2020 Maryland Medical Assistance Program Professional Services Provider Manual

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CHAPTER 1: INTRODUCTION TO THE MANUAL

Introduction

This chapter introduces the format of the Maryland Medical Assistance Program **(the "Program" or "MA")** Professional Services Provider Manual and Fee Schedule and tells the reader how to use the manual. General information on policy and billing instructions for providers enrolled in the Program may be found in this manual. Information in this manual is updated as needed.

A current copy of the Professional Services Provider Manual and Fee Schedule is available on the Program's website: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx.

Background

The purpose of this manual is to provide policy and billing instructions for providers who bill on the paper CMS-1500 claim form or using the electronic CMS 837P (professional) claim format and are reimbursed according to the Professional Services Provider Manual and Fee Schedule.

This manual describes the Maryland Fee-For-Service Program and explains covered services, service limitations, billing practices, and fee schedules.

Please note, the Program's **Managed Care Organizations (MCOs)** have separate manuals and instructions. For more information on Maryland's MCO providers, refer to: https://mmcp.health.maryland.gov/healthchoice/Pages/Home.aspx**.**

There are additional manuals to assist professional services providers linked throughout this document. These manuals are designed to

provide helpful information and resources as supplements to this manual.

Legal Authority

This Manual derives its legal authority from **Code of Maryland Regulations (COMAR)** 10.09.02, Physicians' Services.
The regulations may be viewed in their entirety online at the Maryland Division of State Documents website: www.dsd.state.md.us.

Definitions

"**Acquisition cost**" means the purchase price of a drug, supply, or material, less any discount, for the amount administered or supplied, including any portion of tax or shipping.

"Admission" means the formal acceptance by a hospital, of a patient who is to be provided with room, board, and medically necessary services.

"**Anesthesia time**" means the time in minutes during which the anesthesia provider is both furnishing continuous anesthesia care to a patient and is physically present.

"**Assistant surgeon**" means a second physician, physician assistant, nurse or nurse practitioner who actively assists the primary surgeon during a surgical procedure.

"**Attending physician**" means a physician, other than a house officer, resident, intern, or emergency room physician, directly responsible for the patient's care.

"**Bilateral surgery**" means surgical procedures that are performed on both sides of the body at the same operative session or on the same day.

"**Consultant-specialist**" means a licensed physician who meets at least one of the following criteria:

- Board certified by a member board of the American Board of Medical Specialties and currently retains that status;
- Demonstrates satisfactory completion of a residency program accredited by the Liaison Committee for Graduate Medical Education, or the appropriate Residency Review Committee of the American Medical Association (AMA);
- Board certified by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Specialists; or
- If a residency program was completed in a foreign country, can demonstrate qualifications and training are acceptable for admission into the examination system of the appropriate American Specialty Board.

"**Contiguous state**" means any of the states which border Maryland and the District of Columbia.

"Cosmetic surgery" means surgery which can be expected to improve a patient's physical appearance, but does not restore or materially improve a body function.

"**Critical care**" means the direct delivery of medical care, for a patient whose critically ill or critically injured, by a physician (s) or other qualified health care professional. A critical illness or injury acutely impairs one or. more vital organ systems, such that there is a high probability or life threatening deterioration of the patient's condition.

"**Date of service**" means the date of discharge or the date of service the non-facility provider (physician, physician assistant, nurse practitioner, etc.) performs the service.

"**Emergency services**" means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

(a) Placing the patient's health, or with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

"**Healthcare Common Procedure Coding System (HCPCS)**" means the specified code set for procedures and services, according to HIPAA.

"**HealthChoice Program**" means the Maryland statewide mandatory managed care program.

"**Health Services Cost Review Commission (HSCRC)**" means the independent organization within the Maryland Department of Health which is responsible for reviewing and approving rates for hospitals pursuant to COMAR, Title10, Subtitle 37.

"**International Classification of Diseases, Tenth Revision, Clinical Modification, (ICD-10-CM)**" means the 10th revision to the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO), which was implemented on October 1, 2015. It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

“**Managed Care Organization (MCO)**” means the network of participating health care organizations that provide services to Medicaid participants in the Maryland HealthChoice Program.

"**Medical Assistance Program**" means a program that provides medical coverage for certain low income people and families.

"**Medically necessary**" means a service is :

- Directly related to diagnostic, preventative, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition;
- Consistent with current accepted standards of good medical practice;
- The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
- Not primarily for the convenience of the consumer, their family or the provider.

"**Medicare**" means the medical insurance program administered by the federal government under Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq.

“**Modifier**” means a reporting component, which indicates when a service or procedure was performed in an altered manner that necessitates a change in fee from the schedule rate, but not a change in procedure code.

“**Neonate**” means an infant, birth to 28 days of life.

"**Organ**" means a grouping of bodily tissues which perform a specific function.

"**Participant**" means a person who is enrolled in the Maryland Medical Assistance Program.

"Patient" means an individual awaiting or undergoing health care or treatment.

"**Preauthorization**" means the approval, required for payment, from the Department or its designee before services can be rendered.

"**Program**" means the Maryland Medical Assistance Program.

"**Provider**" means an entity, facility, person or group who is enrolled in the Maryland Medical Assistance Program, renders services to participants, and bills the Program for those services. Under the Program, providers that use a subset of procedure codes found in the Professional Services Provider Manual and Fee Schedule include:

- Certified Nurse Midwives (COMAR 10.09.01)
- Certified Nurse Practitioners (COMAR 10.09.01)
- Certified Registered Nurse Anesthetists (COMAR 10.09.01)
- Clinics (COMAR 10.09.08)
- Physicians (COMAR 10.09.02)
- Physician Assistants (COMAR 10.09.55)
- Podiatrists (COMAR 10.09.15)
- Optometrists (COMAR 10.09.14)
- Audiologists (COMAR 10.09.51)
- Speech/Language Pathologists (COMAR 10.09.50)
- Occupational Therapists (COMAR 10.09.50)
- Physical Therapists (COMAR 10.09.17)
- Portable X-ray (COMAR 10.09.88)

- Other Diagnostic Services (COMAR 10.09.09, 10.09.42, and 10.09.87)
- Nutritionists
- Therapeutic Behavioral Services (COMAR 10.09.34)
- Urgent Care Centers (10.09.77)

"**Reconstructive surgery**" means surgery that is expected to approximate normal physical appearance and/or improve functionality when quality of life is significantly impaired.

"**Referral**" means a transfer of the patient from one provider to another for diagnosis and treatment of the condition for which the referral was made.

"**Unbundling**" means using independent codes to bill separately for ancillary procedures which are already included in the CPT code's procedure definition.

"**Trauma physician"** means a physician who provides care in a trauma center to trauma patients on the State Trauma Registry. Emergency room physicians who are not trauma physicians are paid according to the Manual for Medicaid participants.

CHAPTER 2: GENERAL INFORMATION

Introduction

This chapter introduces key concepts associated with understanding the services that are covered by the Maryland Medical Assistance Program (the "Program") and how to bill for those services.

The Program will accept **only** the revised CMS- 1500 form (version 02-12), in accordance with Federal mandate.

Federal Guidelines

Medicare

The Program is the payor of last resort and generally follows Medicare guidelines. Specifics on coverage are found in the **Coverage** section beginning on page 15.

Free Care Policy

Under the free care policy, Medicaid reimbursement is available for covered services that are provided to Medicaid participants, whether or not the services are rendered without a charge to other patients or to the community at large.

HIPAA and HCPCS

The Administrative Simplification provisions of the **Health Insurance Portability and Accountability Act (HIPAA)** of 1996 require that standard electronic health transactions be used by health plans, including private, commercial, Medical Assistance (Medicaid) and Medicare, health care clearinghouses, and health care providers. A major intent of the law is to allow providers to meet the data needs of every insurer electronically with one billing format using health care industry standard sets of data and codes.

In January 2009, the Federal government mandated the implementation of HIPAA-compliant 5010 transaction standards to support the mandated upgrade to the ICD-10-CM classification system. 5010 compliance allows for improved technical coordination, accommodation for evolving business needs, and consistency in reporting requirements. The 5010 compliance deadline went into effect on July 1, 2012.

Any questions regarding 5010 compliance should be directed to dhmh.hipaaeditest@maryland.gov.

Any concerns regarding production files should be directed to dhmh.ediops@maryland.gov.

Providers must use the **Healthcare Common Procedure Coding System (HCPCS)** code set for procedures and services. Coding usage is detailed in the **Coding and Billing** section on page 20.

More information on HIPAA may be obtained from: http://www.hhs.gov/hipaa/for-professionals/index.html**.**

NPI

Effective July 30, 2007, all health care providers that perform medical services must have a **National Provider Identifier (NPI).** The NPI is a unique, 10-digit, numeric identifier that does not expire or change. NPIs are assigned to improve the efficiency and effectiveness of the electronic transmission of health information. Implementation of the NPI impacts all practice, office, or institutional functions, including billing, reporting, and payment.

The NPI is administered by **the Centers for Medicare and Medicaid Services (CMS)** and is required by HIPAA. Providers must use the legacy Maryland Medical Assistance number as well as the NPI number when billing on paper.

Apply for an NPI by using the web-based NPI application process via the **National Plan and Provider Enumeration System (NPPES)** at https://nppes.cms.hhs.gov/NPPES/Welcome.do. A paper application is available at: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms10114.pdf**.**

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

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

Use the NPI as the primary identifier and the MA provider legacy number as the secondary identifier on all paper and electronic claims. All rendering providers who provide services for Maryland Medicaid participants must be enrolled in the Program and bill under their own NPI and Maryland Medical Assistance provider number and the rendering provider. Billing for services under a different provider's number who did not render the services is considered fraudulent, and those claims will not be paid. The Program does not cover services rendered by an employed non-physician extender under the supervising physician's provider number. All providers, must bill the Program for services provided under their own provider number.

NCCI

The National Correct Coding Initiative (NCCI) edits are a series of coding policies developed and maintained annually by CMS to combat improper coding.

Effective October 1, 2010, both Federal law and CMS guidelines require all state Medical Assistance programs to adopt NCCI edits as part of their respective payment methodologies.

The Program advises providers to check their claims for NCCI compliance prior to submission or appeal. The Program will deny claims when coding conflicts with NCCI edits. For more information regarding NCCI, visit the NCCI homepage at: https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html.

Coverage

Covered Services

The Program covers a wide array of professional services, in accordance with their respective COMAR:

- General
  - Medically necessary services rendered in the following places of service:
    - Provider's office;
    - Participant's home;
    - Hospital;
    - Nursing facility;
    - Free-standing clinic; or
    - Elsewhere when the services are performed by a physician, physician group, or other applicable providers;
  - Services rendered within the limitations of the CPT guidelines;
  - Services rendered within the limitations of Medicaid, Medicare and NCCI guidelines;
  - Services rendered by providers who are participating providers with the Program;
- Evaluation & Management

- Evaluation and management codes related to providing check-ups and care for participants 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 **Services Information** section, beginning on page 54;
  - Medicine codes, including administration codes for the Vaccines for Children Program;
- Drugs & Injectables
  - Drugs dispensed by the provider acquired from a wholesaler or specialty pharmacy;
  - Injectable drugs administered by the provider;
  - Drug and Injectable services within the limitations of COMAR 10.09.03;
  - Equipment and supplies dispensed by the providers within the limitations of COMAR 10.09.12; and
- Other Services
  - Unlisted services and unclassified Injectable drugs when accompanied by a medical report, surgery notes, a wholesaler invoice, and/or any other documentation as requested. Preauthorization may be required.

Services Not Covered

The Program does not cover the following services:

- General
  - Services not considered medically necessary;
  - Services that are investigative, experimental, or part of a clinical trial;
  - Services provided outside of the United States;
  - Services denied by Medicare as not medically necessary, without additional justification;
  - Services prohibited by the Maryland Board of Physicians or the Boards governing the other providers who use these codes; and

- Services rendered by an employed non-physician extender under a supervising physician's provider number. All providers, whether physicians, nurse practitioners, or physician assistants, must bill the Program for services provided under their own provider number (COMAR 10.09.02.05(H)).

