Section 6 Billing and Encounter Data Reporting

A. INTRODUCTION

This section explains the use of the *State of Maryland Eligibility Verification System (EVS) and* provides a brief overview of billing for services provided to MCO recipients, including newborn care. Also included in this section is billing information about fluoride varnish application and other services specific to child health that can be billed to Medicaid Fee-for-Service.

B. VERIFYING ELIGIBILITY

When a child presents with a specific MCO card, use the instructions on that card for eligibility verification or consult the MCO Provider Manual. If the MCO says the child is not eligible, check the EVS for the child may be eligible for services in the fee-for-service (FFS) system.

The EVS is currently a telephone-inquiry system that is available 24 hours a day, 7 days a week. The system verifies whether or not a patient is enrolled in one of the State Medical Care Programs on the day you call. EVS provides the eligibility category of the recipient and, if they are enrolled in a MCO, it gives the name and phone number of the recipient's MCO. In order to use the EVS, the practice must have:

- A touch tone phone
- Provider's MA number
- Recipient's MA number or Social Security number and name code
- The EVS telephone number:

Metropolitan Baltimore	410-333-3020
Outside Baltimore Area	1-800-492-2134

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

To determine past eligibility up to one year after the service was rendered, enter the date of service after the last name code and press the pound (#) button twice. The date of service must contain 6 digits; for example 1/1/03 would be 010103 ##. To search past eligibility, enter the recipient's MA number.

If only the Social Security number is available, at the recipient number cue press "0" and press the pound (#) button twice. The EVS will reply, "Enter Social Security number and name code." If the Social Security number is not on file

recipient eligibility cannot be verified until the Medical Assistance number is obtained. This method does not search past eligibility.

Please listen carefully to the entire EVS message. For recipients that are enrolled in a MCO, the EVS message states the assigned MCO and telephone number. The message does not state the primary care provider. This information is available from the respective MCO. The message for individuals not enrolled in a MCO is "State or federally eligible" or lists the specific program, such as family planning.

Most Common Eligibility Status Messages

- Eligible, Federal - recipient is eligible for benefits and reimbursement from federal funds. These individuals may be in the process of choosing a MCO provider but are not currently restricted to a single provider.
- Invalid Recipient - the recipient's number is entered incorrectly or the person is not eligible.
- HealthChoice (Managed Care Organization name and phone number) - recipient is eligible for services and a member of a Managed Care Organization in the HealthChoice Program. Contact the MCO identified if necessary.
- Rare and Expensive (Call 1-800-565-8190) - recipient is in the Rare and Expensive Case Management Program (REM) and may be eligible to receive an expanded set of benefits. All services for REM are reimbursed by the Medicaid fee-for-service system.

Call the **Medical Assistance Provider Relations Unit** at **410-767-5503 or 1-800-445-1159** to obtain an *EVS User's Guide* pamphlet. In accordance with HIPAA regulations, providers will soon be able to access eligibility information electronically.

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

Note: All billing for application of fluoride varnish, whether the recipient is with a MCO or Medicaid FFS, must be submitted to DentaQuest.

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

- Be enrolled in Maryland's Medical Assistance Program (Medicaid) and have an active Medicaid number with a registered NPI number
- Render services within a practice (solo or group) that has an active Medicaid number with a registered NPI number

- Be EPSDT certified by the Maryland Healthy Kids Program
- Complete the State approved fluoride varnish training program

Reimbursement for Fluoride Varnish Application

All claims for reimbursement for fluoride varnish applications by a Maryland EPSDT provider must be made to DentaQuest, whether the child is enrolled in a MCO or Medicaid FFS. With the exception of the application at 30 months, D1206 must be billed in conjunction with an office well-child visit procedure code. Remember, oral health screening is part of the well-child visit and cannot be billed separately.

Procedure	CDT Code	Maximum Reimbursement
Topical Fluoride Varnish*	D1206	$ 24.92

*With the exception of the application at 30 months, D1206 must be billed in conjunction with an office preventive care procedure code.

