MARYLAND MEDICAID CMS-1500 PAPER BILLING INSTRUCTIONS

A Comprehensive Guide Focusing on Maryland Medicaid Billing Procedures and Other Useful Information

Updated July 2026

Maryland Department of Health
Medicaid Program

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I. GENERAL INFORMATION

A. INTRODUCTION

This manual was prepared to provide proper billing procedures and instructions for Maryland Medicaid professional providers who bill paper claims to Fee for Service (FFS) using the CMS-1500 form. This includes, for example, Certified Nurse Midwives, Certified Nurse Practitioners, Certified Registered Nurse, Anesthetists, Free-Standing Clinics, Physicians, Podiatrists and DME/DMS providers.

The Medical Assistance Program has made numerous revisions to the billing procedures for all Medicaid Programs in order to adhere to the standards created under the Health Insurance Portability and Accountability Act (HIPAA). As a result of the requirement for standardization of code sets and forms, Maryland Medicaid has replaced all local procedure codes to nationally accepted codes. This includes standardization in the way providers transmit claims electronically.

B. HIPAA

The Administrative Simplification provisions of HIPAA require that health plans, including private, commercial, Medicaid and Medicare, healthcare clearinghouses and healthcare providers use standard electronic health transactions. 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. HCPCS is the specified code set for procedures and services. Additional information on HIPAA can be obtained from the State of Maryland website**.**

C. NATIONAL PROVIDER IDENTIFIER (NPI)

NPI is a HIPAA mandate requiring a standard unique identifier for health care providers. Providers must use this unique 10-digit identifier on all electronic transactions. When billing on paper, this unique number and the provider's 9-digit Medicaid provider number will be required in order to be reimbursed appropriately. Details about placement of the NPI and the Medicaid provider number are contained within the block-to-block information beginning on page 10.

II. HEALTHCHOICE

In June 1997, Maryland Medical Assistance began HealthChoice, the mandatory Medicaid Managed Care Program. HealthChoice operates under the authority of a waiver under Section 1115 of the Social Security Act. Medical Assistance pays capitation to Managed Care Organizations (MCOs) to provide care for approximately 86% of all Maryland Medical Assistance participants. This care includes provision, coordination of healthcare, and fiscal management of Medical Assistance benefits for these participants.

Information regarding recipient eligibility or MCO linkages should be obtained using the Eligibility Verification System (EVS) at **1-866-710-1447**. In order to use this system, you must have an active Medical Assistance provider number.

Providers wishing to participate with the MCO program must contact the MCOs directly. If you are having problems with any of the MCOs, please contact the HealthChoice Helpline at 1-800-766-8692. For Medicaid participants and services excluded from HealthChoice, see below.

Participant Protection

MDH understands the importance of protecting the participant's choice of MCOs under this program. Providers who want to provide Medicaid services may notify their Medicaid patients of the MCOs which they have joined or intend to join. *However, providers must disclose the names of all MCOs in which they expect to participate under HealthChoice and may not steer a recipient to a particular MCO by furnishing opinions or unbalanced information about networks.*

In order to communicate HealthChoice information, it is imperative that MDH have current addresses of participants. Providers are in a unique position to inform participants of the importance of passing on any new address information to MDH. When possible, please inform participants that they *must* give their correct address to their Department of Human Services. If participants receive SSI, they will need to change their address with the Social Security office.

A. PAYMENTS TO MANAGED CARE ORGANIZATIONS

Participants are linked by their MCO to a primary care physician or clinic. All MCO-enrolled participants are provided an identification card by their respective MCO. As a result, participants must obtain all services except services excluded (see page 4 for a list of excluded services) through their MCO. The recipient's primary care physician or clinic will give referrals for specialty care.

If you are not part of an MCO, and a recipient identified by EVS as an MCO recipient seeks services from you for which an MCO is responsible, you may contact that MCO to determine if it will approve payment for rendered services. Otherwise, the MCO has no obligation to reimburse you except in the case of providing routine family planning services, or in some instances reimbursement for pregnancy-related services.

NOTE: If the required services are emergency services, you may provide the appropriate services and expect to be reimbursed by the MCO upon billing the MCO directly. If you provide non- emergency services without MCO authorization, Medical Assistance will not reimburse you.

B. MCO EXCLUDED PARTICIPANTS AND SERVICES

Participants

Some Medicaid participants are excluded from HealthChoice and will continue with fee-for-service Medicaid. Those participants are:

- Those participants who are dually eligible for *Medicare and Medicaid*
- Those participants who are *institutionalized* in nursing homes, Chronic Hospitals, Institutions for Mental Diseases (IMDs) or Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
- Individuals who are eligible for Medical Assistance for a *short period of time*
- Those participants in the *Rare and Expensive Case Management* program for children who are medically fragile; and
- Persons receiving family planning services through the *Family Planning Waiver.*

Services (Fee for Service)

The MCOs are responsible for providing all Medicaid covered services **excluding the following,** which are paid fee-for-service by Medicaid:

- ***Abortion Services*** – MCOs are responsible for related services performed as part of a medical evaluation prior to the actual abortion.
- ***Aids Drug Therapies*** - Limited to Protease Inhibitors, Non-nucleoside Reverse Transcriptase Inhibitors and viral load testing.
- ***Dental Services.*** The Maryland Healthy Smiles Dental Program (MHSDP) provides dental care to all eligible Medicaid members. Medicaid covers a wide range of dental services. A benefits management company operates the program for Medicaid. For more information, call 855-934-9812.
- ***Healthy Start Case Management Services***
- ***IEP/IFSP*** - Individual Education Plan (IEP) or Individual Family Services Plan (IFSP). Medically necessary services that are documented on the IEP or IFSP when delivered in schools or by Children's Medical Services community based providers.
- ***Medical Day Care Services***
- ***Nursing Home/Long Term Care Facility Services*** - After the first 90 consecutive days of care.
- ***Personal Care Services***
- ***Rare & Expensive Case Management Services (REM)*** - Participants are eligible based on one of the diagnoses listed in COMAR 10.09.69. participants receive all State Plan Medicaid
- services on a fee-for-service basis.
- ***Specialty Behavioral Health Services*** - Including inpatient admissions to Institutions for Mental Disease (IMD), and Resident Treatment Centers (RTC). These services are payable through Maryland's Behavioral Health ASO. *For information, call* ***1-800-888-1965****.*
- ***Stop Loss Case Management (SLM)*** - A participant in an MCO which does not self insure can become eligible for the Stop Loss Case Management Program when his or her paid inpatient hospital services exceed a certain point. At that point, the Program will pay 90% of inpatient charges, while the MCO pays the remainder. Once SLM eligibility is in effect, the recipient is also eligible to receive case management and additional services available through the REM Program.
- ***Transportation Services*** – MCOs may be responsible for transportation services that are not covered by fee-for-service Medicaid.

C. SELF-REFERRAL SERVICES

Self-referral services are defined in the HealthChoice regulations as health care services for which under specified circumstances the MCO is required to pay without any requirement of referral or authorization by the primary care provider (PCP) or MCO when the enrollee accesses the services through a provider other than the enrollee's PCP.

The following services must be reimbursed by the MCO without a referral:

- Child With Pre-Existing Medical Condition - Medical Services
- Child In State-Supervised Care - Initial Medical Exam
- Emergency Services
- Family Planning Services
- HIV/AIDS Annual Diagnostic and Evaluation Service Visit
- Newborn's Initial Medical Examination In A Hospital
- Pregnancy-Related Services Initiated Prior To MCO Enrollment
- Prenatal, Intrapartum, and Postpartum Services Performed at a Free-Standing Birth Center
- Renal Dialysis Services Provided In A Medicare Certified Facility
- School-Based Health Center Services
- Substance Abuse Assessment

For additional information regarding the above self-referral services, contact the Division of HealthChoice Community Liaison and Care Coordination at 410-767-6750/6859.

III. BILLING

Providers should also contact the MCOs for billing regulations and instructions related to self-referral services. Claims for excluded services and fee-for-service should be submitted to:

Maryland Medical Assistance
Division of Claims Services
P.O. Box 1935
Baltimore, MD 21203.

A. GENERAL INSTRUCTIONS

Before providing services to a Maryland Medicaid recipient make sure that:

- Your enrollment as a Medical Assistance provider is effective on the date of service;
- Your patient is eligible on the date of service. **Always** verify recipient's eligibility using EVS (S*ee instructions on page 8)*
- You determine if the recipient is an MCO. If so, bill the MCO for services rendered;

- You determine if the recipient has other insurance;
- You have obtained preauthorization, if required; and
- You have determined accurate and correct coding.

B. BILLING INFORMATION

Providers must bill on the CMS-1500. Claims can be submitted in any quantity and at any time within the filing limitation.