- Evaluation & Management
  - Pre-operative and post-operative evaluation when billed separately from the **Global Surgery Package** (see page **37**);
  - A separate payment for referrals from one provider to another for treatment of specific participant problems;
  - Professional services included as part of the cost of an inpatient facility or hospital outpatient department charge;
  - Visits solely to accomplish one or more of the following services:
    - Prescription, drug, or food supplement;
    - Collection of specimens for laboratory procedures;
    - Recording of an electrocardiogram;
    - Ascertainment of the participant's weight; and/or
    - Interpretation of laboratory tests or panels;
  - Broken or missed appointments;

- Anesthesia
  - Pre-operative evaluations for anesthesia when billed separately from the administration of anesthesia;
  - Anesthesia for the provision of cosmetic surgery services;

- Surgery
  - Cosmetic surgery when surgery is performed to maintain normal physical appearance or enhance appearance beyond average level toward an aesthetic ideal;
  - Services requiring a preauthorization performed without obtaining a preauthorization from the Program;
  - Radial keratotomy, or other surgical procedures, intended to reduce or eliminate the need for eyeglasses;

- Medicine
  - Specimen collection, except by venipuncture or arterial puncture;
  - Autopsies;
  - Fertility treatment;

- Drugs and Injections
  - Administration of vaccines for participants ages 19 and older;
  - Provider-administered drugs obtained from manufacturers that do not participate in the federal Drug Rebate Program;
  - Immunizations required for travel outside the U.S.;
  - Injections and visits solely for the administration of injections, unless medically necessary and the participant's inability to take appropriate oral medications are documented in the participant's medical record;
  - Program prescriptions and injections for central nervous system stimulants and anorectic agents, when used for weight control;
  - Drugs, vaccines, and supplies dispensed by the provider that the provider acquires at no cost;
  - Drugs written on prescription pads that do not prevent copying, modification, or counterfeiting;
  - Fertility drugs;

- Other Services
  - Laboratory or X-ray services provided by another facility;
  - Disposable medical supplies, usually included with an office visit;
  - Completion of forms and reports;
  - Providing a copy of a participant's medical record when requested by another licensed provider on behalf of the participant; and
  - Telephone calls or emails.

Payment

Professional Services

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 the lesser of either their charge or the maximum allowable fee. Although some providers delegate the task of assigning codes, the accuracy of the claim is solely the provider's responsibility and is subject to audit. Please note the Program pays differentially based on site of service. This information is also included in the fee schedule. The fee schedule is available to view at: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx**.**

Providers must adequately document any service or procedure in the medical record and maintain records as necessary to fully document the services provided. The provider must then retain the records for six years.

Lack of acceptable documentation may cause the Program to deny payment. If the Program has already paid the provider, the Program may request repayment or impose sanctions.

Payment In Full and Maximum Payment

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 participants or participants' families for either covered or denied services; such action constitutes an overpayment and is in violation of both Federal and State regulation.

Providers must bill the Program their usual and customary charge to the general public for similar services, **except** for:

- Injectable drugs;
- The provision of diagnostic or therapeutic pharmaceuticals; and
- Supplies.

In these cases, providers must bill their **acquisition cost**.

Payments to providers will be the lowest of either the provider's customary charge, acquisition cost, or the Program's fee schedule.

Third Party Recoveries

In general, the Program is always the payor of last resort. If a participant is covered by other federal or third-party insurance (e.g., Medicare or CareFirst), the provider must seek payment from that source first.

The only exception to the payor of last resort rule is for the provision of **Early and Periodic Screening, Diagnosis and Treatment services (EPSDT)/ Healthy Kids services**, such as well child care and administration of VFC vaccines and prenatal care. Providers may bill the Program for these services first, even if the participant has other insurance.

For more information, please consult the **EPSDT/ Healthy Kids Manual**, which may be found at: https://mmcp.health.maryland.gov/epsdt/healthykids/Pages/Provider-Manual.aspx.

Coding and Billing

Common Procedure Coding System

The Program uses the five-character HCPCS codes for the billing of services on both the CMS-1500 paper form and CMS 837P electronic claim format. These include the numeric CPT codes and the Level-II alpha-numeric HCPCS codes.

CPT

The Professional Services Provider Manual and Fee Schedule primarily utilizes current CPT codes. Providers must have access to the latest revision of CPT in order to properly bill for services rendered.

The **American Medical Association (AMA)** develops the CPT, and publishes revisions annually; the Program updates this Manual to reflect changes to the CPT.

For more information on AMA products, please call (800)621-8335 or visit:
http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page.

ICD-10-CM Codes

As of October 1, 2015, the Program implemented the use of the ICD-10-CM code sets for all providers. The new code set provides a significant increase in the specificity of the reporting, allowing more information to be conveyed in a code. With the increased specificity of the ICD-10-CM codes, comes the need for complete and accurate documentation.

To download the 2020 update to the ICD-10-CM (which includes guidelines, alpha, and tabular lists), visit:
https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM.

Level-II HCPCS

The Program also utilizes Level-II national alpha-numeric HCPCS codes for procedures or services that do not appear in the CPT. These include some but not all of: the J–codes (physician-administered drugs), A–codes (radiopharmaceuticals), Q–codes (temporary codes for drugs), and G–codes (professional services without CPT codes). For J–codes, the Program requires providers to bill their acquisition costs.

Unbundling

Providers must include all necessary services in the CPT's definition of a given procedure. Though independent CPT codes may exist for ancillary services, billing of these codes separately for packaged procedures, called "unbundling", is prohibited.

Up to four modifiers may be reported on each service line on the CMS-1500 claim form.

Up to four modifiers may be used in the HIPAA-compliant CMS 837P electronic format.

Program-Accepted Modifiers

The Program recognizes two levels of modifiers: Level I modifiers found in CPT, and Level-II modifiers found in HCPCS, which are updated by CMS.

Providers must report modifiers that affect processing and/or payment. Modifiers that affect processing and/or payment are included in the **Appendix.** There are additional modifiers that may affect pricing by individual consideration. Please refer to the **Appendix** for a list of program-accepted modifiers (see page 83).

Example:
Modifiers `-RT` (right side) and `-LT` (left side) are not acceptable substitutes for modifier `-50` (bilateral), and will not process correctly.

Providers may use unlisted modifiers to provide additional information about a service, but the Program does not consider unlisted modifiers in claims processing.

All anesthesia procedure codes `00100 - 01999` require modifiers. The Program will reject anesthesia codes billed without the appropriate modifier. Please refer to the **Appendix** for a complete list of anesthesia modifiers.

If a claim contains multiple procedure codes within the range of 10000 through 69999, the provider is only allowed to bill one code without modifier `-51`; **the provider must bill all other codes with modifier `-51`**. The Program's billing software does not automatically append the modifier -51; codes billed without the modifier -51 will be denied.

Trauma services rendered by trauma physicians to trauma patients on the State Trauma Registry in trauma centers are paid at 100% of the Medicare rate. For more information on trauma services, please consult the **Appendix** (see page 83).

The Program recognizes modifier **-TC (Technical Component)** only on certain radiology procedure codes; providers may not use modifier -TC for procedures outside of radiology. The Program recognizes modifier **-26 (Professional Component)** for both radiology and medicine services.

Informational Modifiers

Providers may use informational modifiers to report additional data on procedures; however, these may or may not affect payment levels or claims processing.

For anesthesia services, modifiers -G8, -G9, and -QS are informational only and do not affect payment.

Modifiers Not Accepted

Using modifiers that the Program does not accept will result in unprocessed and/or unpaid claims. Providers must then resubmit claims using appropriate modifiers.

Commonly used but unacceptable modifiers include, but are not limited to:

- -AD: Medical supervision by physician: more than four procedures (for anesthesia)
- -47: Anesthesia by surgeon
- -66: Surgical team – Info
- -81: Minimum Assistant Surgeon

For a list of acceptable modifiers, refer to the **Appendix** (see page 83).

Payment Rates

The payment rate for each modifier is a percentage of the listed fee. Payment rates for multiple modifiers are multiplied together to determine the payment amount.

Example:
Modifiers **–50** (bilateral) and **–51** (multiple) typically have rates at 150% of the base rate and 50% of the base rate, respectively. If reported together on the same service line, the payment rate is 75% of the base rate (1.50 x .50 = 0.75).

Unlisted Medical or Surgical Codes

There are no listed fees for "unlisted procedure codes" on the Professional Services Fee Schedule. These codes must be manually priced and must include legible surgical notes or other medical record documentation to enable a medical reviewer to arrive at a reimbursement rate for the procedure and to determine whether the service will be covered by the Program. Unclassified J-codes require a preauthorization.
Refer to the beginning of each section of the CPT book for a complete list of unlisted services or procedures.
When billing for unlisted procedures, providers **must** include:

- A description of the service provided as well the reason the procedure was medically necessary;
- A specific comparable CPT code;
- If there is a third party payor (Medicare, CareFirst, etc.), the explanation of Benefits (EOB) from Medicare or third party payer must be attached; and
- In some cases additional information may be required.

Failure to provide the aforementioned information will result in claim denial.

Billing Time Limitations

Providers must submit Fee-For-Service claims within 12 months of when the date the service is rendered. If a claim is received by the Program within the 12-month time limit but it is initially denied due to erroneous or missing data, a resubmittal will be accepted within 12

months from the date the service was rendered or 60 days from the date of initial denial, whichever is later. If the Program rejects a claim because of late receipt, the participant may not be billed for that claim. If a provider submits a claim and receives neither payment nor rejection within 90 days, the claim may be resubmitted.

Crossover Claims

When a provider bills Medicare Part B for services rendered to a Medicaid participant and the provider accepts assignment on the claim, the payments should be made automatically. However, if payment is not received within 30 days, the claim may not have successfully crossed over and the claim should be submitted to the Program on a CMS-1500 along with the Medicare EOB. **Note: When dropping claims to paper, the CMS-1500 and EOB should match Medicare claim line for line.**

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 does not pay Medicare Part B coinsurance or copayments on claims where Medicare payment exceeds the Medicaid fee schedule.

Policy Requirements

Medical Record Documentation

The Program may ask for additional documentation including, but not limited to medical reports, surgery notes, or invoices. This section details the requirements necessary for proper payment.

Providers must include the following in a participant's medical record, presented in a complete and legible manner:

- Details of each participant encounter (including the date, the reason for the encounter, appropriate history and physical exam, review of lab, X-ray, and other ancillary services), assessment, and a plan for care (including discharge plan, if appropriate);
- Past and present diagnoses;
- Relevant health risk factors;
- The participant's progress, including response to treatment, change in diagnosis, and participant non-compliance;
- The written plan for care for ongoing treatment, including medication (specifying frequency and dosage), referrals and consultations, participant/family education, and specific instructions for follow-up;
- Documented support of the intensity of participant evaluation and/or treatment;
- Authentication by date and signature from physician and/or non-physician healthcare professional; and
- Any CPT/HCPCS procedure codes and ICD-10-CM codes (for dates of service on or after October 1, 2015) supported by the information in the medical record about the participant's condition.

Refer to the most recent American Medical Association (AMA) Current Procedural Terminology (CPT®) for Evaluation and Management (E&M) service guidelines.

Preauthorization

Preauthorization is required for some professional services, procedures, and HCPCS Level-II codes within the fee schedule.

MCOs also require preauthorization for certain services; please consult each MCO for more information.

Covered Procedures or Services Requiring Preauthorization

Providers must obtain preauthorization before performing the following services:

- Cosmetic Surgery;
- Contact lens evaluation and fitting;;
- Lipectomy and panniculectomy;
- Transplanting vital organs;
- Surgical procedures for the treatment of obesity;
- Surgical procedures for the purpose of gender reassignment;
- Select HCPCS Level-II codes;
- Vaccine for prevention of Respiratory Syncytial Virus (RSV) can be found in the Pharmacy Program;
- All specialty mental health services, including preoperative psychological evaluations, authorized by the Behavioral Health ASO (COMAR 10.09.59.06);
- Elective services from a non-contiguous state; and
- Services rendered for elective admissions for inpatient hospital services before one pre-operative day.

For Medicaid participants in acute hospitals, the Department, through its Utilization Control Agent, will perform utilization review in accordance with COMAR *10.09.92.06*. The hospitals are responsible for requesting approval and providing documentation to support the following reviews:

- Preauthorization of elective inpatient admissions;
- Authorization for medically necessary pre-operative days;
- Concurrent reviews during inpatient stays;

- Retrospective reviews of all hospital stays to ensure the Department only pays for medically necessary services;
- Authorization of emergency care for non-qualified aliens; and
- Authorization of administrative days.