For More Information:

- For a more detailed description of billing for fluoride varnish application, please refer to the Office of Oral Health website at
  - **www.fha.state.md.us/oralhealth**
- For provider support and information contact :
  - DentaQuest at 888-696-9598
- For answers to questions or for additional information contact the Department of Health and Mental Hygiene Office of Oral Health:
  - Phone: (410) 767-3081
  - E-mail: fvprogram@dhmh.state.md.us

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

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

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

All children in State supervised care can be enrolled in a Managed Care Organization. Children newly eligible for Medical Assistance will have fee-for-service coverage until enrolled in a MCO.

An initial examination must be completed within 5 days of entry into State-supervised care. Prior to rendering care to a child in State supervised care, a provider must be certified by the Maryland Healthy Kids Program (EPSDT).

If the child already has Medicaid and is enrolled in a MCO, bill the MCO for the initial examination. The child's MCO is required to permit the self referral of a child in State-supervised care for an initial examination and is obligated to pay for all portions of the examination except for the mental health screen.

If the child has Medicaid but is not in a MCO, bill fee-for-service Medicaid for the initial examination. If DHR has not yet issued a MA number for the child, work with the caseworker to obtain the number and then bill FFS Medicaid.

Eligible providers should bill using the age appropriate preventive CPT code with **modifier -32** (Mandated Services) for the initial examination and any other procedures provided during this visit. Refer to E: Billing Medical Assistance For Services To Children Not In A MCO (Fee- For-Service), later in this section, for common preventive CPT codes. Contact the staff specialist for Children's Services for additional information at 410-767-1903.

D. BILLING FOR SERVICES TO CHILDREN IN MCOS

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

Suggested Checklist for Billing Managed Care Organization (MCO)

1. Verify through the EVS and the applicable MCO that the child is enrolled with HealthChoice and with your practice.
2. Use the Current Procedural Terminology (CPT) Preventive Medical Services codes.
3. Submit encounter data (for capitation reporting or claim submission) to the respective MCO. Follow the MCO's instructions found in the applicable MCO Provider Manual.
4. For Children in state-supervised care, the MCOs must pay the initial exam as a self-referred service. Use codes 99381–99385 for full screen. Follow the respective MCO directions for submitting vaccine claim information.
5. Follow the directions from each MCO concerning CPT codes for VFC vaccine administration. All PCPs participating with MCOs who serve patients younger than 19 years of age must enroll with the Vaccines for Children (VFC) Program**.**
6. For provider-purchased vaccine stock administered to patients 19-20 years of age, bill the MCOs by submitting the vaccine-specific CPT code following the MCO directions.

7. Since VFC does not cover patients 19 years of age and older, the MCO is responsible for reimbursement of vaccines administered to this age group and reimbursement is generally at acquisition costs.
8. The MCO is also responsible for all medically necessary vaccines for patients not covered by the VFC Program. For example, vaccines such as Meningococcal polysaccharide vaccine and Synagis are not currently included in the VFC Program and therefore providers should bill the MCO.

Newborn Billing Information

Infants born to mothers enrolled in a MCO will be enrolled in the mother's MCO. The delivering hospital is required to submit the Hospital Report of Newborn (DHMH Form 1184) to DHMH. This will serve to initiate the child's temporary MA number and notify the appropriate MCO of the newborn's enrollment. For all mothers with MA at the time of delivery, the newborn's temporary MA number is the same as the mother's number except for the last two digits. The last two digits are 01 for the first baby and consecutively increasing numbers for subsequent children. The permanent number and card will be issued after the local health department or DSS completes the transaction - usually within 4 weeks.

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

Do not bill Medical Assistance for services to newborns using the mother's number. Contact the Newborn Coordinator of the mother's MCO for problems encountered with newborn MA numbers or eligibility (Refer to Section 7 – Appendix V). If you are unable to determine the mother's MCO, or the mother was not enrolled in Medicaid at the time of delivery, call the **Maternal and Child Health Information Line at 1-800-456-8900** for assistance. A *Provider Action Grid* is included to assist providers with issues that may arise in the newborn period (Refer to Section 1 - Addendum).