Filing Statutes: Claims ***must*** be received within 12 months of the date of service. The following statutes are in addition to the initial claim submission.

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

NOTE: Timely filing will not be overridden for situations where the claims are being resubmitted every 60 days meaning continuous billing/resubmission that are resulting from or have been determined as a provider failing to correct the error(s) identified by the Program. If a claim is submitted and neither a payment nor a rejection is received within 90 days, the claim should be resubmitted. (Please allow 120 days for Medicare coinsurance claims before resubmitting.)

The Program **will not** accept computer-generated reports from the provider's office as proof of timely filing. The **only** documentation that will be accepted is a remittance advice, Medicare/Third-party EOB, IMA-81 (letter of retro-eligibility) and/or a returned date stamped claim from the Program.

Paper Claims Submission: Once a claim has been received, it will be processed in order of the date it was received. Invoices are processed on a weekly basis. Payments are issued weekly and mailed to the provider's pay-to address. Medicaid will accept paper claims only on the revised Form 1500, version 02/12.

All claims should be mailed to the following address:

Maryland Department of Health
Division of Claims Services
P.O Box 1935
Baltimore, MD 2120

Electronic Claims Submission: Providers may submit claims using the ANSI ASC X12N 837P format, version 005010X222A1. A signed Submitter Identification Form and Trading Partner Agreement must be submitted, as well as testing before transmitting such claims. Testing information can be found on the MDH website:

https://health.maryland.gov/mmcp/provider/Pages/edi.aspx

If you have any questions regarding HIPAA EDI enrollment and testing, please send an email to:

mdh.hipaaeditest@maryland.gov

Companion guides to assist providers for electronic transactions can be found on the MDH website:

https://health.maryland.gov/mmcp/provider/Pages/edi.aspx

eClaims: Direct billing is available through our eMedicaid website. This service will enable certain provider types, that bill on the CMS 1500, to submit their single claims electronically. Claims that require attachments cannot be submitted through this new feature. Claims will be processed the same week it is keyed and payment to follow the next week.

Providers are also able to submit Part B claims on the eMedicaid website with attachments.

To become an eClaim user, the administrator from the provider's office must register users by going to the eMedicaid website: www.emdhealthchoice.org

If you have questions regarding this new feature, how to register, or to determine if your provider type can submit eClaim, please email your questions to: mdh.emedicaidmd@maryland.gov

IV. ELIGIBILITY VERIFICATION SYSTEM (EVS)

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

Before providing services, you should request the participant's Medical Care Program identification card. If the participant does not have the card, you should request a Social Security number, which may be used to verify eligibility.

To verify online: https://encrypt.emdhealthchoice.org/emedicaid/

To verify via telephone:1-866-710-1447

For instructions on how to use, go to:

https://health.maryland.gov/mmcp/provider/Documents/evs/EVSIVR_Brochure_Jan2023.pdf

V. CMS-1500 BILLING INSTRUCTIONS

Providers must use the CMS-1500 form to bill the Program. Current CMS-1500 forms are available for download here:
https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms1188854
Instructions for the completion of each block of the CMS-1500 are provided in this section. See Section XVI - Appendix, page 62, for a reproduction of a CMS-1500 showing the reference numbers of Blocks. Blocks that refer to third party payers must be completed only if there is a third party payer **other than** Medicare or Medicaid.

The Medical Assistance Program is by law the **"payer of last resort"**. If a recipient is covered by other insurance or third party benefits such as Worker's Compensation, CHAMPUS or Blue Cross/Blue Shield, the provider must first bill the other insurance company before Medical Assistance will pay the claim.

PROPER COMPLETION OF CMS-1500

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

Block 1	Show all type(s) of health insurance applicable to this claim by checking the appropriate box(es).
Block 1a	INSURED'S ID NUMBER – Enter the patient's Medicare number if applicable. The patient's (participant's) 11-digit Maryland Medical Assistance number is required in Block 9a. – **Situational.**
Block 2	PATIENT"S NAME (Last Name, First Name, Middle Initial) – Enter the patient's (participant's) name as it appears on the Medical Assistance card.

Block 3	PATIENT'S BIRTH DATE/SEX – Enter the patient's (participant's) date of birth and sex. – **Optional.**
Block 4	INSURED'S NAME (Last Name, First Name, Middle Initial) – Enter the name of the person in whose name the third party coverage is listed, only when applicable. – **Optional.**
Block 5	PATIENT'S ADDRESS – Enter the patient's (participant's) complete mailing address with zip code and telephone number. – **Optional.**
Block 6	PATIENT'S RELATIONSHIP TO INSURED – Enter the appropriate relationship only when there is third party health insurance besides Medicare and Medicaid. – **Optional.**
Block 7	INSURED'S ADDRESS – When there is third party health insurance coverage besides Medicare and Medicaid, enter the insured's address and telephone number. – **Optional.**
Block 8	RESERVED FOR NUCC USE – **No entry required.**
Block 9	OTHER INSURED"S NAME – **No entry required.**
Block 9a	OTHER INSURED'S POLICY OR GROUP NUMBER – Enter the patient's (participant's) 11-digit Maryland Medical Assistance number exactly as it appears on the MA card. The MA number **must** appear in this Block regardless of whether or not a participant has other insurance. Medical Assistance eligibility should be verified on each date of service by calling EVS. EVS is operational 24 hours a day, 365 days a year at the following number: 1-866-710-1447- **Required.**
Block 9b	RESERVED FOR NUCC USE – **No entry required.**
Block 9c	RESERVED FOR NUCC USE – **No entry required.**
Block 9d	INSURANCE PLAN OR PROGRAM NAME – Enter the insured's group name and group number only when there is third party health insurance coverage besides Medicare and Medicaid. – **Optional.**
Block 10a thru 10c	IS PATIENT"S CONDITION RELATED TO - Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Item 24, if this information is known. If not known, leave blank. – **Optional.**
Block 10d	CLAIM CODES –This field should **ONLY BE USED for abortions and abortion related services, otherwise leave blank.**

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

CODE	REJECTION REASONS
K	Services Not Covered
L	Coverage Lapsed
M	Coverage Not in Effect on Service Date
N	Individual Not Covered
Q	Claim Not Filed Timely (Requires documentation, e.g., a copy of rejection from the insurance company.)
R	No Response from Carrier Within 120 Days of Claim Submission (Requires documentation e.g., a statement indicating a claim submission but no response.)
S	Other Rejection Reason Not Defined Above (Requires documentation, e.g., a statement on the claim indicating that payment was applied to the deductible.) *NOTE: CMS 1500 claims reporting Rejection Reason S require completion and attachment of the Maryland Medicaid CMS 1500 Box 11 Rejection Reason S Provider Attestation Form

Block 11a INSURED'S DATE OF BIRTH – **Not**

Required. Block 11b OTHER CLAIM ID –**Not Required.**

Block 11c INSURANCE PLAN OR PROGRAM NAME – **Not Required.**

Block 11d IS THERE ANOTHER BENEFIT PLAN?- **Not required.**

Block 12 PATIENT'S OR AUTHORIZED PERSON"S SIGNATURE – **Not Required.**

Block 13 INSURED'S OR AUTHORIZED PERSON"S SIGNATURE – **Not Required.**

Block 14 DATE OF CURRENT ILLNESS, INJURY, PREGNANCY – **Not Required.**

Block 15 OTHER DATE – **Not Required.**

Block 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION – **Not Required.**

Block 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE –
Note: Completion of 17-17b is only required for Lab and Other Diagnostic Services.
Completion is optional if a valid Medical Assistance individual practitioner

identification number is entered in Block #17a. To complete, enter the full name of the ordering practitioner. Do not submit an invoice unless there is an order on file that verifies the identity of the ordering practitioner. – **Situational.**

Block 17a (gray shaded area) ID NUMBER OF REFERRING PHYSICIAN – Enter the ID Qualifier – **1D (Medicaid Provider Number)** followed by the provider's 9-digit Medicaid Provider Number. – **Situational.**

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

Block 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES – **Not Required.**

Block 19 ADDITIONAL CLAIM INFORMATION – **Not Required.**

Block 20 OUTSIDE LAB – **Optional.**

Block 21 DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY - Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Enter the indicator between the vertical, dotted lines in the upper right- hand portion of the field.

