

Maryland Medicaid Program Women's Reproductive Health Services

This series of Factsheets replaces the HealthChoice Self-Referral Manual and the OB/GYN/Family Planning Provider Services Manual.

Most women of childbearing age are enrolled in Managed Care Organizations (MCOs). However it is common for beneficiaries to have regular or straight fee-for-service (FFS) Medicaid before MCO enrollment and for short periods of time after breaks in Medicaid eligibility. Also some services, referred to as “carve outs”, are not covered by MCOs but are covered by FFS Medicaid. In addition it is important to understand that beneficiaries can self-refer to out-of-network providers for certain services. Therefore providers need to understand both the FFS and MCO systems.

Medicaid's Community Liaison and Care Coordination Division, which works closely with MCOs and local health departments to ensure that women receive medically necessary and appropriate reproductive health services, has prepared this Overview and the accompanying Factsheets on the following topics:

- Factsheet #1. Self-Referral Provisions for HealthChoice Members**
- Factsheet #2. Family Planning Services**
- Factsheet #3. Maryland Family Planning Waiver Program**
- Factsheet #4. Long-Acting Reversible Contraceptives (LARCs)**
- Factsheet #5. Permanent Sterilizations**
- Factsheet #6. Abortion Services**
- Factsheet #7. Obstetrics and Gynecology**

The Medicaid program covers a wide variety of services including but not limited to:

- General
 - Medically necessary services rendered within the limitations of the CPT, Medicaid, Medicare, and NCCI guidelines, provided by providers who are participating providers with the Program
- Evaluation and Management (E&M)
 - E&M codes related to providing check-ups and care for individuals with acute or chronic health care conditions
- Anesthesia
 - Services rendered by an anesthesiologist other than for cosmetic surgery
- Surgery
 - Medically necessary surgical procedures
 - Abortions, sterilizations, and hysterectomies under the limitations detailed in the ***Women's Reproductive Health Services Factsheets and the Professional Services Provider Manual and Fee Schedule*** available on the Program's website: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

- Drugs and injectables
 - Drugs dispensed by the physician acquired from a wholesaler or specialty pharmacy
 - Injectable drugs administered by the physician
 - Medicine codes, including administration codes for the “Vaccines for Children Program”
- Other Services
 - Unlisted services and injectable drugs when accompanied by a medical report, surgery notes, a wholesaler invoice, and/or any other documentation as requested.

For specific information, go to the **Professional Services Provider Manual and Fee Schedule** at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Lab Tests

Providers and clinics should only bill, as a part of the office visit, for labs and cytopathology services that are provided in their facility. If lab and/or cytopathology results are performed by an outside lab, the provider or clinic may not bill Medicaid for the test(s); the lab should bill Medicaid directly.

Fee-for-Service Billing

Providers rendering services under Medicaid’s “Fee-for-Service” program must bill using the CMS-1500 and submit claims within 12 months of the rendered service date. If a claim is received by the Program within the 12-month limit but is rejected due to erroneous or missing data, providers can resubmit the claim within 60 days of rejection OR within 12 months of the date the service was rendered. If the Program rejects a claim because of late receipt, the recipient may not be billed for that claim. Under no circumstances may a Medicaid recipient be billed for a Medicaid covered service. If a provider submits a claim and receives neither payment nor rejection within 90 days, the claim may be resubmitted.

Claims can be submitted in any quantity at any time within the filing statute of limitations, which is 12 months from the date of service. The following statutes are in addition to the initial claim submission:

- 12 months from the date of service of the IMA-81 (Notice of retro eligibility)
- 120 days from the date of the Medicare Explanation of Benefits (EOB)
- 60 days from the date of Third Party Liability EOB
- 60 days from the date of the Maryland Medicaid Remittance Advice (RA)

The Program **will not** accept computer-generated reports as proof of timely filing. The **only** documentation that will be accepted is a *remittance advice, Medicare or third party EOB, IMA-81* and/or a returned date stamped claim from the Program.

