MARYLAND MEDICAID
CMS 1500
BILLING INSTRUCTIONS

Billing Procedures for the following Community-Based Substance Abuse Services: Substance Abuse Assessment, Individual Outpatient Therapy, Group Outpatient Therapy, Intensive Outpatient and Methadone Maintenance

Effective January 1, 2010

Department of Health and Mental Hygiene
Medical Care Programs

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TABLE OF CONTENTS

I. GENERAL INFORMATION

A. INTRODUCTION

This manual was designed to assist community-based substance abuse (SA) providers understand billing procedures for the following services: Substance Abuse Assessment, Individual Outpatient Therapy, Group Outpatient Therapy, Intensive Outpatient, and Methadone Maintenance. Regulatory requirements for these services can be found in COMAR 10.09.80, COMAR 10.09.08.04, COMAR 10.09.67.28, and COMAR 10.09.7.10. **PLEASE NOTE:** These billing instructions **do not affect** the billing procedures for **Federally Qualified Health Centers (FQHCs)** when patients are HealthChoice enrollees. However, these billing instructions **do apply** when FQHCs are billing for patients with Primary Adult Care (PAC) coverage. Additionally, FQHCs should continue to use their existing billing code (T1015) along with the H codes which describe the substance abuse services for individuals in HealthChoice.

The manual contains instructions on submitting claims using the CMS 1500 Claim Form or 837P electronic format. These instructions are for claims associated with individuals enrolled in a Managed Care Organization (MCO) under HealthChoice and Primary Adult Care (PAC) as well as fee-for-service (FFS) patients.

A Comprehensive Substance Abuse Assessment (CSAA) is reimbursed under self-referral protocol once within a 12 month period per recipient per OHCQ certified program, unless there is more than a 30 day break in substance abuse treatment, if the following conditions are met:

- The recipient is not currently in substance abuse treatment;
- The program providing the assessment is certified by the Office of Health Care Quality (OHCQ) and meets the requirements established by the Alcohol and Drug Abuse Administration (ADAA) as described in COMAR 10.47; and
- The assessment is reviewed and approved by a licensed physician or licensed practitioner of the healing arts, within the scope of his or her practice under State law.

MCOs and Behavioral Health Organizations (BHOs) will also pay for CSAA when the certified program meets the above requirements and:

- Does not offer the level of care the enrollee requires and the enrollee has to be referred to another program;
- Conducts CSAA, but the enrollee does not return for treatment; or
- Determines the enrollee does not need treatment.

Although this manual 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 website or manual (see Attachment 1 for MCO website information). When billing for services provided to patients who are receiving services from SA programs

under the Self-Referred provisions outlined in COMAR 10.09.67.28 – SA programs must follow the specific instructions for billing and reporting encounters provided by the patient's MCO.

Please note that SA programs may not bill the MA Program or HealthChoice MCOs for any services that are provided free of charge to patients without Medicaid coverage. This means that in order to bill Medicaid, providers either need to bill third party insurance for all patients with such insurance or to bill the patients based on a sliding fee scale.

B. HOW TO GET STARTED

To bill an MCO or the Medical Assistance program for community-based SA services, certified SA programs must take the following steps:

STEP 1: OBTAIN OFFICE OF HEALTH CARE QUALITY CERTIFICATION

SA programs must be certified by the Office of Health Care Quality (OHCQ) to perform Substance Abuse services. To obtain information on OHCQ certification, call **877-402-8220**. SA Providers must attach their OHCQ Certification to their MA fee-for-service or MCO provider application. Note that if the date on your certification has expired you will need a letter of good standing from OHCQ.

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. SA programs or their parent organization must use this 10-digit identifier on all transactions. When billing on paper, SA programs must include both their NPI and their 9-digit Medicaid provider number in order to be reimbursed appropriately by the Medicaid fee-for-service program. Additional NPI information can be found on the Center for Medicare and Medicaid Services (CMS) website:

https://nppes.cms.hhs.gov/NPPES/Welcome.do
http://www.dhmh.state.md.us/mma/html/npi_info.htm
Or for NPI assistance, call **1-800-465-3203**

STEP 3: APPLY FOR A MARYLAND MEDICAL ASSISTANCE PROVIDER NUMBER

In order to participate in the Medical Assistance fee-for-service program, SA programs must complete the SA provider application. Applications and instructions were recently mailed to OHCQ-certified substance abuse programs. If you need an application, contact **Susan Harrison** in the Office of Health Services at **410-767-1434**. For assistance or to determine the status of the MA number or application, call **Provider Application Support** at **410-767-5340.** Provider

information and billing instructions are available at **http://www.dhmh.state.md.us/mma/providerinfo/.**

In order to apply as a **COMMUNITY-BASED SUBSTANCE ABUSE TREATMENT PROVIDER**, SA providers should select provider type "32" for Clinic, Drug Abuse (Methadone) or type "50" for ADAA Certified Addictions Outpatient Program. If you are already enrolled as provider type 32 or 50 you **do not** need to reapply.

Community-based providers should also familiarize themselves with the regulations in COMAR 10.09.36 and COMAR 10.09.80. In addition, methadone maintenance providers should review COMAR 10.09.08.04. Updated regulations will be issued in December 2009, so providers should look for these changes in the regulations.

STEP 4: SUBMIT INFORMATION TO BECOME AN MCO SELF-REFERRED PROVIDER

SA providers are not required to contract with MCOs; however, before receiving payment from MCOs, OHCQ certified SA programs must be set up as non-contracted providers. In order to be recognized as a billable non-contracted program with HealthChoice MCOs, SA providers must submit the following information to Molly Marra at mmarra@dhmh.state.md.us:

- Full name of SA program
    - Address
    - Telephone number
    - NPI number for SA program
    - Medicaid (MA) 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
    - Telephone number

STEP 5: 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 6: BILL APPROPRIATE PARTY FOR SERVICES RENDERED

To ensure payment, before providing services to a **Maryland Medicaid recipient**, SA providers must determine whether:

- Their Medical Assistance provider number is effective on the date of service;
- The individual is eligible for Medical Assistance on date of service. **Always** verify the patient's eligibility using the Eligibility Verification System (EVS) (see page 5 for details);
- If EVS indicates that the individual is an MCO enrollee and the services rendered are not free of charge, bill the MCO for services rendered (see Attachment 1: MCO Contact Information for MCO billing addresses);
- If the patient with Medical Assistance coverage also has other third party insurance, bill the other insurance for services rendered; and
- The service rendered is billable under self-referral regulations for SA providers. For example, mental health services are not billable under these provisions.
    - For more details on how to become a mental health provider, contact the **Provider Relations Unit** at **410-767-5340**.

STEP 7: FOLLOW AUTHORIZATION AND NOTIFICATION PROCEDURES

To ensure payment, all SA providers must follow the authorization and notification procedures beginning on page 18. The chart includes information about the five self-referred services, in addition to other SAII services not included in these billing instructions.

II. ELIGIBILITY VERIFICATION SYSTEM

To ensure the patient's eligibility, it is the provider's responsibility to check the Eligibility Verification System (EVS) on the date of service prior to providing services.

Before providing services, request the patient's Medical Assistance Program identification card to attain their member number for use on the EVS. The EVS enables providers to verify a Medical Assistance recipient's current eligibility status. If applicable, the EVS system will also provide information regarding a recipient's MCO or third party insurance enrollment. The EVS allows a provider to verify past dates of eligibility for up to one year prior.

If the enrollee does not have the card, request their Social Security Number, which can also be used to verify eligibility via EVS. If the Social Security Number is on file, SA providers may search current eligibility (or past eligibility up to one year) by using a recipient's Social Security Number and first two letters of the last name.

For additional information on eligibility verification, please call the **Provider Relations Unit** at **410-767-5503** or **800-445-1159**.

A. HOW TO USE WEB EVS

For providers enrolled in eMedicaid, WebEVS 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. For provider application support, please visit the website or call **410-767-5340**. This is the quickest method for obtaining eligibility information.

B. 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 Medicaid Eligibility Verification System. For past eligibility status checks, you must enter the month, date and 4-position year. To end, press the pound (#) 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 patient eligibility.

For Current Eligibility: Enter the 11-digit recipient'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 recipient Mary Stern, you would enter:
1 1 2 2 3 3 4 4 5 5 6 78#

Recipient Number **Last Name Code***

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

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

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

1 1 2 2 3 3 4 4 5 5 6 78 0 1 0 1 2 0 0 9#
Recipient Number Last Name Code Service Date

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

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 recipient's 9-digit Social Security Number and 2-digit name code.

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

9 9 9 8 8 7 7 7 7 **78#**
Social Security Number Last Name Code

NOTE: *Social Security Numbers are not on file for all recipients. 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 recipient is currently eligible for Medical Assistance, EVS will provide you with a valid recipient number, which you should record with the current eligibility status.*

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

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

III. BILLING INFORMATION

A. FILING STATUTES

For timely billing, programs must adhere to the following statutes:

- MCO claims must be received within 180 days from the date of service.
- Fee-For-Service (FFS) claims must be received within 12 months from the date of service.

