Section 6   **Billing and Encounter Data Reporting**

Contents

Section 6   **Billing and Encounter Data Reporting**

A. INTRODUCTION

This section explains the use of the *State of Maryland Eligibility Verification System (EVS)* and briefly summarizes the billing for services provided to MCO recipients, including newborn care. Although the section provides resource information on relevant MCO billing instructions, it is not intended to supplant the MCO's billing instructions. MCO specific billing instructions can be found on each MCO's web site or in their manual.

Included in this section is also billing information about fluoride varnish application, Vaccines for Children program, and other services specific to child's health that should be billed to Medicaid Fee-for-Service (FFS). In addition, the section instructs providers how to bill using the CMS-1500 Claim Form or 837P electronic format.

B. ELIGIBILITY VERIFICATION

When a child presents with a specific MCO card, use the instructions on that card for eligibility verification or consult the MCO Provider Manual. If the MCO says the child is not eligible, check the EVS, because the child may be eligible for services in the Fee-for-Service (FFS) system. EVS is a system available to providers to allow verification of Maryland Medicaid recipient's eligibility status.

EVS/Interactive Voice Response (EVS/IVR)

EVS/IVR is a telephone-inquiry system that is available 24 hours a day, 7 days a week. The system verifies whether a patient is enrolled in one of the State Medical Care Programs on the day you call. EVS can verify past dates of eligibility for services rendered up to 1 year ago. EVS provides the eligibility category of the recipient and, if he/she is enrolled in a MCO, it gives the name and phone number of the recipient's MCO and the option to transfer the call. The message does not state the primary care provider (PCP). This information is available from the respective MCO.

In order to use the EVS, the practice must have:

> ➢ A touch tone phone

> ➢ Provider's MA number of NPI number,

> ➢ Recipient's MA number and Name Code or Social Security Number (SSN) and Name Code

> ➢ The EVS telephone number: **1-866-710-1447**.

Section 6   Billing and Encounter Data Reporting

<u>For current eligibility,</u> enter the 9-digit provider number and press the pound (#) button. If the EVS replies without an error, enter the recipient's 11-digit number and the 2-digit name code. The name code is the first two characters of the recipient's last name converted into numeric touch-tone numbers. Press the pound (#) button once and carefully listen to the entire message. Enter another number immediately after the EVS message to determine the MA eligibility of another recipient, or press # to end the call.

<u>For past eligibility up to one year after the service was rendered</u>, enter the date of service after the recipient MA number, last name code, and press the pound (#) button. The date of service must contain six (6) digits; for example, 1/1/15 would be 010115 #. EVS will respond with eligibility information for the Date of Service requested or an error message if incorrect information has been entered. If you enter the date incorrectly, EVS re-prompts you to reenter only the date.

<u>If only the Social Security number is available</u>, at the recipient number cue press "0" and press the pound (#) button. The EVS will reply, "Enter Social Security Number and Name Code." By using a recipient SSN and Name Code, you may search current eligibility or optionally search past eligibility up to 1 year. To search past eligibility, follow the Name Code data entry with the Date of Service. If you have entered a valid SSN, which is on file, and the recipient is currently eligible for Medical Assistance, EVS will provide you with a current eligibility status and the valid Recipient MA Number. You should record the Recipient Number that the system provides. If the SSN is not on file, recipient eligibility cannot be verified until the MA number is obtained.

The message for individuals not enrolled in a MCO is "State or federally eligible," or it will list the specific program, such as Family Planning.

Most Common Eligibility Status Messages:

> ➢ Eligible for date of service;

> ➢ Not eligible for date of service;

> ➢ Recipient has other health insurance. Policy number(s): Phone number: The insurance company listed should be billed prior to State Medicaid. For further information, call 410-767-1773.

> ➢ Recipient is in HealthChoice. MCO name: MCO phone number:

> ➢ Recipient is in the Rare and Expensive Case Management Program (REM). All services for REM are reimbursed on a FFS basis. Contact the REM program at 1-800-565-8190.

> ➢ Medicare is primary payer. Providers may not balance bill recipients.

> ➢ Valid card number: <Card #>. A duplicate MA card has been issued and the previous card is no longer valid.

For further assistance, call **Provider Relations Division** at **410-767-5503** or **1-800-445-1159.**

Section 6   Billing and Encounter Data Reporting

Web-based EVS

For providers enrolled in *eMedicaid*, *WebEVS*, a web-based eligibility application, is now available at *https://encrypt.emdhealthchoice.org/emedicaid/*. The provider must be enrolled in *eMedicaid* in order to access the web EVS system.