For information concerning proper protocol and interaction with the UCA, please consult the Telligen hotline at (888)276-7075 or visit the website http://www.telligenmd.qualitrac.com/.

If a professional service that requires a preauthorization is billed on a UB04 claim, facilities are responsible for ensuring that a preauthorization approval has been obtained from the Professional Services Program. Any claim without a valid preauthorization is subject to recoupment.

Preauthorization Procedures

The Program will preauthorize services when the provider submits adequate documentation demonstrating that the service is medically necessary. The fee schedule is subject to change at any time; therefore, providers are responsible for determining if a CPT/HCPCS code requires preauthorization, prior to the service being rendered. All CPT and HCPCS Level-II codes that require a preauthorization can be found in the most recent version of the Professional Services Fee Schedule, in the Billing Guidance, Fee Schedules, and Preauthorization sections of the Medicaid Provider Information webpage. For professional services and physician administered injectable drugs that require preauthorization, providers must submit the request **in writing**. Providers must complete and fax the **Preauthorization Request Form for Physician Services** **or the** **Preauthorization Request Form for Physician Administered Injectable Drugs** to:

Providers must also attach supporting documentation which includes, but is not limited to, the following:

- Complete narrative justification of the procedure(s);
- Brief history and physical examination;
- Result of pertinent ancillary studies, if applicable; and
- Pertinent medical evaluations and consultations, if applicable.

Required documentation for transplant preauthorizations is included in the Appendix. Medical necessity criteria for certain procedures or injectable drugs are posted on the Preauthorization website.

The Program will send a written decision in response to all written requests for preauthorization.

If the Program approves the request, the provider will receive a preauthorization number. The provider must then enter the number in **Block 23 of the CMS-1500 claim form** when billing for the service. **Authorizations are valid for the time period allotted in the approval letter**. Preauthorization only relates to the medical necessity of providing the service described in the written request. The approval is not a verification of the participant's eligibility for Medical Assistance, nor is it an approval for the provider to perform the service for other participants.

It is the responsibility of the provider to determine the patient's insurance coverage for the date of service. Preauthorizations approved by the Program expire the date of the patient's enrollment in any other insurance carrier, including the HealthChoice MCO's. Once a patient is

enrolled into another insurance carrier, it is solely at the discretion of that insurance carrier to honor any preauthorizations received from the Program.

Providers must obtain preauthorization for making arrangements to send a participant out-of-state for elective services. All requests for preauthorization for treatment out-of-state should be sent to:

Acute Care Administration
Medical Benefits Management
Division of Hospital Services
201 W Preston St, 2nd Floor, Room 211
Baltimore, Maryland 21201

Referrals for participants to receive elective services in Washington, D.C. do not require an out-of-state preauthorization.

To receive a preauthorization for an elective out-of-state hospital inpatient admission (both contiguous states and Washington D.C.) hospitals should contact **Telligen** at (888)276-7075 or at http://www.telligenmd.qualitrac.com/.

Preauthorization Decision Procedure

It is the provider's responsibility to check EVS prior to rendering services to ensure participant's eligibility for a specific date of service.

Step 1: Verify the participant's eligibility by either:

- Calling the Medicaid EVS hotline at 1-866-710-1447 and following the instructions; or
- Logging into the Web-EVS system through eMedicaid at http://emdhealthchoice.org. Providers must be enrolled in eMedicaid to utilize this option.

Note: To enroll in eMedicaid, go to the URL above and select 'Services for Medical Care Providers' and follow the login instructions. If you need information, please visit the website or, for provider application support, call 410-767-5340.

Step 2: Determine whether the participant is having an inpatient service or outpatient service completed.

● If inpatient, please submit a request for preauthorization of the hospital stay to Telligen (call 1-888-276-7075 for more info); or

● If outpatient, please proceed to the next step.

Step 3: Determine whether the participant has coverage through both Medicaid AND Medicare.

● If Yes, please refer to the section on Dual-Eligibles and Medicare crossover claims, then proceed to Step 5; or

● If No, proceed to the next step.

Step 4: Determine whether the participant has coverage through the Medicaid HealthChoice program.

● If Yes, call the participant's HealthChoice MCO to obtain the needed preauthorization; or

● If No, proceed to the next step.

Step 5: Look up the most recent Professional Services Fee Schedule and locate the CPT procedure codes the participant is planning to receive. In the "Note" column next to your code, determine whether it is blank or if it has a letter indicator.

● If blank, then the procedure does not require preauthorization through Maryland Medicaid; or

● If an indicator is present (either a P, A, H, or S), proceed to the next step.

Step 6: Determine the letter of the indicator – P, A, H, or S.

● If P, then a Preauthorization is required. Please fill out the Medicaid Preauthorization Request Form for Physician Services or the Preauthorization Request Form for Physician Administered Injectable Drugs, per the guidelines found in the Preauthorization Procedures section of this manual.

● If A, then a Certification for Abortion is required. Please fill out the Certification for Abortion form per the guidelines and keep them in the participant's medical record. No additional preauthorization is required.

● If H, then a Certification for Hysterectomy is required. Please fill out the Document for Hysterectomy form per the guidelines and keep them in the participant's record. No additional preauthorization is required.

● If S, then a Certification for Sterilization is required. Please fill out the Sterilization Consent Form per the guidelines and keep in the participant's record. No additional preauthorization is required.

Dual-Eligibles and Coordination with Medicare

Many Medical Assistance participants are also eligible for Medicare benefits. Since Medicare is the primary payer for a dually-eligible participant, the Program will waive otherwise required preauthorization if the service is both approved and covered by Medicare.

While the Program generally follows Medicare guidelines, there may be billing differences between the Program and Medicare (codes, modifiers, etc.). Since Medicare is the primary payer for dually-eligible participants, providers should follow Medicare guidelines for completing the CMS-1500 claim form posted at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf.

In most cases, the Program does not pay Medicare Part B coinsurance or copayments on claims where Medicare payment exceeds the Medicaid fee schedule.

Providers must submit claims, for participants who are Medicare/Medicaid dually-eligible, directly to the Medicare intermediary.

Place the participant's 11-digit Maryland Medical Assistance identification number in Block 9A of the CMS-1500 claim form and check "Accept Assignment" in Block 27 when billing Medicare. This will assure that Medicare will automatically forward the appropriate information to the Program. Check both Medicare and Medicaid in Block 1 of the CMS-1500 claim form; failure to do so will delay payment.

Refer to p. 25 in the **Billing Time Limitations** section for information regarding participants who are dually-eligible and billing time limitations.

Services Not Covered by Medicare

The Program generally does not cover services that Medicare has determined to be medically unnecessary. However, the Program may authorize these services if the provider can satisfactorily document medical necessity in a particular case.

Additional Guidelines and Resources

Please refer to the regulations for Physicians' Services in COMAR 10.09.02, the Professional Services Fee Schedule, and/or transmittals for additional information on services requiring preauthorization.

For complete CMS-1500 claim form billing instructions, please visit: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx.

Consultation & Referral

There are important distinctions between a consultation and a referral. See the definitions portion of the **Introduction** for details (see page **6**). Appropriate billing is dependent upon whether the provider is an attending physician or is a consultant-specialist.

A consultation requires a written opinion or advice rendered by a consultant-specialist, whose opinion or advice is requested by the participant's attending physician, for the further evaluation or management of the participant by the attending physician. If the consultant-specialist assumes responsibility for the continuing care of the participant, any subsequent service rendered by him/her is not a consultation, but is an established participant office visit or is subsequent hospital care, depending on the setting. The consultation must be provided in the specialty in which the consultant-specialist is registered with the Program.

The physician, to whom a referral for treatment is made, whether he/she is a generalist or a specialist, will be considered to be the treating physician and not the consultant.

NDC Reporting Requirements

Federal regulations require states to collect **National Drug Code (NDC)** numbers from providers for the purpose of billing manufacturers for drug rebates.

In order for provider-administered drugs to be paid by the Program, the manufacturer must participate in the Medicaid Drug Rebate Program. The provider must also report a valid 11-digit NDC number and the quantity administered on the CMS-1500 claim form; this includes

provider-administered drugs for immunizations and radiopharmaceuticals.

Codes Requiring NDC Numbers

Providers must report the NDC/quantity when billing for drugs using J–codes. The NDC reporting requirements for provider-administered drugs also extend to claims when the Program is not the primary payor, but is either the secondary or tertiary payor.

Denials

The Program will deny claims for drugs if the:

- NDC is missing or invalid;
- NDC is unable to be rebated;
- NDC Unit of Measure is missing or invalid; or
- NDC Quantity is missing.

For reporting the NDC on 837P electronic claims, providers must use the 2410 Loop (Drug Identification):

- LIN03 = NDC code;
- CTP04 = Quantity; and
- CTP05 = Unit of Measure (UOM).

Additional Information

Tamper Proof Prescription Pads

Providers must write prescriptions on tamper-proof pads which prevent copying, modification, and/or counterfeiting. Pharmacies will not fill prescriptions written on pads that do not meet these standards. Providers may also call in, e-prescribe or fax in prescriptions.

CHAPTER 3: SERVICES INFORMATION

Introduction

This chapter provides an overview of services that are reimbursable by the Maryland Medical Assistance Program (the "Program" or "MA"), and instructions for billing them under normal and modifying circumstances.

Evaluation & Management

CPT Guidelines & Modifiers

CPT **Evaluation & Management (E&M)** service guidelines apply for determining an appropriate level of care. Generally, CPT descriptions for E&M services indicate "per day" with a few exceptions, **only one E&M service may be reported per date of service**.

Modifier –21 for prolonged E&M service is informational only and does not affect payment.

Preventive Exams

The comprehensive nature of the preventive medicine service codes (99381–99397) reflects an age and gender appropriate history/exam and is **not** synonymous with the "comprehensive" examination required in E&M codes 99201–99350.

The Program will pay for tobacco cessation counseling services by providers using procedure codes 99406 and 99407. In addition, we will pay for Screening, Brief Intervention, and Referral to Treatment (SBIRT). Please see page **72**.

Modifier -25 should be added to the office/outpatient code to indicate that a significant, separately identifiable E&M service was provided by the same provider on the same day as the preventive medicine service. The appropriate preventive medicine service should be reported. Any claim using a modifier -25 requires review by the Program. If a separately identifiable E&M code is denied, please submit an appeal including proper, clear, and complete medical records for review.

Failure to submit the aforementioned will result in appeal denial or delay in processing.

For details regarding **medical record documentation**, please refer to page 26.

Surgery

Global Surgery Package

The Program generally follows CPT surgery guidelines for the following surgical scenarios:

- Bilateral and multiple procedures;
- Separate procedures;
- Add-on procedures; and
- Modifier `-51` exempt procedures.

Payment for surgery includes related services that are furnished either by the surgeon who performs the surgery or by members of the same specialty group. This payment method is known as the global surgery package.

The global surgery package includes the following services:

- Pre-operative visits beginning with the day before the surgery for major surgeries (those with at least a 90 day post-operative period) and the day of the surgery for minor surgeries;
- Intra-operative services that are a usual and necessary part of a surgical procedure;
- Treatment for complications following surgery, including additional medical or surgical services required of the surgeon during the post-operative period;
- Follow-up visits within the post-operative period related to recovery from the surgery, including a surgeon's visits to a participant in an intensive care or critical care unit;
- Post-surgical pain management administered by the surgeon;

- Supplies for certain services furnished in a physician's office;
- Miscellaneous services and items, including: dressing changes; local incision care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

The Program does not pay the surgeon for hospital and office visits during the surgical aftercare period. Providers should report complications, the presence of other diseases, or injuries requiring additional services using the appropriate procedures. An E&M service is not payable on the days included in the global surgery period.

When the follow-up period is listed as zero, the listed value is for the procedure only. In such cases, providers should bill for all post-operative care on a service-by-service basis.

Less Than Full Global Surgery Package

Physicians furnishing less than the full global surgery package for procedures with 10 or 90 day global periods must bill their portion of care correctly.