Enter the 5-digit ICD-10-CM diagnosis code related to the procedures, services, or supplies listed in Block #24e. List the primary diagnosis on Line A, with any subsequent codes to be entered on Lines B thru H (the highest level of specificity in priority order). Additional diagnoses are optional and may be listed on Lines I thru L. – **Required.**

Block 22 MEDICAID RESUBMISSION – **Not Required.**

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

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

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

ME Milligram

Example: NDC/Quantity Reporting

24A DATE(S) OF SERVICE FROM: MM DD YY	TO: MM DD YY	D. PROCEDURES, SERVICES CPT/HCPCS	G. DAYS OR UNITS
N400009737604ML1 (SHADED AREA)			
01 01 08	01 01 08	J1055	1

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

NOTE: *These instructions detail only those data elements for Medical Assistance (MA) paper claim billing. For electronic billing, please refer to the Maryland Medicaid 837-P Electronic Companion Guide which can be found on our website: https://health.maryland.gov/mmcp/provider/Pages/edi.aspx*

Block 24A DATE(S) OF SERVICE – Enter each separate date of service as a 6-digit numeric date (e.g. June 1, 2023 would be 06/01/23) under the **FROM** heading. Leave the space under the **TO** heading blank. Each date of service on which a service was rendered must be listed on a separate line. Ranges of dates **are not** accepted on this form. – **Required.**

Block 24B PLACE OF SERVICE – For each date of service, enter the appropriate 2-digit place of service code listed below to describe the site. – **Required.**

Code	Location
01	Pharmacy
02	Telehealth Provided Other than in Patient's Home
03	School
10	Telehealth Provided in Patient's Home
11	Office
12	Patient's Residence
15	Mobile Unit
19	Off Campus-Outpatient Hospital
20	Urgent Care
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Ctr.
25	Birthing Ctr
26	Military Treatment Ctr
31	Skilled Nursing Facility
32	Nursing Home
33	Custodial Care
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
50	Federally Qualified Health Ctr.
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Ctr.
56	Psychiatric Residential Treatment Ctr.
57	Non-Residential Substance Abuse Facility
61	Comprehensive Inpatient Rehabilitation Ctr.
62	Comprehensive Outpatient Rehab. Ctr
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

81 Independent Laboratory 99 Other Unlisted Facility

Block 24C EMG – **Leave Blank**.

Block 24D PROCEDURES, SERVICES OR SUPPLIES – Enter the five-character procedure code that describes the service provided and two-character modifier, if required. See Professional Services Provider Manual for use of modifiers. Physician Fee Schedule can be found at: https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx – **Required.**

Block 24E DIAGNOSIS POINTER – Enter a single or combination of diagnosis items (A thru H) from Block #21 above for each line on the invoice. – **Required.**

NOTE: *The Program only recognizes up to eight (8) pointers A-H.*

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

Block 24G DAYS OR UNITS – Enter the total number of units of service for each procedure. The number of units must be for a single visit or day. Multiple, identical services rendered on different days should be billed on separate lines. – **Required.**

NOTE: *Multiple, identical services for medical, radiological, or pathological services, within the CPT code range of 70000-89999, rendered on the same day, must be combined and entered on one line.*

Block 24H EPSDT FAMILY PLAN – **Leave Blank.**

Block 24I ID. QUAL. – Enter the ID Qualifier **1D (Medicaid Provider Number)** – **Required.**

NOTE: *This two-digit qualifier identifies the non-NPI number followed by the ID number. When required to indicate the provider's 9-digit MA provider number, the ID Qualifier **1D** must precede this number.*

Block 24J (gray shaded area) RENDERING PROVIDER ID # – Enter the 9-digit MA provider number of the practitioner rendering the service. In some instances, the rendering number may be the same as the payee provider number in Block #33. Enter the rendering provider's **NPI** in the **unshaded area.** – **Required.**

Block 25 FEDERAL TAX ID NUMBER – **Optional.**

Block 26 PATIENT'S ACCOUNT NUMBER – An alphabetic, alpha-numeric, or numeric patient account identifier (up to 13 characters) used by the provider's office can be entered. If recipient's MA number is incorrect, this number will be recorded on the Remittance Advice. – **Optional.**

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

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

Block 28 TOTAL CHARGE – Enter the sum of the charges shown on all lines of Block #24F of the invoice. – **Required.**

Block 29 AMOUNT PAID – Enter the amount of any collections received from any third party payer, **EXCEPT Medicare**. If the recipient has third party insurance and the claim has been rejected, the appropriate rejection code shall be placed in Block # 11. – **Situational.**

NOTE: *The Program does not consider Medicare as a third party payer.*

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

Block 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS – **Optional.**

NOTE: *The date of submission must be entered here in order for the claim to be reimbursed.*

Block 32 SERVICE FACILITY LOCATION INFORMATION – Complete only if billing for medical laboratory services referred to another laboratory or the facility where trauma services were rendered. Enter the name and address of facility. – **Situational**

NOTE: *Matching Locations: If the service facility (Item 32) is the same physical location as the billing provider (Item 33), Item 32a must be blank. According to standard billing guidelines, a Service Facility Location NPI should only be reported in Item 32a when the service was rendered at a different location than the billing provider's address.*

Block 32a NPI – Enter facility's NPI number. – **Required.**

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

NOTE: *The Program will not pay a referring laboratory for medical laboratory services referred to a reference laboratory that is not enrolled. The referring laboratory also agrees not to bill the participant for medical laboratory services referred to a nonparticipating reference laboratory.*

Block 33 BILLING PROVIDER INFO & PH# - Enter the name, complete street address, city, state, and zip code of the provider. This should be the address to which claims may be returned. – **Required.**

Block 33a NPI - Enter the NPI number of the billing provider in Block # 33. Errors or omissions of this number will result in non-payment of claims. – **Required.**

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

NOTE: *It is the provider's responsibility to promptly report all changes of name, pay to address, correspondence address, practice locations, tax identification number, or certification to the Provider Enrollment Unit at 1-844-463-7768.*
https://health.maryland.gov/mmcp/provider/Pages/enrollment.aspx

A. THIRD PARTY BILLING

The Medical Assistance Program is by law the "payer of last resort". Therefore, if a participant is covered by insurance or other third-party benefits **(such as Worker's Compensation, CHAMPUS or Blue Cross/Blue Shield)**, the provider must seek payment from that source. Before Medical Assistance can pay, you must bill all third parties which might help to pay for the services you provided. If the third party insurance makes a payment, we will pay the provider up to Medicaid's allowed amount. If the third party insurance pays more than Medicaid's allowed amount, we will make no additional payment to the claim.

If Medical Assistance has a record of other coverage for your patient and if you have not billed the other insurance carrier, you must bill or contact the other carrier first except for ***prenatal care, well child care, and immunization services.*** If you do not bill the other carrier first, the Medical Assistance Program will deny your claim.

Step **Action**

1. Locate the potential payer's address and telephone number in the supplemental third carrier listing. If your Medical Assistance claim was denied because of other insurance, the address will also appear on the remittance advice.

2. Contact the insurance carrier or other payer by telephone, if possible

    - If the coverage has expired or is not applicable, ask the company to send you a denial letter and ask that a cancellation date be provided if in fact the coverage is canceled. If they refuse, write down the contact person's name.

    - If the coverage does apply, ask if preauthorization is required

3. Submit the claim to Medical Assistance. Attach the appropriate supporting documentation, If necessary, i.e., copy of the other carrier's remittance or denial or a summary of your collection efforts

    - If payment is made by the other payer, indicate the other payment on block 29 of the claim form

    - If you have not received payment or a rejection of liability from the health insurance carrier within 120 days of submission of the claim to the carrier, You may submit the claim to the Medical Assistance Program for payment. Follow the block by block billing instructions on page 10 to complete the claim for the appropriate rejection code in block 12.

    - If you have billed a claim for services rendered to a medical support enforcement beneficiary with third party insurance and have not received a response from the third party payer within 100 days of the date of service after billing the third party, you may submit the claim to the Program for

payment. Providers must use rejection reason S in box 11 and attach a completed Maryland Medicaid CMS 1500 Box 11 Rejection Reason S Provider Attestation Form, alongside any other required supporting documentation.

4. Notify the Division of Medical Assistance Recoveries when you receive a denial of third party responsibility due to policy coverage termination by calling 410-767-1773 or 410-767-1771, Toll Free: 844-TPLINSUR / 844-787-5467.

If payment of a claim is made by both the Medical Assistance Program and a third party source, the provider must refund to the Medical Assistance Program either the amount paid by the Medical Assistance Program or the third party, whichever is less. This refund is due within 60 days of receipt of payment.