Please bill promptly. Claims received after the deadlines will be denied. If the patient is enrolled in an MCO on the date of service, the MCO must be billed directly. Please find MCO billing information in Attachment 8.

B. PAPER CLAIMS

If an SA program is submitting paper claims for these services, the program must file using 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 program's pay-to address.

For those services rendered to Fee-For-Service enrollees (those not enrolled in an MCO), mail claims to the following address:

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

For MCO Paper Claims: Paper claims for patients enrolled in HealthChoice must be submitted to the appropriate MCO. Once an MCO receives a claim, they are required to process clean claims within 30 calendar days (or pay interest). For MCO contact information, please see Attachment 1. For MCO billing addresses, please see Attachment 2.

C. ELECTRONIC CLAIMS

If an SA program chooses to submit claims electronically, HIPAA regulations require providers to complete electronic transactions using ANSI ASC X12N 837P, version 4010A. Electronic claims are generally paid within two weeks of submission. **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. The *Submitter Identification Form* is available at ***http://www.dhmh.state.md.us/hipaa/pdf/SubmitterIdentificationForm032907.pdf*** . The

Trading Partner Agreement is available at ***http://www.dhmh.state.md.us/hipaa/pdf/tradpartagree.pdf*** .

Programs must also undergo testing before transmitting such claims. Testing information can be found on the DHMH website: ***http://www.dhmh.state.md.us/hipaa/testinstruct.html***

If you have any questions regarding HIPAA testing, please send an email to: ***hipaaeditest@dhmh.state.md.us***

Companion guides to assist providers for electronic transactions can be found on the DHMH website: ***www.dhmh.state.md.us/hipaa/transandcodesets.html***

For MCO Electronic Claims: Each MCO will require separate testing. SA programs should contact individual MCOs if interested in billing electronically (see Attachment 8: MCO/BHO Electronic Billing Information).

IV. CMS 1500 BILLING INSTRUCTIONS

When filing a paper claim, programs 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.***

On the form, 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, TRICARE or Blue Cross/Blue Shield, the provider must first bill the other insurance company.

A. HOW TO PROPERLY COMPLETE THE CMS 1500 FORM

The following table provides information on how to complete the **required** blocks on the CMS 1500 form. All blocks not listed in this table may be left blank. For help completing the CMS 1500 form, please see mock-claims in Attachments 3 - 7.

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

Block 1	Check all appropriate box(es) for all type(s) of health insurance applicable to this claim.
Block 1a	**INSURED'S ID NUMBER** **1. When billing an MCO**, enter the recipient's unique MCO number. Please note that not all MCOs have unique MCO numbers for their clients. If there is no unique MCO number, enter the recipient's MA number in this box. Currently, the following MCOs have unique numbers: MedStar Family Choice, UnitedHealthcare, and Priority Partners. If you do not have the recipient's unique number, call the MCO and get that number at the same time that you are calling to get information on the recipient's PCP. All other MCOs accept the member's MA number in this block. **2. When billing DHMH for a Fee-For-Service patient**, no number is required in this box.
Block 2	**PATIENT'S NAME** (Last Name, First Name, Middle Initial) – Enter the recipient's name as it appears on the Medical Assistance card.
Block 3	**PATIENT'S BIRTH DATE/SEX** – Enter the recipient's date of birth and sex.
Block 4	**INSURED'S NAME** (Last Name, First Name, Middle Initial) – Enter the name of the person in whose name the third party coverage is listed, only when applicable. ***(No entry required when billing for a patient without third party insurance).***

Block 5	**PATIENT'S ADDRESS** – Enter the recipient's complete mailing address with zip code and telephone number.
Block 6	**PATIENT'S RELATIONSHIP TO INSURED** – If the recipient has other third party insurance, aside from Medicare, enter the appropriate relationship to the insured. ***(No entry required when billing for a recipient without third party insurance).***
Block 7	**INSURED'S ADDRESS** – When the recipient has third party insurance coverage aside from Medicare, enter the insured's address and telephone number. ***(No entry required when billing for a recipient without third party insurance).***
Block 8	**PATIENT STATUS** – Enter the recipient's status.
Block 9a	**OTHER INSURED'S POLICY OR GROUP NUMBER** – Enter the recipient's 11-digit Maryland Medical Assistance number. The MA number **must** appear in this Block regardless of whether or not a recipient has other insurance. Medical Assistance eligibility should be verified on each date of service by 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	**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 recipient has other third party health insurance and the claim has been rejected by that insurer, enter the appropriate rejection code listed below: **CODE REJECTION REASONS** **K** Services Not Covered **L** Coverage Lapsed **M** Coverage Not in Effect on Service Date **N** Individual Not Covered **Q** Claim Not Filed Timely (Requires documentation, e.g.,a copy of rejection from the insurance company.) **R** No Response from Carrier Within 120 Days of Claim Submission (Requires documentation e.g., a statement indicating a claim submission but no response.) **S** Other Rejection Reason Not Defined Above (Requires Documentation (e.g., a statement on the claim indicating that payment was applied to the deductible.) For information regarding recipient's coverage, contact Third Party Liability Unit at 410-767-1771.
Block 11a	**INSURED'S DATE OF BIRTH** – ***No entry required when billing for a recipient without third party insurance.***
Block 11b	**EMPLOYER'S NAME OR SCHOOL NAME** – ***No entry required when billing for a recipient without third party insurance.***
Block 11c	**INSURANCE PLAN OR PROGRAM NAME** – ***No entry required when***

	billing for a recipient without third party insurance.
Block 11d	**IS THERE ANOTHER BENEFIT PLAN? – *(No entry required when billing for a recipient that does not have another third party insurance in addition to the one already described in 11 above).***
Block 12	**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE –** This section should include a signature, as well as the billing date.
Block 13	**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE** – ***No entry required when billing for a FFS recipient or a client without third party insurance.***
Block 14	**DATE OF CURRENT ILLNESS, or INJURY, or PREGNANCY**
Block 15	**IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS**
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 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 #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.
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 the HCPCS J-code. Allow for the entry of 61 characters from the beginning of 24A to the end of 24G. Begin by entering the qualifier **N4** and then the 11-digit NDC number. It may be necessary to pad NDC numbers with left-adjusted zeroes in order to report eleven digits. Without skipping a space or adding hyphens, enter the unit of measurement qualifier followed by the numeric quantity administered to the patient. Below are the measurement qualifiers when reporting NDC units: **<u>Measurement Qualifiers</u>** **F2 International Unit, GR Gram, ML Milliliter, UN Units** More than one NDC can be reported in the shaded lines of Box 24. Skip three spaces after the first NDC/Quantity has been reported and enter the next NDC qualifier, NDC number, unit qualifier and quantity. This may be necessary when multiple vials of the same drug are administered with different dosages and NDCs.
Block 24A	**DATE(S) OF SERVICE –** Enter each separate date of service as a 6-digit numeric date (e.g. June 1, 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	**PLACE OF SERVICE –** For each date of service, enter the code to describe the site. **Note: SA Programs must enter Place of Service code "11"**

Block 24D	**PROCEDURES, SERVICES OR SUPPLIES** – Enter the five-character procedure code (H0001, H0004, H0005, H0015 or H0020) that describes the service provided.
Block 24E	**DIAGNOSIS POINTER** – Enter a single or combination of diagnosis from Block #21 above for each line on the invoice. Write the number (1, 2, 3 or 4) rather than the actual diagnosis code in this box.
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 SA clinic/program, not the individual provider.
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 recipient's MA number is incorrect, this number will be recorded on the Remittance Advice.
Block 27	**ACCEPT ASSIGNMENT** – For payment of Medicare coinsurance and/or deductibles, this Block must be checked "Yes". Providers agree to accept Medicare and/or Medicaid assignment as a condition of participation.
NOTE: Regulations state that providers shall accept payment by the program as payment in full for covered services rendered and make no additional charge to any recipient for covered services.	
Block 28	**TOTAL CHARGE** – Enter the sum of the charges shown on all lines of Block #24F of the invoice.
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	**BALANCE DUE –** Enter the balance due to your program. ***(No entry required when billing for a FFS client).***
Block 31	**SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS –** For recipients enrolled in MedStar Family Choice, please give the actual name of the rendering provider. For all other MCOs/FFS, please write "Signature on File." In both cases, please include the date of submission.
NOTE: The date of submission must be in Block 31 in order for the claim to be reimbursed.	
Block 32	**SERVICE FACILITY LOCATION INFORMATION** – Enter complete name and address for SA program.
Block 32a	**NPI** – Enter SA program's group NPI number. This should be the same 10-

	digit number entered in Block 24J.
Block 32b (shaded area)	Enter the ID Qualifier "**1D" (Medicaid Provider Number)** followed by the SA provider's 9-digit Maryland Medicaid provider number.
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 ID 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 provider number of the pay-to provider in Block #33. Errors or omissions of this number will result in non-payment of claims by the Medicaid fee-for-service program.
NOTE: It is the provider's responsibility to promptly report all name changes, pay-to address, correspondence address, practice locations, tax identification number, or certification to the Provider Master File in Provider Relations at 410-767-5340. SA providers should also contact Molly Marra at 410-767-5949 or mmarra@dhmh.state.md.us with any changes. Also, SA providers should report any changes to MCOs you have contracts with.	