Use modifier -54, surgical care only, to bill for a surgery when another physician, who is not a member of the same group, provides all or part of the outpatient post-operative care. The Program generally assumes that the surgeon is responsible for pre-operative, intra-operative, and inpatient hospital post-operative care at a minimum. Payment to the surgeon who does not perform the outpatient post-operative care will be 80% of the listed fee for the procedure.

Use modifier -55, post-operative management only, **to bill** when a physician other than the surgeon provides all or part of the post-

operative care after hospital discharge. The surgeon must transfer care to the second physician and both must keep a copy of the written transfer agreement in the participant's medical record. The physician assuming care must bill the surgical code, use the date of surgery as the date of service, and report modifier -55.

Modifier -56, pre-operative management only, is not payable by the Program.

Report modifier -52, reduced services, if a service or procedure is partially reduced or eliminated at the physician's discretion.

Report modifier -53, discontinued procedures, if a surgical or diagnostic procedure is terminated after it was started. There is no fixed payment rate for modifier -53. Payment from the Program is dependent upon the details of the operative note.

Modifier -22, unusual procedural services, is informational and does not affect payment. The Program uses it for data reporting services, but it is not reimbursable.

The reporting of modifiers is subject to post-payment audit.

Multiple Surgical Procedures

For multiple surgical procedures performed during the same surgical session, by the same provider, report the major or primary surgery on the first service line with no modifier. **Report each additional procedure performed by the same provider during the same surgical session on subsequent service lines with the modifier -51. Including "Add-On codes", "51- exempt codes", any any additional procedure or service codes. All services should be reported on one claim.** The maximum units of service allowed for a surgery procedure without a modifier -51 is one.

Example: Excision of tendon

26180: Excision of tendon, finger, flexor or extensor, each tendon

26180-51: Excision of tendon, finger, flexor or extensor, each tendon (multiple procedures)

Procedures identified as "Add-on" or "-51-exempt" should still be reported using the modifier - 51. They are paid at 100% of the listed fee for the procedure and are not subject to the multiple surgery reduction of 50%.

When more than one of the same subsequent procedure is performed, please refer to the CMS-1500 Billing Instructions to complete the form.

Bilateral Surgical Procedures

The descriptions for some procedure codes include the term "bilateral" or the phrase "unilateral or bilateral." The fee for these codes reflects the work involved if done bilaterally, as the description states.

If a procedure is performed bilaterally, report the bilateral procedure code, if available. When there is no code describing bilateral services, report the bilateral service on one claim line, adding modifier -50, bilateral procedure. Payment for a bilateral procedure reported appropriately with modifier -50 is based on the lower of the amount billed or 150% of the listed fee for the procedure.

For bilateral procedures, do not bill the same code on two separate lines using the modifiers -RT (right side) and -LT (left side). Modifiers -RT and -LT are not acceptable substitutes for modifier -50 (bilateral), and will not process correctly.

Co-Surgeons

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, two or more surgeons from different specialties work

together as primary co-surgeons performing distinct part(s) of a single reportable procedure. **All** surgeons should report their distinct operative work by adding the co-surgeon modifier -62 to the single definitive procedure code. Documentation of the medical necessity of two or more surgeons is required for certain services. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure or procedures, including add-on procedures, are performed by one of the primary surgeons during the same surgical session, separates code(s) may be reported by that provider without the modifier -62 added (Modifier -51 is, however, required. See "Multiple Surgical Procedures" section). Modifier -62 may only be used when the co-surgeons are of different specialties and are working simultaneously.

Assistant Surgeons

The Program covers assistant surgeon services for designated surgical procedures when the services are medically necessary.

Use either modifier -80, assistant surgeon, or modifier -82, assistant surgeon (when qualified resident surgeon is not available), to report surgical procedures with an assistant surgeon. In teaching facilities, modifier -82 may only be used when a qualified resident is not available to act as an assistant surgeon; documentation to this effect is required in the operative note. Payment for assistant surgeon services will be 20% of the fee for the surgical procedure.

Modifier -81, minimum assistant surgeon, is not payable by the Program.

Payment for services at the assistant surgeon rate will not be made if reported with modifiers -54, surgical care only, and -55, post-operative management only. Modifier -54 will be paid at 80% of the listed fee for the procedure.

Anesthesia

Procedure Codes

Use procedure codes 00100 – 01999 to report the administration of anesthesia. These codes describe anesthesia for procedures categorized by areas or systems of the body. Other codes describe anesthesia for radiological and miscellaneous procedures. Report only one primary anesthesia service for a surgical session using the anesthesia code related to the major surgery. Every anesthesia service must have an appropriate anesthesia modifier reported on the service line, except for procedure code 01996.

Modifiers

If an appropriate modifier for anesthesia services is not reported, the service will be denied. A separate payment will not be made for any anesthesia services performed by the physician or nurse anesthetist who also performs the medical or surgical service for which the anesthesia is required. For a list of modifiers accepted by the Program, consult the Appendix.

Modifier **–**47, anesthesia by surgeon, is not payable by the Program.

The Program will not make additional payments for participant risk factors such as participant age, health status (CPT Physical Status Modifiers or Qualifying Circumstance procedure codes), or for **monitored anesthesia care (MAC)**. There is no separate payment for the medical supervision of a **Certified Registered Nurse Anesthetist (CRNA)** by a physician.

Modifier **–AD** is not payable by the Program.

Use of modifier –QS is for informational purposes only and will not change payment.

Occasionally, a procedure that usually requires either no anesthesia or local anesthesia must be done under general anesthesia due to unusual circumstances (e.g., CT-scans and MRI procedures). Report this by adding modifier **-23**, unusual anesthesia, to the procedure code of the basic service. The Program requires an anesthesia report to be submitted with the claim when modifier -23 is used. The report must document the total anesthesia time in minutes, the qualified individual who performed the anesthesia, and under what circumstances.

There is no separate payment made for any services ordinarily provided as part of the anesthesia service. This includes the pre-anesthetic examination of the participant, pre- or post-operative visits, intubation, and normal monitoring functions. These procedures should not be reported separately when provided in conjunction with the provision of anesthesia.

Unusual forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included in the payment for anesthesia services. These may be reported separately, in addition to providing the basic anesthesia administration.
Use unlisted procedure code 01999 when surgery is aborted after general or regional anesthesia induction has taken place. Include a copy of the anesthesia report with an indication that the surgery was cancelled.

Time and Base Units

Anesthesia time starts when the anesthesia provider begins to prepare the participant for induction of anesthesia and ends when the participant is placed under post-operative supervision, and the anesthesia provider is no longer in personal attendance. In the event of an interruption, only the actual anesthesia time is counted; all anesthesia start and stop times must be documented in the medical record.

Report the total anesthesia time in minutes in Block 24G of the CMS-1500 claim form.

Convert hours to minutes and enter the total anesthesia minutes provided for the procedure. **Do not include base units and do not divide the total anesthesia time into 15-minute time units.** To bill for anesthesia administered for multiple surgeries, use the anesthesia code with the highest anesthesia base unit value and report the actual time in minutes that extends over all procedures.

Time units are not recognized for anesthesia procedure code 01996 (daily management of epidural or subarachnoid continuous drug administration). For this particular code, only one unit of service is allowed and providers are not required to report an anesthesia modifier.

Base units have been assigned to each anesthesia procedure code and reflect the difficulty of the anesthesia service, including the usual pre-operative and post-operative care and evaluation. **Do not include base units when reporting anesthesia time. Base units will be added during claims processing.**

Preauthorization

Anesthesia code 00802, anesthesia for panniculectomy, is the sole anesthesia code that requires preauthorization, as it may be for cosmetic purposes, and therefore, considered medically unnecessary.

If a surgical procedure itself requires prior authorization, the Program assumes that the operating physician or nurse anesthetist has obtained the appropriate authorization to perform the service. The anesthesia provider will not be held responsible for providing proof that the procedure was authorized. Federal statute requires that all claims for services, including anesthesia claims related to hysterectomies or sterilization procedures, must have proof that informed consent was obtained and meets the Program's consent requirements. Anesthesia claims for induced abortion procedures must have proof that the service

was performed for one of the five medical reasons allowed for an abortion. Proof of consent must be retained in the participant's medical record and is subject to an audit.

Medical Direction

The Program will make separate payment to physicians and CRNAs for medically directed anesthesia services. All of the following conditions must be met for medically directed anesthesia services to be paid to the physician or CRNA. For each participant, the physician or CRNA must:

- Perform a pre-anesthetic examination and evaluation;
- Prescribe the anesthesia plan;
- Personally participate in the most demanding procedures in the anesthesia plan including, if applicable, induction and emergence;
- Ensure that procedures in the anesthesia plan, which are not performed by the physician, are performed by a qualified individual;
- Monitor the course of anesthesia administration at frequent intervals;
- Remain physically present and available for immediate diagnosis and treatment of emergencies; and
- Provide indicated post-anesthesia care.

The medical direction service furnished by a physician is not covered if the physician directs anyone other than a qualified physician or CRNA. The physician must document in the participant's medical record that the physician performed the pre-anesthetic exam and evaluation, provided post-anesthesia care, and was present during some portion of both the anesthesia monitoring and the most demanding procedures (including induction and emergence), where indicated. Total anesthesia care time must also be clearly indicated in the medical record.

A physician who is directing the concurrent administration of anesthesia to four or fewer surgical patients should not be involved in furnishing additional services to other patients.

If the physician is addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or providing periodic (as opposed to continuous) monitoring of an obstetrical patient, it does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. A physician may also receive patients entering the operating suite for subsequent surgeries, check on or discharge patients from the recovery room, or handle scheduling matters while directing concurrent anesthesia procedures without affecting coverage for medical direction.

If the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case, or is not available to respond to the immediate needs of the surgical participant, the physician's services are considered supervisory and are not covered as medical direction.

Routine post-operative pain management is the responsibility of the surgeon and is part of the global fee paid to the surgeon, which includes all care after surgery. Non-routine post-operative pain management, however, may be provided by an anesthesiologist under certain circumstances. For example, placement of a continuous epidural to manage post-operative pain is separately covered under the appropriate CPT code for a continuous epidural when a physician (or CRNA under a physician's supervision) performs the service and the procedure was not used as the mode of anesthesia for the surgery. Daily management of a continuous epidural on subsequent post-operative days is covered under the appropriate procedure code.

Payment and Add-on Codes

All claims reporting the administration of anesthesia must include the following:

- The appropriate anesthesia procedure code (00100 – 01999);
- Anesthesia time (in minutes); and
- The appropriate anesthesia modifier to identify who rendered the service.

The anesthesia procedure code, modifier, base units, total time in minutes, and procedure fee are utilized for calculating payments for anesthesia services.

Payment for anesthesia services is based on the following formula:
[Time Units (minutes) + (Base Units x 15)] x Fee x Modifier = Payment.

Example: 00500
time = 300 minutes, ABU's = 15, Modifier = QX
[300 + (15 x 15)] x 1.1486 x 0.50 = 301.51

The Program does not determine time units on the basis of one time unit for each 15 minutes of anesthesia time. Instead, **anesthesia base units (ABUs)** are converted to time units by multiplying by 15. Payment for anesthesia services will be the sum of the total time in minutes and the base units converted to time units multiplied by the listed fee per unit and by the modifier rate (50% or 100%). Payment will be the lower of the provider's charge or the calculated fee amount.

If a physician personally provides the entire anesthesia service, payment will be 100% of the calculated amount. Medically directed anesthesia services will be paid at 50% of the calculated amount for both the CRNA and the physician. Non-medically directed CRNA services are paid at 100% of the calculated fee. Physician supervision services are not paid separately.

When billing for anesthesia for multiple surgical procedures, report the anesthesia procedure code with the highest base unit value and indicate the total time for all procedures.

The Program uses the anesthesia relative value units established by Medicare in its payment methodology. The Anesthesia Uniform Relative Value Units Guide can be found on the Novitas Medicare Solutions web site at https://www.novitas-solutions.com.

Current CPT includes add-on codes for two areas: anesthesia, involving burn excisions or debridement, and obstetrical anesthesia. The add-on codes should be billed in addition to the primary anesthesia code. Report the anesthesia time separately for both the primary and the add-on code, based upon the amount of time appropriately associated with each code. The appropriate anesthesia modifier must also be reported with the add-on codes to identify who rendered the service.

Burn Excisions and Debridement

In the burn area, use code 01953 in conjunction with code 01952.