Authorized Users can:

> ➤ Verify recipient eligibility;
>
> ➤ Check if the recipient is enrolled at MCO or has other third party insurance;
>
> ➤ Verify current date of service and past eligibility up to 1 year;
>
> ➤ View archived Remittance Advice for up to two years;
>
> ➤ Access Remittance Advice on Monday of each week.

For additional information view the *eMedicaid* website, or contact **410-767-5340** for provider application support.

Section 6   Billing and Encounter Data Reporting

C.   GENDERAL RULES FOR MEDICAL ASSITANCE BILLING

Filling Statues for Billing

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;

Please Note: 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 recipient is enrolled in an MCO on the date of service, the MCO must be billed directly.

Paper Claims

If a provider is submitting paper claims, he/she 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. **Medicaid will accept paper claims only on the revised Form 1500, version 02/12. Providers cannot report both ICD-9-CM and ICD-10-CM codes on the same claim form.** For those services rendered to recipients **not** enrolled in an MCO, mail FFS claims to the following address:

<div align="center">

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

</div>

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).

Section 6   Billing and Encounter Data Reporting

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 at the following link: *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: Providers should contact individual MCOs if interested in billing electronically. MCOs are not required to accept electronic claims. Each MCO may require separate testing.

Healthy Kids/EPSDT Exceptions for Third Party Billing

When participants have both Medicaid and other insurance coverage, the provider must bill the other insurance first. However, States are required to exempt certain Healthy Kids/ EPSDT 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 other insurances for these services. When the patient has Medical Assistance and other third party insurance, do not bill the patient for any co-pay or deductable associated with other insurance policies.

Section 6   Billing and Encounter Data Reporting

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

Section 6　　　　　　Billing and Encounter Data Reporting

D.　　**BILLING FOR FLUORIDE VARNISH APPLICATION AS PART OF THE EPSDT PREVENTIVE CARE VISIT**

Note:　All billing for application of fluoride varnish, whether the recipient is with a MCO or Medicaid Fee for Service (FFS), must be submitted to *DentaQuest*[1].

In order to be reimbursed by Maryland Medicaid for the fluoride varnish application, EPSDT certified and licensed medical providers, nurse practitioners and physician assistants must:

➢ Be enrolled in Maryland's Medical Assistance Program (Medicaid) and have an active Medicaid number with a registered NPI number

➢ Render services within a practice (solo or group) that has an active Medicaid number with a registered NPI number

➢ Be EPSDT certified by the Maryland Healthy Kids Program

➢ Complete the State approved fluoride varnish training program

Reimbursement for Fluoride Varnish Application

All claims for reimbursement for fluoride varnish applications by a Maryland EPSDT provider must be made to *DentaQuest*, whether the child is enrolled in a MCO or Medicaid FFS.　D1206 must be billed in conjunction with an office well-child visit procedure code.　Oral health screening is part of the well-child visit and cannot be billed separately.

For the specific fluoride varnish application CDP code, see the Table below.

Table 1: Fluoride Varnish Application CDT Code	
Procedure	**CDT Code**
Topical Fluoride Varnish	D1206

For More Information:

➢ For a more detailed description of billing for fluoride varnish application, or for additional information, refer to the *DHMH Office of Oral Health* website at *http://phpa.dhmh.maryland.gov/oralhealth* or contact the Office**:**

▪ By phone at 410 767-3081

▪ By e-mail: *dhmh.fvprogram@maryland.gov*

➢ For provider support and information, contact ***DentaQuest*** at **1-888-696-9598.**

---

[1] See *http://www.dentaquest.com/*

Section 6   Billing and Encounter Data Reporting

E.   BILLING FOR VACCINES FOR CHILDREN PROGRAM

Providers must use vaccines provided by the *Vaccines for Children (VFC) Program*[2] for patients from birth to the 19th birthday. At present, the State reimburses the provider for administrative costs associated with administering VFC vaccines. The provider should bill the "usual and customary" charge for administration of each vaccine to the State. You should use the appropriate CPT code for the vaccine/toxoid or immune globulin in conjunction with the modifier – SE (State and/or Federally-funded programs/services). You will not be reimbursed for vaccine administration unless the modifier – SE is added to the end of the appropriate CPT vaccine code.