Paper claim submissions may take up to 30 days from date of receipt to process. Invoices are processed weekly. Payments are issued weekly and sent to the provider’s “pay-to-address”.

Claims should be mailed to the following address:

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

Electronic claim submissions are processed faster. Claims submitted electronically must be done in the ANSI ASC X12N 837P format, version 5010A. A signed *Submitter Identification Form and Trading Partner Agreement* must be submitted, as well as testing before transmitting such claims.

Companion guides to assist providers with electronic transactions can be found on the DHMH website: <http://dhmh.maryland.gov/HIPAA/Pages/transandcodesets.aspx>. Testing information can be found on the DHMH website:

<http://dhmh.maryland.gov/hipaa/pages/testinstruct.aspx>. If you have problems with your electronic claims submission, please send inquiries to: dhmh.ediops@maryland.gov

eClaims allows for direct billing through the e-Medicaid website. This service enables certain provider types that bill using the CMS-1500 to submit their single claims electronically. Claims that require attachments cannot be submitted through this new feature. Claims will be processed the same week they are keyed and payment will follow the next week.

To become an eClaim user, the administrator from the provider's office must register users by going to the eMedicaid website: <https://encrypt.emdhealthchoice.org/emedicaid>. For questions regarding this new feature, how to register, or to determine if your provider type can submit eClaims, please email your questions to: dhmh.emedicaidmd@maryland.gov.

Go to **CMS-1500 Billing Instructions** at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx> for additional information regarding billing.

Payment in Full and Maximum Payment

The fee schedule for professional services lists the *Current Procedural Terminology (CPT)* codes and the maximum fee paid for each procedure. A provider using CPT coding selects the procedure or service that most accurately identifies the service performed. Providers are paid either the lesser of their usual and customary charge or the maximum allowable fee. All payments made by the Program to providers shall be considered payment in full for services rendered. Providers are prohibited from collecting additional payment from Program recipients or recipients' families for either covered or denied services; such action constitutes an overpayment and is in violation of both Federal and State regulation. Refer to the **Professional Services Provider Manual and Fee Schedule** at:

<https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Under no circumstances may a Medicaid provider bill a Medicaid beneficiary or MCO member for a Medicaid covered service. For provider transmittals, go to:

<https://mmcp.dhmh.maryland.gov/MCOupdates/Pages/Home.aspx>

Other Third Party Insurance

In general, the Program is always the payer of last resort. If a recipient is covered by other federal or third-party insurance (i.e. Medicare or commercial insurance), the provider must seek payment from that source first before billing FFS Medicaid. There is an exception for prenatal care. Providers may first bill the Program for prenatal care even if the recipient has other insurance. For more information, see the **Professional Services Provider Manual and Fee Schedule** at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Medicare Crossover Claims

Some women of reproductive age have Medicare. *If a beneficiary has Medicare they will not be enrolled in an MCO.* The Program is the payer of last resort and follows Medicare guidelines. Physician services that are not medically necessary are not covered under the Program. When a provider bills Medicare B for services rendered to a Medicaid recipient, and the provider accepts assignment on the claim, the payments are made automatically. In the uncommon event that a provider is not paid within four weeks of receipt of the Medicare payment, the provider should submit a hardcopy CMS-1500 form to the Program.

Providers should only submit claims to Medicare for services rendered to patients who are dually eligible for both Medicare and Medicaid. The Program must receive Medicare/Medicaid Crossover claims within 120 days of the Medicare payment date. This is the date on Medicare's "Explanation of Benefits" form. The Program recognizes the billing time limitations of Medicare and will not make payment when Medicare has rejected a claim due to late billing. In general, the Program will only pay up to the maximum of its allowed amount. For additional information regarding Medicare Crossover claims, go to **CMS-1500 Billing Instructions** at: <https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx>

Hospital Admissions

Pre-authorization by Telligen, the Program's Utilization Control Agent (UCA) is required for all elective hospital admissions for recipients covered under Medicaid's fee-for-service program. It is the hospital's responsibility to obtain pre-authorization by using Qualitrac to submit level of care requests. For more information regarding Qualitrac, go to <http://www.telligenmd.qualitrac.com/home> or call at 888-276-7075.

