

**MARYLAND MEDICAID
CMS-1500
BILLING INSTRUCTIONS**

*A Comprehensive Guide Focusing on
Maryland Medicaid Billing Procedures for
School-Based Health Centers*

Revised August 25, 2015

**Department of Health and Mental Hygiene
Medical Care Programs**

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GENERAL INFORMATION

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 children are enrolled in a HealthChoice MCO. However, if the student is not in an MCO, bill the MA Program directly 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 can be found on each MCO's web site or in their manual. SBHCs must follow the billing and reporting instructions when billing for services provided to students who are receiving services in SBHCs under the Self-Referred provisions outlined in COMAR 10.09.68 – School Based Health Centers.

FEDERAL FREE POLICY AND THIRD-PARTY BILLING

SBHCs may not bill the Medical Assistance (MA) program or HealthChoice MCOs for any service that is provided free of charge to students without Medicaid coverage. In order to bill Medicaid, schools either need to bill third-party insurance for all children with such insurance, or bill the student's family based on a sliding fee scale. SBHCs must charge non-MA students on a sliding fee scale or, at minimum, they must charge all other insurers. Non-covered services and service limitations are described in COMAR 10.09.68 – School Based Health Centers, COMAR 10.09.08 – Freestanding Clinics, and COMAR 10.09.23 – EPSDT Services. Further, while this manual provides commonly used billing codes, local health department (LHD) SBHCs can only bill CPT codes that have been submitted to and approved by Program Cost and Analysis. Also, please note that these billing instructions do not apply to the following services: Mental Health; Substance Abuse; and Dental, including the application of fluoride varnish.

BILLING EXCEPTION FOR 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 for FQHCs pertain 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

HOW TO GET STARTED

In order to bill an MCO or the Medical Assistance program 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 obtain information about the SBHCs in Maryland:

http://www.marylandpublicschools.org/MSDE/divisions/studentschoolsvcs/student_services_alt/school_based_health_centers/

In addition to general SBHC information, the site will link to all of the application materials and instructions for application submission to MSDE.

Local jurisdictions must apply for new SBHC locations through MSDE first.

Pending approval, MSDE will return the application to the applicant for use in the following steps.

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 organization must obtain this unique 10-digit identifier and use it on all electronic transactions. When billing on paper, this unique number and the provider's 9-digit Medicaid provider number will be required in order to be reimbursed. Additional NPI information can be found on the Centers for Medicare and Medicaid Services (CMS) website:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

http://mmcp.dhmh.maryland.gov/communitysupport/SitePages/npi_info.aspx
Or for NPI assistance, call **1-800-465-3203**

Some sponsoring agencies may use a single NPI for all practice locations, while others may have a unique NPI for each location.

STEP 3: APPLY FOR A MARYLAND MEDICAL ASSISTANCE PROVIDER NUMBER

In order for SBHCs to participate in the MA Program, a sponsoring agency such as a local health department (LHD) or an FQHC must apply for the SBHC using the sponsor's federal tax identification number. When filling out the provider application, **SBHCs must only select**

provider type 34 (FQHC), 35 (LHD Clinic) or 38 (general clinic). SBHCs should **not** select “SBHC” on the provider application as a provider type.

Additional information about provider numbers can be found online at: www.emdhealthchoice.org. For assistance or to determine the status of the MA number or application, call **Provider Application Support** at **410-767-5340**.

If SBHCs require additional assistance with the application process, please contact program staff in the Division of Dental, Clinics, and Laboratory Services at 410-767-1737.

STEP 4: EPSDT CERTIFICATION

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

When the SBHC application has been approved by Medicaid, an EPSDT nurse will be in contact to schedule a site visit.

EPSDT/Healthy Kids Program information, including provider application and DHMH EPDST staff contact information may be obtained at: <http://dhmh.maryland.gov/epsdt>

STEP5: ENROLL 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. In order to be recognized as a billable non-contracted provider with HealthChoice MCOs, SBHCs must submit the following information to Sarah Reese-Carter at sarah.reese-carter@maryland.gov:

- Full name of school-based health center
 - Address
 - Telephone number
 - NPI number for SBHC
 - SBHC-specific Medical Assistance number
- 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 legacy Medical Assistance (MA) number

Note: If sponsoring agency (e.g., FQHC or LHD) does not have specific NPI and Medical Assistance number for each SBHC, information of sponsoring agency needs to be provided instead.