For VFC immunization administration codes, see the Table below:

Table 2: VFC Program CPT Codes	
Vaccine	**CPT-MOD**
Hepatitis B Immune Globulin (HBIg)	90371-SE
Influenza virus, quadrivalent (IIV4), split virus, preservative free, for IM use	90630-SE
Hepatitis A, pediatric/adolescent (2 dose)	90633-SE
Hemophilus influenza b, HbOC conjugate (Hib)	90645-SE
Hemophilus influenza b, PRP-OMP conjugate (Hib)	90647-SE
Hemophilus influenza b, PRP-T conjugate (Hib)	90648-SE
Human Papilloma, quadrivalent (3 dose) (HPV)	90649-SE
Human Papilloma virus (HPV) vaccine, types 6,11,16,18,31,33,45,52,58 nonavalent, (3 dose) for ID use	90651-SE
Influenza virus, split virus, preservative free, 6-35 months	90655-SE
Influenza virus, split, preservative free, > 2 yrs	90656-SE
Influenza virus, split virus, 6-35 months	90657-SE
Influenza virus, split virus, 3-18 years	90658-SE
Influenza virus, live, intranasal	90660-SE
Pneumococcal conjugate, 7 valent, < 5 years	90669-SE
Pneumococcal conjugate, 13 valent	90670-SE
Rotavirus, pentavalent, live,oral, (3 dose)	90680-SE
Rotavirus, monovalent, live, 6-32 weeks	90681-SE
Diptheria, tetanus toxoids, acellular pertussis and polio virus, inactivated, 5th dose, 4-6 years (DTaP- IPV)	90696-SE

---

[2] See *http://www.marylandvfc.org/*

Section 6   Billing and Encounter Data Reporting

Table 2: VFC Program CPT Codes	
Vaccine	**CPT-MOD**
Diptheria, tetanus toxoids, acellular pertussis, haemophilus influenza type b, poliovirus, 2-59 months (DTaP-Hib-IPV)	90698-SE
Diphtheria, tetanus toxoids and acellular pertussis, < 7 years (DTaP)	90700-SE
Diphtheria and tetanus toxoids, < 7 years(DT)	90702-SE
Measles, mumps and rubella virus, live (MMR)	90707-SE
Measles, mumps, rubella and varicella (MMRV)	90710-SE
Poliovirus, inactivated (IPV)	90713-SE
Tetanus and diphtheria toxoids, 7-18 years (Td)	90714-SE
Tetanus diphtheria toxoids and acellular Pertussis (Tdap) 7-18 years	90715-SE
Varicella virus live	90716-SE
Tetanus toxoid and diphtheria (Td) 7-18 years	90718-SE
Diphtheria, tetanus toxoids, acellular pertussis and Hemophilus influenza b (DTaP-Hib)	90721-SE
Diphtheria, tetanus toxoids, acellular pertussis and Hepatitis B and poliovirus (DTaP-HepB-IPV)	90723-SE
Pneumococcal polysaccharide, 23-valent, 2-18 yrs	90732-SE
Meningococcal conjugate, tetravalent	90734-SE
Hepatitis B, adolescent (2 dose)	90743-SE
Hepatitis B, pediatric/adolescent (3 dose)	90744-SE
Hepatitis B and Hemophilus influenza b (HepB-Hib)	90748-SE

For vaccines not included in the VFC Program, but considered medically necessary vaccines (e.g., flu vaccines for high-risk patients), and for patients 19-20 years of age**,** Medicaid will reimburse providers for the acquisition cost of vaccines purchased by the provider. Managed Care Organizations (MCOs) are also required to cover such vaccines. Use the CPT codes with no modifier for the applicable immunizations administered to the Medicaid recipient. 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. However, a visit for the sole purpose of providing a vaccine with no other service rendered **may not be billed.**

Section 6   Billing and Encounter Data Reporting

Contact your VFC provider at the *VFC Contact Center* using one of the phone numbers listed on the **Vaccines for Children** website at the following link: *http://www.marylandvfc.org* (Refer to Section 7, Appendix III), to find answers to questions regarding enrolling in the VFC Program, ordering vaccines and vaccine administration.

Contact the **Healthy Kids Program at 410-767-1836** with questions about vaccine reimbursement.

Section 6   Billing and Encounter Data Reporting

F.   BILLING FOR SERVICES TO CHILDREN IN STATE-SUPERVISED CARE

A child in State-supervised care is a child in the care and custody of a State agency as a result of a court order or voluntary placement agreement, including by not limited to children that are:

- ➢ Under the supervision of the Department of Juvenile Services
- ➢ In kinship or foster care under the Department of Human Resources
- ➢ In residential treatment centers or psychiatric hospitals for the first 30 days after admission.

All children in State supervised care can be enrolled in a Managed Care Organization (MCO).[3] Children newly eligible for Medical Assistance will have Fee-for-Service (FFS) coverage until enrolled in a MCO. An initial examination must be completed with care by a Maryland Healthy Kids Program (EPSDT) certified provider preferably prior to or within 24 hours of removal, but no later than 5 days of removal.[4]

If the child already has Medicaid and is enrolled in a MCO, bill the MCO for the initial examination. The child's MCO is required to permit a self-referral of a child in State-supervised care for an initial examination and is obligated to pay for all portions of the examination to out-of-network providers except for the mental health screen within 30 days of rendering service. However, in-network MCO providers other than the child's designated Primary Care Provider (PCP) must obtain MCO authorization before rendering this service.

