and use the appropriate CPT preventive code. However, providers typically cannot bill for a "problem-oriented" and preventive visit for the same student, on the same day. If only "problem-oriented" care is rendered, use the appropriate Evaluation and Management (E&M) CPT codes provided on the previous page for time and level of complexity.

Under certain situations, however, a preventive exam and another E&M service may be payable on the same day. In this case, providers should select the most appropriate single E&M service based on all services provided. If an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventative medicine E&M service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the appropriate office/outpatient code should also be reported; conversely, an insignificant or trivial abnormality should not be reported.

Modifier -25 should be added to the office/outpatient code to indicate that a significant, separately identifiable E&M service was provided by the same physician on the same day as the preventative medicine service. The appropriate preventative medicine service should be reported separately.

Payment for oral health assessment completed by Healthy Kids certified providers as part of the preventive care examination is included in the preventive code.

2. Objective Hearing and Vision Tests, Developmental Screening Codes

Objective hearing and vision tests can be billed in addition to the preventive screen. Providers can also bill separately for developmental screening with an approved or recommended standardized, validated general developmental screening tool during either a preventive or episodic visit using CPT code 96110 (see below).

Procedure	**CPT Code**
Hearing/Screening test, Pure air only	92551
Vision screen	99173
Developmental testing: Limited (e.g. Ages and Stages Questionnaire, Pediatric Evaluation of Developmental Status) with interpretation and report. Documentation for developmental screening should include: • Any parental concerns about the child's development; • The name of screening tool used; • The screening tool results, reviewing all major areas of development; • An overall result of the development assessment for age (e.g. normal, abnormal, needs further evaluation); and • A plan for referral or further evaluation when indicated.	96110[1, 2]

[1] For FFS patients: Providers may bill a maximum of two units of CPT 96110 on the same date of service when a screening tool for autism or a social-emotional screening tool is administered in addition to a general developmental screening tool. A standardized, validated tool must be used.

[2] For MCO patients: If providers bill for more than one unit of service, they must use the modifier "59" following the CPT code.

3. Vaccine Administration/Vaccines for Children (VFC) Program

In order to provide Healthy Kids/EPSDT preventive services, SBHC's must register with the Vaccines For Children (VFC) Program and **must** provide the recommended childhood vaccines when performing EPSDT preventive screens. EPSDT providers **must** administer services specified in the Maryland Healthy Kids Preventive Health Schedule, available at https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx.

The VFC Contact Center is available to answer questions regarding enrollment, ordering vaccines, and vaccine administration. Visit the VCF Contact Center website for list of phone numbers for providers do contact the center based on their location. Contact the center by email at MDH.IZinfo@maryland.gov.

SBHCs may bill for administering childhood vaccines received free from the VFC Program by using the appropriate CPT code for the vaccine/toxoid or immune globulin in conjunction with the modifier – SE (State and/or Federally-funded programs/services). Providers will not be reimbursed for vaccine administration unless the modifier –SE is added to the end of the appropriate CPT vaccine code.

VFC immunization administration codes are as follows:

VACCINE	CPT-MOD
Hepatitis B Immune Globulin (HBIg)	90371-SE
Influenza virus, quadrivalent (IIV4), split virus, preservative free, for IM use	90630-SE
Hepatitis A, pediatric/adolescent (2 dose)	90633-SE
Hemophilus influenza b, HbOC conjugate (Hib)	90645-SE
Hemophilus influenza b, PRP-OMP conjugate (Hib)	90647-SE
Hemophilus influenza b, PRP-T conjugate (Hib)	90648-SE
Human Papilloma, quadrivalent (3 dose) (HPV)	90649-SE
Human Papilloma virus (HPV) vaccine, types 6,11,16,18,31,33,45,52,58 nonavalent, (3 dose) for ID use	90651-SE
Influenza virus, split virus, preservative free, 6-35 months	90655-SE
Influenza virus, split, preservative free, > 2 yrs	90656-SE
Influenza virus, split virus, 6-35 months	90657-SE
Influenza virus, split virus, 3-18 years	90658-SE
Influenza virus, live, intranasal	90660-SE
Pneumococcal conjugate, 7 valent, < 5 years	90669-SE
Pneumococcal conjugate, 13 valent	90670-SE