All refund checks should be payable to the Division of Medical Assistance Recoveries and mailed to:

Division of Medical Assistance Recoveries
P.O. Box 13045
Baltimore, MD 21203

B. MEDICARE CROSSOVER CLAIMS

The Maryland Medicaid Program follows the Medicare "lesser of payment methodology" and will not pay Part B Medicare coinsurance or copayments, on claims where the Medicare payment exceeds the Medicaid fee schedule. Therefore, if Medicare pays the claim equal to or greater than the Medicaid fee schedule, Medicaid will make no additional payment. The remittance advice will show a $0.00 dollar payment under the **"paid"** column reflecting that Medicare paid more on the claim than the allowed amount on Medicaid's fee schedule. If Medicare pays the claim at an amount less than the Medicaid fee schedule, Medicaid will pay all or part of the coinsurance to bring the total payment to the provider equal to the Medicaid fee schedule. See examples below or refer to Transmittal 79, which can be found at:

Example 1:
Medicaid allowable = $103.55
Medicare paid = $108.91
Reimbursement to the provider = $0.00
(Medicaid paid more on the claim than the allowed amount in the Maryland Medicaid fee schedule. Medicaid will not make any additional payments.)

Example 2:
Medicaid allowable = $108.91
Medicare paid = $103.55
Reimbursement to the provider = $5.36
(Medicaid allowed more on the claim than what Medicare paid, which results in the provider receiving the difference to meet the allowed amount in the Maryland Medicaid fee schedule.)

This methodology will ***not*** *be applied when:*

- The amount submitted to Medicaid is for the deductible
- The service is not covered by Medicaid
- The service is a mental health service (applies to specific codes)
- The service is billed using a HCPCS beginning with a letter from A to W
- CPT codes priced by report
- The service is billed using CPT codes 00100 to 01999

Please remember that Medicaid providers are prohibited from balance billing participants. In order for claims to be accurately paid, your NPI number must be on our Medicaid system. To verify your NPI number, contact Provider Enrollment at 1-844-463-7768.

PROCEDURES FOR SUBMITTING HARD COPY MEDICARE CLAIMS

Billing a CMS-1500 with a Medicare EOMB:

On the Medicare EOMB, ***each individual claim*** is generally designated by two horizontal lines. Therefore, you should complete ***one*** CMS-1500 form per set of horizontal lines.

- When billing Medical Assistance, the information on the CMS-1500 must be identical to the information that is ***between the two horizontal lines*** on the Medicare EOMB.
    - Dates of service ***must*** match
    - Procedure codes ***must*** match
    - Amount(s) on line #24F of the CMS-1500 ***must*** match the "amount billed" on the EOMB.

- Claims that have ***more*** than six lines, write ***"cont."*** in Block #28 of each CMS-1500 claim and total all the lines on the ***last*** CMS-1500 claim.

- When submitting your Medicare claims for payment, the writing should be legible. In addition, when attaching a copy of the Medicare EOMB make sure it is clear and that the entire EOMB, including the information on the top and the glossary is included on the copy. Write in bold letters **"Medicare EOMB"** on each claim. In order for MA to make the necessary payments, the CMS-1500 and the Medicare EOMB must be submitted. Claims should be sent to the original claims address:

Maryland Medical Assistance
Division of Claims Services
P.O. Box 1935
Baltimore, MD 21203

CLAIM SUBMISSION

Claims submitted via electronic media are processed more quickly and accurately. For further information on how to bill electronically, please visit https://health.maryland.gov/mmcp/provider/Pages/edi.aspx, or contact the Electronic Billing Unit at mdh.hipaaeditest@maryland.gov. If you have problems with your electronic claims submission, please send inquiries to mdh.ediops@maryland.gov .

If you choose to submit paper claims, please use the following checklist before submitting your claims to the Medical Assistance Program for reimbursement.

CHECKLIST

- Is your copy legible? Did you ***type or print*** your form? Although not required, typing the form will speed up the process.
- Did you follow the ***Billing Instructions****?*
- Did you enter your ***provider name and number***? Without this information payment will not be made correctly.
- Are ***attachments*** required? Claims cannot be paid without required attachments.
- Did you enter your ***preauthorization number*** for services, which require prior approval? Without this number payment will be denied.
- Do you have the correct P.O. Box Number for submitting your claims? Correct address for submission is listed on page 6 of this manual.
- Do you have any questions not answered in this handout? If so, please contact the Provider Relations Unit at 410-767-5503 or 800-445-1159 and select option 2 for assistance.

C. CLAIM TROUBLESHOOTING

This section provides information about the most common billing errors encountered when providers submit claims to the Medical Assistance Program. Preventing errors on the claim is the most efficient way to ensure that your claims are paid in a timely manner.

Each rejected claim will be listed on your remittance advice along with an Explanation of Benefits (EOB) code that provides the precise reason a specific claim was denied. EOB codes are very specific to individual claims and provide you with detailed information about the claim. The information provided below is intended to supplement those descriptions and provide you with a summary description of reasons your claim may have been denied.

Claims commonly reject for the following reasons:

1. ***The appropriate provider and/or recipient identification is missing or inaccurate.***

   - ✓ Verify that your NPI and 9-digit Medical Assistance provider numbers are entered in Blocks #33a/b. The ID Qualifier **1D** must precede the 9-digit Medical Assistance provider number. **Do not** use your PIN or tax identification number.

   - ✓ Verify that a valid NPI and 9-digit Medical Assistance provider number for the requesting, referring or attending provider are entered in the Blocks #17a/b and each provider is correctly identified. The ID Qualifier 1D must precede the 9-digit Medical Assistance provider number in block 17a.

     Note: Completion of 17-17b is only required for IEP/IFSP, Lab, and Other Diagnostic Services.

   - ✓ Verify that the NPI and 9-digit rendering Medical Assistance provider number you entered in Block #24j. is in fact, a rendering provider. The ID Qualifier **1D** must precede the 9-digit Medical Assistance provider number. If you enter a group NPI and provider number in the block for the rendering provider, the claim will deny because group provider numbers cannot be used as rendering provider numbers.

   - ✓ When billing for pre authorized procedures, verify that the 9-digit provider number entered on the claim form is the same 9-digit provider number that was authorized to provide the services.

   - ✓ Verify that the recipient's 11-digit Medical Assistance identification number is entered in the Block #9a.

   - ✓ Verify that the participant's name is entered in Block #2, last name first.

   - ✓ When billing for pre authorized procedures, verify that the 11-digit participant number entered on the claim form is the same 11-digit participant number that was authorized to receive the services.

- ✓ Verify that you did not use the mother's 11-digit number if you are billing for services provided to a child. Age and procedure codes will ensure that such claims are automatically rejected.

2. ***Provider and/or recipient eligibility was not established on the dates of services covered by the claim.***

   - ✓ Verify that you did not bill for services provided prior to or after your provider enrollment dates.

   - ✓ Verify that you entered the correct dates of service in the Block #24a of the claim form. You **must** call EVS on the day you render service to determine if the recipient is eligible on that date. If you have done this and your claim is denied because the recipient is ineligible, double-check that you entered the correct dates of service.

   - ✓ Verify that the participant is not part of the Medical Assistance HealthChoice Program. If you determine that the participant is in HealthChoice, contact the appropriate Managed Care Organization (MCO).

   - ✓ Verify that the participant is not covered by Medicare. If you determine that the participant is covered by Medicare, bill the appropriate Medicare carrier.

3. ***Preauthorization is required.***

   - ✓ Certain procedures require preauthorization. If you obtain preauthorization, verify that you entered the number correctly in Block #23 on the claim. If you did not obtain preauthorization, remove the unauthorized procedure from the claim and resubmit the claim to receive payment for the procedures that do not require preauthorization.

   - ✓ When billing for pre authorized procedures, verify that the dates of service entered on the claim are the same dates of service that were authorized.

4. ***The medical services are not covered or authorized for the provider and/or recipient.***

   - ✓ There are limits to the number of units that can be billed for certain services. Verify that you entered the correct number of units on the claim form.

   - ✓ A valid 2-digit place of service code is required. Please refer to the Place of Service List on page 15 in this manual.

   - ✓ When billing for pre authorized procedures, verify that the units entered on the claim form are not more units then were authorized.

- ✓ If you receive a 110 denial code, some tests are frequently performed as groups or combinations and must be billed as such. Verify the procedure codes and modifiers that were entered on the claim form and determine if they should have been billed as a group.

- ✓ Claims will be denied if the procedure cannot be performed on the participant indicated because of gender, age, prior procedure or other medical criteria conflicts. Verify that you entered the correct 11-digit participant identification number, procedure code and modifier on the claim form.

- ✓ Verify that the billed services are covered for the recipient's coverage type. Covered services vary by program type. For example, some participants have coverage only for family planning services. If you bill the Program for procedures that are not for family planning, these are considered non-covered services and the Program **will not** pay you. Refer to regulations for each program type to determine the covered services for that program.

- ✓ Some procedures cannot be billed with certain place of service codes. Verify that you entered the correct procedure and place of service codes in the appropriate block on the claim form.