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

1. Enter the appropriate pay-to provider information in Blocks 31 and 33.

- ✓ Block 24J and Block 32 should contain information for the SA program; and
- ✓ Block 25 and Block 33 should contain information for the sponsoring/pay-to provider if it is different from the rendering program information.

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

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

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

- ✓ A valid 2-digit place of service code is required. SA programs must use Place of Service "11";
- ✓ Claims will be denied if the procedure cannot be performed on the recipient indicated because of gender, age, prior procedure or other medical criteria conflicts. Verify the 11-digit patient MA number and procedure code on the claim form; and
- ✓ Verify that the services are covered for the recipient's coverage type. Covered services vary by population and program. For example, hospital-based services are not covered under PAC. If you bill the program for hospital-based services for a PAC recipient this is considered a non-covered service and the claim **will not** be paid. Refer to regulations for each program type to determine the covered services for that program.

B. REJECTED CLAIMS

Rejected claims will be listed on your Remittance Advice along with an Explanation of Benefits (EOB) code that provides the precise reason a specific claim was denied. EOB codes are very specific to individual claims and provide you with detailed information about the claim. There are a few common 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 Remittance Advice with the file copy of your claim. If the claim was denied because of a keystroke 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 has determined that a recipient has third party coverage that will pay for medical services, the claim will be denied. Submit the claim to the third party payer first. See exceptions on page ##; 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 applies to claims submitted to Medical Assistance; each MCO sets its own rules for rejection of claims and provides varying information on the EOB. See MCO Provider manuals for further information.

C. 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 you billed the incorrect number of units, you must complete an Adjustment Request Form following the directions on the back of the form. Additionally, please be aware that SA provider charges may differ from reimbursement rates.

When completing the Adjustment Form, do not bill only for remaining unpaid amounts or units; bill for the entire amount(s). For example, if you submitted and received payment for three units, but you should have billed for five units, **do not** bill for the remaining two units; bill for the **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 is incorrect (e.g., none of the recipients listed are your patients). When this occurs, send a copy of the Remittance Advice and the check with a complete Adjustment Request Form to the address on the bottom of the form.

Partial Refunds – If you receive a Remittance Advice which lists some correct payments and some incorrect payments, do not return the Medical Assistance Program check. Deposit the check and file an Adjustment Request Form for only 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 remittance advices and CMS-1500 claim forms. Adjustment Request Forms should be mailed to:

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

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

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 MCOs. SA providers will have to submit corrected claims or appeals to MCOs. For information on how to file an adjustment with an MCO, see the contact information provided in Attachment 1.

V. SELF-REFERRED SUBSTANCE ABUSE SERVICES

DHMH has developed uniform codes and rates for the following self-referred services: Substance Abuse Assessment, Individual Outpatient Therapy, Group Outpatient Therapy, Intensive Outpatient, and Methadone Maintenance. These codes are to be used by providers who bill with the CMS 1500 form and who are certified by the OHCQ to provide SA treatment and by local health departments for the listed levels of care. The HealthChoice program and the Medicaid FFS system will use the same codes. This will simplify billing procedures for SA providers. Uniform billing codes will be effective as of January 1, 2010.

A. CODES AND RATES FOR COMMUNITY-BASED SUBSTANCE ABUSE SERVICES

Service	Code	HCPC Description	Unit of Service	Rate
Comprehensive Substance Abuse Assessment (CSAA)	H0001	Alcohol and/or drug assessment	Per assessment	$142
Individual outpatient therapy	H0004	Behavioral health counseling and therapy	Per 15 minutes	$20
Group outpatient therapy	H0005	Alcohol and/or drug services; group counseling by a clinician	Per 60-90 minute session	$39
Intensive outpatient	H0015	Alcohol and/or drug services; intensive outpatient, including assessment, counseling, crisis intervention, and activity therapies or education.	Per diem (minimum 2 hours of service per session) Maximum 4 days per week Minimum 9 hours of service per week	$125
Methadone maintenance	H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	Per week	$80

Note: On January 1 2010, the ICF-A cost-based cap rate for adolescents will be raised to $350 per day.

If you have any questions regarding provider services or to request a copy of the fee schedule, please contact the Staff Specialist at **410-767-1722**. A copy of the fee schedule can be viewed by visiting the DHMH website: ***www.dhmh.state.md.us/mma/providerinfo***

B. LABORATORY AND PATHOLOGY SERVICES

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

Services a**t 410-767-1462** 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.

C. ADDITIONAL GUIDELINES

1. A HealthChoice enrollee can self-refer for a CSAA to any appropriate, willing substance abuse treatment provider.

- The enrollee cannot already be in substance abuse treatment;
- The enrollee cannot have already self-referred for an assessment during the calendar year;
- The provider does not need to be part of the enrollee's MCO/BHO network; and
- A provider is not required to accept the enrollee as a patient, but does have a professional obligation to refer the individual to another provider.

2. The Self-Referral Treatment Protocol

- The protocol includes preauthorized units of service, the notification process for each treatment modality, and other important information. When a HealthChoice enrollee presents, the provider should identify the ASAM level of care and follow the provisions for the appropriate treatment modality. This protocol starts on page 18. The authorization protocol chart includes information about the five self-referred services, in addition to other SAII services not included in these billing instructions. **Familiarity with the entire protocol is crucial. Providers not following these procedures could be denied authorization and/or payment.**

D. HealthChoice & PAC Substance Abuse Treatment Self-Referral Protocols – in ASAM Order
Substance Abuse Improvement Initiative (SAII)
January 1, 2010

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
Comprehensive Substance Abuse Assessment (CSAA)				
H0001	NA	NA	(1) A Managed Care Organization (MCO) or the Behavioral Health Organization (BHO) which administers the substance abuse services for certain MCOs will pay for a Comprehensive Substance Abuse Assessment once per enrollee per program per 12-month period, unless there is more than a 30-day break in treatment. If a patient returns to treatment after 30 days, the MCO/BHO will pay for another CSAA.	The same rules for HealthChoice apply for PAC.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: I-Outpatient Services (Ambulatory detox) – In this context, ambulatory detox refers to services provided in the community or in outpatient departments of hospitals or ICF-As. It is only covered under HealthChoice.				
H0014 for community-based providers using CMS 1500 0944 and 0945 revenue codes for facility-based providers using UB-04	Provider must notify MCO/BHO and provide treatment plan (by fax or email) within one (1) business day of admission to ambulatory detox.	MCO or BHO liaison will respond to provider within one (1) business day of receipt with final disposition concerning ASAM criteria, including confirmation number if approved.	1) If MCO/BHO **does not** respond to provider's notification, MCO/BHO will pay up to five (5) days. 2) If MCO/BHO responds by approving authorization, a LOS of five (5) days will automatically be approved. Additional days must be preauthorized as meeting medical necessity criteria. 3) If MCO/BHO determines client does **not** meet ASAM LOC, MCO/BHO will pay for care up to the point where they formally communicate their disapproval.	Ambulatory detox is not covered by the PAC program.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: I – Outpatient Services (Individual, family, and group therapy) – Self-referred individual, family or group therapy services must be provided in the community (not in hospital rate regulated settings).[1] [2]				
H0004 for individual or family therapy H0005 for group therapy	Provider must notify (by fax or email) MCO/BHO and provide initial treatment plan within three (3) business days of admission to Level I therapy services	MCO or BHO liaison must respond to provider within two (2) business days of receipt with confirmation of receipt of notification.	MCO/BHO will pay for 30 self-referred sessions (any combination of individual, group, and family therapy) within 12-month period per client. Any other individual or group therapy services within the 12-month period must be preauthorized. Medicaid MCOs/BHOs will pay for additional counseling services as long as deemed medically necessary. In order for a provider to bill for family counseling, the enrollee must be present for an appropriate length of time, but does not need to be present for the entire counseling session. In some circumstances the counselor might spend part of the session with the family out of the presence of the enrollee. Family therapy is billed under the individual enrollee's Medicaid number.	PAC only covers Level 1, individual, family, and group therapy in community-based settings. All other approval rules for HealthChoice apply for PAC.