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:

<http://www.cms.hhs.gov/HIPAAGenInfo/>
<http://www.dhmh.state.md.us/hipaa/>

STEP 7: BILL APPROPRIATE PARTY FOR SERVICES RENDERED

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

- 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 Electronic Verification System (EVS) (see page 6 for details);
 - If EVS indicates that the student is an MCO enrollee, and the services rendered are not services that the SBHC provides free of charge, 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. For example, the following services are currently **not** billable under these provisions:
 - Mental Health;

- Substance Abuse Services, unless the SBHC is also certified by the Office of Health Care Quality (OHCQ) as a substance abuse provider;
- 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 see the following contact information:

- To become a Mental Health and/or Substance Abuse provider, contact the **Medicaid Provider Relations Unit** at **410-767-5340**;
- To become a Dental provider, contact **DentaQuest** at **800-341-8478**; and
- To obtain information on OHCQ certification for Substance Abuse providers, contact their office at **877-402-8220**.

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.

Before providing services, or at the time of enrollment, request the student's Medical Assistance Program identification card to obtain their 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 Managed Care Organization (MCO) or third party insurance enrollment. The EVS also allows a provider to verify past dates of eligibility for up to one year.

If the student does not have the 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 DHMH's **Provider Relations Unit** at **410-767-5503** or **800-445-1159**.

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. For provider application support, call **410-767-5340**.

HOW TO USE Phone EVS

STEP 1: Call the EVS access telephone number: **1-866-710-1447**

EVS answers with the following prompt: *"Welcome to the Maryland Medicaid Eligibility Verification System. To check past eligibility status, you must enter month, day and 4-position year. To end press the # key twice."*

STEP 2: Enter your 10-digit NPI number or 9-digit (MA legacy) provider number and press pound (#). For example: **0 1 2 3 4 5 6 7 8 #**

STEP 3: Check student eligibility.

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

Current Eligibility Example: For participant Mary Stern, you would enter:

<u>1 1 2 2 3 3 4 4 5 5 6</u>	<u>78#</u>
Participant Number	Last Name Code*

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

For Past Eligibility: Enter the 11-digit number and the participant’s 2-digit name code (the first two letters of the last name converted into numeric touchtone numbers), **then** enter a date of up to one-year prior using format MMDDYYYY and then press pound (#).

Past Eligibility Example: For Mary Stern with a prior date of service of January 1, 2009, you would enter:

<u>1 1 2 2 3 3 4 4 5 5 6</u>	<u>78</u>	<u>0 1 0 1 2 0 0 9#</u>
Participant Number	Last Name Code	Service Date

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

For Eligibility with Social Security Number: Press zero, pound, pound (0##) at the number prompt. EVS will then prompt with the following: “Enter Social Security Number and Name Code”. Enter the participant’s 9-digit Social Security Number and 2-digit name code.

Social Security Example: For participant Mary Stern, you would enter:

<u>9 9 9 8 8 7 7 7 7</u>	<u>78#</u>
Social Security Number	Last Name Code

NOTE: Social Security numbers are not on file for all participants. When not available, eligibility cannot be fully verified until the Medical Assistance number is obtained. If you have entered a valid Social Security number and the participant is currently eligible for Medical Assistance, EVS will provide you with a valid participant number, which you should record with the current eligibility status.

STEP 4: If applicable, search eligibility for additional students.

EVS allows you to enter another participant number or you can immediately press the pound button **twice** (##) to end the call.

BILLING INFORMATION

FILING STATUTES

The following statutes must be followed for timely billing:

- MCO claims must be received within 180 days from the date of service;
- Fee-For-Service (FFS) claims must be received 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 bill promptly. Claims received after the deadlines will be denied. If the student is enrolled in an MCO on the date of service, the MCO must be billed directly. Please find MCO contact information in Attachment 1.