5. ***The claim is a duplicate, has previously been paid or should be paid by another party.***

   - ✓ MMIS-II edits all claims to search for duplications and overlaps by providers. Verify that you have not previously submitted the claim.

   - ✓ If the Program has determined that a recipient has third party coverage that will pay for medical services, the claim will be denied. Submit the claim to the third-party payer first.

   - ✓ If a participant is enrolled in an MCO, you must bill that organization for services rendered. Verify that the participant's 11-digit MA number is entered correctly on the claim form.

6. ***Required attachments are not included.***

   - ✓ For some procedures there is no established fee, and the claim must be manually priced. These claims require that a report be attached. Verify that you have completed such a report, attach it to the claim form and then resubmit the claim.

Lastly, some errors occur simply because the data entry operators have incorrectly keyed or were unable to read data on the claim. In order to avoid errors when a claim is scanned, please ensure that this information is either typed or printed clearly. When a claim is denied, always compare data from the remittance advice with the file copy of your claim. If the claim denied because of a keying or scanning error, resubmit the claim.

D. HOW TO FILE AN ADJUSTMENT REQUEST

If you have been paid, but paid incorrectly for a claim or received payment from a third party after Medical Assistance has made payment, you must complete and submit an Adjustment Request Form (MDH 4518A) to correct the payment. See Section XVIII-Appendix, page 63 for an example of the MDH 4518A.

If an incorrect payment was due to a keying error made by Medical Assistance, or you billed the incorrect number of units, you must complete an Adjustment Request Form following the directions on the back of the form.

When completing the Adjustment Form, do not bill only for remaining unpaid amounts or units, bill for the entire amount(s).

> **Example:** You submitted and received payment for three units, but you should have billed for five units. **Do not** bill for the remaining two units; bill for the full five units.
>
> **Total Refunds –** If you receive an incorrect payment, return the check issued by the Medical Assistance Program only when every claim payment listed on the remittance advice is incorrect, i.e., none of the participants listed are your patients. When this occurs, return with a copy of the remittance advice and the check with a complete Adjustment Request Form to the address on the bottom of the form.
>
> **Partial Refunds –** If you receive remittance advice, which lists some correct payments and some incorrect payments, do not return the Medical Assistance Program check. Deposit the check and file an Adjustment Request Form for each individual claim paid incorrectly.
>
> **NOTE:** For overpayments or refunds, the provider may issue and submit one check to cover more than one Adjustment Request Form.
>
> Before mailing Adjustment Request Forms, be sure to attach any supporting documentation such as remittance advices and CMS-1500 claim forms. Adjustment Request Forms should be mailed to:
>
> Medical Assistance Adjustment Unit
> P.O. Box 13045
> Baltimore, MD 21203

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

Medical Assistance Payments

You must accept payment from Medical Assistance as *payment in full* for a covered service.

You ***cannot*** bill a Medical Assistance recipient under the following circumstances:

1. For a covered service for which you have billed Medical Assistance;
2. When you bill Medical Assistance for a covered service and the claim denies because of

a billing error(s) on your part such as:

- wrong procedure and diagnosis codes,
- lack of preauthorization,
- invalid consent forms,
- unattached necessary documentation,
- incorrectly completed claim form,
- filing after the time limitations, or
- other provider errors.

3. When Medical Assistance denies your claim and Medicare or another third party has paid up to or exceeded what Medical Assistance would have paid;
4. For the difference in your charges and the amount Medical Assistance has paid;
5. For transferring the participant's medical records to another health care provider or
6. When services were determined to not be medically necessary.

You ***can*** only bill the participant under the following circumstances:

1. If the service provided is not covered by Medical Assistance and you have notified the participant prior to providing the service that the service is not covered; or
2. If the participant is not eligible for Medical Assistance on the date you provided the service(s)

VI. FRAUD AND ABUSE

It is illegal to submit reimbursement requests for the following:

- Amounts greater than your usual and customary charge for the service. If you have more than one charge for a service, the amount billed to the Maryland Medical Assistance Program should be the lowest amount billed to any person, insurer, health alliance or other payer
- If a service is not provided, or is not provided in the manner described on the claim. *You must accurately describe the service performed, correctly define the time and place where the service was provided and identify the professional status of the person providing the service.*
- Any procedures other than the ones you actually provided to an eligible recipient.
- Multiple, individually described or coded procedures if there is a comprehensive procedure that could be used to describe the group of services provided.
- Unnecessary, inappropriate, non-covered or harmful services, whether or not you actually provided the service.
- Items or services that are performed without the required referrals or pre-authorizations.
- Services for which you have received full payment by another insurer or third party.

You are required to refund all overpayments received from the Medical Assistance Program within 30 days. Providers must not rely on Department requests for any repayment of such overpayments. Retention of any overpayments is also illegal.

Fraud and Abuse concerns can be submitted anonymously to the Fraud and Abuse Hotline.

https://health.maryland.gov/oig/Pages/Report_Fraud.aspx

Sanctions Against Providers – General

If the Program determines that a provider, any agent or employee of the provider or any person with an ownership interest in the provider or related party of the provider has failed to comply with applicable federal or State laws or regulations, the Program may initiate one or more of the following actions against the responsible party:

1. Suspension from the Program.
2. Withholding of payment by the Program.
3. Removal from the Program.
4. Disqualification from future participation in the Program, either as a provider or as a person providing services for which Program payment will be claimed.
5. Referral to the Medicaid Fraud Control Unit for investigation and possible prosecution. The Medical Assistance Program will give reasonable written notice of its intention to impose any of the previously noted sanctions against a provider. The notice will state the effective date and the reasons for the action and will advise the provider of any right to appeal.

If the U.S. Department of Health and Human Services suspends or removes a provider from Medicare

enrollment, the Medical Assistance Program will take similar action against the provider.

A provider who is suspended or removed from the Medical Assistance Program or who voluntarily withdraws from the Program must inform participants *before* rendering services that he/she is no longer a Medical Assistance provider, and the recipient is therefore financially responsible for the services.

Sanctions Against Providers – Specific

In addition to penalties arising from any criminal prosecution which may be brought against a provider, Medical Assistance may impose administrative sanctions on a provider should the provider defraud or abuse the Program.

Administrative sanctions include termination from the Medical Assistance Program, suspension from the Program or required participation in provider education. Examples of instances in which Medical Assistance may take administrative action are when a provider:

- Refuses to allow authorized auditors or investigators reasonably immediate access to records substantiating the provider's Medical Assistance billings

- Is not in compliance with the following:
    1. Maryland Statutes
    2. Federal and State rules and regulations
    3. Medical Assistance policy handbooks
    4. Medical Assistance provider agreement
    5. Maryland Administrative Code

- Furnishes a recipient goods or services that are determined to be:
    1. In excess of the participant's needs
    2. Harmful to the participant
    3. Of inferior quality
    4. Insufficient to meet the participant's needs

- Fails to provide necessary access to medical care for participants who are bound to the provider through MCOs, including:

    1. Not providing necessary preventive care and treatment in a reasonably timely manner,
    2. Failing to provide reasonable accessible and adequate 24-hour coverage for evaluation of emergency complaints,
    3. Discouraging a recipient from seeking medically necessary care,
    4. Failing to provide a timely referral to an accessible provider for medically necessary care and/or ancillary services, or
    5. Making a misleading statement of a material fact as to the participant's medical condition or need for referred or emergency care, either to the Program or to another provider.

- Provides misleading or false information to the Medical Assistance Program, or to its authorized representatives or delegates;
- Demands, bills or accepts payments from participants or others for services covered by

Medical Assistance;

- Has been indicted for, convicted of, or pled guilty to Program related offenses, or is suspended or terminated from the Medicare Program; or
- Does not have all required professional licensure and certifications necessary for the services he/she is performing.

VII. MARYLAND MEDICAID PROGRAM/PROVIDER SERVICES INFORMATION

A. EMERGENCY SERVICE TRANSPORTERS

When billing for Emergency Transport Services, use procedure code **A0427**.

Additional Instructions

Block #24B – Place of Service Code: 41
Block #24G – Units of Service: 1 (per trip)

If you have any questions concerning this Program, please contact the Transportation Policy Specialist at 410-767-7283.

B. EPSDT/HEALTHY KIDS

The Maryland Healthy Kids/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a comprehensive pediatric program to be billed only by those physicians, nurse practitioners and free-standing clinics who have been certified by the Program as Healthy Kids/EPSDT providers. These services are available to Medicaid participants from birth through 20 years of age on a fee-for-service basis including children enrolled in a Managed Care Organization (MCO).

Please refer to the Maryland Healthy Kids / EPSDT Provider Manual for more information:

If you have any questions about EPSDT services, call the Healthy Kids Program Staff Specialist at 410-767-1683 for expanded EPSDT services.