Obstetrics

In the obstetrical area, use codes 01968 and 01969 in conjunction with code 01967.

Trauma Services

Details

Trauma services may only be rendered in a trauma center (see Appendix for a complete list).

To bill for trauma services, use modifier –U1.

Trauma Billing Instructions

The following billing instructions for the **CMS-1500 form** must be adhered to by trauma physicians in order to be reimbursed by Medicaid for trauma services at the higher Medicare rate:

a) **Report modifier -U1** in one of the modifier positions for the trauma service in **Block 24D** (modifier field). This modifier is being used to reimburse trauma physicians **only,** for trauma services at the Medicare rate instead of the Medicaid rate.

b) List a primary, secondary, or additional diagnosis code in **Block 21** (diagnosis or nature of illness or injury field) from S00-T34 or use a supplementary classification of external causes and injury and poisoning code from V00–Y99 as a subsequent supplementary classification code in **Block 21**.

c) List a primary, secondary, or additional diagnosis code in **Block 24E** (diagnosis code field) for each line item on the invoice that must be from S00-T34, or a supplementary classification of external causes, injury, and poisoning codes that range from V00-Y99 must appear as a subsequent supplementary classification code in **Block 24E** for each line item on the invoice when the -U1 modifier is reported.

d) Report the last two-digits of the trauma center identification number and the six-digit trauma registry (patient identification) in **Block 23** (prior authorization number field) as an eight-digit number (see table below). The trauma registry number is available from the trauma center where care was provided. If the trauma registry number is less than six digits, place zeros in front of the trauma registry number until you have a six-digit number. For example, if there is only a four-digit trauma registry patient number, fill in the first two positions with zeros.

e) Report only the place of service codes -19 (off- campus outpatient hospital), -21 (inpatient), -22 (outpatient), -23 (emergency room), -61 (inpatient rehab hospital) in **Block 24B** (place of service field) for trauma services.

f) Enter the **ID Qualifier 1D,** followed by the nine-digit Medical Assistance Program provider number of the hospital where the

trauma center is located, in **Block 32B** (service facility location information) on the CMS-1500.

The increased fees are only applied to the trauma services rendered during the initial admission or trauma center visit and the resulting acute care stay. **ALL REPORTING OF THE U1 MODIFIER WILL BE SUBJECT TO POSTPAYMENT AUDIT**.

NOTE: The current revision to the Professional Services Provider Manual and Fee Schedule can be obtained from the Department of Health and Mental Hygiene's website at: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx.

NOTE:. Billing instructions for the CMS 1500 form can be found at: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx.
NOTE: CMS-1500 (08/05) claim form changes include blocks:

17A/B Name of Referring Provider or Other Source
24C EMG (not required)
24I ID Qualifier
24D Rendering Provider ID #
32A/B Service Facility Location Information
33 Billing Provider Info & PH #

NOTE: The nine-digit Medical Assistance Program Provider Number will continue to be required on all paper claims. When entering a provider's nine-digit provider number, it must be preceded by the ID Qualifier 1D.

Critical Care Services

Coding Guidelines

The Program covers critical care services consistent with CPT definitions and guidelines. Each day that critical care codes are billed, the medical record must support the level of service provided.

Procedure code 99291 is used to report the first 30-74 minutes of critical care provided to a critically ill or injured participant who is over 24 months of age on a given date. Report critical care of less than 30 minutes in total duration on a given date using the appropriate E&M code. Use procedure code 99292 to report additional block(s) of time, up to 30 minutes each, beyond the first 74 minutes.

Providers must document the actual time spent with the participant while delivering critical care services in the medical record. For any period of time spent providing critical care services, the provider must devote full attention to the participant and may not provide services to any other patient during the same period of time. When billing for critical care services, report a quantity of “1” for up to the first 74 minutes of critical care provided. If 75 minutes of care, or more, is provided, report a quantity of “1” for each additional 30 minutes of care under the appropriate code.

Do not bill ventilation management in addition to critical care services by the same provider on the same day; critical care includes ventilation management.

For neonates who are receiving ventilation management services, not critical care, the services should be reported under the ventilation management codes.

The following services are included in reporting the critical care codes 99291-99292 and should not be billed separately:

- Interpretation of cardiac output measurements (93561, 93562);
- Interpretation of Chest x-rays (71010, 71015, 71020);
- Interpretation of Pulse oximetry (94760, 94761, 94762);
- Interpretation of Blood gases and information data stored in computers (e.g. ECGs and blood pressures);
- Interpretation of Hematologic data (99090);
- Gastric intubation (43752, 43753);
- Temporary transcutaneous pacing (92953);
- Ventilator management (94002-94004, 94660, 94662); and
- Vascular access procedures (36000, 36410, 36415, 36591, 36600).

Neonatal and Pediatric Critical Care

All newborns born to women who are enrolled in Medicaid at the time of birth are also eligible for Medicaid. Coverage will begin at birth and continue at least through the infant's first birthday. If a pregnant woman is enrolled in an MCO at the time of delivery, her newborn is automatically enrolled in the same MCO. Providers seeing a pregnant woman should encourage her to choose a provider for her newborn by the eighth month of pregnancy.

The Program reimburses twin deliveries under the same policy as multiple surgical procedures (see Multiple Procedures on Page 39). Please report the second delivery procedure code – regardless of whether the second delivery is by the same method or a different method – on a separate line with a modifier -51. The Program may request additional notes and documentation to verify a second delivery.

Do not use the mother's MA number when billing for services rendered to a neonate. The neonate must have his or her own MA number. Hospitals are responsible for sending information to the Program so that the baby can be assigned a new number.

To ensure or to verify proper enrollment procedures for billing purposes, please consult the Maryland Reproductive Health Provider Resources.

Critical care services provided to neonates are reported with the neonatal critical care codes 99468 and 99469. These codes represent care starting with the date of admission (99468) and subsequent day(s) (99469), and may be reported only once per day.

If a neonate is no longer considered to be critically ill, use either the Intensive Low Birth Weight Services codes for those with present body weight of less than 2500 grams (99478, 99479) or the Subsequent Hospital Care codes (99231-99233) for those with present body weight over 2500 grams.

Critical care services provided to persons 29 days through 24 months of age are reported with pediatric critical care codes 99471 (care starting with date of admission) and 99472 (subsequent days); these codes may be reported by a single provider only once per day, per participant, in a given setting.

For neonatal and pediatric critical care codes, age determination in days is calculated by subtracting the date of birth from the date of service.

Reproductive Health

Obstetrics

Providers must bill deliveries separately from prenatal care. The Program does not use global procedure codes 59400, 59510, and 59610.

The Program will pay prenatal care providers a separate fee for the **Maryland Prenatal Risk Assessment (MPRA**) process which includes:

1) Completion of the MPRA at the first prenatal visit;
2) Forwarding the form to the local health department; and
3) Development of a plan of care.

Use code H1000; limited to one unit per pregnancy. The Program does not use code 99420.
In addition to the E&M code, the Program will pay prenatal care providers an additional fee for “Enriched Maternity Services."
An “Enriched Maternity Service” includes all of the following:

1) Individual prenatal health education;
2) Documentation of topic areas covered (See Appendix for sample content and form);
3) Health counseling; and
4) Referral to community support services.

Use code H1003, limited to one unit during the prenatal period only. The Program does not use codes 99411 and 99412.

The Program will pay separately for smoking and tobacco cessation counseling codes 99406 and 99407. However, when billing with H1003 the provision of this service must be in addition

to the smoking and tobacco use/cessation counseling component of the "Enriched Maternity Service."

Effective July 1, 2016, providers may bill for SBIRT services in conjunction with an office visit. For more information about SBIRT, see page 72.

Gynecology

Use the appropriate Preventive Medicine codes for routine annual gynecologic exams. Use 99383 – 99387 for new participants or 99393 - 99397 for established participants. Use the appropriate E&M codes for problem-oriented visits. Use 99201 - 99205 for a new participant or 99211 - 99215 for an established participant.

The collection of specimens to be processed by an outside lab, such as pap smears, is considered part of the office visit and will not be reimbursed separately. Payments to the laboratory which processes the specimen and determines the results will be paid under the Laboratory Program.

Hysterectomies

Regulations require providers who perform hysterectomies (not secondary providers, such as assisting surgeons or anesthesiologists) to complete the Document for Hysterectomy form (DHMH 2990) **.**

The Program will pay for a hysterectomy only under the following conditions :

1. The physician who secured authorization to perform the hysterectomy has informed the individual and/or her representative, both orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing;

2. The individual or her representative, has signed a written acknowledgement of receipt of that information (participants over the age of 55 do not have to sign);
3. The physician who performs the hysterectomy certifies, in writing, that either the individual was already sterile at the time of the hysterectomy and states the cause of the sterility or the hysterectomy was performed under a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible; and
4. The physician must include a description of the nature of the emergency.

The completed form, **"Document for Hysterectomy" (DHMH 2990),** must be kept in the participant's medical record.

The Program will not pay for a hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing. Hysterectomies are also prohibited when performed for family planning purposes, even when there are medical indications, which alone do not indicate a hysterectomy.

Abortions

Abortions are covered by the Program for five medical reasons:

- Risk to life of the mother;
- Risk to mother's current or future somatic health;
- Risk to mother's current or future mental health;
- Fetal genetic defect or serious deformity or abnormality; or
- Mother was a victim of rape or incest.

Either a law enforcement official or public health service provider is required to submit documentation where the rape or incest of the mother was reported. The document must include the following information:

- Name and address of victim;

- Name and address of person making report (if different from the victim);
- Date of the rape or incest incident;
- Date of the report;
- Statement that the report was signed by the person making it; and
- Name and signature of the person at the law enforcement agency or public health service who took the rape or incest report.

The **"Certification for Abortion" (DHMH 521)"** form must be completed and kept in the participant's medical record for services related to the termination of a pregnancy (except spontaneous abortion or treatment of ectopic pregnancy) or for medical procedures necessary to voluntarily terminate a pregnancy for victims of rape and incest. These include surgical CPT procedures 59840-59841, 59850–59852, 59855-59857, and 59866 and anesthesia code 01966.

Providers who choose to submit paper claims are not required to submit the DHMH 521 form with the claim. Please refer to the Program's CMS- 1500 billing instructions for complete details.

When billing for the medical termination of early intrauterine pregnancy through the administration of mifepristone, also known as RU-486, use the unlisted CPT Medicine code S0190 and S0191. S0199 is to be used for the office visit. "Medical Abortion" must be written on the CMS-1500 claim form below the procedure code in Block 24D. **Please select a billable ICD-10 code from the Z30 family. The date of service on the "Certificate for Abortion" DHMH Form 521 and the CMS- 1500 claim form is the date that the participant signs the required Patient Agreement and takes the 600 mg oral dose of mifepristone.** The fee for this procedure includes all medically necessary office or outpatient clinic visits over a two week period for

administration of the drugs and appropriate follow-up, and the actual cost of the drugs.

The patient's medical record must reflect the medical necessity for the therapeutic abortion, as determined by the certifying physician. The specific condition for which the abortion is being performed must be documented in the record. Completion of the certification form alone is not sufficient to serve as documentation, nor is it sufficient to render a clinical opinion and/or diagnosis without supporting evidence in the medical record. Lack of acceptable documentation in the medical record will cause the Program to deny payment, or in those cases where payment has been made, the Program will require repayment from the provider.

Family Planning Services

The Program recognizes office visit codes and preventive visit codes as family planning services when billed with a contraceptive management diagnosis code. Please select a billable ICD-10 code from the Z30 family.

Use the appropriate E&M code for new and established participants for family planning visits based on the complexity of services provided during the visit.

Preventive codes may be used instead of E&M if the service meets the CPT definition. When using a preventive code for an individual under 21 years of age, refer to the Healthy Kids/EPSDT Provider Manual for age-specific screening requirements.
Abortions and hysterectomies are covered in previous sections of this Manual.

The Program covers all FDA-approved contraceptive products and devices, generally identified by –A and –J codes. Providers must bill acquisition costs.

If the provider can document that the acquisition cost of the contraceptive product or device is greater than the allowed fee, the acquisition cost will be paid. Attach a copy of the invoice for the contraceptive product to the claim form for verification purposes.

Providers must report the NDC/quantity when billing drugs, products, and devices using –A and –J codes. For information concerning **billing with NDC**, see page 34.