If the child has Medicaid, but is not in a MCO, bill FFS Medicaid for the initial examination. If Department of Human Resources has not yet issued a MA number for the child, work with the caseworker to obtain the number and then bill FFS Medicaid.

Eligible providers should bill using the age appropriate preventive CPT code with **modifier-32** (Mandated Services) for the initial examination and any other procedures provided during this visit. When this modifier is used, MCOs will be obligated to pay for all portions of the EPSDT examination. Providers should use modifier "32" for initial visits only. Refer to the Table on the next page to bill for age appropriated preventative CPT codes in conjunction with modifier "32".

---

[3] See Department of Human Resource. (2014). Policy #: SSA-CW#14-17.

[4] *Ibid.*

Table 3: Preventive Medicine CPT Codes with 32 Modifier		
Procedure	**CPT Code**	**Modifier**
Comprehensive Preventive Medicine (New Patient)		
New patient 0 – 11 months	99381	32
New patient 1 – 4 years	99382	32
New patient 5 – 11 years	99383	32
New patient 12 – 17 years	99384	32
New patient 18 – 39 years	99385	32
Comprehensive Preventive Medicine (Established Patient)		
Established patient 0 – 11 months	99391	32
Established patient 1 – 4 years	99392	32
Established patient 5 – 11 years	99393	32
Established patient 12 – 17 years	99394	32
Established patient18 – 39 years	99395	32

Contact the staff specialist for **Children's Services** for additional information at **410-767-1836.**

Section 6　　　　　　　**Billing and Encounter Data Reporting**

G.　BILLING FOR SERVICES TO CHILDREN IN MANAGED CARE ORGANIZATIONS (MCOs)

Most children are enrolled in MCOs and therefore providers must be familiar with the specific instructions for billing and reporting encounters for each MCO. Please refer to each MCO's Provider Manual.

Recipients must obtain all services except services excluded through their MCO. The recipient's Primary Care Provider (PCP) will give referrals for specialty care.

Suggested Checklist for Billing MCO

1. Verify through the EVS and the applicable MCO that the child is enrolled with HealthChoice and with your practice.

2. Use the Current Procedural Terminology (CPT) Preventive Medical Services codes.

3. Submit encounter data (for capitation reporting or claim submission) to the respective MCO. Follow the MCO's instructions found in the applicable MCO Provider Manual.

4. For Children in State-supervised care, the MCOs must pay the initial exam as a self-referred service. **Use codes 99381–99385** for full screen. Follow the respective MCO directions for submitting vaccine claim information.

5. Follow the directions from each MCO concerning CPT codes for VFC vaccine administration. **All PCPs participating with MCOs who serve patients younger than 19 years of age must enroll with the Vaccines for Children (VFC) Program.**

6. For provider-purchased vaccine stock administered to patients 19-20 years of age, bill the MCOs by submitting the vaccine-specific CPT code following the MCO directions. Since Vaccines for Children (VFC) program does not cover patients 19 years of age and older, the MCO is responsible for reimbursement of vaccines administered to this age group and reimbursement is generally at acquisition costs.

7. The MCO is also responsible for all medically necessary vaccines for patients not covered by the VFC Program. For example, vaccine such as Synagis is not currently included in the VFC Program and therefore providers should bill the MCO.

8. If you are not part of an MCO and a recipient identified by EVS as an MCO recipient sees services from you for which an MCO is responsible, you may contact the MCO to determine if it will approve payment for rendered services. Otherwise, the MCO has not obligation to reimburse you. If the recipient-required services are emergency services, you may provide the appropriate services and expect to be reimbursed by the MCO by billing the MCO directly. If you provided non-emergency services without MCO authorization, Medical Assistance will not reimburse you.

Section 6 Billing and Encounter Data Reporting

Newborn Billing Information

Medical Assistance will automatically cover all infants born to women with MA coverage on the date of delivery through their first birthday. The Program, however, cannot issue the newborn's card until the hospital or Department of Social Services' worker notifies Department of Health and Mental Hygiene (DHMH). DHMH will enroll the newborn upon receipt of the Hospital Report of Newborn form (DHMH-1184). Since 2012, DHMH enrolls newborns online via the Program's *eMedicaid* application (1184 process). For detailed instructions, refer to *1184 New Born Processing-eMedicaid Manual*.[5] The 1184 process serves to initiate the child's temporary MA number and notify the appropriate MCO of the newborn's enrollment.