If an out-of-plan provider renders the initial medical examination of a newborn in the hospital because the MCO does not arrange for a network provider, the MCO must reimburse this service as a self-referral service at no less than the Medicaid rate. Use CPT Code 99460 (eff. 1/1/09): the Medicaid rate for this service is currently $42.14.

E. BILLING MEDICAL ASSISTANCE FOR SERVICES TO CHILDREN NOT IN A MCO (FEE- FOR-SERVICE)

Providers will find that most children are enrolled in a MCO. However, if the patient is not in a MCO, bill the Medical Assistance/Medicaid Fee-For-Service

Program. To participate in the Medicaid Program, apply on line at: **www.emdhealthchoice.org**.

All rendering providers, solo practices and group practices must have a **National Provider Identifier (NPI),** a 10-digit, numeric identifier that does not expire or change. It is administered by CMS and is required by HIPAA. **You should be using the NPI as your primary identifier and your Medicaid provider legacy ID as the secondary identifier on all paper and electronic claims.**

Apply for National Provider Identifiers through the National Plan and Provider Enumeration System (NPPES):

- Online at: **nppes.cms.hhs.gov/NPPES/Welcome**, or
- Obtain the NPI Application/Update Form (CMS-10114) available through the NPI Enumerator:
  - Call 1-800-465-3203, or
  - E-mail to: **mailto:hcustomerservice@npienumerator.com**, or
  - Write to NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059
- Mail the completed, signed application to:

  NPI Enumerator
  P.O. Box 6059
  Fargo, ND 58108-6059

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

Follow the General Billing Practices noted in the *Maryland Medical Assistance Provider Handbook* and the most current *Physicians' Services Provider Fee Manual.* Contact the **Provider Training Unit at 410-767-6024 or 1-800-445-1159** to request these materials or access information on the following DHMH website: **www.dhmh.state.md.us/mma/providerinfo/**. Always refer to your copy of the *Current Procedural Terminology (CPT*) edition published yearly by the **American Medical Association** to verify current codes.

In general, the Medical Assistance Program is always the payer of last resort. If a recipient is covered by other third-party insurers, the provider must seek payment from that source first. The only exception to the Medicaid as "payer of last resort rule" is for the provision of well child/Healthy Kids services and prenatal care. Bill Medical Assistance first for these services, even if the recipient has other insurance. If payment of a claim is made by both the Program and a third party, the provider must refund to the Program either the amount paid by the Program or the third party.

Section 6 Billing and Encounter Data Reporting

Preventive Medicine Services Codes

Procedure	CPT Code	Maximum Reimbursement
New patient 0 – 11 months	99381	$ 85.95
New patient 1 – 4 years	99382	$ 92.36
New patient 5 – 11 years	99383	$ 90.41
New patient 12 – 17 years	99384	$ 98.07
New patient 18 – 39 years	99385	$ 98.07
Established patient 0 – 11 months	99391	$ 64.94
Established patient 1 – 4 years	99392	$ 72.60
Established patient 5 – 11 years	99393	$ 71.62
Established patient 12 – 17 years	99394	$ 79.02
Established patient 18 – 39 years	99395	$ 80.00

If a child presents for a sick visit and the child is due for a preventive visit, it is recommended that the provider complete the Healthy Kids preventive care in addition to rendering care for the presenting problem, and use the appropriate CPT preventive code. If only "sick care" is rendered, use the Evaluation and Management (E&M) CPT codes for the level of complexity.

Oral health assessment by the primary care provider is included in the preventive code as part of the Healthy Kids preventive care examination. Dentists, however, should consult DentaQuest at 888-696-9598 regarding coding for dental services.