VACCINE	CPT-MOD
Rotavirus, pentavalent, live,oral, (3 dose)	90680-SE
Rotavirus, monovalent, live, 6-32 weeks	90681-SE
Diptheria, tetanus toxoids, acellular pertussis and polio virus, inactivated, 5th dose, 4-6 years (DTaP-IPV)	90696-SE
Diptheria, tetanus toxoids, acellular pertussis, haemophilus influenza type b, poliovirus, 2-59 months (DTaP-Hib-IPV)	90698-SE
Diphtheria, tetanus toxoids and acellular pertussis, < 7 years (DTaP)	90700-SE
Diphtheria and tetanus toxoids, < 7 years(DT)	90702-SE
Measles, mumps and rubella virus, live (MMR)	90707-SE
Measles, mumps, rubella and varicella (MMRV)	90710-SE
Poliovirus, inactivated (IPV)	90713-SE
Tetanus and diphtheria toxoids, 7-18 years (Td)	90714-SE
Tetanus diphtheria toxoids and acellular Pertussis (Tdap) 7-18 years	90715-SE
Varicella virus live	90716-SE
Tetanus toxoid and diphtheria (Td) 7-18 years	90718-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
Pneumococcal polysaccharide, 23-valent, 2-18 yrs	90732-SE
Meningococcal conjugate, tetravalent	90734-SE
Hepatitis B, adolescent (2 dose)	90743-SE
Hepatitis B, pediatric/adolescent (3 dose)	90744-SE
Hepatitis B and Hemophilus influenza b (HepB-Hib)	90748-SE

For participants?students? 19 or 20 years of age (past the VFC age group)**,** Medicaid will reimburse providers for the acquisition cost of vaccines purchased by the provider. MCOs are also required to cover such vaccines. Use the CPT codes with no modifier for the applicable immunizations administered to the Medicaid participant. A separate administration fee is not paid for provider stock used for MA participant/student.

Students who are behind on their immunizations can be scheduled for additional inter-periodic preventive visits to “catch up” on their vaccinations using the appropriate Evaluation and Management (E&M) CPT code based on “complexity” and time with an ICD-10 diagnosis code

in the Z00 family (see primary care services on page 19). **However, a visit for the sole purpose of providing a vaccine with no other service rendered may not be billed. Contact the Healthy Kids Program at 410-767-1683 with questions about vaccine reimbursement.**

Fulfillment of the requirements of the Maryland Healthy Kids Preventive Health Schedule is mandatory for reimbursement. Medicaid will not reimburse providers for a well-child visit if the provider cannot meet the requirements of the schedule.

C. LABORATORY AND PATHOLOGY SERVICES

All providers billing for any laboratory service(s) must be CLIA certified and have Maryland State laboratory certification. Contact MDH's **Division of Hospital and Physician Services** a**t 410-767-3074** for information regarding CLIA certification. For MCO enrollees, any lab tests not performed "in house" must go through a lab contracted with the enrollee's MCO. All MCOs currently have contracts with LabCorp with the exception of Kaiser Permanente, which contracts with Quest Diagnostics. The following lab codes are frequently used in SBHC/primary care settings and can also be billed in addition to the Healthy Kids preventive codes:

Procedure	**CPT Code**
Venipuncture under 3 yrs, physician skill (e.g. blood lead)	36406
Venipuncture, physician skill, child 3 yrs and over (e.g. blood lead)	36410
Venipuncture, non-physician skill, all ages	36415
Capillary blood specimen collection, finger, heel, earstick (e.g. PKU, blood lead filter paper, hematocrit)	36416
Urinalysis/microscopy	81000
Urine Microscopy	81015
Urine Dipstick	81005
Urine Culture (Female Only)	87086
Hematocrit (spun)	85013
Hemoglobin	85018
PPD – Mantoux	86580

D. HEALTHY KIDS/EPSDT EXCEPTIONS FOR THIRD PARTY BILLING

When participants have both Medicaid and other insurance coverage, the SBHC must bill the other insurance first. However, States are required to exempt certain Healthy Kids/EPSDT services from this rule.

For preventive services, SBHCs may submit the following codes directly to the appropriate MCO (or Medical Assistance, if appropriate) even if the child is covered by other third party insurance*:

- Preventive Medical Services (99381-99385, 99391-99395)
- Immunizations
- Developmental Tests (96110, 96111)
- Objective Hearing Tests (92551)
- Objective Vision Tests (99173)

**The Medical Assistance Program or the MCO will handle recoveries from the other insurances for these services. When the student has Medical Assistance and other third party insurance, do not bill the student for any co-pay or deductible associated with other insurance policies.*

Only the services/codes listed above are exempt. Other EPSDT components, such as laboratory tests and other primary care services, must first be submitted to the other insurer prior to billing Medical Assistance or the MCO.