For more information about contraceptive devices and product codes used by the Program, please refer to the Reproductive Health Provider Resources.

Sterilizations

The Program will pay for sterilization procedures, including tubal ligation or tubal occlusion, only if ALL of the following conditions are met:

- The individual is at least 21 years of age at the time of consent;
- The individual is not mentally incompetent;
- The individual is not institutionalized;
- The individual has voluntarily given informed consent as described in Part I of the consent document, **Sterilization Consent Form (HHS 687, HHS 687-1);**
- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery; and
- An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

A **Sterilization Consent Form (HHS 687, HHS 687-1)** must be completed and kept in the participant's medical record for all sterilization procedures.

If the procedure was performed on the same date of service as another procedure, a modifier -51 is required for the second or subsequent procedure (see page 38).

The individual is not eligible for the sterilization procedure until the 32nd day after giving consent (signature date on the consent form). The sterilization form consists of four parts:

PART I: Consent to Sterilization – The provider must complete this section for all sterilizations and obtain the dated signature of the individual being sterilized;

PART II: Interpreter's Statement - This section must be completed only when an interpreter is provided to assist the individual to be sterilized to understand the consent statement;

PART III: Statement of Person Obtaining Consent - This section must be completed for all sterilizations and must be signed and dated by the person who counseled the individual to be sterilized; and

PART IV: Physician's Statement - This section must be completed for all sterilizations by the physician. One of the final paragraphs, the one which is not used, must be crossed out. This section is worded so that the physician is required to sign this form either on or after the date of sterilization. **This section may not be signed or dated by the physician prior to the date of sterilization.**

Tubal Ligation and Occlusion

Use the appropriate CPT code for sterilization procedures and retain the Sterilization Consent Form in the participant's medical record. When performing a surgical hysteroscopy in an office setting, to induce occlusion, bill using procedure code 58565. This code includes payment for both the procedure and the device. When the procedure is performed in a hospital outpatient setting, use procedure code 99070 and attach the invoice for payment of the device.

For the three month follow-up hysterosalpingogram, to confirm placement of the implants for bilateral occlusion of the fallopian tubes, use procedure code 58340.

For the occlusion of fallopian tubes by other devices (bands, clips, rings, etc.), use procedure code 58615 and attached the invoice for payment of the device.

Healthy Kids / EPSDT

Preventive Medicine Services

The Maryland Healthy Kids/Early and Periodic Screening, Diagnosis and Treatment **(EPSDT)** Program is a comprehensive pediatric program. This program uses Preventive Medicine (full screening) CPT codes for billing well-child care.

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

- **Established Patient/Full Screening** (99391 – 99395) **:**

A full periodic screening is completed on an established participant at subsequent intervals according to the age intervals displayed on the Maryland Healthy Kids Preventative Health Schedule.

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

Substance Abuse Screening

The Maryland Healthy Kids program requires that any provider seeing Medicaid children must perform a yearly assessment of substance use beginning at 11 years of age, and recommends assessment at earlier ages when the provider suspects problems. Effective July 1, 2016, providers may bill for SBIRT services in conjunction with an office visit. For more information about SBIRT, see page 72.

Vaccine Administration / Vaccines for Children Program

Eligible providers should bill for administering childhood vaccines received at no cost from the federal **Vaccines for Children Program (VFC)** by using the appropriate CPT code for the vaccine/toxoid or immune globulin in conjunction with the modifier `-SE` (State- and/or Federally-funded programs/services)**.** Providers will not be paid for vaccine administration unless the modifier `-SE` is appended to the appropriate CPT vaccine code. VFC immunization administration codes are as follows:

VACCINE	CPT-MOD
Diphtheria and tetanus toxoids, < 7 years (DT)	90702-SE
Diphtheria, tetanus toxoids and acellular pertussis, < 7 years (DTaP)	90700-SE
Diphtheria, tetanus toxoids, acellular pertussis and Hepatitis B and poliovirus (DTaP-HepB-IPV)	90723-SE
Diptheria, tetanus toxoids, acellular pertussis and polio virus, inactivated, 5th dose, 4-6 years (DTaP-IPV)	90696-SE
Diptheria, tetanus toxoids, acellular pertussis, haemophilus influenza type b, poliovirus, 2-59 months (DTaP-Hib-IPV)	90698-SE
Hemophilus influenza b, PRP-OMP conjugate (Hib)	90647-SE
Hemophilus influenza b, PRP-T conjugate (Hib)	90648-SE
Hepatitis A, pediatric/adolescent (2 dose)	90633-SE
Hepatitis B, adolescent (2 dose)	90743-SE
Hepatitis B, pediatric/adolescent (3 dose)	90744-SE
Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use	90650-SE
Human Papillomavirus vaccine types 6,11,16,18,31,33,45,52,58, nonavalent (HPV), 3 dose schedule, for intramuscular use	90651-SE
Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	90630-SE
Influenza virus vaccine, quadrivalent, live	90672-SE
Influenza virus vaccine, quadrivalent, split virus > 3 years	90686-SE
Influenza virus vaccine, quadrivalent, split virus > 3 years	90688-SE
Influenza virus vaccine, quadrivalent (ccIIV4) >4 years	90674-SE
Influenza virus vaccine, quadrivalent (IIV4), 6-35 months	90687-SE
Influenza virus vaccine, quadrivalent, split virus, 6-35 months	90685-SE
Influenza virus, live, intranasal	90660-SE
Influenza virus, split virus, 3-18 years	90658-SE
Influenza virus, split virus, 6-35 months	90657-SE

Influenza virus, split virus, preservative free, 6-35 months	90655-SE
Influenza virus, split, preservative free, > 2 yrs	90656-SE
Measles, mumps and rubella virus, live (MMR)	90707-SE
Measles, mumps, rubella and varicella (MMRV)	90710-SE
Meningococcal conjugate, tetravalent	90734-SE
Meningococcal recombinant protein	90620-SE
Meningococcal recombinant lipoprotein	90621-SE
Pneumococcal conjugate, 13 valent	90670-SE
Pneumococcal polysaccharide, 23-valent, 2-18 yrs	90732-SE
Poliovirus, inactivated (IPV)	90713-SE
Rotavirus, monovalent, live, 6-32 weeks	90681-SE
Rotavirus, pentavalent, live, oral, (3 dose)	90680-SE
Tetanus and diphtheria toxoids, 7-18 years (Td)	90714-SE
Tetanus diphtheria toxoids and acellular Pertussis (Tdap) 7-18 years	90715-SE
Varicella virus live	90716-SE

Sick Visits

When a child is seen for an illness, if the child is both due for a well-child exam and if all of the requirements for a Healthy Kids exam can be completed, the provider should bill for both a preventative and sick visit. If the child has already received a preventive well-child exam, or is too sick to complete a full Healthy Kids exam, use the E&M codes (99201 - 99215) for sick or acute illness related office visits.

Payment is based on the fee schedule or contracted/negotiated rate for the preventive medicine and the allowed sick visit.

The comprehensive nature of the preventive medicine service codes (99381-99397) reflects an age and gender appropriate history/exam and is **not** synonymous with the “comprehensive” examination required in E&M codes 99201-99350.

If the service was an EPSDT well-child check-up, the preventive medicine code must be reported. Under certain situations, however,

both a preventive exam and another E&M service may be payable on the same day. If an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventive medicine E&M service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the appropriate office/outpatient code should also be reported. Conversely, an insignificant or trivial abnormality should not be reported.

Modifier –25 should be added to the office/outpatient code to indicate that a significant, separately identifiable E&M service was provided by the same provider on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported. Any claim using a modifier -25 requires review by the Policy Unit. If a separately identifiable E&M code is denied; please submit an appeal including proper, clear, and complete medical records for review. Failure to submit the aforementioned will result in appeal denial or delay in processing.

For detail regarding participant medical record documentation, please refer to page 26.

For information regarding EPSDT, please consult the EPSDT manual.

Objective Tests and Other Ancillary Services

Immunizations, laboratory services performed on-site, and family planning procedures are additional procedures which can be used in conjunction with a preventative well-child exam. Refer to the Healthy Kids Provider Manual or call the Maryland Healthy Kids Program at (410)767-1836 for more details.

Allergy Immunotherapy

Procedure Code 95117

This code refers to professional services for two or more injections of allergen immunotherapy. The Program will pay for a maximum of **two** units of service for this procedure, regardless of the number of injections given at one visit.

Procedure Codes 95120 through 95134

These codes refer to the injection of the allergen in the prescribing provider's office and include the office visit. **Do not bill for an office visit in addition to these codes**. The Program will pay for only **one** unit of service for these procedures regardless of the number of injections given at one visit.

When allergy injections are administered in an office other than the prescribing provider's office, use the appropriate office visit code only if there is a separate identifiable medical service, otherwise, use code 95117. The length of observation time spent by the participant in the office or facility does not increase the level of service.

Do not bill for procedure codes 95120 - 95134 in addition to an office visit code.

Procedure Code 95144

This code refers to the preparation and provision of antigens for the participant and includes an office visit. The Program will pay for only **one** unit of service for this procedure regardless of the number of injections given at the visit.

Vision Services

General

For more information about covered vision services, please reference the Vision Services section of the EPSDT manual.

Renal Dialysis

General

Physicians' services associated with renal dialysis must include all of the following medically appropriate standards:

- Visits by the physician to the participant during dialysis at the free-standing dialysis facility, review of laboratory test results, nurse's notes, and any other medical documentation, as a basis for:
  - Adjustment of the participant's medication or diet, or the dialysis procedure;
  - Prescription of medical supplies; and
  - Evaluation of the participant's psychosocial status and the appropriateness of the treatment modality;
- Medical direction of staff in delivering services to the participant during a dialysis session;
- Pre-dialysis and post-dialysis examinations, or examinations that could have been furnished on a pre-dialysis or post-dialysis basis;
- Insertion of catheters for participants who are on peritoneal dialysis and do not have indwelling catheters; and
- Documentation in the medical record written and signed by the physician, documenting that the services were personally provided by the physician.

Procedure Codes 90951 through 90962

These codes refer to age-specific services related to the participant's **end-stage renal disease (ESRD)** in an **outpatient setting**. ESRD-related physician services include establishment of a dialyzing cycle, outpatient evaluation and management of dialysis visits, and participant management during the dialysis provided, during a full month. Report these codes **once per month,** but do not use if the physician reports hospitalization codes during the same month.

Procedure Codes 90963 through 90966

These codes refer to age-specific services related to ESRD performed **in the participant's home**. Report these codes **once per month**. Codes 90967 – 90970 are used to report ESRD services less than a full month, per day.

Lab and Pharmacy Services

Radiopharmaceuticals

Payment for radiopharmaceuticals is usually considered separately from the procedure. Use HCPCS codes A9500 – A9604. If a HCPCS code has not been established for the radiopharmaceutical used, use code A4641 for a diagnostic agent and code A9699 for a therapeutic agent. A participant specific invoice is required for payment of those two codes.

The invoice must supply all of the following information:

- Participant name;
- Name of radiopharmaceutical;
- Dosage being administered;
- Cost of radiopharmaceutical; and
- Date radiopharmaceutical was administered.

Use HCPCS codes Q9965-Q9967 for **Low Osmolar Contrast Media (LOCM).**

Injectable Drugs and Biologicals

The Program covers injectable drugs and biologicals which are FDA-approved and medically necessary.

If a drug is given on **the same day** as another service, the administration is considered part of the other service and cannot be reported separately. If the only service rendered is the injection, the

administration cannot be billed separately. Only the J-code for the drug can be reported.

The Program pays providers the acquisition cost for injectable drugs. Providers must bill their actual cost for drugs and biologicals.

The Program's maximum payment established for each J-code represents the estimated actual cost of the drug to the provider. If the Program's fee is less than the provider's actual cost, the Program will pay the provider the difference between their actual cost and the amount paid by the Program upon appeal. The fees for J-codes are not listed in this Manual.

Reporting Acquisition Costs using J-Codes

Providers must bill their **acquisition cost** for injectable drugs.

Charge the acquisition cost in **Block 24F of the CMS-1500 claim form.**

The **CMS-1500 claim form must include the J-code in Block 24D** and the number of units administered in **Block 24G**.

The dosage indicated in the J-code description multiplied by the number of units reported should equal the total amount of the drug administered.