For all mothers with MA at the time of delivery, the newborn's **temporary MA number** is the same as the mother's number except for the last two digits. The last two digits are 01 for the first baby and consecutively increasing numbers for subsequent children. The permanent number and card will be issued after the local Health Department or Department of Social Services completes the transaction, usually within 4 weeks.

Infants born to mothers enrolled in a MCO will be enrolled in the mother's MCO. To assure coordination of care, a *Newborn Coordinator* is assigned to each MCO to handle newborn assignment in the MCOs (Refer to Section 8).

If the mother does not have MA at the time of delivery, an application can be completed in the hospital and sent to Medical Assistance for eligibility determination. If the newborn is determined eligible, coverage starts on the first day of the month on which the application was submitted.

Do not bill Medical Assistance for services to newborns using the mother's number. If the mother was eligible, use the temporary newborn MA number that has been assign. **Contact the Newborn Coordinator of the mother's MCO for problems encountered with newborn MA numbers or eligibility**. If you are unable to determine the mother's MCO, or the mother was not enrolled in Medicaid at the time of delivery, call the *Health Choice Hot Line* at **1-800-456-8900** for assistance. A *Provider Action Grid* is included to assist providers with issues that may arise in the newborn period (Refer to Section 1, Addendum).

Providers should bill MA directly for children who are not enrolled with an MCO. If you provide any health care services to a recipient enrolled in an MCO, you must seek reimbursement from the MCO. For example, if an out-of-plan provider renders the initial medical examination of a newborn in the hospital, because the MCO does not arrange for a network provider, the MCO must reimburse this service as a self-referral service at no less than the Medicaid rate. **Use CPT Code 99460** (eff. 1/1/09).

---

[5] See *https://mmcp.dhmh.maryland.gov/docs/1184%20E-Medicaid%20Manual%20New%20Born%20Processing.pdf*.

H.   **BILLING FOR SERVICES TO CHILDREN NOT IN A MCO (FEE-FOR-SERVICE)**

Providers will find that most children are enrolled in a Managed Care Organization (MCO). However, if the patient is not in a MCO, bill the Medical Assistance/Medicaid Fee-For-Service (FFS) Program. To participate in the Medicaid Program, apply online at *http://www.emdhealthchoice.org.*

All rendering providers, solo practices and group practices must have a **National Provider Identifier (NPI),** a 10-digit, numeric identifier that does not expire or change. NPI is a HIPAA mandate requiring a standard unique identifier for health care providers. It is administered by the Centers for Medicare and Medicaid Services (CMS). Additional information on NPI can be obtained from the CMS website at: *http://www.cms.hhs.gov/NationalProvIdentStand/.* **Providers must use the NPI on all electronic transactions. When a provider bills on paper, the NPI number and the provider's 9-digit Medicaid provider number will be required in order to be reimbursed appropriately.**

Providers should apply online for NPIs through the National Plan and Provider Enumeration System (NPPES) at *nppes.cms.hhs.gov/NPPES/Welcome.* A paper application is available at *http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms10114.pdf .*

Submit completed, signed paper copies of the NPI Application/Update Form **(CMS-10114)** to the NPI Enumerator at the address below:

<div align="center">

NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059
1-800-465-3203
customerservice@npienumerator.com

</div>

All rendering providers, solo practices and group practices must also have a valid Medical Assistance (MA) provider number. For assistance or to determine the status of the MA number or application, call **Provider Enrollment Support** at **410-767-5340.**

Follow the general billing practices noted in the *Physicians' Services Provider Fee Manual* and the most current *Physicians' Services Provider Fee Schedule.* Contact the **Provider Relations Unit at 410-767-5503 or 1-800-445-1159** to request these materials or access information on the following DHMH webpage: *www.dhmh.maryland.gov/providerinfo.*

Section 6   Billing and Encounter Data Reporting

Always refer to your copy of the *Current Procedural Terminology (CPT)* edition published yearly by the *American Medical Association* to verify current codes. For more information on AMA products, please call **1-800-621-8335** or visit: *http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page*.

Section 6   Billing and Encounter Data Reporting

Preventive Medicine Services Codes

The EPSDT program uses the following Preventive Medicine (full screening) CPT codes for billing well-child care.

➢ New Patient/Full Screening: 99381 – 99385 – A full screening includes a health and developmental history, unclothed physical exam, appropriate laboratory tests, immunizations and health education/anticipatory guidance. Note: A newborn infant history and examination completed in a hospital should be billed using CPT newborn care code 99460.