Objective Hearing and Vision Tests, Developmental Screening

Objective hearing and vision tests can be billed in addition to the preventive screen. Providers can also bill separately for developmental screening with an approved or recommended standardized, validated general developmental screening tool (Refer to Section 3, Addendum) during either a preventive or episodic visit using CPT code 96110 (see below). CPT 96111 should be used for a longer, more comprehensive developmental evaluation performed by a physician or other specially trained professional.

Procedure	CPT Code	Maximum Reimbursement
Hearing/Screening test, Pure air only	92551	$ 7.82
Tympanometry (impedance testing)	92567	$ 18.42
Screening test of visual acuity, quantitative, bilateral	99173	$ 2.19

Procedure (Continued)	**CPT Code**	**Maximum Reimbursement**
Vision function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates and field of vision	99172	$ 4.50
Substance abuse screening: Alcohol and/or substance (other than tobacco) abuse structured screening, and brief intervention (SBI) services 15 to 30 minutes	99408[1]	$ 22.27
Substance abuse screening: Alcohol and/or substance (other than tobacco) abuse structured screening, and brief intervention (SBI) services greater than 30 minutes	99409[1]	$ 43.64
Developmental testing: Limited (e.g. Ages and Stages Questionnaire, Pediatric Evaluation of Developmental Status) with interpretation and report*	96110[1,2]	$ 10.99
Developmental testing: Extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g. Bayley Scales of Infant Development with interpretation and report	96111	$ 96.70

[1] *A standardized, validated tool must be used.* [2] Providers may bill a maximum of 2 units of CPT 96110 on the same date of service when a screening tool for autism or a social-emotional screening (e.g. ASQ-SE) is administered in addition to a general developmental screening tool.

*Documentation for developmental screening should include:

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

Laboratory Services

All providers billing for any laboratory service(s) must be CLIA certified and have Maryland State laboratory certification. Contact the **Division of Hospital and Physician Services at 410-767-1462** for information regarding CLIA certification. The following lab codes are frequently billed in addition to the Healthy Kids preventive code:

Procedure	CPT Code	Maximum Reimbursement
Venipuncture under 3 yrs, physician skill (e.g. blood lead)	36406	$ 13.19
Venipuncture, physician skill, child 3 yrs and over (e.g. blood lead)	36410	$ 13.90
Venipuncture, non-physician skill, all ages	36415	$ 2.22
Capillary blood specimen collection, finger, heel, earstick (e.g. PKU, blood lead filter paper, hematocrit)	36416	$ 1.50
Urinalysis/microscopy	81000	$ 3.42
Urine Microscopy	81015	$ 2.98
Urine Dipstick	81005	$ 2.34
Urine Culture (Female Only)	87086	$ 8.70
Hematocrit (spun)	85013	$ 2.45
Hemoglobin	85018	$ 2.45
PPD – Mantoux	86580	$ 6.60

Vaccine Administration CPT Codes

Providers must use vaccines provided by the Vaccines For Children (VFC) Program for patients from birth to the 19th birthday**.** At present, the State reimburses the provider for administrative costs associated with administering VFC vaccines. The provider should bill the 'usual and customary' charge for administration of each vaccine to the State. Currently, Medicaid pays an administration fee of $15.49 (maximum) per vaccine.

Vaccine	CPT Code
Diphtheria, tetanus toxoids and acellular pertussis vaccine (DTaP), younger than 7 yrs., for IM use	90700-SE
Diphtheria and tetanus toxoids (DT) younger than 7 yrs., for IM use	90702-SE
Diphtheria, tetanus toxoids, acellular pertussis and Hemophilus influenza b vaccines, (DTaP-Hib) for IM use	90721-SE
Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for IM use	90723-SE
Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (Dtap-IPV), for IM use	90696-SE
Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hemophilus influenza b vaccine (Hib), and poliovirus vaccine, inactivated (DtaP-Hib-IPV), for IM use	90698-SE