[1] Hospital rate regulated clinics must seek preauthorization to provide such services under HealthChoice. In preauthorizing, MCO may refer to in-network community providers if those providers are easily available geographically and with no waiting lists.
[2] Hospital-based services are not covered under PAC.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: II.1 – Intensive Outpatient (IOP – intensive outpatient) - Self-referred intensive outpatient services only apply to care delivered in community-based settings. Hospital rate regulated clinics must seek preauthorization to provide such services[3].				
H0015 for community-based providers using CMS 1500 0906 revenue codes for facility-based providers using UB-04	Provider must notify and provide treatment plan to MCO (by fax or email) within three (3) business days of admission to IOP. If they do not notify, they will not be paid for services rendered.	MCO or BHO liaison will respond to provider (by fax or email) within two (2) business days with final disposition concerning ASAM criteria, including confirmation number if approved.	If the treatment plan is approved, MCO/BHO will pay for 30 calendar days of IOP. At the end of week three (3), for care coordination purposes, the provider must notify the MCO of discharge plan or need for remaining treatment. Additional days must be approved based on medical necessity. If determined that client **does not** meet ASAM LOC, MCO/BHO will pay for all services delivered up until the point that they formally notify the provider of the denial. If the client does not qualify for IOP, the MCO/BHO will work with the provider to determine the appropriate level of care.	The same approval rules for HealthChoice apply for PAC. PAC providers must bill using the CMS 1500 form and the H0015 for PAC recipients.

[3] Hospital regulated clinics must seek preauthorization to provide services under HealthChoice. In preauthorizing, MCO may refer to in-network community providers if those providers are easily available geographically and with no waiting lists. Hospital regulated clinics are not covered under the PAC program.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: II.5 – Partial Hospitalization (Partial hospitalization (adults and children)) - HealthChoice reimburses this service only when it occurs in a hospital or other facility setting. It is not covered under PAC.				
0912 and 0913 revenue codes for facility-based providers using UB-04	By morning of second day of admission to this service setting, provider will review client's Treatment Plan with MCO/BHO by telephone. Provider must submit progress report **and** assessment for justification of continued stay beyond day five (5). Provider obtains patient consent and submits progress report or discharge summary to PCP for their records and coordination of care within 10 days.	MCO or BHO liaison will respond to providers within two (2) hours of review. Confirmation number will be provided. MCO/BHO must have 24/7 availability for case discussion with provider.	1) Two (2) day minimum guaranteed. If ASAM is met, MCO/BHO will authorize an additional three (3) days. Any additional days must be preauthorized by the MCO based on medical necessity. 2) If the MCO/BHO is **not available or does not respond** to provider within two (2) hours, they will pay the extra three (3) days. Any additional days must be preauthorized by the MCO/BHO based on medical necessity. Providers shall provide the least restrictive level of care. If the client does not qualify for partial hospitalization, the MCO/BHO will work with the provider to determine the appropriate level of care.	Partial hospitalization is not covered by the PAC program.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: III – Residential and Inpatient (ICF-A, under 21) - HealthChoice only covers children and adolescents under age 21 for as long as medically necessary and the enrollee is eligible for the service. HealthChoice does not pay for these services if they are not medically necessary, even if a Court has ordered them. This service is not covered under PAC.				
Providers should speak to MCOs/BHOs about appropriate codes to use within their billing systems	Within two (2) hours, provider calls MCO or BHO for authorization.	MCO/BHO liaison will respond to provider within two (2) hours with a final disposition concerning ASAM criteria, including confirmation number if approved. MCO/BHO must have 24/7 availability.	1) If MCO **does not** respond to urgent call, up to three (3) days will be paid. Additional days must be preauthorized. 2) If ASAM is met and MCO/BHO has authorized, a LOS of three (3) days will be approved. Additional days must be preauthorized. 3) If client does not meet criteria, the MCO/BHO will work with provider to determine appropriate level of care.	ICF-A is not covered by the PAC program.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: Opioid Maintenance Treatment (Methadone) - In regards to the self-referral option under HealthChoice, methadone maintenance refers to services provided in the community or in outpatient departments of hospitals. It will not however be covered under PAC.				
H0020	Within five (5) calendar days of admission to methadone program, provider notifies MCO/BHO (by fax or email) and submits initial treatment plan. The provider will submit an updated treatment plan to the MCO/BHO by the 12th week of service to promote the coordination of care. Next approvals will be at six-month intervals.	MCO or BHO will respond to provider within two (2) business days (by fax or email) with final disposition, including confirmation/ authorization number if approved. The provider will inform the PCP that patient is in treatment after obtaining the patient's consent.	If approved, MCO/BHO will pay for 26 weeks under the self-referral option. Continued eligibility for coverage will be determined by medical necessity. Additional approvals beyond the first 26 weeks will be at six-month intervals. Unit of service is one week. Any care provided prior to a denial based on medical necessity will be paid by the MCO/BHO.	PAC covers methadone treatment only in a community-based setting (not hospital). All other HealthChoice approval rules apply. PAC providers must bill using the CMS 1500 and the H0020 code.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: IV.D -Medically Managed Patient (Inpatient detox in an inpatient hospital setting or ICF-A facility) - This service is provided in a hospital or ICF-A setting and is only covered under HealthChoice.				
0126 and 0136 revenue codes for facility-based providers	Within two (2) hours, provider calls MCO/BHO for authorization.	MCO or BHO will respond to provider within two (2) hours with a final disposition, including confirmation number if approved. MCO/BHO must have 24/7 availability.	If ASAM is met and MCO/BHO authorizes, a LOS of three (3) days will be approved. Additional days must be preauthorized as medically necessary. If client does not meet criteria, the MCO/BHO will work with provider to determine appropriate level of care. If MCO/BHO does not respond to the provider's authorization call, up to three (3) days will be paid. Additional days must be preauthorized as medically necessary.	Inpatient detox is not covered by PAC.

Footnotes

1. MCOs/BHOs must have 24/7 availability for Partial Hospitalization, ICF-A, and Inpatient Acute. These services are only covered under HealthChoice.
2. MCOs/BHOs will honor substance abuse authorizations for all services made by an enrollee's previous MCO provided the ASAM level of care is met and there is no break in service. The provider must submit written verification of this authorization to the new MCO within 72 hours of receiving it from the previous MCO.
3. MCOs pay the full FQHC per visit rate for services rendered for HealthChoice patients. MCOs do not have to pay the full FQHC rates for PAC patients.
4. An MCO may not require a peer-to-peer review for a pre-certification in cases where the patient is new and has not been seen by the provider's physician.
5. An MCO may not require written approval from a commercial insurer before deciding on a preauthorization in cases where the patient has dual insurance.
6. Proof of notification is the faxed confirmation sheet and/or a documented phone conversation (date, time and person spoken to).
7. "One session" means a face-to-face meeting with a provider.
   ☞Note: HealthChoice regulations require the use of a placement appraisal to determine the appropriate level and intensity of care for the enrollee-based on the current edition of the American Society of Addiction Medicine Patient Placement Criteria, or its equivalent as approved by the Alcohol and Drug Abuse Administration for most services covered under this protocol.

Department of Health and Mental Hygiene website: http://www.dhmh.state.md.us/
DHMH Provider Hotline: 1-800-766-8692 Or call the **Complaint Resolution Unit's** supervisor, Ellen Mulcahy-Lehnert, or Division Chief, Ann Price, at 1-888-767-0013 or 1-410-767-6859 from 8:30 AM to 4:30 PM Monday - Friday