NEWBORN BILLING INSTRUCTIONS

Medicaid will automatically cover all infants born to women with MA coverage on the date of delivery through their first birthday; however, the Program cannot issue the newborn's Medicaid card until the hospital, caseworker or MCO enrolls the newborn via the online 1184 process on eMedicaid.

If Mom was enrolled in an MCO on the newborn's date of birth, then the newborn is automatically enrolled into mom's MCO as of the newborn's date of birth. The newborn must remain enrolled in the MCO for at least the first 90 days before any enrollment changes can be requested.

To assure continuity and coordination of care, a newborn coordinator is assigned to each MCO to handle newborn assignment in the MCOs. For a list of these newborn coordinators and an information grid on how to handle newborn problems, please visit our website at: *https://health.maryland.gov/mmcp/healthchoice/Pages/MCO-Newborn-Coordinator.aspx*

When billing for a newborn, always call EVS to verify that the mother was eligible on the baby's date of birth. If the mother was eligible, use the temporary newborn MA number that has been assigned. This number can be derived by replacing the last two numbers of

the mother's MA number with 01 (first child) or 02 (second child), etc., following the order of sequential births. It takes two to four weeks for the mother to receive the newborn's Medicaid card. For assistance with newborn eligibility, have the mother call 1-800-456-8900.

Providers should bill MA directly for children who are not enrolled with an MCO. If you provide any health care services to a recipient enrolled in an MCO, you must seek reimbursement from the MCO. Verify the recipient's enrollment with the MCO through EVS.

AUDIOLOGY

Maryland Medicaid's EPSDT Audiology Services Program requires the provider to specify the procedure code that describes the type of aid(s) (i.e. monaural, binaural, digital etc.) on all claims and preauthorization requests that are submitted to the Program. Bill one unit of service when using the procedure code describing "binaural" hearings aids. For more information check the EPSDT: Audiology Services Provider Manual.

NOTE: *Audiologists are not considered physician extenders under the Medicaid Program. These providers must be enrolled in the Program via an enrollment application and be assigned a provider number for billing purposes.*

If you have any questions regarding the coverage, policy or regulations for EPSDT: Audiology Services please contact Children's Services at 1-800-565-8190.

IEP/IFSP HEALTH RELATED SERVICES

The Maryland State Department of Education and the Maryland Department of Health (the Department) established an Interagency Medicaid Monitoring Team (IMMT) in 2000 to provide technical assistance and monitor the delivery of Individualized Education Program (IEP) and Individualized Family Service Plan (IFSP) services provided by local school systems (LSS), local lead agencies (LLA), and non-public schools. The goal of the IMMT is to facilitate and monitor compliance with COMAR 10.09.25, COMAR 10.09.36, COMAR 10.09.40, COMAR 10.09.50, and COMAR 10.09.52.

For details about the program and specific billing instructions, please refer to the IEP / IFSP Policy and Procedure Manual located here:

https://health.maryland.gov/mmcp/epsdt/pages/home.aspx

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH LANGUAGE-PATHOLOGY AND CHIROPRACTIC SERVICES

Under Maryland Medicaid, payment for these services is made on a per visit basis rather than on a per treatment basis regardless of the number of treatments rendered to the patient during a single visit.

Providers should visit the EPSDT Provider Manual: to view the procedure codes and fee schedules for these services. Coverage for EPSDT Speech, Occupational and Chiropractic Services are limited to participants under the age of 21.

NOTE: *Physical therapists, occupational therapists, speech-language pathologists and chiropractors are not considered physician extenders under the Medicaid Program. These providers must be enrolled in the Program via an enrollment application and be assigned a provider number for billing purposes. Contact the Program's Provider Enrollment Office at*
(410) 767-5340 for an application.

NOTE: *EPSDT Chiropractic Services are coverable through the MCO. Contact the MCO for coverage procedures.*

If you have any questions concerning these Program services, contact Children's Services at (410)767-1903

VACCINE ADMINISTRATION/VACCINES FOR CHILDREN PROGRAM

Eligible providers should bill for administering childhood vaccines received free 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 – SF (State and/or Federally-funded programs/services). The maximum reimbursement is **$23.28** per administration. Providers will not be reimbursed 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

Diptheria, tetanus toxoids, acellular pertussis, haemophilus b, and hepatitis b (DTAP-IPV-HIB-HEPB)	90697-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 conjugate, quadrivalent	90619-SE
Meningococcal recombinant protein	90620-SE
Meningococcal recombinant lipoprotein	90621-SE
Pneumococcal conjugate, 13 valent	90670-SE
Pneumococcal conjugate, 15 valent	90671-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

For more information, please visit https://www.marylandvfc.org/

If you have any questions regarding these procedure codes or a list of covered services, please contact mdh.professionalservicespolicy@maryland.gov

VISION CARE SERVICES

The Medical Assistance Program covers the following vision care services:

Eyeglasses

Use the following procedure codes when billing for frames:

V2020 – child/adult ZYL frame.

V2025 – metal or combination frame when required for a proper fit.

V2799 – special or custom frame when necessary and appropriate (preauthorization required).

92390 – single vision integrated glasses.

92340 – 92342 – fitting of spectacles.

Contact Lenses

Contact lens services require preauthorization and include the prescription of contact lenses (specification of optical and physical characteristics), the proper fitting of contact lenses (including the instruction and training of the wearer, incidental revision of the lens and adaptation), the supply of contact lenses, and the follow-up of successfully fitted extended wear lenses. Use the following procedure codes when billing for these services:

– professional services of prescription, fitting, training and adaption.

V2500 – V2599 – contact lenses.

92012 – follow-up subsequent to a proper fitting.

Services that require preauthorization must be requested in writing. A Preauthorization Request Form for Vision Care Services (MDH 6326) must be completed and submitted to:

Office of Systems, Operations & Pharmacy
Division of Claims Processing
P.O. Box 17058
Baltimore, MD 21203

A copy of the Vision Care Services Procedure Code and Fee Schedule can be viewed by visiting the EPSDT Provider Manual. If you have any questions concerning this Program, contact Children's Services at (410)767-1903.

C. HEALTHY START SERVICES FOR PREGNANT AND POSTPARTUM WOMEN

Providers must bill using these codes for Medicaid reimbursement:

- H1000 Prenatal Care, At-Risk Assessment.
- H1003 Prenatal and Postpartum Care, and At-Risk Enhanced Service/Education.

There have been no changes to the fees and limitations. If you have questions concerning the Program, please call Healthy Kids at 410-767-6750.

D. DISPOSABLE MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT

Maryland Medicaid updates the DMS/DME Approved List of Items/Fee Schedule annually. The items on the Approved List of Items/Fee Schedule are covered as long as the items requested are deemed medically necessary. It is important that you review the current list to ensure that you are using the correct procedure code when seeking preauthorization from our Utilization Control Agent, Telligen. For additional information on Telligen, please see Transmittal PT 4-17. Before requesting prepayment authorization, ensure that the procedure codes require prepayment authorization by referring to the "PA" column on the Approved List of Items/Fee Schedule. It is also important to make sure that miscellaneous procedure codes are not used when there is an available code for that item.

If the request has been approved, place the prepayment authorization number in Block #23 of the CMS-1500 form. All the information entered on the claim must correspond to the information on the approved prepayment authorization. Separate claims based on items that require authorization. Submit items that do not require authorization on a different CMS-1500 form.

When billing for disposable medical supplies, indicate the number of units in Block #24G based on the pricing units stipulated in the Approved List of Items/Fee Schedule.

Use of Modifiers: When billing for rentals, use the modifier **"RR"**. Any rentals beyond three (3) months require prepayment authorization. When billing for new equipment, use **"NU".** When billing for used equipment use **"UE"**, which requires prepayment authorization.

NOTE: *The column referred to as "Medicare Coverage" indicates whether Medicare covers that particular item. A block that is blank indicates that Medicare either covers the item with special coverage instruction or it is up to the MME Regional Carrier's (DMERC) discretion.*

Please visit the Division of Community Support Services DME/DMS webpageif you have questions or concerns about these policies, or would like a copy of the Approved List of Items. Also available on that site are the provider memos/transmittals, and access to the DMS/DME regulations (COMAR 10.09.12). If you prefer to speak with a Staff Specialist, call 410-767-7283.