Vaccine (Continued)	**CPT Code**
Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose), for IM use	90645-SE
Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose) for IM use	90647-SE
Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose), for IM	90648-SE
Hepatitis A, Pediatric/ Adolescent dosage, 2 dose schedule, for IM use	90633-SE
Hepatitis B immune globulin (HBIg), human, for IM use	90371-SE
Hepatitis B vaccine, adolescent (2 dose), for IM use	90743-SE
Hepatitis B vaccine, pediatric/adolescent (3 dose), for IM use	90744-SE
Hepatitis B and Hemophilus influenza b vaccine, (HepB-Hib), for IM use	90748-SE
Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for IM use	90649-SE
Human Papilloma virus (HPV) vaccine, types 16, 18 bivalent, 3 dose schedule, for IM use	90650-SE
Influenza virus vaccine, split virus, preservative free, 6-35 months, for IM use	90655-SE
Influenza virus vaccine, split virus, 6-35 months, for IM use	90657-SE
Influenza virus vaccine, split virus, 3 years/above, for IM use	90658-SE
Influenza virus vaccine, live, for intranasal use	90660-SE
Measles, mumps and rubella virus vaccine (MMR), live, for SQ use	90707-SE
Measles, mumps, rubella and varicella vaccine (MMRV), live, for SQ use	90710-SE
Meningococcal conjugate vaccine (MCV-4), serogroups A, C, Y and W-135 (tetravalent), for IM use	90734-SE
Meningococcal polysaccharide vaccine, A, C, Y and W-135 (tetravalent) for SQ use	90733**
Pneumococcal conjugate vaccine, polyvalent, under 5 yr, for IM use	90669-SE
Pneumococcal conjugate vaccine, 13 valent, for IM use	90670-SE
Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dose, for 2 yrs and older, for SQ or IM use	90732-SE
Poliovirus vaccine, inactivated, (IPV), for SQ use	90713-SE
Rotavirus vaccine (RV), pentavalent, 3 dose schedule, live, for oral use	90680-SE
Rotavirus vaccine (RV-1), human, attenuated, 2 dose schedule, live, for oral use	90681-SE
Tetanus and diphtheria toxoids (Td), preservative free, for use in 7yrs or older, for IM use	90714-SE

Vaccine (Continued)	**CPT Code**
Tetanus and diphtheria toxoids (Td) for use in 7yrs or older, for IM use	90718-SE
Tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap) for use in individuals 7yrs and older – for IM use	90715-SE
Varicella virus vaccine, live, for SQ use	90716-SE

******Not available through VFC

For vaccines not included in the VFC Program but considered a medically necessary vaccine (eg. Synagis for high risk infants), and for patients 19 – 20 years of age**,** Medicaid will reimburse providers for the acquisition cost of vaccines purchased by the provider. Use the CPT codes with no modifier for the applicable immunizations administered to the Medicaid recipient. A separate administration fee is not paid for provider stock used for MA patients.

Contact the VFC consultant in your jurisdiction (Refer to Section 7 – Appendix V), to answer questions regarding enrolling in the VFC Program and ordering of vaccines. Contact the **Center for Immunization at 410-767-6679** with questions regarding vaccine administration. Contact the **Healthy Kids Program at 410-767-1683** with questions about vaccine reimbursement**.**

Evaluation and Management Office Visits Codes

Procedure	**CPT Code**	**Maximum Reimbursement**
New patient (10 minutes)	99201	$ 29.50
New patient (20 minutes)	99202	$ 52.13
New patient (30 minutes)	99203	$ 77.42
New patient (45 minutes)	99204	$116.02
New patient (60 minutes)	99205	$145.36
Established patient (5 minutes)[1]	99211	$ 17.61
Established patient (10 minutes)	99212	$ 31.08
Established patient (15 minutes)	99213	$ 49.56
Established patient (25 minutes)	99214	$ 75.06
Established patient (40 minutes)	99215	$101.36

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

Children who are behind on their immunizations can be scheduled for additional inter-periodic preventive visits to "catch up" on their vaccinations using the appropriate Evaluation and Management (E&M) CPT code based on "complexity" and time with a V20, ICD-9 diagnosis code.