➢ Established Patient/Full Screening: 99391 – 99395 – A full periodic screening is completed on an established patient at subsequent intervals according to the age intervals on the *Maryland Healthy Kids Preventive Care Schedule* (Refer to Section 2).

Preventive Medicine CPT codes are also used to report a full EPSDT screening provided in a hospital outpatient department setting (when the physician's services are not included in the cost-based hospital rate) and for patients who are in the care and custody of a State agency pursuant to a court order or a voluntary placement agreement.

See the Table below for specific codes. For fee schedule, refer to the most current *Medicaid Provider Fee Schedule Manual* at *www.dhmh.maryland.gov/providerinfo*.

Table 4: Preventive Medicine CPT Codes	
Procedure	**CPT Code**
Comprehensive Preventive Medicine (New Patient)	
New patient 0 – 11 months	99381
New patient 1 – 4 years	99382
New patient 5 – 11 years	99383
New patient 12 – 17 years	99384
New patient 18 – 39 years	99385
Comprehensive Preventive Medicine (Established Patient)	
Established patient 0 – 12 months	99391
Established patient 1 – 4 years	99392
Established patient 5 – 11 years	99393
Established patient 12 – 17 years	99394

If a child presents for a problem-oriented visit and the child is due for a preventive visit, it is recommended that the provider complete the Healthy Kids preventive care 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 for time and level of complexity.

Under certain situations, 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 E&M services, 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. 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 preventive medicine service. The appropriate preventive medicine service is additionally reported.

Oral health assessment by the Primary Care Provider (PCP) is included in the preventive code as part of the Healthy Kids preventive care examination. Dentists, however, should consult *DentaQuest*[6] at **1-888-696-9596** regarding coding for dental services.

---

[6] See *http://www.dentaquest.com/*

Section 6   Billing and Encounter Data Reporting

Objective Hearing and Vision Tests, Developmental Screening

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 (Refer to Section 3, Addendum) during either a preventive or episodic visit using CPT code 96110 (see below).   CPT 96111 should be used for a longer, more comprehensive developmental evaluation performed by a physician or other specially trained professional.

 See the Table below for specific codes. For fee schedule, refer to the most current *Medicaid Provider Fee Schedule Manual* at *www.dhmh.maryland.gov/providerinfo.*

Table 5: Objective Hearing & Vision Tests, Development Screening CPT Codes	
Procedure	**CPT Code**
Hearing/Screening test, Pure air only	92551
Visual Screening Test	99173
Smoking and Tobacco Use Cessation Counseling Visit; Intermediate**, Greater than 3 Minutes and up to 10 Munutes**	99406
Smoking and Tobacco Use Cessation Counseling Visit; Intensive, **Greater than 10 Minutes**	99407
Substance abuse screening: Alcohol and/or Substance (Other than Tobacco) Abuse Structured Screening (e.g., AUDIT, DAST) **and** brief intervention (SBI) services **15 to 30 Minutes Long**	99408[1]
Substance abuse screening: Alcohol and/or Substance (Other than Tobacco) Abuse Structured Screening, **and** Brief Intervention (SBI) Services **Greater than 30 Minutes**	99409[1]
Developmental testing: **Limited** (e.g., Ages and Stages Questionnaire, Pediatric Evaluation of Developmental Status) with Interpretation and Report*	96110[1,2,3]
Developmental Testing: Extended (Includes Assessment of Motor, Language, Social, Adaptive and/or Cognitive Functioning by Standardized Developmental Instruments, e.g., Bayley Scales of Infant Development with Interpretation and Report	96111

Section 6   Billing and Encounter Data Reporting

[1]A standardized, validated tool must be used.

[2]For FFS patients: Providers may bill a maximum of two (2) units of CPT 96110 on the same date of service when a screening tool for autism or a social-emotional screening (e.g., ASQ-SE) is administered in addition to a general developmental screening tool.

[3]For MCO patients: If providers bill for more than one unit of services, they must use modifier "59" following the CPT code. Modifier 59 is used to identify procedures/services, other than E&M services, that are not normally reported together, but are appropriate under the circumstance

*Documentation for developmental screening should include:

- ➢ Any parental concerns about the child's development,
- ➢ The name of screening tool used,
- ➢ The screening tool results, reviewing all major areas of development,
- ➢ An overall result of the development assessment for age (e.g., normal, abnormal, needs further evaluation), and
- ➢ A plan for referral or further evaluation when indicated.

