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

CMS-1500 PART B
MEDICARE ADVANTAGE PLAN
BILLING INSTRUCTIONS

Effective September, 2008

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INTRODUCTION

These billing instructions have been prepared to provide proper procedures and instructions for Medicare Advantage Plans for Maryland Medicaid providers who use the CMS-1500 (08-05) form.

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI is a HIPAA mandate requiring a standard unique identifier for health care providers. When billing on paper, providers must include their unique 10-digit NPI number and the provider's 9-digit Medicaid provider 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 7. Additional information on NPI can be obtained from the CMS website at:

http://www.cms.hhs.gov/NationalProvIdentStand/
http://www.dhmh.state.md.us/mma/mmahome.html

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. (S*ee instructions on page 3.)*
- You determine if the recipient is in 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 claim form. Claims can be submitted in any quantity and at any time within the filing limitation.

Filing Statutes: Claims ***must*** be received within 9 months of the date of service. The following statutes are in addition to the initial claim submission.

- 9 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.

Once a paper 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. All claims should be mailed to the following address:

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

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.

MEDICARE/MEDICAL ASSISTANCE CROSSOVER CLAIMS

When a Medical Assistance provider bills Medicare Part B for services rendered to a MA recipient, and the provider accepts assignment on the claim (Block #27), Medical Assistance pays the provider the Medicare coinsurance and/or deductible amount(s) in full less any other third party payments (i.e., Medigap).

In order for claims to be accurately cross-referenced to your Medicaid provider number, be sure to advise the Claims Processing/Medicare Crossover Unit of your Medicare provider number and NPI number so that all provider numbers can be properly linked in the Medicaid system. Requests to add, change, or delete information on the Medicare crossover file must be sent in writing to the address below Attention: Jack Collins or call 410-767-5559.

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. In order for MA to pay for co-insurance and deductibles, the CMS-1500 and the Medicare EOMB must be submitted. Claims should be sent to the original claims address:

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

CMS-1500 MEDICARE EOMB REQUIREMENTS

Medicaid requires an EOMB for all Medicare crossover claims filed on a paper claim.

- **NOTE: Medicaid will reimburse Medicare Advantage Plans co-payments, coinsurance and deductibles, with the following exceptions:**

  We will not reimburse Medicare Advantage Plan claims for recipients deemed eligible for the Specified Low Income Medicare Beneficiaries (SLMB) Program.

  Combined co-payments and coinsurance may not exceed 20%.

In order to ensure that claims are processed appropriately, the following information is required on the EOMB:

Requirements for EOMB Header:

- **In the absence of identifying Medicare information on the EOMB, the provider must label the EOMB attachment "MEDICARE EOMB" to assure proper processing of the claim.**
- Provider Name
- Provider Medicare Legacy Number
- Provider NPI number
- Medicare Payment Date
- Column Headings (title)

Requirements for individual claim lines CMS-1500 Part B:

- Date of service
- Procedure code plus modifiers (up to 4 spaces for modifiers when applicable)
- Charged amount for each procedure
- Allowed amount for each procedure
- List deductible amounts (if any)
- List co-insurance amounts (co-pay amounts not payable)
- Patients Medicare ID number
- Total deductible amounts (if any)
- Total co-insurance amount
- Total Medicare payment (even if zero)

Note: If Medicare denies a service or claim, a written description of the reason/remark code(s) is required for all code(s).

Failure to comply with the above requirements will result in a denial of the claim and further delay in processing of the claim for payment. You may contact the Medicare Liaison Unit at 410-767-5559 for further assistance.

CMS-1500 BILLING INSTRUCTIONS FOR MEDICARE PART B CROSSOVER CLAIMS

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 firms, or visit: ***(http://www.cms.hhs.gov/providers/edi/cms1500.pdf)***

Instructions for the completion of each block of the CMS-1500 are provided in this section. See page 20 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.

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. - **Required**

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 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 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 410-767-1771. **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 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE – 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. **Required**

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

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 21 DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY – Enter the 3, 4, or 5 character code from the ICD-9 related to the procedures, services, or supplies listed in Block #24d. List the primary diagnosis on Line 1 and secondary diagnosis on Line 2. Additional diagnoses are optional and may be listed on Lines 3 and 4. **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. 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: **Required**

Measurement Qualifiers

F2 International Unit
GR Gram
ML Milliliter
UN Units

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		
N400009737604UN1 (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 NDCs.