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 and Mental Hygiene
P.O Box 1935
Baltimore, MD 21203-1935**

Remember: Changes to the CMS 1500 form will also occur in anticipation of ICD-10 coding changes. **MA will accept only the revised CMS 1500 form beginning April 1, 2014.**

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.

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 can be found on the DHMH website:

<http://www.dhmh.maryland.gov/hipaa/SitePages/testinstruct.aspx>

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

dhmh.hipaamedicaid@maryland.gov

Companion guides to assist providers for electronic transactions can be found on the DHMH website: <http://www.dhmh.maryland.gov/hipaa/SitePages/transandcodesets.aspx>

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.

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:
http://www.cms.hhs.gov/electronicbillingeditrans/16_1500.asp

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 will accept only the revised CMS 1500 form.

Changes to the CMS 1500 form were made to accommodate the upcoming mandatory implementation of ICD-10 diagnostic coding format. Changes are NOT yet 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: dhmh.maryland.gov/icd10info.

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	<p>INSURED’S ID NUMBER</p> <p>1. When billing an MCO, enter the participant’s unique MCO 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,</p>

	<p>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.</p> <p>2. When billing DHMH for a FFS client, no number is required in this box.</p>
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. <i>(No entry required when billing for a student without third-party insurance)</i>
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. <i>(No entry required when billing for a student without third party insurance).</i>
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. <i>(No entry required when billing for a student without third party insurance).</i>
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	<p>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:</p> <p>CODE REJECTION REASONS</p> <p>K Services Not Covered L Coverage Lapsed M Coverage Not in Effect on Service Date N Individual Not Covered</p>

	<p>Q Claim Not Filed Timely (Requires documentation, e.g., a copy of rejection from the insurance company)</p> <p>R No Response from Carrier Within 120 Days of Claim Submission (Requires documentation e.g., a statement indicating a claim submission but no response)</p> <p>S Other Rejection Reason Not Defined Above (Requires documentation, e.g., a statement on the claim indicating that payment was applied to the deductible)</p> <p>For information regarding patient’s coverage, contact DHMH’s Third Party Liability Unit at 410-767-1771.</p>
Block 11a	INSURED’S DATE OF BIRTH – <i>(No entry required when billing for a student without third party insurance).</i>
Block 11b	EMPLOYER’S NAME OR SCHOOL NAME – <i>(No entry required when billing for a student without third party insurance).</i>
Block 11c	INSURANCE PLAN OR PROGRAM NAME – <i>(No entry required when billing for a student without third party insurance).</i>
Block 11d	IS THERE ANOTHER BENEFIT PLAN? – <i>(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).</i>
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 – <i>No entry required when billing for a FFS client or a client without third party insurance.</i> 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 physician.
Block 18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES – No entry required.
Block 19	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Block 20	OUTSIDE LAB – <i>No entry required</i>
Block 21	DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY – Enter the 3, 4, or 5 character code from the ICD-9 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.
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

	<p>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:</p> <p><u>Measurement Qualifiers</u> 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.</p>
Block 24A	DATE(S) OF SERVICE – Enter each separate date of service as a 6-digit numeric date (e.g. June 1, 2009 would be 06/01/09) 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 or combination of diagnosis from Block #21 above for each line on the invoice. <i>Note: the Program only recognizes up to eight (8) pointers, A-H.</i>
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 # – Enter the NPI number of the SBHC. Note: Use the NPI number of sponsoring agency (e.g.: LHD or FQHC) 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.
<i>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.</i>	
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 – For students enrolled in MedStar Family Choice, please give the actual name of the rendering provider (nurse practitioner). For all other MCOs/FFS, please write “Signature on File.” In both cases, please include the date of submission.
<i>NOTE: The date of submission must be in Block 31 in order for the claim to be reimbursed.</i>	
Block 32	SERVICE FACILITY LOCATION INFORMATION – Enter complete name and address of the SBHC.
Block 32a	NPI – Enter SBHC’s NPI number. This should be the same 10-digit number entered in Block 24J. 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 the NPI number of the “pay-to” billing provider in Block # 33. 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.
<i>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 DHMH’s Provider Master File via Provider Relations at 410-767-5340. SBHCs should also contact Sarah Reese-Carter at 410-767-4804 with any changes.</i>	

Additionally, 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 and Block 32 should contain information for the SBHC (Note: Use the NPI number of sponsoring agency (e.g.: LHD or FQHC) when there is no specific NPI number for each SBHC site);
- ✓ Block 25 and Block 33 should contain information for the sponsoring/pay-to provider; and

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

- ✓ Verify that you did not bill for services provided prior to or after your provider enrollment dates; and
- ✓ 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 participant is eligible on that date. If you have done this and your claim is denied because the participant is ineligible, double-check that you entered the 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.