Reporting Acquisition Costs using Unclassified J-Codes

When a drug is administered that does not have a specific J-code or the "strength" is different from the J-codes listed, use the appropriate unclassified J-code in Block 24D of the CMS-1500 claim form.

The maximum number of units that can be administered for an unlisted injectable drug is "1."

Use J9999 for unclassified antineoplastic drugs and J3490 for all other unclassified drugs.

Claims that contain unlisted codes cannot be processed for payment without an attached copy of a recent invoice which clearly shows the per-unit cost of the drug. Unclassified procedure codes require manual review and payment may be delayed if the detailed invoice is not submitted with the claim.

Payment processing can be facilitated by writing on the attached invoice the calculation used to determine the acquisition cost of the unlisted drug. The NDC in the shaded area of **Block 24 A on the CMS-1500 claim form** must agree with the name of the drug listed on the invoice. The actual cost documentation is only required for unlisted injectable drugs. The drug will not be paid for if its actual cost cannot be determined from the information reported on the claim or from the invoice.

Other Requirements

The Program does not pay separately from the E&M visit code for immunization administration (CPT codes 90465 – 90474 are not used/payable by the Program), except for immunizations covered under the **Vaccines for Children Program** (see page 62).

The Program will not pay providers for drugs unless their manufacturers participate in the Medicaid Drug Rebate Program and the NDC and quantity administered are reported on the **CMS-1500 claim form**. See **NDC Reporting Requirements** on page 34.

The quantity reported should reflect the dose given according to the HCPCS description for the code. Use the code with the exact dosage or round the quantity up to best describe the amount given. When administering a dose from a multiple dose vial, only the amount given to the participant should be billed to the Program. If a drug is only

available in a single use size and any drug not used must be discarded, the Program will pay for the amount supplied in the vial.

Pathology & Laboratory

Providers may only bill the Program for laboratory procedures which they perform or are performed **under their direct supervision**.

Physicians' service providers cannot be paid for clinical laboratory services without both a **Clinical Laboratory Improvement Amendments (CLIA)** certification and approval by the Maryland Laboratory Administration, if located in Maryland. Laboratory procedures that the physician refers to an outside laboratory or practitioner for performance must be billed by that laboratory or practitioner. The physician may not bill for any laboratory procedure that is referred to a laboratory or another physician.

Interpretation of laboratory results, or the taking of specimens other than blood, is considered part of the office visit and may not be billed as a separate procedure. Specimen collections for Pap smears and newborn screens for infants are not billable by a physician. Specimen collection by venipuncture or arterial puncture are billable.

Specific information concerning pathology and laboratory services can be found in the Medical Laboratories Provider Fee Schedule under COMAR 10.09.09.

Call (410)767-3074 for additional information.

Supplies & Materials

General

Procedure code 99070 refers to supplies and materials. Providers will be paid their acquisition cost for these services.

Invoice documentation is only required for supplies with an acquisition cost of 10 dollars or more. Report the name of the supply and the amount supplied in **Block 24D of the CMS-1500 claim form**. A copy of a current invoice that clearly shows the per-unit cost of the supply must be attached to the claim. The calculation used to determine the acquisition cost should be written on the invoice. No payment will be made if the actual cost cannot be determined from the documentation provided.

Only those supplies provided by the provider **over and above those usually included** with the office visit or other services rendered may be listed separately under procedure code 99070.

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

General

Effective July 1, 2016 providers may bill for SBIRT services in conjunction with an office visit. SBIRT is the screening and early intervention for substance use disorders and people at risk for developing substance use disorders. SBIRT codes are defined by two screening codes (self-administered and provider-administered) and 3 intervention codes (greater than 3 minutes up to 10 minutes, greater than 10 minutes up to 20 minutes, and greater than 30 minutes).

These services may be billed when rendered by Physicians, Nurse Practitioners and Physician Assistants. Behavioral health providers may not provide SBIRT services outside of a primary care setting. Physician Assistants must have a Board of Physicians approved delegation agreement with a physician that authorizes the rendering and supervision of other SBIRT providers before they may provide those services.

The limitations on billing for SBIRT are:

1) The Department will pay a billing provider for a maximum of one screening and 4 interventions annually per participant ages 11 and up;
2) The initial screening and intervention (if the intervention takes place on the same day as the screening), should be billed with the office visit;
3) When additional interventions are completed with a participant, the provider should only bill for the intervention if an office visit does not occur;
4) If both screening methods are administered, you may bill for only one of the screenings; and
5) Only one intervention may be billed per participant, per day.

In order to effectively provide SBIRT services to participants, the Department encourages providers to participate in a brief training. The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a free online training. Completing the training qualifies the participant for Continuing Education Units (CEUs). Training through SAMHSA may be found at: http://www.integration.samhsa.gov/clinical-practice/sbirt/training-other-resources.

The codes for SBIRT are:

Code	Description
W7000	Alcohol and /or substance (other than tobacco) use disorder screening, self-administration, self- administered
W7010	Alcohol and /or substance (other than tobacco) use disorder screening, self-administration, provider-administered screening

W7020	Alcohol and /or substance (other than tobacco) use disorder intervention; greater than 3 minutes up to 10 minutes
W7021	Alcohol and /or substance (other than tobacco) use disorder intervention; greater than 10 minutes up to 20 minutes
W7022	Alcohol and /or substance (other than tobacco) use disorder intervention

Transplant Billing Guidelines

General

1) The Program will cover the reasonable and necessary costs of solid organ or stem cell transplantation for an eligible recipient including:

- Donor and recipient pre-transplant inpatient and outpatient medical evaluations;
- Cadaveric or living donor organ acquisition;
- Physician fees associated with the transplant procedure and post-operative care; and
- Inpatient transplant surgery charges and post-surgical hospital stay.

2) The Cadaveric Donor Standard Acquisition Charge (SAC) for the appropriate organ should be billed using the transplant recipient's Medicaid ID number. The following costs are included in the Cadaveric Donor SAC:
Physician and hospital costs associated with excision of organs from cadaveric donors;

- Costs of organ transportation;
- Organ preservation costs;
- Transplant registry fees;
- Laboratory tests (including tissue typing of recipients and donors);
- General medical evaluation of recipients and donors (including medical evaluation and management services provided by physicians in their offices); and
- Inpatient hospital and physician services associated with the medical evaluation of recipients before admission for transplantation.

3) The Living Donor Standard Acquisition Charge (SAC) for the appropriate organ or allogenic stem cells should be

billed using the transplant recipient's Medicaid ID number.

The following costs are included in the Living Donor SAC:

- Hospital costs associated with harvesting or organs and stem cells from living donors;
- Costs of organ transportation;
- Organ preservation costs;
- Transplant registry fees;
- Laboratory tests (including tissue typing of recipients and donors);
- General medical evaluation of recipients and donors (including medical evaluation and management services provided by physicians in their offices);
- Inpatient hospital and physician services associated with the medical evaluation of recipients before admission for transplantation; and
- Inpatient hospital and physician services associated with the medical evaluation of living donors before admission for harvesting the organ or stem cells.

4) The following living donor services are also a covered benefit for the transplant recipient and should be billed using the transplant recipient's Medicaid ID number:

- Physician services for living donor's organ excision;
- Routine living donor post-operative follow-up and treatment of complications by the operating physician (included in the 90-day global payment for the surgery); and
- Other expenses related to living donor complications that are directly attributable to the organ donation for up to 90 days following donation surgery.

5) The Program will reimburse the reasonable and necessary costs of a stem cell transplant for an eligible recipient including:

- Stem cell acquisition, including the harvesting and processing of autologous stem cells when provided in hospital outpatient settings. (When harvesting of autologous stem cells occurs during the same inpatient hospitalization as the transplant, the harvesting procedures are not separately payable and are included in the MS-DRG payment for the transplant);

- Physician fees associated with the transplant procedure and post-transplant care;
- Inpatient charges associated with a stem cell transplant procedure and post-procedure hospital stay; and
- Outpatient hospital charges associated with a transplant procedure performed on an outpatient basis.

6) Allogeneic stem cell acquisition should be billed using the transplant recipient's Medicaid ID number. The Program considers the following to be reasonable and necessary costs of allogeneic stem cell acquisition for an eligible recipient:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;
- Tissue typing of donor and recipient;
- Donor evaluation;
- Physician pre-admission/pre-procedure donor evaluation services;
- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);
- Post-operative/post-procedure evaluation of donor; and
- Preparation and processing of stem cells

7) The following living donor services are also a covered benefit for the transplant recipient and should be billed using the transplant recipient's Medicaid ID number:

- Physician services for stem cell harvesting;
- Medically necessary inpatient hospital days of care or outpatient care provided in connection with donation procedure; and
- Other expenses related to living donor complications that are directly attributable to the stem cell donation for up to 90 days following donation procedure.

Preauthorization

Preauthorizations are required for transplant procedures. It is the responsibility of the provider to ensure that the Preauthorization Decision Procedures are followed in order to obtain a valid preauthorization number. Refer to p. 27 in the **Preauthorization Procedures** section for additional information.

The program has the responsibility to review prior authorizations until the patient's enrollment in a Managed Care Organization begins. Preauthorizations approved by the program expire the date of the patient's enrollment in an MCO. The MCO is not required to honor any prior authorization previously approved by the Program for services rendered after the start of the MCO coverage.

Initial Requests for Transplant Preauthorizations

An initial request is a preauthorization request made for the first time with the program (i.e., different than previous requests through MCOs) or for a request >1 year since last authorization. Required documentation includes:

1) All health care records supporting the medical necessity of transplant, specifically:
   - Letter of medical necessity from a transplant service physician; and
   - Documentation of the patient meeting the requesting institution's transplant candidacy guidelines for the organ(s) to be transplanted;
   Note: Please include a copy of the institution's organ-specific candidacy guidelines.
2) History and Physical evaluation from transplant surgeon and/or transplant specialist (i.e., hepatologist, nephrologist);
3) Height, weight, and BMI;
4) History of tobacco and/or nicotine delivery system use, and if positive, documentation of program's efforts to address use;
5) Psychosocial evaluation and clearance, to address:
   - Patient's medical compliance;
   - Patient's support network;
   - Post-transplant care plan, with identification of primary and secondary care providers;
   - History of mental health, substance, or legal issues; and
   - Patient's understanding of surgical risk and post-procedure compliance and follow-up requirements;
6) Diagnostic studies (within past 6 months):
   - EKG;
   - Chest x-ray;
   - Echocardiogram;
   - Pulmonary function test, if smoking history; and
   - Cardiac stress test, as indicated;

7) Dental clearance by dentist, for patients > 5 years old;
8) Specialty clearance:
   - Cardiac clearance for chronic smokers, ≥ 50 years old or history of heart disease; and/or
   - Pulmonary clearance for history of pulmonary artery hypertension or chronic pulmonary disease;
9) Age- and sex-appropriate cancer screenings:
   - Colonoscopy, if indicated or if patient is ≥ 50 years old. Include surgical pathology report for any samples obtained;
   - Gynecologic exam and Pap smear for women ≥ 21 years old; and/or
   - Mammogram, if indicated or if patient is ≥ 50 years old;
10) Lab results (within past 3 months) including:
   - Complete blood count, with differential;
   - Electrolytes;
   - BUN;
   - Creatinine;
   - Glucose;
   - Hemoglobin A1c (if patient has Type I or II diabetes mellitus);
   - Calcium;
   - Phosphorus;
   - Liver enzymes;
   - Coagulation profile (INR, prothrombin time);
   - Blood type; and
   - Serum or urine drug screen (for adults);
11) Infectious Disease screening including:
   - HIV;

- If HIV positive, documentation showing:
  - CD4 count >200 cells/µL for >6 months;
  - Undetectable HIV RNA;
  - On stable anti-retroviral therapy for > 3 months; and
  - No complications from AIDS;
  - Hepatitis B;
  - Hepatitis C;
  - RPR, for adults and sexually active adolescents;
  - EBV;
  - CMV; and
  - Tuberculosis testing (PPD, T-spot, or Quantiferon), may be >3 months old if positive.