Laboratory Services

All providers billing for any laboratory service(s) must be CLIA certified and approved by the Maryland Laboratory Administration, if located in Maryland. Contact the **Division of Hospital and Physician Services at 410-767-1462** for information regarding CLIA certification. Interpretation of laboratory results, or the taking of specimens other than blood, is considered part of the office visit and may not be billed as a separate procedure. Specimen collection for Pap smears and PKU (Phenylketonuria) for infants is not billable by a physician

See the Table below for specific laboratory services CPT codes frequently billed in addition to the Healthy Kids preventive code. For fee schedule, refer to the most current *Medicaid Provider Fee Schedule Manual* at *www.dhmh.maryland.gov/providerinfo.*

Table 6: Laboratory Services CPT 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

Section 6   Billing and Encounter Data Reporting

Evaluation and Management Office Visits (E&M) Codes

Generally, CPT descriptions for E&M services indicate "per day" and only one E&M service may be reported per date of service. Modifier - 21 for prolonged E&M service is informational only and does not affect payment. Providers cannot bill for a "problem-oriented" and preventive visit for the same child, on the same day. The comprehensive nature of the preventive medicine services codes (99381-99394), however, reflects an age and gender appropriate history/exam and is not synonymous with the "comprehensive" examination required in E&M codes (99201-99215). Under certain situations, a preventive exam and another E&M service may be payable on the same day. Modifier-25 should be added to the office/outpatient code to indicate that the same physician provided significant, separately identifiable E&M services on the same day as the preventive medicine services. The applicable preventative medicine service is additionally reported.

See specific E&M codes in Table 7 below. For fee schedule, see the most current *Medicaid Provider Fee Schedule Manual* at *www.dhmh.maryland.gov/providerinfo.*

Table 7: Evaluation & Management Office Visit Codes	
Procedure	**CPT Code**
New patient (10 minutes)	99201
New patient (20 minutes)	99202
New patient (30 minutes)	99203
New patient (45 minutes)	99204
New patient (60 minutes)	99205
Established patient (5 minutes)[1]	99211
Established patient (10 minutes)	99212
Established patient (15 minutes)	99213
Established patient (25 minutes)	99214
Established patient (40 minutes)	99215

[1] **E&M "that may not require the presence of a physician"**

Section 6   Billing and Encounter Data Reporting

I. 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.

Proper Submission of the CMS 1500 Billing Form

The following table provides information on how to complete the required blocks on the CMS-1500 form. Please note that for the 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 – Show all type(s) of health insurance applicable to this claim by checking the appropriate box(es).

Block 1a – INSURED'S ID NUMBER
1. When billing a Managed Care Organization (MCO), enter the participant's unique MCO number. Please note that 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 of time, MedStar Family Choice, United Healthcare, and Priority Partners are the only MCOs that have unique numbers. If you do not have the patient's unique number, call the MCO and get that number. All other MCOs accept the students MA number in this block.

2. When billing DHMH for a Fee-For-Service participant, no number is required in this box.

Block 2 – PATIENT'S NAME – (Last Name, First Name, and 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 (Optional).

Section 6   Billing and Encounter Data Reporting

Block 4 – INSURED'S NAME – Enter name (Last Name, First Name, and Middle Initial) – If the patient has other third party insurance, enter the name of the person in whose name the third party coverage is listed (*No entry required when billing for a patient without third-party insurance*).

Block 5 – PATIENT'S ADDRESS – Enter the patient'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 (*No entry required when billing for a patient without third-party insurance*).

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 (*No entry required when billing for a patient without third-party insurance*).

Block 8 – RESERVED FOR NUCC USE.

Block 9 – OTHER INSURED'S NAME – No entry required.

Block 9a – OTHER INSURED'S POLICY OR GROUP NUMBER – Enter the patient's *eleven digit Maryland medical assistance number* exactly as it appears on the Medical Assistance card. Check for transposition of numbers. The MA number must appear here regardless of whether or not a patient has other insurance. A patient's Medicaid eligibility should be verified on *each* date of service, *prior* to rendering service, by calling the 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 9b – RESERVED FOR NUCC USE – No entry required.

Block 9c – RESERVED FOR NUCC USE – No entry required.

Block 9d – INSURANCE PLAN OR PROGRAM NAME – Enter the insured's group name and group number if the patient has health insurance besides Medicare/Medicaid (*No entry required when billing for a patient without third-party insurance).*

Block 10a thru 10c (Block 10d only for abortion-related billing) – **IS PATIENT'S CONDITION RELATED TO** – Check "Yes" or "No" to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in Item 24, if this information is known. If not known, leave blank.

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

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 (Required 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., statement indicating a claim submission, but to response)
S   Other Rejection Reasons Not Defined Above (Requires documentation e.g., a statement on the claim indicating that payment was applied to the deductible)

For information regarding participant's coverage, contact Third Party Liability Unit at **410-767-1765** .