REJECTED CLAIMS

Rejected claims will be listed on your 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 you with 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 that you have not previously submitted the claim;
- 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, you 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).

HOW TO FILE AN ADJUSTMENT REQUEST

If you have been 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. If an incorrect payment was due to an error made by Medical Assistance, or an incorrect number of units were inadvertently billed, complete an Adjustment Request Form following the directions on the back of the form. Additionally, please be aware that SBHC charges may differ from reimbursement rates, and reimbursement rates may vary depending on the insurer.

When completing the Adjustment Request Form, bill for the entire amount(s) due, rather than any unpaid amounts or units.

Example: You submitted and received payment for three units, but should have billed five units. **Do not** bill for the remaining two units; bill for the entire 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 (RA) is incorrect (e.g., none of the enrollees listed are your patients). When this occurs, send a copy of the RA and the check with a complete Adjustment Request Form to the address on the bottom of the form.

Partial Refunds – If you receive a RA that lists correct and incorrect payment, do not return the Medical Assistance Program check. Deposit the check and file an Adjustment Request Form for those claims 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 RAs 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 DHMH's **Adjustment Unit** at **410-767-5346**.

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.

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. Also, while this manual provides commonly used billing codes, local health department (LHD) SBHCs can only bill for CPT codes that have been submitted to and approved by the DHMH’s Program Cost and Analysis unit.

FOR CURRENT FEE SCHEDULE, SEE THE MEDICAID PHYSICIANS’ SERVICES FEE MANUAL, ONLINE AT:

<http://mmcp.dhmf.maryland.gov/SitePages/Provider%20Information.aspx>

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 *Maryland Medical Assistance Provider Handbook* and the most current *Physicians’ Services Provider Fee Manual*. 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

If you have any questions regarding the physician/nurse practitioner services or to request a copy of the fee schedule, please contact the staff specialist at **410-767-1462**.

A copy of the fee schedule can be viewed by visiting the DHMH website:
dhmf.maryland.gov/providerinfo

HEALTHY KIDS/EPSTD

NOTE: For complete information regarding Healthy Kids/EPSTD—including program overview, applicable procedure and diagnostic codes, and program staff contact information, please refer to: <http://dhmh.maryland.gov/epsdt>

The Maryland Healthy Kids/Early and Periodic Screening, Diagnosis and Treatment (EPSTD) 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/EPSTD providers. These services are available to Medicaid participants from birth through 20 years of age. For questions regarding EPSTD services, call the **Healthy Kids Program Staff Specialist**, at **410-767-1836**

It is recommended that SBHCs use the Age-Specific Encounter Forms to document Healthy Kids/EPSTD preventive health care screens. These forms are available online:

http://www.dhmh.maryland.gov/epsdt/healthykids/SitePages/table_contents.aspx

To bill for EPSTD services, SBHCs must:

- Be certified to provide Healthy Kids/EPSTD services (contact the Healthy Kids nurse will contact you to become certified);
- Render preventive care services according to Healthy Kids/EPSTD standards as described in the Healthy Kids Manual published at:
http://www.dhmh.maryland.gov/epsdt/healthykids/SitePages/table_contents.aspx
- Provide follow-up of positive or suspect EPSTD 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.

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 child presents for a problem-oriented visit and the child 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 cannot bill for a “problem-oriented” and preventive visit for the same child, 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 is additionally reported.

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

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: <ul style="list-style-type: none"> • 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.

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. Contact your VFC provider at the VFC Contact Center using one of the phone numbers listed at <http://phpa.dhmh.maryland.gov/OIDEOR/IMMUN/SitePages/VFC-contact-center.aspx> to find answers to questions regarding enrollment, ordering vaccines, and vaccine administration.