E. FAMILY PLANNING

SBHCs may provide self-referred family planning services. Family Planning services provide individuals with the information and means to prevent an unwanted pregnancy and maintain reproductive health, including medically necessary office visits and the prescription of contraceptive devices. HealthChoice members may self-refer for family planning services without prior authorization or approval from their PCP with the exception of sterilization procedures.

The scope of services covered under this provision is limited to those services required for contraceptive management. In accordance with ICD-10, claims for family planning services must now use the diagnosis code "**Z30**." To indicate an Evaluation and Management code relates to a Family Planning service, include **Z30** on claims to HealthChoice MCOs. The following is a partial list of CPT codes that may be used to bill MCOs for these services:

Office visit, new patient, minimal (10 minutes)	99201
Office visit, new patient, moderate (20 minutes)	99202
Office visit, new patient, extended (30 minutes)	99203
Office visit, new patient, comprehensive (45 minutes)	99204
Office visit, new patient, complicated (60 minutes)	99205
Office visit, established patient, minimal (5 minutes)	99211
Office visit, established patient, moderate (10 minutes)	99212
Office visit, established patient, extended (15 minutes)	99213
Office visit, established patient, comprehensive (25 minutes)	99214
Office visit, established patient, complicated (40 minutes)	99215
Child office visit, new patient, preventative (age 12-17)	99384
Adult office visit, new patient, preventative (age 18-39)	99385
Child office visit, established patient (age 12-17)	99394
Adult office visit, established patient (age 18-39)	99395

Note: Special contraceptive supplies not listed above should be billed under CPT code 99070*
*A copy of the invoice for the contraceptive product must be attached to the claim when billing under procedure codes 99070, A4261, A4266, J7303, and J7304.

Please find the Professional Services Billing Manual as well as a list of Reproductive Health Provider Resources at http://health.maryland.gov/providerinfo.

MCOs must pay providers for pharmacy items and laboratory services when the service is provided onsite in connection with a self-referral service. For example, MCOs must reimburse medical providers directly for the administration of Depo-Provera from a stock supply of the drug. This eliminates unnecessary barriers to care which are created when members are asked to go to an outside pharmacy to get a prescription for Depo-Provera filled and then are required to return to the provider's office for the injection. Contact the staff specialist for Family Planning Services for additional information at **410-767-6750**.

F. TELEHEALTH

Maryland Medicaid's Telehealth Program employs a "hub-and-spoke" model. This model involves real-time interactive communication between the originating and distant sites via a secure, two-way audiovisual telecommunication system. The "hub," or "distant site," is the location of the provider who will perform the services. The "distant site provider" is the rendering practitioner that is physically present at the distant site. The "spoke," or "originating site" is where the participant/patient is located. The "telepresenter," physically located at the originating site with the participant, facilitates the telehealth communication between the participant and distant site provider by arranging, moving, or operating the telehealth equipment.

SBHCs that wish to bill Maryland Medicaid for telehealth services must register with the Maryland Medicaid Telehealth Program and comply with telehealth program regulations. Please find the Maryland Medicaid Telehealth Program manual, telehealth regulations, frequently asked questions, and telehealth provider registration forms at: https://mmcp.health.maryland.gov/Pages/telehealth.aspx.