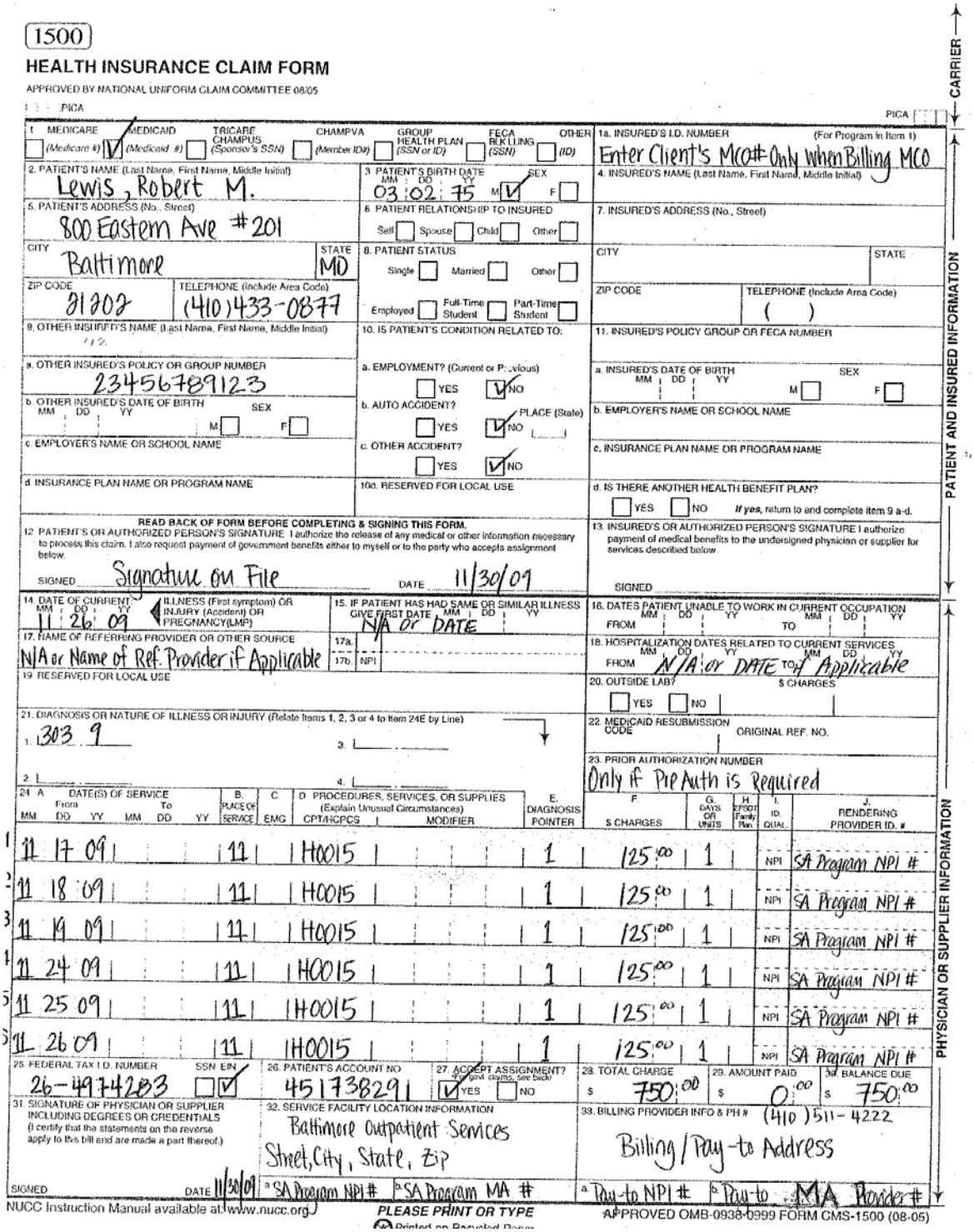
ATTACHMENT 1
MCO CONTACT INFORMATION FOR SUBSTANCE ABUSE PROVIDERS

Managed Care Organization Behavioral Health Organization (BHO)	Authorization/ Notification Both in- & out-of-network	MCO Problem/Concern Contact Call numbers to the left first	Provider Relations	Claims	Special Needs Coordinator
AMERIGROUP Community Care	Providers: 1-800-454-3730 (have AMERIGROUP provider ID number or NPI number to more easily navigate system) Members: 1-800-600-4441 Fax: 1-800-505-1193	Mark Segal 410-859-5800 x44526	Helen Homon Director, Network Management 410-981-4516 Fax: 1-866-920-1873 hhomon@amerigroupcorp.com	Provider Relations Department 1-800-454-3730	Ornita Moore 410-981-4060 Fax: 866-920-1867 omoore1@amerigroupcorp.com
Diamond Plan Coventry Health Care BHO: MHNet	1-800-454-0740 Fax: 1-407-831-0211	Malaika Vasilidas 800-835-2094	Carol Robinson Network Contracting Director 1-800-727-9951 x 1523 Fax: 1-866-602-1246 crobinson@cvty.com	Joel Coppadge VP. of Service Operations 211 Lake Drive Newark, DE 19702 302-283-6564 Fax: 302-283-6787 jcoppadge@cvty.com	Denise Defoe 1-800-727-9951 x1551
MedStar Family Choice BHO: Value Options	1-800-496-5849	Victoria Gonzalez, Sr.Acct.Exec. 433 River Street Troy, NY 12180 (518) 271-2126	1-800-397-1630	1-800-496-5849	Blaine Willis 410-933-2226
Jai Medical Systems	Jemma Chong Qui 410-327-5100 Fax: 410-327-0542 Jemma@jaimedical.com	Jemma Chong Qui 410-327-5100	Adrienne McPherson 410-433-2200 Fax: 410-433-4615 adrienne@jaimedical.com	Provider Relations Department 410-433-2200	Georgia West 410-433-2200 Fax: 410-433-8500 georgia@jaimedical.com
Maryland Physicians Care	1-800-953-8854 option 7 Fax: 860-907-2649	Linda Dietsch 410-401-9452 Fax: 860-907-2684 linda.dietsch@ marylandphysicianscare.com	Barbara LaPlante 410-401-9508 Fax: 860-907-2694 barbara.laplante@ marylandphysicianscare.com	All Authorizations Fax: 860-907-2649 Claims Inquiry-Research 1-800-953-8854	Shannon Jones 410-401-9443 Fax: 860-970-2710 shannon.jones@ marylandphysicianscare.com
Priority Partners	1-800-261-2429 Option 3 Fax: 410-424-4891	Jamie Miller 1-800-261-2429 or 410-424-4919 Fax: 410-424-4891	Dina Goldberg, Director 410-424-4634 Fax: 410-424-4604 dgoldberg@jhhc.com	Provider Customer Service 410-424-4490 or 1-800-819-1043	Michael Papi 1-800-261-2396 Fax: 410-424-4906 snc@jhhc.com
UnitedHealthcare BHO: United Behavioral Health	1-888-291-2507 Fax: 1-855-250-8159	Christine Foreman, LCSW Account Director 727-772-6893 Fax: 727-773-8564 Christine.Foreman@optumhealth.com Note: Effective 04/01/2012 Alicia McKnight Account Director 615-297-1995 alicia.s.mcknight@optum.com	Katie Hinkle Network Manager 215-231-3005 Fax: 215-832-4707 Katie.hinkle@optumhealth.com	1-888-291-2507	Brenda McQuay 410-379-3434 Fax: 410-540-5977 E-Fax: 1-855-273-1594 brenda_e_mcquay@uhc.com

ATTACHMENT 2
MCO Billing Addresses

MCO (BHO)	Billing Address
AMERIGROUP	Amerigroup PO Box 61010 Virginia Beach, VA 23466-1010
DIAMOND PLAN Coventry Health Care (MHNet)	MHNet Claims Department P.O. Box 7802 London, KY 40742
MEDSTAR FAMILY CHOICE (Value Options)	MedStar Family Choice P.O. Box 383 Latham, NY 12110
JAI MEDICAL SYSTEMS	Jai Medical Systems Attention: Claims Department 5010 York Road Baltimore, MD 21212
MD PHYSICIANS CARE	Maryland Physicians Care MCO Claims P.O. Box 61778 Phoenix, AZ 85082-1778
PRIORITY PARTNERS	Johns Hopkins Health Care Attn: Priority Partners Claims 6704 Curtis Court Glen Burnie, MD 21060
UNITEDHEALTHCARE (United Behavioral Health)	United Behavioral Health P.O. Box 30757 Salt Lake City, UT 84130-0757

ATTACHMENT 3
MOCK UP OF CMS 1500 FORM FOR PATIENT
RECEIVING INTENSIVE OUTPATIENT THERAPY



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☑ TRICARE CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☐

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Enter Client's MCO# Only When Billing MCO

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Lewis, Robert M.

3. PATIENT'S BIRTH DATE MM DD YY: 03 02 75 SEX M ☑ F ☐

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

5. PATIENT'S ADDRESS (No., Street): 800 Eastern Ave #201

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY: Baltimore STATE: MD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE: 21202 TELEPHONE (Include Area Code): (410)433-0877

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 234567891 23

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☑

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

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

b. AUTO ACCIDENT? YES ☐ NO ☑ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☑

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE: 11/30/09

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

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 11 26 09

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY: N/A or DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: N/A or Name of Ref. Provider if Applicable

17a. ☐

17b. NPI ☐

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: N/A or DATE TO: if Applicable

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

1. 303.9 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Only if Pre Auth is Required

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
11 17 09		11		H0015		1	125.00	1		NPI	SA Program NPI #
11 18 09		11		H0015		1	125.00	1		NPI	SA Program NPI #
11 19 09		11		H0015		1	125.00	1		NPI	SA Program NPI #
11 24 09		11		H0015		1	125.00	1		NPI	SA Program NPI #
11 25 09		11		H0015		1	125.00	1		NPI	SA Program NPI #
11 26 09		11		H0015		1	125.00	1		NPI	SA Program NPI #