For questions regarding Medicaid's women's reproductive health services, contact the Division of Community Liaison and Care Coordination at 410-767-6750.

Websites and Resources

CMS-1500 Billing Instructions

<https://mmcp.dhmf.maryland.gov/Pages/Provider-Information.aspx>

Code of Maryland Regulations (COMAR)

http://www.dsd.state.md.us/COMAR/subtitle_chapters/10_Chapters.aspx

Electronic Claim Submission

<http://dhmf.maryland.gov/hipaa/pages/testinstruct.aspx>

<http://dhmf.maryland.gov/HIPAA/Pages/transandcodesets.aspx>

EPSDT/Maryland Healthy Kids Program

<https://mmcp.dhmf.maryland.gov/epsdt/Pages/Home.aspx>

EVS User Guide

<https://mmcp.dhmf.maryland.gov/Pages/Provider-Information.aspx>

Formulary Information

www.epocrates.com

HealthChoice MCO Program

<https://mmcp.dhmf.maryland.gov/healthchoice/Pages/Home.aspx>

HealthChoice Provider Brochure

[https://mmcp.dhmf.maryland.gov/healthchoice/Documents/HC%20Provider%20Brochure%207.21.15rb%20\(1\).pdf](https://mmcp.dhmf.maryland.gov/healthchoice/Documents/HC%20Provider%20Brochure%207.21.15rb%20(1).pdf)

ICD 10

The Maryland Medical Assistance Program began accepting ICD-10 codes on **October 1, 2015**.

<https://mmcp.dhmf.maryland.gov/Pages/ICD-10-Conversion.aspx>.

For general questions about ICD-10, send an email to dhmf.icd10@maryland.gov

Medicaid Provider Information

<https://mmcp.dhmf.maryland.gov/Pages/Provider-Information.aspx>

Professional Services Provider Manual and Fee Schedule

<https://mmcp.dhmf.maryland.gov/Pages/Provider-Information.aspx>

Program Transmittals <https://mmcp.dhmf.maryland.gov/Pages/Provider-Information.aspx> <https://mmcp.dhmf.maryland.gov/mcouupdates/Pages/Home.aspx>

SBIRT (Screening, Brief Intervention, and Referral to Treatment)

<http://www.marylandsbirt.org/>

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<https://mmcp.dhmf.maryland.gov/Pages/Provider-Information.aspx>

Frequently Requested Phone Numbers

Maryland Medicaid:

- Beneficiary Services/Pharmacy Access: 410-767-5800
- Eligibility Services: 410-767-1594
- HealthChoice Member Helpline: 1-800-284-4510
- HealthChoice Provider Helpline: 1-800-766-8692
- Helpline for Pregnant Women: 1-800-456-8900
- Maryland Pharmacy Program: 410-767-1455
- Mental Health and Substance Use: 1-800-888-1965
- Office of Health Care Quality: 410-402-8000
- Provider Enrollment/Services (covered services, coding, etc.): 410-767-5340
- Provider Relations (billing, claims, other issues): 410-767-5503

HealthChoice Managed Care Organization (MCOs) Contacts for Providers:

- Amerigroup Community Care: 410-859-5800
- Jai Medical System, INC.: 888-524-1999
- Kaiser Permanente: 301-816-2424
- Maryland Physicians Care: 800-953-8854
- MedStar Family Choice: 800-905-1722
- Priority Partners: 410-424-4500
- Riverside Health of Maryland: 410-878-7709
- United Health Care: 800-487-7391