OXYGEN AND RELATED RESPIRATORY EQUIPMENT SERVICES

Maryland Medicaid's DMS/DME/OXYGEN Approved List of Items/Fee Schedule also includes oxygen and related oxygen services. The items on the Approved List of Items/Fee Schedule are covered as long as the items requested are deemed medically necessary. It is important that you review the current list to ensure that you are using the correct procedure code when requesting prepayment authorization seeking preauthorization from our Utilization Control Agent, Telligen, or processing direct bill oxygen items. For additional information on Telligen, please see Transmittal PT 4-17. Before requesting prepayment authorization, ensure that the procedure codes require prepayment authorization by referring to the "PA" column on the Approved List of Items/Fee Schedule. It is also important to make sure that miscellaneous procedure codes are not used when there is an available code for that item.

If the prepayment authorization has been approved for covered oxygen, oxygen equipment, related respiratory equipment, component replacements, equipment repairs and/or tracheostomy items, place the approved prepayment authorized number in Block #23 of the CMS-1500 form. All the information entered on the claim must correspond to the information on the prepayment preauthorization. Separate claims based on items that require authorization. Submit items that do not require authorization on a different CMS-1500 form.

Use of Modifiers: When billing for rentals, use the modifier **"RR"**. Any rentals beyond three (3) months require prepayment authorization.. When billing for new equipment, use **"NU".** When billing for used equipment use **"UE"**.

NOTE: *The column referred to as "Medicare Coverage" indicates whether Medicare covers the particular item. A block that is blank indicates that Medicare either covers the item with special coverage instruction or it is up to the MME Regional Carrier's (DMERC) discretion.*

Please visit the Division of Community Support Services DME/DMS webpage if you have questions or concerns about these policies, or would like a copy of the Approved List of Items. Also available on that site are the provider memos/transmittals, and access to the DMS/DME regulations (COMAR 10.09.12). If you prefer to speak with a Staff Specialist, call 410-767-7283.

E. LABORATORY AND PATHOLOGY SERVICES

When billing for laboratory services, enter the name of the ordering practitioner in Block #17. In Block #17a, the ID Qualifier 1D must precede the ordering practitioner's 9-digit MA provider number. In Block #17b, enter the ordering practitioner's NPI number.

Medical laboratories **must** use "81" as the place of service for all services that are actually performed in the laboratory, regardless of where the specimen was collected. Use the appropriate place of service for the site of collection and immediately performed tests, such as bleeding time.

When billing for medical laboratory services referred to other enrolled and certified laboratories, use the modifier "90" for the procedure that was performed. The referring laboratory's charge is limited to the amount actually paid to the reference laboratory. Payment to the referring laboratory will be the lower of the referring laboratory's charge or the Maryland Medicaid maximum rate of reimbursement for that service. The reference laboratory must be enrolled with Maryland Medicaid, and its 9-digit MA provider number and NPI number must be entered in Block #32. If services were referred to more than one reference laboratory, use a separate invoice for each different reference laboratory. The referring laboratory is prohibited from billing Medical Assistance participants for services referred to non- participating reference laboratories.

Laboratories with Waived or Provider Performed Microscopy CLIA certificates are required to use the "QW" modifier on all laboratory codes. These claims must be submitted on paper, as they are processed manually. Claims that are sent to the original processing address or submitted electronically will result in denial of the claim. To avoid a delay in reimbursement, **please send all claims using the modifier "QW" to**:

Professional Provider Relations Unit
P.O. Box 22811
Baltimore, MD 21203

NOTE: *Medical Laboratory Providers must supply a copy of their CLIA certificate and a Maryland Lab permit, if located in Maryland and/or receiving specimens originating in Maryland for each site where services are performed. If a laboratory does not receive specimens originating in Maryland, a statement declaring they do not receive specimens originating in Maryland is needed.*

If you have any policy questions or any program changes, please contact Lab Services at 410-767-3074.

F. MEDICAL DAY CARE

When billing for Medical Day Care Services, use procedure code **S5102**.

Medical Day Care providers are only required to complete 11 fields on the CMS-1500. The required fields are: 2, 9A, 11, 24A, 24B, 24D, 24F, 24G, 28, 31, and 33.

Additional Instructions

Block #11: Enter "K". This indicates that medical day care is not covered by any other insurance.

Block #24B: Enter place of service code "99".

Block #31: A signature and date are required for this field.

If you have any questions regarding the Program, please contact the Medical Day Care Program Specialist at 410-767-1444.

G. PROFESSIONAL (PHYSICIAN'S) SERVICES

Providers should refer to the fee schedule available on the MDH-Provider Information webpage to obtain a list of approved CPT and national HCPCS codes used by the Program and the maximum fee paid for each procedure code. A provider using CPT terminology and coding, selects the procedure or service that most accurately identifies the service performed.

Some physician services within the fee schedule require preauthorization. The Program will preauthorize services when the provider submits adequate documentation demonstrating that the service is both necessary and appropriate. Preauthorization for these services must be requested in writing. All instructions and Preauthorization Request Forms for Physician/Professional Services, Injectable Drugs, and Laboratory Services can be found on the MDH- Preauthorization Information webpage. To submit preauthorization requests for professional services, injectable drug or laboratory service, submit forms by secured email or Fax:

mdh.preauthfax@maryland.go
v 410-767-6034

A valid 11-digit National Drug Code (NDC) number and quantity administered be reported on the CMS-1500 in order to be reimbursed for drugs. Details about placement of the NDC/Quantity are contained within the block-to-block information on page 10.

If you have any questions regarding the Program or to request a copy of the fee schedule, please email mdh.professionalservicespolicy@maryland.gov A copy of the fee schedule can be viewed by visiting the MDH Provider Information website *https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx*

MODIFIERS

A modifier provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. When applicable, the modifying circumstance would be identified by the appropriate modifier(s), which is a two-character code appended to the procedure code in Block #24D of the CMS-1500. Up to four modifiers can be reported on one service line.

NOTE: *Up to four modifiers can be used in the HIPAA compliant electronic format.*

The modifiers listed below must be reported when applicable and affect the processing and/or reimbursement of claims billed to the Program. Generally, only those modifiers that affect payment should be reported. The payment rate for each modifier is a percentage of the listed fee. Payment rates for multiple modifiers are multiplied together to determine the reimbursement amount.

Anesthesia

Anesthesia procedure codes 00100 – 01999 billed without an appropriate modifier will be **rejected**. Modifiers – AD (Medical supervision by physician: more than four procedures) and –47 (Anesthesia by surgeon) **are not** used/payable by the Program. Modifiers –G8, -G9 and –QS are informational and do not affect payment.

Modifier	Description	% Payment
AA	Anesthesia performed personally by anesthesiologist	
QK	Medical direction of 2-4 concurrent anesthesia procedures	
QX	CRNA service with medical direction by a physician	
QY	Medical direction of 1 CRNA by an anesthesiologist	
QZ	CRNA service w/o medical direction by a physician	
23	Unusual anesthesia	

COMPONENT BILLING

Certain procedures (e.g., radiology, electrocardiograms, specific diagnostic procedures) are a combination of a professional component and a technical component and must be reported in order to receive reimbursement. When the physician component is billed separately, the service must be identified by adding the modifier –26 to the usual procedure code. Modifier – TC (Technical Component) is used/payable by the Physicians' Services Program.

Modifier	Description	% Payment
26	Professional Component	28-100
TC	Technical Component	Difference of -26 Modifier

Medicine

26	Professional Component	50-100
SE	State or Federally funded service (VFC)	($23.28)

Radiological Services

26	Professional Component	28-50
50	Procedures performed on left **and** right side of body	150

Surgical Services

50	Bilateral procedure	150
51	Multiple procedures	50
52	Reduced services	50
53	Discontinued procedure	B.R.
54	Surgical care only	80
55	Postoperative management only	20

NOTE: *Modifier –56 (Preoperative management only) and –66 (Surgical team) are not used/payable.*

Surgical Assistance

Modifier	**Description**	**% of Payment**
62	Co-Surgeon	62.5
80	Assisted surgeon	20
82	Assistant surgeon (when qualified resident not available)	20

NOTE: *Modifier –81 (Minimum assistant surgeon) is not used/payable*

Trauma Services

Trauma services rendered by trauma providers to trauma patients on the State Trauma Registry are reimbursed at 100% of the Medicare rate.

Modifier	**Description**	**% of Payment**
U1	Trauma Services	100% of MC

Telehealth Services

Modifier	**Description**	**% of Payment**
GT	Services delivered via telehealth using two-way audio-visual technology assisted communication	100%

UB	Identifies the claim as telephonically delivered service	100

Multiple and Bilateral Surgical Procedures

If multiple procedures are performed on the same day or at the same operative sessions, the procedure code must be followed by the two-positions modifier "51" for all procedures following the first procedure. The major procedure should be reported without a modifier. The modifier "51" should be used for the second and subsequent procedures.