25. FEDERAL TAX I.D. NUMBER SSN EIN: 26-4974283 ☑

26. PATIENT'S ACCOUNT NO: 45173829

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

28. TOTAL CHARGE: $ 750.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 750.00

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

SIGNED DATE 11/30/09

32. SERVICE FACILITY LOCATION INFORMATION: Baltimore Outpatient Services Street, City, State, Zip

a. SA Program NPI # b. SA Program MA #

33. BILLING PROVIDER INFO & PH # (410)511-4222 Billing/Pay-to Address

a. Pay-to NPI # b. Pay-to MA Provider #

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

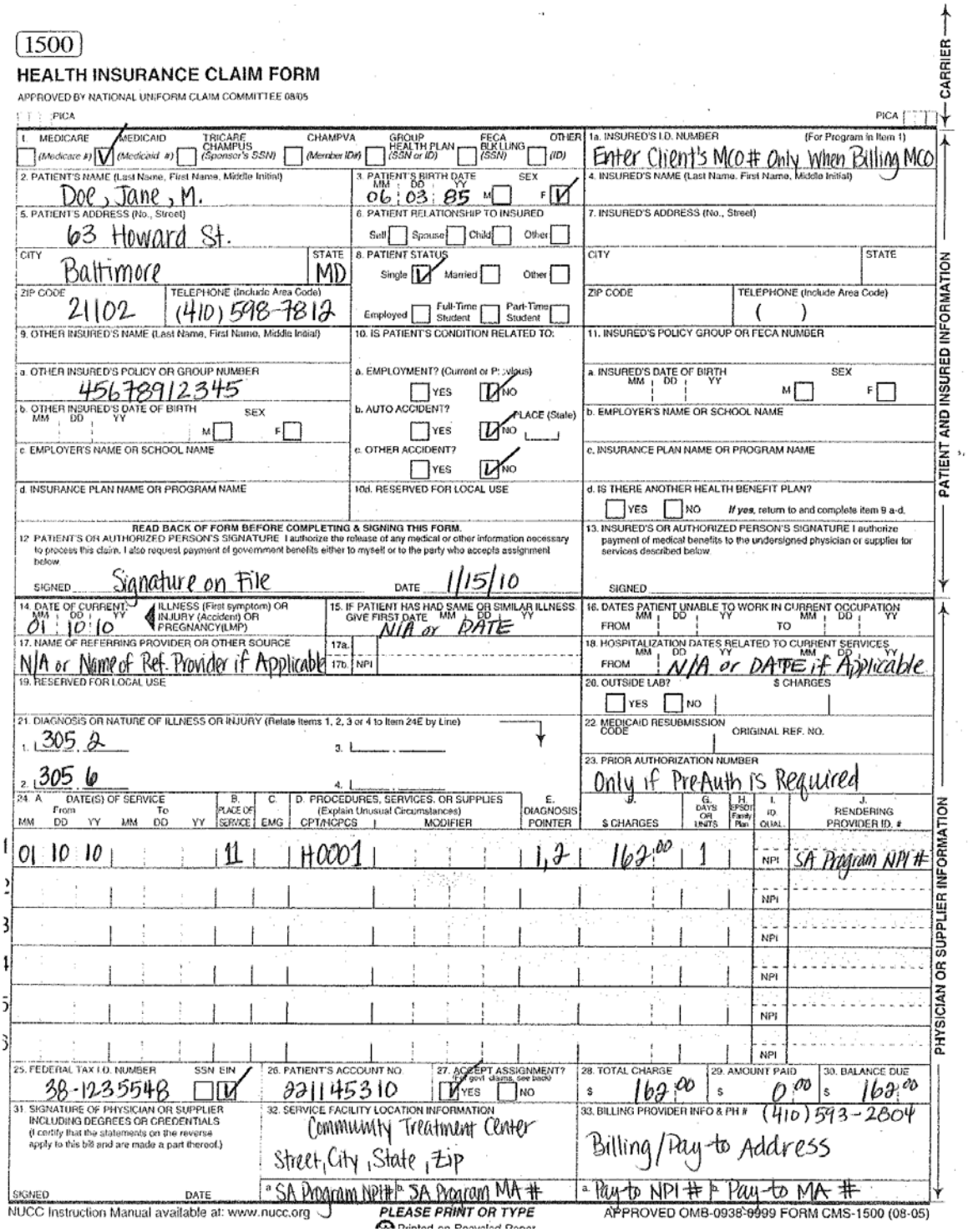
CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

ATTACHMENT 4
MOCK UP OF CMS 1500 FORM FOR PATIENT
RECEIVING A COMPREHENSIVE SUBSTANCE ABUSE ASSESSMENT



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [V] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Enter Client's MCO # Only When Billing MCO

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane, M.

3. PATIENT'S BIRTH DATE MM DD YY: 06 03 85 SEX M [ ] F [V]

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

5. PATIENT'S ADDRESS (No., Street): 63 Howard St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: Baltimore STATE: MD

8. PATIENT STATUS: Single [V] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 21102 TELEPHONE (Include Area Code): (410) 598-7812

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 456789123 45

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [V]

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

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

b. AUTO ACCIDENT? YES [ ] NO [V] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [V]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE: 1/15/10

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

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 01 10 10

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY: N/A or DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: N/A or Name of Ref. Provider if Applicable

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: N/A or DATE if Applicable

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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

1. 305.2
2. 305.6
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Only if PreAuth is Required

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
01 10 10	11		H0001		1,2	162.00	1		NPI	SA Program NPI #
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 38-1235548 [V]

26. PATIENT'S ACCOUNT NO.: 22114531 0

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

28. TOTAL CHARGE: $ 162.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 162.00

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: Community Treatment Center

Street, City, State, Zip

a. SA Program NPI # b. SA Program MA #

33. BILLING PROVIDER INFO & PH #: (410) 593-2804

Billing/Pay-to Address

a. Pay-to NPI # b. Pay-to MA #

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

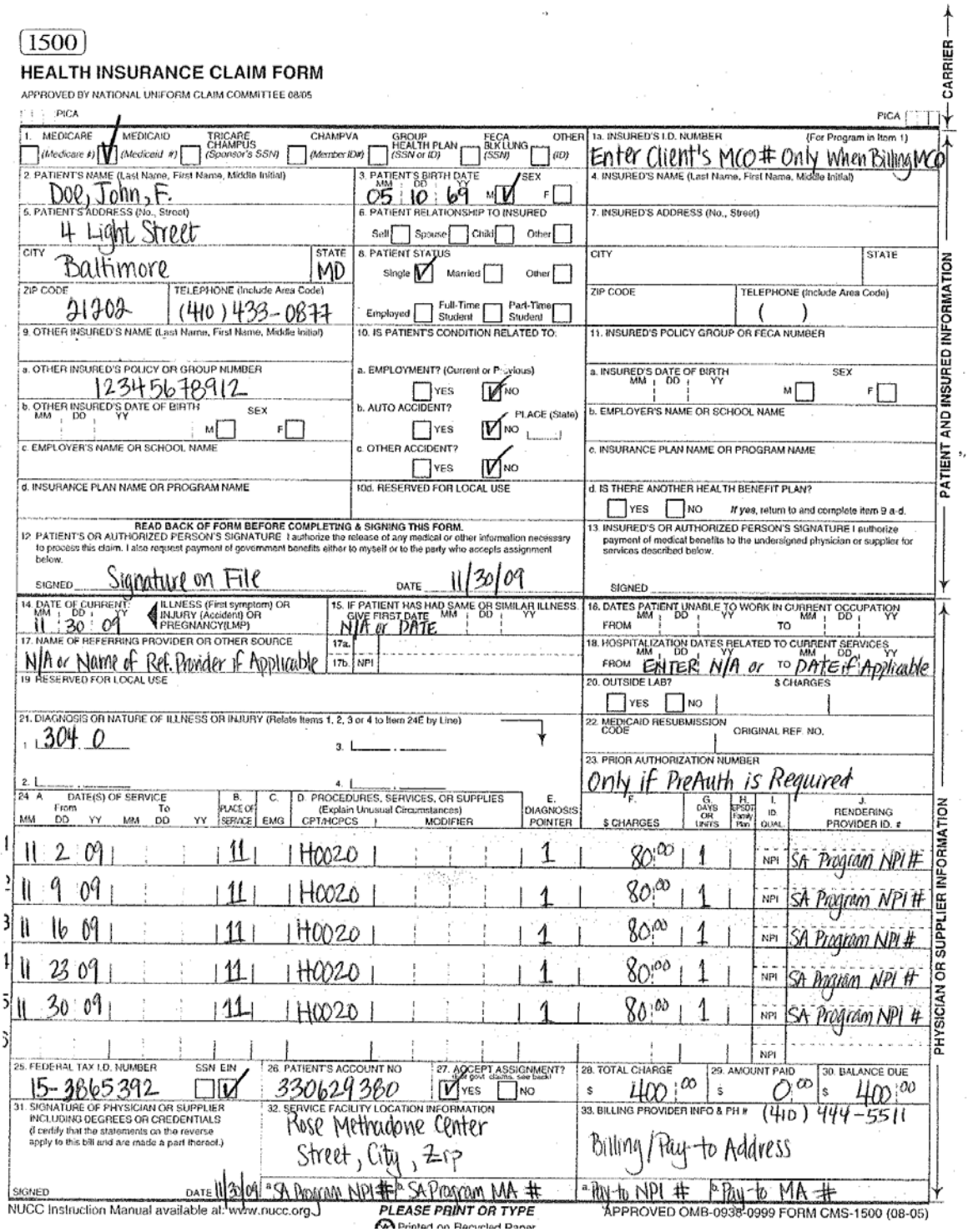
CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

ATTACHMENT 5
MOCK UP OF CMS 1500 FORM FOR PATIENT
RECEIVING METHADONE MAINTENANCE THERAPY



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☑ TRICARE CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☐

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Enter Client's MCO # Only When Billing MCO

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John, F.