Blocks 11a – INSURED'S DATE OF BIRTH – (*No entry required when billing for a patient without third-party insurance).*

Block 11c – EMPLOYER'S NAME OR SCHOOL NAME – (*No entry required when billing for a patient without third-party insurance).*

Block 11c – INSURANCE PLAN OR PROGRAM NAME – (*No entry required when billing for a patient without third-party insurance).*

BLOCK 11d – IS THERE ANOTHER BENEFIT PLAN? – *(No entry required when billing for a patient that doesn't have another third party insurance in addition to the one already described in 11 above).*

Block 12 – PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – If the provider already has an authorized signature on file for the patient, this section should read "Signature on File" and include the billing date.

Block 13 – INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – If the provider already has an authorized signature on file for the patient, the section should read "Signature of File" and include the billing date. (*No entry required when billing for a FFS client or a client without third party insurance*.)

Block 14 – DATE OF CURRENT ILLNES, OR INJURY OR PREGNANCY

Block 15 – IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (OTHER DATE)

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

Block 17 – NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
Note: Completion of 17-17b is only required for Lab and Other Diagnostic Services.
Block 17 should be completed in cases where there is a referring physician. 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. **–** No entry required.

Block 17a (gray shaded area) – ID OF REFERRING PHYSICAIN – Enter the ID Qualifier **–1D (Medicaid Provider Number)** followed by the provider's 9-digit Medicaid Provider Number. **–** No entry required.

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

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

Block 19 – ADDITIONAL CLAIM INFORMATION

Block 20 – OUTSIDE LAB – Check "no"

Block 21 – DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY –
Enter the 3, 4, or 5 alpha/numeric code from the ICD-9 related to the procedures, or services, 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.

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

REMINDER: ICD-9 and ICD-10 codes **cannot** be reported on the same claim   form.

Block 22 – MEDICAID RESUBMISSION – No entry required.

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

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

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

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

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

Section 6   Billing and Encounter Data Reporting

Block 24a – DATE OF SERVICE – Enter each separate dates of service as a **six (6) digit numeric date (e.g. 03/31/14) 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.** If more than one type of billable service was rendered on a given day, each service should be billed on a separate line. Thus, one date of service may be used on more than one line.

Block 24b. – PLACE OF SERVICE – Enter 11 for Doctor's Office visits.

Block 24c. – EMG – No entry required.

Block 24d. – PROCEDURES, SERVICES OR SUPPLIES – List the appropriate five (5) character procedure code. The Physician Fee Schedule can be found at *www.dhmh.maryland.gov/providerinfo*.

Block 24e. – DIAGNOSIS POINTER – Enter a single or combination of diagnosis from Block #21 above for each line on the invoice.

Note: the Program only recognizes up to eight (8) pointers, A-H.

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

Block 24g. – DAYS OR UNITS OF SERVICE – Enter the total number of units or service for each procedure. Multiple, identical services rendered on different days should be billed on separate lines.

Block 24h. – EPSDT FAMILY PLAN – No entry required.

Block 24i. – ID. QUAL. – Enter the ID Qualifier **1D (Medicaid Provider 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.

Block 25 – FEDERAL TAX ID NUMBER

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

Section 6   **Billing and Encounter Data Reporting**

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

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

Block 28 – TOTAL CHARGE – Enter the sum of the charges shown on all lines of Block 24f.

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.

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

Block 31 – SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS – Please write "Signature on File" and include the date of submission.

*Note: **The date of submission must be in Block 31 in order for the claim to be reimbursed.***

Block 32 – SERVICE FACILITY LOCATION INFORMATION – 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.

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

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.

Section 6   **Billing and Encounter Data Reporting**

Block 33 – BILLING PROVIDER INFO & PH # – Enter the name, complete street address, city, state, and zip code of the provider. This should be address to which claims may be returned. The nine (9) digit Maryland Medical Assistance provider number to which payment is to be made must be entered in the lower right hand section of this block. Errors in this area are likely to result in denied or misdirected payment.

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.

Block 33b (gray shaded area) – Enter the ID Qualifier 1D (Medicaid Provider Number) followed by the shaded area) 9-digit MA provider number of the provider in Block #33. Errors or omissions of this number will result in non-payment of claims.

Note: It is the provider's responsibility to promptly report all name changes, addresses, correspondence addresses, practice locations, tax identification number certification to the DHMH's Provider Master File via Provider Relations at 410-767-5340.

Section 6   Billing and Encounter Data Reporting

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:

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 was denied because of a keying or scanning error, resubmit the claim with the corrected data.

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; 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).

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 provider's 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:

<div align="center">

Medical Assistance Adjustment Unit
Box 13045
Baltimore, MD 21203

</div>