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
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
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
Rotavirus, pentavalent, live,oral, (3 dose)	90680-SE
Rotavirus, monovalent, live, 6-32 weeks	90681-SE
Diphtheria, tetanus toxoids, acellular pertussis and polio virus, inactivated, 5 th dose, 4-6 years (DTaP-IPV)	90696-SE
Diphtheria, tetanus toxoids, acellular pertussis,	90698-SE

VACCINE	CPT-MOD
haemophilus influenza type b, poliovirus, 2-59 months (DTaP-Hib-IPV)	
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 vaccines not included in the VFC Program but considered medically necessary (e.g., flu vaccines for high risk patients), and for children 19 or 20 years of age, 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 patients.

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 a V20, ICD-9 diagnosis code (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.**

LABORATORY AND PATHOLOGY SERVICES

All providers billing for any laboratory service(s) must be CLIA certified and have Maryland State laboratory certification. Contact DHMH’s **Division of Hospital and Physician Services** at **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. 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

HEALTHY KIDS/EPSTDT 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/EPSTDT services from this rule.

For preventive services, you 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 EPSTDT 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.

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. The diagnosis code, “V25,” must be indicated on the claim form in order for the MCO to recognize that the Evaluation and Management code is related to a Family Planning service. 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 refer to the Physicians’ Services Fee Manual for a complete list of codes related to family planning:

https://mmcp.dhmdh.maryland.gov/docs/Phys-svcs-prov-fee-man_2013.pdf

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**.

ATTACHMENT 1
MCO CONTACT INFORMATION FOR SCHOOL BASED HEALTH CENTERS
MCO Contacts for School-Based Health Centers

MCO Contact for SBHC Health Visit Reports	I. PCP Information	II. Coordination of Care	III. Billing	IV. Claims
<p>AMERIGROUP Community Care Mr. Brian Shird, Special Needs Coord. 410-981-4060 Fax: 866-920-1867 E-mail: brian.shird@amerigroup.com</p>	<p>Member/Provider Services 1-800-600-4441 (ask for live agent).</p>	<p>Mr. Brian Shird, Special Needs Coord. 410-981-4060 Fax: 866-920-1867 E-mail: brian.shird@amerigroup.com</p>	<p>Sandra Parker PH: 410-981-4594 FAX: 866-920-1873 Email: Sandra.Parker@amerigroup.com</p>	<p>Attn: Claims Dept. Amerigroup Community Care P.O. Box 61010 Virginia Beach, VA 23466-1599</p>
<p>Jai Medical System, Inc Nyo Khine, M.D., UM Coordinator, phone 410.433.5600, fax 410.433.8500, nyo@jaimedical.com</p>	<p>Customer Service Department phone 1.888.524.1999, fax: 410.433.4615, CustomerService@jaimedical.com</p>	<p>Chardae Buchanan, RN Special Needs Coordinator, phone 410.433.5600, fax 410.433.8500, chardae@jaimedical.com</p>	<p>Provider Relations Department, phone 1.888.524.1999, fax: 410.433.4615, ProviderRelations@jaimedical.com</p>	<p>Provider Relations Department, phone 1.888.524.1999, fax: 410.433.4615, ProviderRelations@jaimedical.com</p>
<p>Kaiser Permanente Kenya Onley, Senior Director, Medicaid Operations Kenya.C.Onley@kp.org 301.816.6564</p>	<p>Member Services Call Center Victor Nevilles, Member Services Operations Manager 301-931-4187 Victor.I.nevilles@kp.org</p>	<p>Christine Storey Senior Director, Continuing Care 301-816-6798 Christine.storey@kp.org</p>	<p>Provider Relations Jay Brain, Executive Director, Provider Contracting 301.816.6321 Jay.Brain@kp.org</p>	<p>William Winters, Director of Claims 301-625-2207 William.m.winters@kp.org</p>
<p>Medstar Family Choice Ms. Laura Trembly, 410-933-2241 Fax: 410-933-2209 E-mail: Laura.A.Trembly@medstar.net www.medstarfamilychoice.com</p>	<p>Outreach Department 1-800-905-1722 (Option 1)</p>	<p>Ms. Laura Trembly, 410-933-2241 Fax: 410-933-2209 E-mail: Laura.A.Trembly@medstar.net</p>	<p>Provider Relations Department 1-800-905-1722 (Option 5)</p>	<p>Attn: Claims Dept. Medstar Family Choice Claims Processing Center 10201 N. Port Washington Road Mequon, WI 53092 1-800-261-3371</p> <p>After August 31, 2015: MedStar Family Choice Claims Processing Center P.O. Box 2189 Milwaukee, WI 53201</p>
<p>Maryland Physicians Care MCO Ms. Shannon Jones, Special Needs Coord. Phone: 410-401-9443 FAX: 860-907-2710 E-mail: SHANNON.JONES@MARYLANDPHYSICIANS CARE.COM www.marylandphysicianscare.com/</p>	<p>Member Services 800-953-8854 Fax: 1-866-648-1012</p>	<p>Shannon Jones Phone: 410-401-9443 Fax: 860-907-2710 Shannon.Jones@marylandphysicianscare.com</p>	<p>Mia Williams Manager, Provider Relations and Member Services Phone: 410-401-9404 Fax: 1-860-907-2715 mia.williams@marylandphysicianscare.com</p>	<p>Mia Williams Manager, Provider Relations and Member Services Phone: 410-401-9404 Fax: 1-860-907-2715 mia.williams@marylandphysicianscare.com</p>