VI. ATTACHMENTS

A. MCO CONTACT INFORMATION FOR SCHOOL-BASED HEALTH CENTERS

MCO Contacts for School-Based Health Centers

MCO Contact for SBHC Health Visit Reports	PCP Information	Coordination of Care	Billing	Claims
AMERIGROUP Community Care Mr. Brian Shird, Special Needs Coor. Phone: 410-981-4060 Fax: 866-920-1867 E-mail: brian.shird@amerigroup.com	Member/Provider Services Phone: 1-800-600-4441 (ask for live agent).	Mr. Brian Shird, Special Needs Coor. Phone: 410-981-4060 Fax: 866-920-1867 E-mail: brian.shird@amerigroup.com	Sandra Parker Phone: 410-981-4594 Fax: 866-920-1873 Email: Sandra.Parker@amerigroup.com	Attn: Claims Dept. Amerigroup Community Care P.O. Box 61010 Virginia Beach, VA 23466-1599
Jai Medical System, Inc Nyo Khine, M.D., UM Coor. Phone: 410.433.5600 Fax 410.433.8500 E-mail: nyo@jaimedical.com	Customer Service Department Phone 1.888.524.1999 Fax: 410.433.4615 E-mail: CustomerService@jaimedical.com	Chardae Buchanan, RN Special Needs Coordinator, Phone: 410.433.5600, Fax: 410.433.8500, E-mail: chardae@jaimedical.com	Provider Relations Department, Phone 1.888.524.1999, Fax: 410.433.4615, E-mail: ProviderRelations@jaimedical.com	Provider Relations Department, Phone 1.888.524.1999, Fax: 410.433.4615, E-mail: ProviderRelations@jaimedical.com
Kaiser Permanente Kenya Onley, Senior Director, Medicaid Operations Phone: 301.816.6564 E-mail: Kenya.C.Onley@kp.org	Member Services Call Center Victor Nevilles, Member Services Operations Manager Phone: 301-931-4187 E-mail: Victor.l.nevilles@kp.org	Christine Storey, Senior Director, Continuing Care Phone: 301-816-6798 E-mail: Christine.storey@kp.org	Provider Relations Jay Brain, Executive Director, Provider Contracting Phone: 301.816.6321 E-mail: Jay.Brain@kp.org	William Winters, Director of Claims Phone: 301-625-2207 E-mail: William.m.winters@kp.org
Medstar Family Choice Ms. Laura Trembly Phone: 410-933-2241 Fax: 410-933-2209 E-mail: Laura.A.Trembly@medstar.net	Outreach Department Phone: 1-800-905-1722 (Option 1)	Ms. Laura Trembly, Phone: 410-933-2241 Fax: 410-933-2209 E-mail: Laura.A.Trembly@medstar.net	Provider Relations Department Phone: 1-800-905-1722 (Option 5)	Attn: Claims Dept. Medstar Family Choice Claims Processing Center 10201 N. Port Washington Road Mequon, WI 53092 Phone: 1-800-261-3371 After August 31, 2015: MedStar Family Choice Claims Processing Center P.O. Box 2189 Milwaukee, WI 53201

MCO Contact for SBHC Health Visit Reports	PCP Information	Coordination of Care	Billing	Claims
Maryland Physicians Care Ms. Shannon Jones, Special Needs Coor. Phone: 410-401-9443 Fax: 860-907-2710 E-mail: Shannon.jones@marylandphyscicianscare.com	Member Services Phone: 800-953-8854 Fax: 1-866-648-1012	Shannon Jones Phone: 410-401-9443 Fax: 860-907-2710 E-mail: Shannon.Jones@marylandphysicia nscare.com	Mia Williams Manager, Provider Relations and Member Services Phone: 410-401-9404 Fax: 1-860-907-2715 E-mail: mia.williams@marylandphysiciansc are.com	Mia Williams Manager, Provider Relations and Member Services Phone: 410-401-9404 Fax: 1-860-907-2715 E-mail: mia.williams@marylandphysiciansc are.com
Priority Partners Julie Krenzer, Provider Engagement Liaison Provider Relations Johns Hopkins HealthCare LLC 6704 Curtis Court Glen Burnie, MD 21060 Phone: 1-855-633-7362 Fax: 410-641-2723 E-mail: jkrenzer@jhhc.com	Patrice Williamson, Network Manager (for SBHC's associated with BMS) Provider Relations Johns Hopkins HealthCare LLC 6704 Curtis Court Glen Burnie, MD 21060 Phone: 410-424-4400 x1509 Fax: 410-424-4604 E-mail: pwilliamson@jhhc.com Lory Marciniak, Network Manager (for SBHC's associated with Choptank Community Health) Provider Relations Johns Hopkins HealthCare LLC 6704 Curtis Court Glen Burnie, MD 21060 Phone: 443-249-0184 Fax: 410-424-4604 E-mail: lmarciniak@jhhc.om	Mateo, Ofelia, Program Manager Intake & Outpatient Medical Review, Utilization Management Johns Hopkins HealthCare LLC 6704 Curtis Court Glen Burnie, MD 21060 P/F: 410-762-5314 E-mail: OMateo@jhhc.com	Ivy Sims, Reporting and Compliance Analyst, Priority Partners Administration Johns Hopkins HealthCare LLC 6704 Curtis Court Glen Burnie, MD 21060 P/F: 410-762-1601 E-mail: isims@jhhc.com	Steve Lees, Director of Operations Office of COO Johns Hopkins HealthCare LLC 6704 Curtis Court Glen Burnie, MD 21060 Phone: 410-424-4950 E-mail: slees@jhhc.com
Riverside Health, Inc. Stephanie Selby, RN Acting Vice President of Health Services Phone: 443-552-3250 E-mail: sselby@myriversidehealth.com	Dan Fredman Vice President of Provider Relations Phone: 443-552-3263 E-mail: dfredman@myriversidehealth.com	Stephanie Selby, RN Acting Vice President of Health Services Phone: 443-552-3250 E-mail: sselby@myriversidehealth.com	Provider Relations Department Phone: 800-730-8543 / 410-779-9359	Riverside Health of Maryland, Inc. PO Box 1572 Bowie, MD 20717-1572 Phone: 800-730-8543 / 410-779-9359
UnitedHealthcare Community Plan Theresa Ervin, Director of Operations 6220 Old Dobbin Lane Columbia, MD 21075 Phone: 443-896-9069 Fax: 866-373-1098	UnitedHealthcare Community Plan Theresa Ervin, Director of Operations 6220 Old Dobbin Lane Columbia, MD 21075 Phone: 443-896-9069 Fax: 866-373-1098	UnitedHealthcare Community Plan Theresa Ervin, Director of Operations 6220 Old Dobbin Lane Columbia, MD 21075 Phone: 443-896-9069 Fax: 866-373-1098	UnitedHealthcare Community Plan Theresa Ervin, Director of Operations 6220 Old Dobbin Lane Columbia, MD 21075 Phone: 443-896-9069 Fax: 866-373-1098	UnitedHealthcare Community Plan Theresa Ervin, Director of Operations 6220 Old Dobbin Lane Columbia, MD 21075 Phone: 443-896-9069 Fax: 866-373-1098