3. PATIENT'S BIRTH DATE MM DD YY: 05 10 69 SEX M ☑ F ☐

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

5. PATIENT'S ADDRESS (No., Street): 4 Light Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY: Baltimore STATE: MD

8. PATIENT STATUS: Single ☑ Married ☐ Other ☐

CITY STATE

ZIP CODE: 21202 TELEPHONE (Include Area Code): (410) 433-0877

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 123456789 12

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☑

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

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

b. AUTO ACCIDENT? YES ☐ NO ☑ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☑

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE: 11/30/09

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

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 11 30 09

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A or DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: N/A or Name of Ref. Provider if Applicable

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: ENTER N/A or TO DATE if Applicable

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

1. 304.0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Only if PreAuth is Required

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 2 09		11		H0020		1	80.00	1		NPI	SA Program NPI #
2 11 9 09		11		H0020		1	80.00	1		NPI	SA Program NPI #
3 11 16 09		11		H0020		1	80.00	1		NPI	SA Program NPI #
4 11 23 09		11		H0020		1	80.00	1		NPI	SA Program NPI #
5 11 30 09		11		H0020		1	80.00	1		NPI	SA Program NPI #
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 15-3865392 SSN ☐ EIN ☑

26. PATIENT'S ACCOUNT NO: 330629380

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

28. TOTAL CHARGE $ 400.00

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ 400.00

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

SIGNED DATE 11/30/09

32. SERVICE FACILITY LOCATION INFORMATION: Rose Methadone Center Street, City, Zip

a. SA Program NPI # b. SA Program MA #

33. BILLING PROVIDER INFO & PH # (410) 444-5511

Billing/Pay-to Address

a. Pay-to NPI # b. Pay-to MA #

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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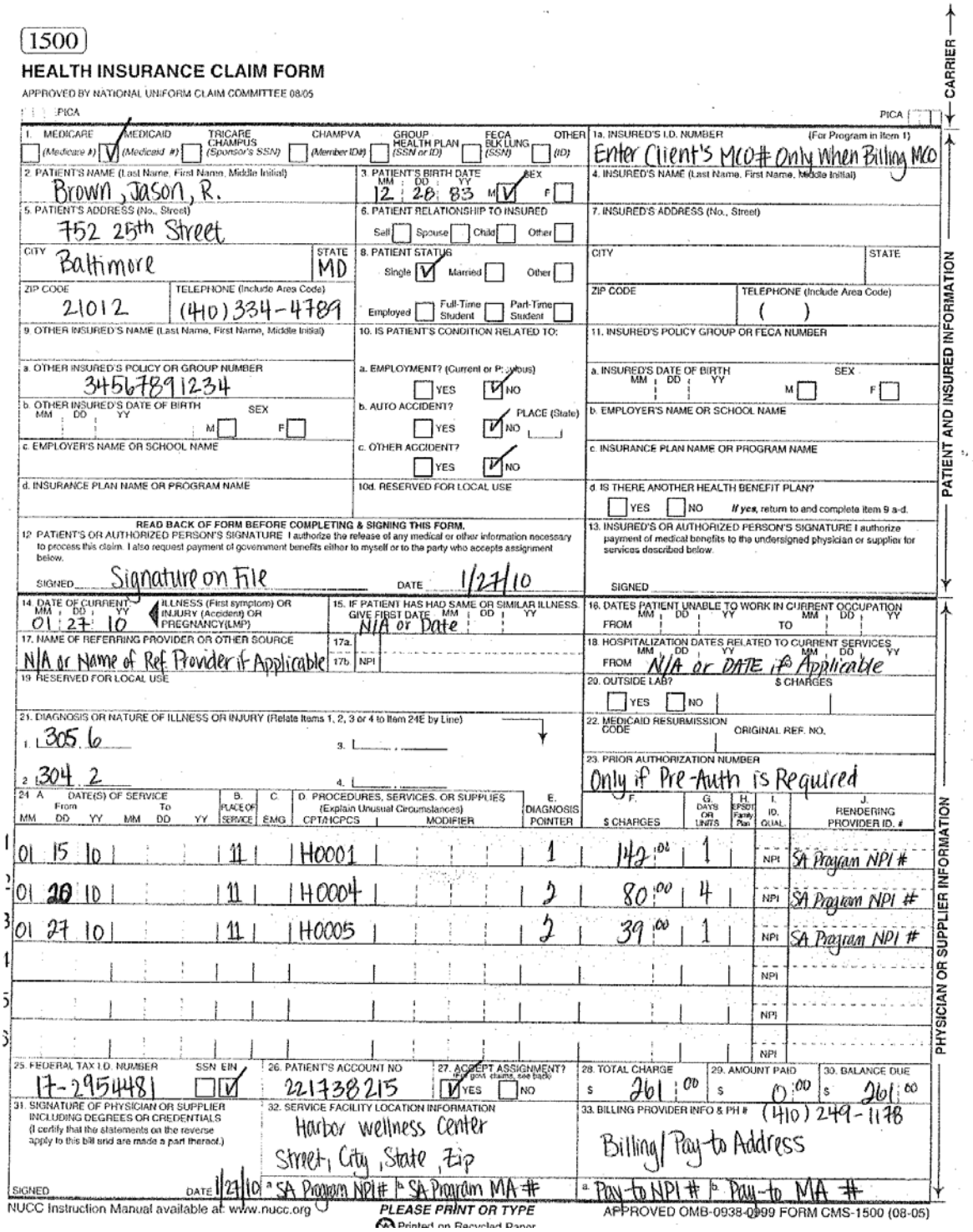
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

ATTACHMENT 6
MOCK UP OF CMS 1500 FORM FOR PATIENT
RECEIVING CSAA, INDIVIDUAL AND GROUP OUTPATIENT THERAPY



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [✓] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Enter Client's MCO# Only When Billing MCO

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Brown, Jason, R.

3. PATIENT'S BIRTH DATE: 12 28 83 SEX: M [✓] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 752 25th Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: Baltimore STATE: MD

8. PATIENT STATUS: Single [✓] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 21012 TELEPHONE (Include Area Code): (410) 334-4789

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 3456789 1234

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [✓]

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

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

b. AUTO ACCIDENT? YES [ ] NO [✓] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [✓]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE: 1/27/10

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

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 01 27 10

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: N/A or Date

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: N/A or Name of Ref Provider if Applicable

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: N/A or DATE if Applicable

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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

1. 305.6
2. 304.2
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Only if Pre-Auth is Required

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 15 10		11		H0001		1	142.00	1		NPI	SA Program NPI #
2 01 20 10		11		H0004		2	80.00	4		NPI	SA Program NPI #
3 01 27 10		11		H0005		2	39.00	1		NPI	SA Program NPI #
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 17-2954481 SSN [ ] EIN [✓]