Section 6 Billing and Encounter Data Reporting

Submitting the CMS 1500 Billing Form

When submitting paper claims, make sure the items listed below are completed correctly on the CMS 1500 form. Check the "MEDICAID" block at the top of the form.

1. Enter the patient's 11-digit Medical Assistance number in Item 9a
2. Call the Eligibility Verification System (EVS) to verify the patient's Medicaid eligibility & assigned MCO on each date of service prior to rendering services
3. If the recipient is also covered by a third party insurer, enter the I.D. number of the insured, relationship, group name and group number in Block 9a-d, even if the services are not covered by the third party insurer
4. Medicaid is usually the "payer of last resort," meaning that when recipients have both Medicaid and other insurance coverage, the provider must bill the other insurance first. However, States are required to exempt certain EPSDT/Healthy Kids services from this rule.
   - Submit the following codes directly to Medical Assistance even if the child is covered by third party insurance:*
     - Preventive Medical Services (99381-99385, 99391-99395)
     - Immunizations
     - Developmental Tests (96110, 96111)
     - Objective Hearing Tests (92551)
     - Objective Vision Tests (99173)

   ** The Medical Assistance Program will handle recoveries from the other insurances for these services. Do not bill the MA recipient for any co-pay or deductible associated with other insurance policies.*
5. Use '11' as the place of service code (block 24B) for a doctor's office
6. Place the rendering provider's Medical Assistance number in Block 19
7. Place the billing provider's name and address in Block 33
8. Place the date in Block 31 after the word 'date'
9. Enter the 9-digit billing provider's MA provider in the lower right-hand section of Block 33 after 'GRP#'
10. Mail completed CMS 1500 forms to:

    State of Maryland
    Department of Health and Mental Hygiene
    Program Systems and Operations Administration
    P.O. Box 1935
    Baltimore, MD 21203-1935

Section 6 Billing and Encounter Data Reporting

An original CMS 1500 form is **RED**. Typed or computer generated forms can be scanned thus improving turn-around time and payment. Reproductions of the CMS 1500 and those completed by hand may take longer as they must be manually keyed. The CMS 1500 forms may be purchased through the American Medical Association, Government Printing Office or other major printing companies.

Submitting Electronic Claims

HIPAA mandates the standardization of Electronic Data Interchange formats for health care data transmission, including claims, remittance, eligibility, and claims status inquires. HIPAA regulations have replaced the electronic CMS 1500 and UB92 claim formats with ANSI ASC X12N 837 Transactions, version 4010A. In order to submit electronic claims directly or through a billing service, a provider must have a signed *Submitter Identification Form* and *Trading Partner Agreement* on file. Obtain information about the electronic transactions at: **www.dhmh.state.md.us/hipaa/transandcodesets**.

Contact the **Systems Administrator at 410-767-5863** to obtain an application and transmittal code unique to each provider number. Trading Partners who plan to submit electronic transmissions directly to the Program must test for HIPAA compliance before they can transmit claims for payment. Access information about free testing at: **www.dhmh.state.md.us/hipaa/testinstruct**.

In accordance with HIPAA, *Remittance Advice and Claims Status* information will soon be available electronically. In the interim, you will continue to receive remittance advice by mail. For claims status, continue to contact **Provider Relations at 410-767-5503 or 1-800-445-1159**, or **fax at 410-333-7118**, or write:

Provider Relations
P.O. Box 2281
Baltimore, MD 21201

Providers sometimes receive payment vouchers that include payment for services billed in error by the provider or keypunched to the wrong provider number. If this occurs obtain an *Adjustment Request Form (DHMH 4518A)* by calling **Operations Administration at 410-767-5346** or writing to the address below. Send a copy of your Remittance Advice with the patient's name highlighted and the *Adjustment Request Form* to:

Operations Administration
P.O. Box 13045
Baltimore, MD 21203