12) Additional organ-specific testing including:
    - Liver: MELD or PELD score, CT or MRI of abdomen, liver biopsy (if indicated);
    - Kidney: GFR and Creatinine clearance (if not on dialysis);
    - Heart: cardiac catheterization, peak VO2 mL/kg/min;
    - Lung: PFT, imaging, and 6-minute walk test;
    - Pancreas: c-peptide; and/or
    - Bone marrow or Stem cell: bone biopsy, Karnofsky score; and

13) Additional clinical information may be requested based on the patient's past medical history.

Renewal Requests for Transplant Preauthorizations

A renewal request is a preauthorization request when there has been <1 year since last authorization. Required documentation includes:

1) History and Physical evaluations from transplant surgeon and/or relevant specialist (e.g., hepatologist or nephrologist) completed since last authorization approval;
2) Height, weight and BMI, within past 3 months;
3) CBC, CMP (and Hgb A1c if diabetic), within past 3 months;
4) Diagnostic tests completed since last authorization approval;
5) Annual tuberculosis testing;
6) Annual dental screening;
7) Annual drug screening, if history of positive substance use or positive drug screen;
8) Updates to psychosocial evaluation annually; and
9) Notification to the Program of significant changes to patient's medical or psychosocial history.

APPENDICES

Introduction

This chapter provides information that supplements other chapters in the Manual.

Trauma Center Information

Facility Name	Trauma Center ID (Last 2-Digits of the MIEMSS Facility ID#) + Trauma Registry #
State Primary Adult Resource Center	
R. Adams Cowley, Shock Trauma Center, Baltimore	34 + 6-Digit Trauma Registry Patient Number
Level-I Trauma Center	
Johns Hopkins Medical System, Adult Trauma Center, Baltimore	04 + 6-Digit Trauma Registry Patient Number
Level-II Trauma Centers	
Johns Hopkins Bayview Medical Center, Adult Trauma Center, Baltimore	01 + 6-Digit Trauma Registry Patient Number
Prince George's Hospital Center, Adult Trauma Center, Cheverly	32 + 6-Digit Trauma Registry Patient Number
Sinai Hospital of Baltimore, Adult Trauma Center, Baltimore	10 + 6-Digit Trauma Registry Patient Number
Suburban Hospital, Adult Trauma Center, Bethesda	49 + 6-Digit Trauma Registry Patient Number
Level-III Trauma Centers	
Western Maryland Health System, Cumberland Memorial Trauma Center, Cumberland	20 + 6-Digit Trauma Registry Patient Number
Peninsula Regional Medical Center, Adult Trauma Center, Salisbury	08 + 6-Digit Trauma Registry Patient Number
Washington County Hospital, Facility Name	89 + 6-Digit Trauma Registry

	Trauma Center ID (Last 2-Digits of the MIEMSS Facility ID#) + Trauma Registry #
Adult Trauma Center, Hagerstown	Patient Number
Pediatric Trauma Centers	
Johns Hopkins Medical System, Pediatric Trauma Center, Baltimore	05 + 6-Digit Trauma Registry Patient Number
Children's National Medical Center, Pediatric Trauma Center, Washington, D.C.	17 + 6-Digit Trauma Registry Patient Number

Trauma Center Identification (continued)

Trauma Specialty Referral Centers	
Johns Hopkins Medical System, Burn Center, Baltimore	91 + 6-Digit Trauma Registry Patient Number
Johns Hopkins Medical System, Pediatric Burn Center, Baltimore	93 + 6-Digit Trauma Registry Patient Number
Johns Hopkins Medical System, Eye Trauma Center, Baltimore	95 + 6-Digit Trauma Registry Patient Number
Union Memorial Hospital, Curtis National Hand Center, Baltimore	94 + 6-Digit Trauma Registry Patient Number

Frequently Asked Questions

FAQ

Q: Is the fee schedule listed in this Manual?

A: Yes, it is attached to the end of the Manual. Additionally, the fee schedule may be found online at: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx.

Q: Can the fee schedule be used for Ambulatory Surgical Centers (ASCs)?

A: ASCs rates cannot be found on the Professional Services Fee Schedule. Reimbursement fees are equal to 80% of the current

Medicare-approved ASC facility fee for services rendered to Medicaid recipients in connection with covered surgical procedures.

Q: How is a participant's preauthorization determined?

A: If the services are rendered in an inpatient setting, preauthorization must be determined by Telligen at (888)276-7075. If the services are rendered in an outpatient setting and the participant only has Fee-For-Service coverage through Maryland Medicaid, the Professional Services Fee Schedule may be used to determine preauthorization based on the CPT code. If the **Note** field has a letter “P” next to a specific code, then that code requires preauthorization. If it a code does not have a letter “P” in the **Note** field, then that code does not require preauthorization. For other letters that may appear in that field, see the following question.

Q: What does “A”, “H”, and “S” stand for in the Fee Schedule?

A: “A”, “H”, and “S” stand for Abortion, Hysterectomy, and Sterilization, respectively. Those procedures do not require preauthorization, but require the provider and the participant to complete their respective forms to keep on the participant’s file.

Q: Where can I find a fee schedule for HCPCS Level-II codes, especially J-codes?

A: The Professional Services Fee Schedule does not display the reimbursement amounts for HCPCS Level-II codes. Providers billing J-codes must bill their acquisition costs.

Q: What codes can specialist providers bill?

A: We do not have separate fee schedules for different provider specialty types. They should bill according to their scope of practice and expect payment to be the lower of their charge or the rate in the current Professional Services fee schedule.

Q: Why are the facility rates lower than the non-facility rates?

A: Both facility and non-facility rates are based on the Medicare rate. For certain codes, the facility rate is lower than the non-facility rate because providers in a non-facility setting also have to take into account administrative overhead and practice expenses.

Q: What is the Program's anesthesia conversion factor?

A: The Program does not reimburse anesthesia in the same way as Medicare. Reimbursement is calculated per one-minute increments instead of per 15-minute increments. Please see **Anesthesia** in the **Services Information** section for further details.

Q: How does the Program cover new injectable drugs?

A: The Program reimburses all injectable drugs if they are FDA-approved and federally rebatable, not for use in a clinical trial, and not used for cosmetic surgery or off-label. All injectable drugs are reimbursed based on acquisition cost and may be subject to program review or preauthorization.

Program-Accepted Modifiers

Modifier	Description	% of Fee
Anesthesia		
-AA	Anesthesia performed personally by anesthesiologist	100%
-QK	Medical direction of 2-4 concurrent anesthesia procedures	50%
-QX	CRNA service with medical direction by a physician	50%
-QY	Medical direction of 1 CRNA by an anesthesiologist	50%
-QZ	CRNA service without medical direction by a physician	100%
-23	Unusual Anesthesia	Med. Report Required
Evaluation & Management		

-25	Separately Identifiable E&M	100% after review
Surgery		
-50	Bilateral Procedures	150%
-51	Multiple Procedures	50%
-52	Reduced Services	50%
-53	Discontinued Procedure	Med. Report Required
-54	Surgical Care Only	80%
-55	Post-operative Management Only	20%
Surgical Assistance		
-62	Co-Surgeon	62.5%
-80	Assistant Surgeon	20%
-82	Assistant surgeon (when qualified resident not available)	20%
Trauma Services		
-U1	Trauma Services	Medicare Conv. Factor
Component Billing		
-26	Professional Component	Same as Medicare
-TC	Technical Component	Difference of -26 Modifier
Vaccine for Children Program		
-SE	VFC Administration	$23.28

Telephone Directory

Professional Services Program

To obtain a toll-free number for any of the (410)767- exchanges below, call (877)463-3464 and ask for the appropriate 4-digit extension.

Policy/Coverage Issues	(410)767-1462 mdh.professionalservicespolicy@maryland.gov

Other Programs

Telligen	(888)276-7075
Eligibility Verification System (EVS)	(866)710-1447
Laboratory Services/Policy/Coverage	(410)767-5706
Provider Master File (Enrollment)	(410)767-5340
Provider Relations	(410)767-5503
LTC Problem Resolution	(410)767-8699
Institutional Services	(410)767-5457
Electronic Media Submittal	(410)767-5863
Missing Payment Voucher or Lost/Stolen Check	(410)767-5503
Third Party Liability/Other insurance	(410)767-1771
Recoveries	(410)767-1765
Medical Assistance Program Training Liaison Unit	(410)767-6024
Claims (CMS-1500) & Claims Adjustments	(410)767-5346

Links Directory

Forms

- **CMS-10114:** NPI Application/Update Form
- **CMS-1500:** Health Insurance Claim Form
- **CMS-837P:** Electronic Health Insurance Claim Form Guidance
- **DHMH-521:** Certification of Abortion
- **DHMH-2990:** Document For Hysterectomy
- **DHMH-4523:** Preauthorization Request Form for Physician Services
- **DHMH 4850:** MPRA Form
- **HHS-687:** Sterilization Consent Form (English)

- **HHS-687-1:** Sterilization Consent Form (Spanish)

Websites and Other Resources

- **5010 Compliance:** dhmh.hipaaeditest@maryland.gov
- **Aetna Better Health:** https://www.aetnabetterhealth.com/maryland
- **AMA/CPT:** http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page
- **AMERIGROUP Community Care:** https://www.amerigroup.com/
- **CMS-1500 Billing Instructions (complete):** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
- **COMAR:** http://www.dsd.state.md.us/comar/subtitle_chapters/10_Chapters.aspx
- **EPSDT/ Maryland Healthy Kids Manual:** https://mmcp.health.maryland.gov/EPSDT
- **EVS User Guide:** https://mmcp.health.maryland.gov/docs/EVS_Brochure_July2017.pdf
- **General HealthChoice MCO Program:** https://mmcp.health.maryland.gov/healthchoice/Pages/Home.aspx
- **HIPAA:** https://health.maryland.gov/hipaa/Pages/home.aspx
- **Jai Medical Systems:** http://www.jaimedicalsystems.com/
- **Kaiser Permanente:** http://www.kp.org/medicaid/md
- **Maryland Healthy Kids Preventative Care Schedule:** https://mmcp.health.maryland.gov/Documents/Maryland%20Healthy%20Kids%20Preventive%20Health%20Schedule-.pdf
- **Maryland Physicians Care:** www.marylandphysicianscare.com/
- **Medical Assistance Program State Plan Disposable Medical Supplies and Durable Medical Equipment:** https://mmcp.health.maryland.gov/communitysupport/Pages/whatwedo.aspx
- **Medical Laboratories Fee Schedule:** https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx
- **MedStar Family Choice:** http://www.medstarfamilychoice.net
- **Novitas Medicare Solutions:** https://www.novitas-solutions.com/webcenter/portal/FeeSchedules

- **NCCI:** https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html
- **NPPES:** https://nppes.cms.hhs.gov/NPPES/Welcome.do
- **OB/GYN/Family Planning Manual:** https://mmcp.health.maryland.gov/Documents/Maryland%20Medicaid%20Overview.pdf
- **Production Files Information:** dhmh.ediops@maryland.gov
- **Professional Services Fee Schedule:** https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx
- **Professional Services Preauthorization information:** https://mmcp.health.maryland.gov/Pages/Preauthorization-Information.aspx
- **Priority Partners:** http://www.ppmco.org/
- **Self-Referred Services:** https://mmcp.health.maryland.gov/Documents/Factsheet1_Self-Referral%20Provisions%20for%20HealthChoice%20Members.pdf
- **Transmittals:** https://mmcp.health.maryland.gov/mcoupdates/Pages/Home.aspx
- **Telligen:** http://www.telligenmd.qualitrac.com/
- **UnitedHealthcare:** http://www.uhccommunityplan.com
- **University of Maryland Health Partners:** https://www.umhealthpartners.com/

Acronyms

ABUs	Anesthesia Base Units
AMA	American Medical Association
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services
COMAR	Code of Maryland Regulation
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
E&M	Evaluation & Management
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
ESRD	End-Stage Renal Disease
FFS	Fee-For-Service
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HSCRC	Health Services Cost Review Commission
ICD	International Classification of Disease
LOCM	Low Osmolar Contrast Media
MAC	Monitored Anesthesia Care
MCOs	Managed Care Organizations
MHCC	Maryland Heath Care Commission
MIEMSS	Maryland Institute for Emergency Medical Services System
NCCI	National Correct Coding Initiative
NDC	National Drug Code
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OB-GYN	Obstetrics and Gynecology
UCA	Utilization Control Agent
VFC	Vaccines for Children Program