<p>Priority Partners MCO Julie Krenzer, Provider Engagement Liaison Provider Relations Johns Hopkins HealthCare LLC 6704 Curtis Court Glen Burnie, MD 21060 P: 1-855-633-7362 F: 410-641-2723 jkrenzer@jhhc.com</p>	<p>Patrice Williamson, Network Manager (for SBHC's associated with BMS) Provider Relations Johns Hopkins HealthCare LLC 6704 Curtis Court Glen Burnie, MD 21060 P: 410-424-4400x1509 F: 410-424-4604 pwilliamson@jhhc.com</p> <p>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 P: 443-249-0184 F: 410-424-4604 lmarciniak@jhhc.com</p>	<p>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 OMateo@jhhc.com</p>	<p>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 isims@jhhc.com</p>	<p>Steve Lees, Director of Operations Office of COO Johns Hopkins HealthCare LLC 6704 Curtis Court Glen Burnie, MD 21060 410-424-4950 slees@jhhc.com</p>
<p>Riverside Health, Inc Stephanie Selby, RN Acting Vice President of Health Services sselby@myriversidehealth.com (office) 443-552-3250</p>	<p>Dan Fredman Vice President of Provider Relations dfredman@myriversidehealth.com (office) 443-552-3263</p>	<p>Stephanie Selby, RN Acting Vice President of Health Services sselby@myriversidehealth.com (office) 443-552-3250</p>	<p>Provider Relations Department 800-730-8543 / 410-779-9359</p>	<p>Riverside Health of Maryland, Inc. PO Box 1572 Bowie, MD 20717-1572 800-730-8543 / 410-779-9359</p>
<p>UnitedHealthcare Community Plan Theresa Ervin, Director of Operations 6220 Old Dobbin Lane Columbia, MD 21075 Phone: 443-896-9069 Fax: 866-373-1098</p>	<p>UnitedHealthcare Community Plan Theresa Ervin, Director of Operations 6220 Old Dobbin Lane Columbia, MD 21075 Phone: 443-896-9069 Fax: 866-373-1098</p>	<p>UnitedHealthcare Community Plan Theresa Ervin, Director of Operations 6220 Old Dobbin Lane Columbia, MD 21075 Phone: 443-896-9069 Fax: 866-373-1098</p>	<p>UnitedHealthcare Community Plan Theresa Ervin, Director of Operations 6220 Old Dobbin Lane Columbia, MD 21075 Phone: 443-896-9069 Fax: 866-373-1098</p>	<p>UnitedHealthcare Community Plan Theresa Ervin, Director of Operations 6220 Old Dobbin Lane Columbia, MD 21075 Phone: 443-896-9069 Fax: 866-373-1098</p>