B. GUIDANCE ON BILLING REQUIREMENTS FOR LOCAL HEALTH DEPARTMENT-SPONSORED SCHOOL BASED HEALTH CENTERS

Health-Gen. § 16-201(b)(1) requires the local health departments (LHD) to set charges for the services that they provide subject to approval by the Secretary.[1] Additionally, state regulations require LHDs to assess a patient's ability to pay and, if necessary, collect payment using a sliding fee scale developed by the Department.[2] However, Health-Gen § 16-201(b) (2) allows Local Health Officers (LHOs) the authority to waive charges entirely when doing so is in the best interest of public health.[3] This guidance document provides clarification on LHD billing requirements, specifically related to MSDE-approved, LHD-sponsored School Based Health Centers (SBHCs).

SBHCs are safety net providers operating within schools to improve access of children and families to needed clinical services. Coordinating billing and payment collection within a school setting is challenging, and even minimal charges to families may deter use of an important safety net service. Students obtaining services within a SBHC may have varying insurance status including public or private insurance or be uninsured. SBHCs may bill and be reimbursed for services by the Maryland Medicaid fee-for-service (FFS) program, the Medicaid HealthChoice managed care organizations (MCOs), private insurance or other insurers.

Several LHD sponsored SBHCs have asked for clarification regarding whether the SBHC may waive charges for some students, specifically uninsured students, or if the SBHC is still bound by the Maryland requirement to charge according to a LHD sliding fee scale.

SBHCs should charge students who are uninsured using the Department approved sliding fee scale, or SBHCs may seek a waiver from their LHO from this requirement.

For SBHCs that choose *not* to bill uninsured students and the LHO approves a waiver, recent federal guidance clarifies that providers can bill Medicaid for these services that are provided free of charge to the non-Medicaid population. The Centers for Medicare and Medicaid Services (CMS) issued guidance in December 2014 clarifying that Medicaid may pay providers (including SBHCs) for services provided free of charge to non-Medicaid patients. The guidance primarily impacts public health providers who may have previously wanted to bill Medicaid for certain services provided free of charge to those without any insurance or to undocumented individuals, but could not before this Free Care Policy clarification from CMS.

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[1] Health-Gen. § 16-201(b)(1): "The Secretary shall require political subdivisions and grantees to set, subject to approval and modifications of the Secretary, charges for services that are provided by the political subdivisions or grantees and that are supported wholly or partly by State or federal funds administered by the Department."

[2] COMAR 10.02.01.08B (4): "All local health departments and other providers shall use the uniform method of determining ability to pay as set forth by the Secretary." Department funded programs should use the sliding fee scale set forth by the Secretary.

[3] Health-Gen § 16-201(b)(2): "If a health officer for a political subdivision considers it to be in the best interest of public health, the health officer may waive a charge set under this subsection." The basis for granting waivers must be documented and be applied in in accordance with the Department's Service Nondiscrimination Policy 01.02.01.