26. PATIENT'S ACCOUNT NO: 221738215

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

28. TOTAL CHARGE: $ 261 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 261 00

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

SIGNED DATE: 1/27/10

32. SERVICE FACILITY LOCATION INFORMATION: Harbor Wellness Center Street, City, State, Zip

a. SA Program NPI # b. SA Program MA #

33. BILLING PROVIDER INFO & PH #: (410) 249-1178 Billing/Pay-to Address

a. Pay-to NPI # b. Pay-to MA #

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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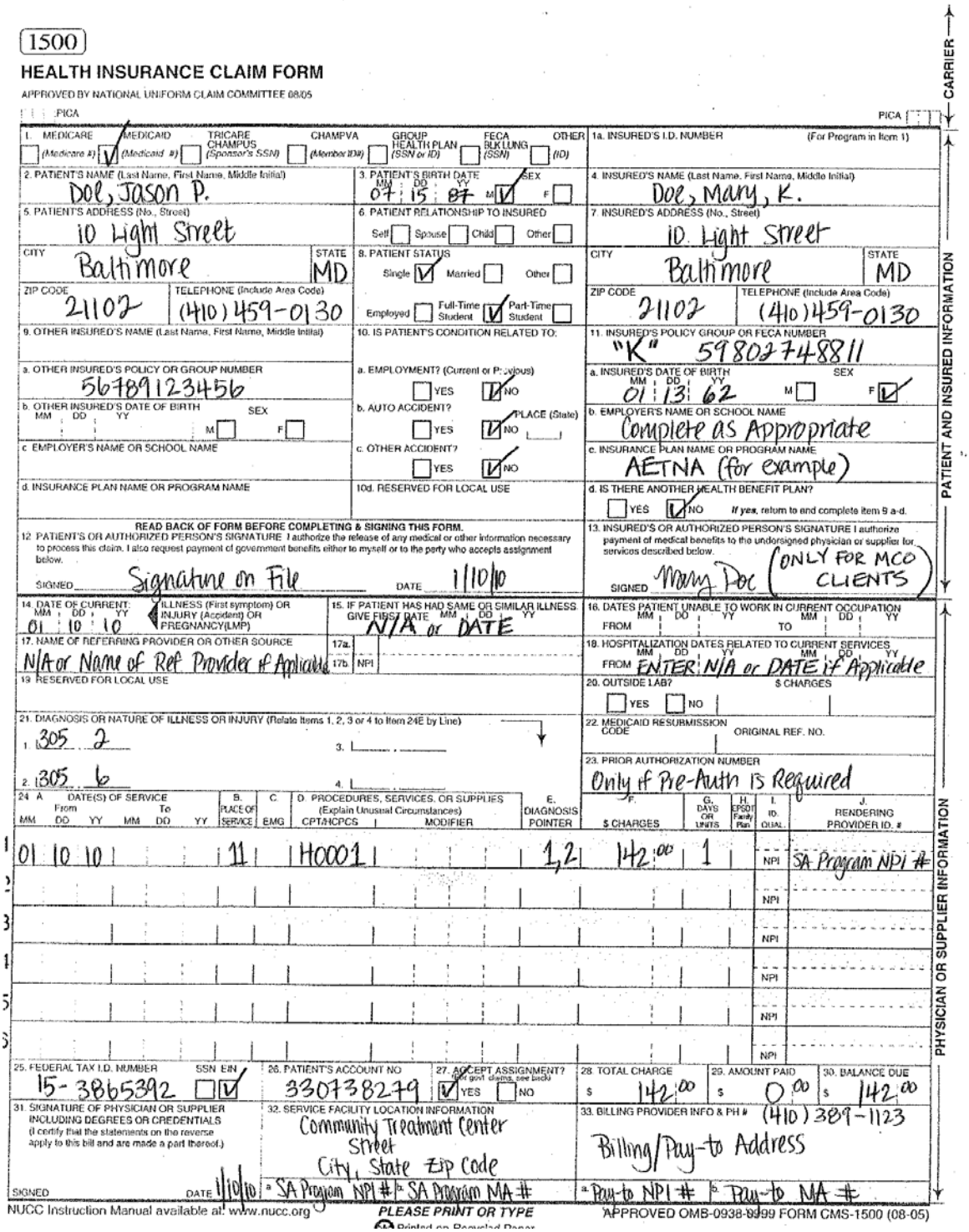
ATTACHMENT 7
MOCK UP OF CMS 1500 FORM FOR PATIENT RECEIVING CSAA,
GROUP AND INDIVIDUAL OUTPATIENT THERAPY <u>WITH THIRD PARTY INSURANCE</u>



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☑ TRICARE CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☐

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jason P.

3. PATIENT'S BIRTH DATE: 07 15 87 SEX: M ☑ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Mary, K.

5. PATIENT'S ADDRESS (No., Street): 10 Light Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 10 Light Street

CITY: Baltimore STATE: MD

8. PATIENT STATUS: Single ☑ Married ☐ Other ☐

CITY: Baltimore STATE: MD

ZIP CODE: 21102 TELEPHONE (Include Area Code): (410) 459-0130

Employed ☐ Full-Time Student ☐ Part-Time Student ☑

ZIP CODE: 21102 TELEPHONE (Include Area Code): (410) 459-0130

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: "K" 59802748811

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 567891234456

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☑

a. INSURED'S DATE OF BIRTH: 01 13 62 SEX: M ☐ F ☑

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

b. AUTO ACCIDENT? YES ☐ NO ☑ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: Complete as Appropriate

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☑

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA (for example)

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE 1/10/10

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

SIGNED Mary Doe (ONLY FOR MCO CLIENTS)

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 01 10 10

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY: N/A or DATE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: N/A or Name of Ref Provider if Applicable

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: ENTER N/A or DATE if Applicable

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

1. 305 2

2. 305 6

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Only if Pre-Auth IS Required

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
01 10 10		11		H0001		1,2	142 00	1		NPI	SA Program NPI #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 15-3865392 ☐ ☑

26. PATIENT'S ACCOUNT NO: 33073827 9

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

28. TOTAL CHARGE: $ 142 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 142 00

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

SIGNED DATE 1/10/10

32. SERVICE FACILITY LOCATION INFORMATION: Community Treatment Center Street City, State Zip Code

a. SA Program NPI # b. SA Program MA #

33. BILLING PROVIDER INFO & PH #: (410) 389-1123 Billing/Pay-to Address

a. Pay-to NPI # b. Pay-to MA #

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ATTACHMENT 8
MCO/BHO ELECTRONIC BILLING INFORMATION

MCO (BHO)	Status/Procedure
AMERIGROUP	Available with no transaction costs, but setup fees might be charged. Following is contact information to obtain software. Emdeon (formerly WebMD) 1-877-469-3263 Option 3 - AMERIGROUP Payor ID: 27517 MedAdvant (formerly ProxyMed) 1-800-586-6870 - AMERIGROUP Payor ID: 28807 For issues with electronic transmission from a Clearinghouse to AMERIGROUP, call AMERIGROUP's EDI Support line at 1-800-590-5745
DIAMOND PLAN Coventry Health Care (MHNet)	Network individual providers can submit bills and members can submit claims on line at ***www.mhnet.com*** Facilities and large groups can submit electronically via a third party vendor which is Emdeon, etc.
MEDSTAR FAMILY CHOICE (Value Options)	Providers can access the electronical data interchange (EDI) by downloading the software from www.valueoptions.com/providers/ProCompliance.htm or requesting a CD through VO's EDI Helpdesk 1-888-247-9311 or email: e-supportServices@ValueOptions.com
JAI MEDICAL SYSTEMS	Electronic billing is available to contracted participating providers and facilities. If interested, either call Jai Medical Systems at (410) 433-2200 and ask for the HIPAA EDI Coordinator or email your request to HIPAAEDI@jaimedical.com.
MD PHYSICIANS CARE	Emdeon WebMD 800-735-8254, Ext. 17903 MD Physicians Care Payor ID: 22348 ProxyMed 888-894-7888 MD Physicians Care Payor ID: 00247
PRIORITY PARTNERS	JHHC accepts claims from Emdeon (WebMD) and Payer Path (Relay Health). If interested in submitting electronically to JHHC, please contact ProviderRelations@jhhc.com. Upon receipt of your interest e-mail, a member of the EDI Task Force will contact you.
UNITEDHEALTHCARE (United Behavioral Health)	Network individual providers can submit bills and members can submit claims on line at ***www.ubhonline.com***. Facilities and large groups can submit electronically via third party vendors such as WebMD, etc.

Office of Health Services
Department of Health and Mental Hygiene
December 10, 2009

ATTACHMENT 9
TIME LIMITS FOR SUBMISSION AND RESUBMISSION OF CLAIMS TO HEALTHCHOICE
MANAGED CARE ORGANIZATIONS AND THEIR BEHAVIORAL HEALTH ORGANIZATIONS
Information Provided by MCOs and BHOs

AMERIGROUP

Submission of Claims:

- 180 days to submit clean claims.
- Administrative appeals must be submitted within 90 days of the date on the EOP.

Diamond Plan from Coventry (managed by **MHNet**)

Submission of Claims:

- Participating providers, 180 days from the date of service.
- No time limit for nonparticipating providers

Resubmission:

- Participating providers, 365 days, as long as no more than 18 months from the date of service. Timely filing is waived with retroactive authorizations and if the claim was denied incorrectly by MHNet.
- Non-participating providers, 365 days, as long as no more than 18 months from the date of service

MedStar Family Choice (managed by **Value Options)**

Submission of claims:

- Participating providers, 180 days from the date of service.
- No time limit for nonparticipating providers

Resubmissions:

- Participating providers, 365 days, as long as no more than 18 months from the date of service. Timely filing is waived with retroactive authorizations and if the claim was denied incorrectly by MHNet.
- Non-participating providers, 365 days, as long as no more than 18 months from the date of service.

Jai Medical Systems

Submission of Claims:

- 180 days from the date of service.

Resubmission/Appeal:

- 90 business days from the Explanation of Payment date.

Maryland Physicians Care

Submission of Claims:

- Claims must be submitted within 180 days from the date of service.

Coordination of Benefits:

- MPC is a secondary payer to all other parties. If there is third-party coverage for a member, the provider shall identify and seek payment from any third party obligated to pay for Member's health care services before submitting claims to MPC.

Resubmissions:

- Claim resubmissions must be submitted within 90 days from the date of denial.

Appeals:

Providers have 90 business days from the date of claim denial to file an appeal.

Priority Partners

Submission of Claims:

- Claims must be submitted within 180 days from the date of service.

Resubmission:

- Administrative Appeals must be submitted within 90 working days from the date of the denial.

UnitedHealthcare (Managed by **United Behavioral Health**)

Submission of claims:

- Participating and nonparticipating providers, 180 days from the date of service.

Resubmissions:

- Participating providers, 365 days, as long as no more than 18 months from the date of service. Timely filing is waived with retroactive authorizations and if the claim was denied incorrectly by UBH
- Non-participating providers, 365 days, as long as no more than 18 months from the date of service.

Prepared by the Office of Health Services, Maryland Department of Health and Mental Hygiene from information provided by MCOs/BHOs., December 10, 2009.