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
11	Office	42	Ambulance – Air or Water
12	Patient's Residence	50	Federally Qualified Health Ctr.
21	Inpatient Hospital	51	Inpatient Psychiatric Facility
22	Outpatient Hospital	52	Psychiatric Facility Partial Hospitalization
23	Emergency Room – Hospital	53	Community Mental Health Ctr.
24	Ambulatory Surgical Ctr.	56	Psychiatric Residential Treatment Ctr.
25	Birthing Ctr	61	Comprehensive Inpatient Rehabilitation Ctr.
26	Military Treatment Ctr	62	Comprehensive Outpatient Rehab. Ctr.
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 6-8 in Physicians' Fee Schedule for use of modifiers. **Required**

Block 24E DIAGNOSIS POINTER – Enter a single or combination of diagnosis items 1, 2, 3, 4) from Block #21 above for each line on the invoice. **Required**

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 I.D. 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.

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. **Required**

Block 30 BALANCE DUE – **Optional.**

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.

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 Provider Master File at 410-767-5340.*

CLAIM SUBMISSION CHECKLIST

Prior to submitting your claims to the Medical Assistance, use the following 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.
- Do you have the correct P.O. Box Number for submitting your claims? Correct address for submission is listed on page 2 of these billing instructions.
- 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 or the Medical Care Training & Liaison Unit 410-767-6024 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.

- ✓ 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.

- ✓ 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.

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).

3. ***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 9 in this manual.

   - ✓ 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.

4. ***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.

Finally, 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 page 21 for a reproduction of 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.

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

The Department's website will contain up-to-date information relative to Maryland Medicaid Programs, provider training seminars, and physician's fee schedule and program transmittals. Providers can access the website via the following address: ***www.dhmh.state.md.us*****.**

The Department of Health and Mental Hygiene (DHMH) has developed a new website called eMedicaid. This website is an interactive site that allows providers to electronically add new providers to their practice, download copies of their remittance advices for up to a year and other documents such as the EVS brochure, provider handbook, etc. Providers can access the website via the following address: ***www.emdhealthchoice.org***. Providers can also access EVS through the eMedicaid website. It is recommended that the office administrator register all users for this site. For navigation questions, call 410-767-5503. To request a copy of the eMedicaid brochure, please call 410-767-6024.

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

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

Medical Care Liaison & Training Unit
201 W. Preston Street, Room LL-3
Baltimore, MD 21201 — 410-767-6024

Medicare Crossover Section
P.O. Box 1935
Baltimore, MD 21203
Attn: Jack Collins — 410-767-5559

Provider Master File Unit
P.O. Box 17030
Baltimore, MD 21203 — 410-767-5340

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

Third Party Recovery
Office of Systems, Operations & Pharmacy
Division of Recoveries & Financial Services
P.O. Box 13045 — 410-767-1764
Baltimore, MD 21298 — 410-767-1771/3

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 ***www.state.md.us/mma/providerinfo.***

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.

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. To request an eMedicaid brochure, please call the Provider Training and Liaison Unit at 410-767-6024. To obtain copies of RAs older than two years, you may call a representative at (410) 767-5503 between the hours of 8:00 a.m. – 5:00 p.m.

5. How can a provider request a check tracer?

You may call Provider Relations (410) 767-5342 between the hours of 8:00 am to 4:30 pm.

6. How can a provider request training for paper billing?

The Provider Training and Liaison Unit provides quarterly trainings to Maryland Medicaid providers. To register for the training, call 410-767-6024 or go to ***www.dhmh.state.md.us*** and click on Provider Training to view the schedule and registration form.

7. Can you check EVS for future dates?

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

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

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

9. Claims should be mailed to what address?

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

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

Under normal conditions, if you have sent a paper claim, wait six weeks before calling Provider Relations.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) 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. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID 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. BALANCE DUE $

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.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

MARYLAND MEDICAL ASSISTANCE PROGRAM
ADJUSTMENT REQUEST FORM

Page ___ of ___

Remittance Advice **MUST** Be Attached

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

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