When a procedure has a code for both a single procedure and for each additional procedure, use the modifier "51" for the second and subsequent procedures. When only one procedure is available, regardless of the number of procedures performed, use the same procedure code with the modifier "51" to report the second and subsequent procedures and report the additional procedures in Block #24D.

When there is no procedure code to identify bilateral procedures, use the procedure code for the unilateral procedure without a modifier and use the same procedure code with a modifier "51" to identify that the procedure was performed bilaterally.

"50" for Bilateral procedures: If a bilateral procedure is performed, report the bilateral procedure if available. When there is no code describing bilateral services, report the bilateral service on one line with the modifier –50.

If you have any questions regarding this program or to request a copy of the fee schedule, please contact the Staff Specialist at mdh.professionalservicespolicy@maryland.gov

PODIATRY

ROUTINE PODIATRIC CARE

Maryland Medicaid reimburses one routine podiatric care visit every 60 days for participants who have a metabolic, neurologic, or vascular disease affecting their lower extremities. The appropriate ICD-10-CM code indicating a condition relating to diabetes or peripheral vascular disease must be entered in Block 21 (Diagnosis or Nature of Illness or Injury) of the CMS-1500 as the secondary diagnosis. The podiatric diagnosis must be listed as primary.

The following CPT-4 surgery codes are used to bill for routine care for qualifying participants: 11055-11057 and 11719. These codes should be used when they are the only services provided. Routine care for those participants who qualify may be billed separately when provided in conjunction with other medically necessary surgical procedures at the same visit. Routine foot care provided "incident to" a surgical procedure is considered part of the surgical procedure.
No additional allowance will be made for such incidental care.

Evaluation and management services provided on the same day as routine foot care by the same doctor for the same condition are not eligible for payment except if it is the initial E&M service performed to diagnose the patient's condition or if the E&M service is a significant separately identifiable service.

The global surgery rules apply to routine foot care procedure codes 11055-11057 and 11719. An E&M service billed on the same day as a routine foot care service is not eligible for reimbursement unless the E&M service is a significantly separately identifiable service documented by medical records.

PODIATRIC VISITS

The following CPT-4 Evaluation and Management codes are used to bill for podiatric visits which include the key components of an history, examination and medical decision making:

OFFICE	HOME	NURSING FACILITY	DOMICILIARY
99202-99204	**99341**	**99304-99305, 99307**	**99324, 99334**
99211-99214	**99347**		

Podiatric visit codes are not to be used if the only service rendered was routine care.

RADIOLOGY

Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound and other imaging procedures. The nuclear medicine codes (78000-79999) are to be used for in-vitro testing only. In-vitro tests are described in the Pathology and Laboratory section of CPT (80049 – 89399).

Providers **can** bill for the global service in a non-hospital setting or professional only component service in any setting. Providers **cannot** bill for the technical component only. The global service includes all resources necessary to perform the procedure and the professional physician services to interpret the output. The professional component includes the specialized interpretation or reading of the test results and preparation of a detailed written report of the findings for the referring/attending physician. Interpretation of radiology services are payable to any physician trained in the interpretation of the study. The provider who bills for the interpretation must be the provider who evaluates the study and prepares and signs the written report for the medical record and is subject to post-payment review. Review of results and explanation to the patient is part of the attending physician's E & M service and cannot be billed as an interpretation of the study.

When performing radiology service using hospital equipment and/or staff, bill only for the professional component by adding the modifier **–26** to the procedure code.
NOTE*: Computerized tomography CT's PET's and SPECT's.*

Bilateral services are studies done on the same body area, once on the left side and once on the right side. Providers should use the "bilateral" CPT code to bill the service when available. If a bilateral code is not available, report bilateral radiological studies on one claim line with the modifier –50. Do not use modifier –51 to report multiple radiology studies of the same area on the same day.

If the same x-ray is repeated on the same patient on the same day, report two units in Block #24G on the claim form. Generally, the maximum two units are allowed for radiology procedures.

NOTE: *Radiology services billed with a place of service code of 21 or 22 will be denied without a modifier –26.*

If you have any questions regarding this program or to request a copy of the fee schedule, please contact the Staff Specialist at mdh.professionalservicespolicy@maryland.gov.

ABORTION

Abortions are covered by the Program and may be rendered by qualified health providers in accordance with Maryland HB0937.

NOTE: *See professional services provider manual for information about Mifeprex – medical termination of early intrauterine pregnancy through administration of mifeprestone.*

If you have any questions regarding the Program or to request a copy of the fee schedule, please email mdh.professionalservicespolicy@maryland.gov. The fee schedules are also available on line at the MDH website.

https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx

HYSTERECTOMY

The Program **will not** reimburse for a hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing, or if there was more than one purpose to the procedure, and it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

The Program **will** reimburse for a hysterectomy only if the following conditions are met:

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

2. The individual or her representative, if any, has signed a written acknowledgement of receipt of that information, or

3. The individual was already sterile before the hysterectomy, or

4. The individual requires a hysterectomy due to a life-threatening emergency situation and the physician determines that prior informing and acknowledgement are not possible, and

5. The physician who performs the hysterectomy:

    a. Certifies in writing, that the individual was already sterile at the time of the hysterectomy and states the cause of the sterility.

    b. Certifies in writing, that the hysterectomy was performed under a life-threatening emergency situation in which the physician determines that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

Regulations require the physician who performs the hysterectomy (not a secondary provider such as an assisting surgeon or anesthesiologist) to certify that the woman met one of the specified exemptions. The **"Document for Hysterectomy"** (MDH-2990) **must be completed and kept in the patient's medical record** for a hysterectomy (for covered procedure codes please refer to the Professional Services Fee Schedule)). **Do not** bill other services on the same claim form with this procedure. Patient's signature **is not** required if the patient is over age 55.

See Section XVI - Appendix, page 64 for a reproduction of MDH 2990.

If you have any questions regarding the Program or to request a copy of the fee schedule, please email mdh.professionalservicespolicy@maryland.gov. The fee schedules are also available on line at the MDH website:

https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx

STERILIZATION AND TUBAL LIGATION

Sterilizations have special conditions that **must** be met in order for them to be covered by the Medical Assistance Program. The Program will reimburse for the sterilization of an individual, including a tubal ligation, only if **all** of the following conditions are met:

1. The individual is at least 21 years of age at the time consent is obtained.

2. The individual is not mentally incompetent.

3. The individual is not institutionalized.

4. The individual has voluntarily given informed consent as described in Part I of the consent document, **"Sterilization Consent Form"** (HHS 687), **and**

5. 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, 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.

The "**Sterilization Consent Form"** (HHS-687) **must be completed and kept in the patient's medical record** for sterilizations (for covered procedure codes please refer to the Professional Services Fee Schedule). A sterilization/tubal ligation procedure must be billed on a separate CMS-1500 claim form. If the procedure was performed on the same date of service as another procedure, a modifier –51 is required in Block #24D for the second or subsequent procedure.

The sterilization form consists of four parts:

Part I - Consent to Sterilization – This section must be completed for all

sterilizations and must be signed and dated by 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 individuals to be sterilized.

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

***NOTE**: The individual is not eligible for the sterilization procedure until the 32nd day after giving consent (signature date).*

See Form HHS- 687.

If you have any questions regarding the Program or to request a copy of the fee schedule, please email mdh.professionalservicespolicy@maryland.gov. The fee schedules are also available on line at the MDHwebsite:

https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx

TRAUMA SERVICES BILLING

A trauma provider is defined as a Physician, Registered Certified Nurse Anesthetists, Nurse Practitioners, Physician Assistants, Physical Therapists, Occupational Therapists, and Speech Therapists, who provides care in a trauma center to trauma patients on the State Trauma Registry. Emergency room providers who are also not trauma providers are paid according to the Professional Services Fee Schedule for Medicaid participants.

NOTE: *Claims for trauma services by emergency room physicians will be denied.*

The following billing instructions for CMS-1500 must be followed by trauma providers in order to be reimbursed for trauma services at the higher Medicare rate:

1. A primary, secondary or additional diagnosis code listed in Block #21 (diagnosis or nature of illness or injury field) must be from **S00-T34**, or if not, a supplementary classification of external causes and injury and poisoning code from **V00–Y99** must appear as a subsequent supplementary classification code in Block #21.

2. A primary, secondary or additional diagnosis code listed in Block #24E (diagnosis pointer field) for **each** line item on the invoice, must be from **S00-T34**, if not, a supplementary classification of external causes and injury and poisoning code from **V00-Y99** must appear as a subsequent supplementary classification code in Block #24E.

3. The last 2-digits of the trauma center identification number **and** the 6-digit trauma registry (patient identification) number must be reported in Block #23 (prior authorization number field) as an eight position number. The trauma registry number is less than 6-digits, place zeros in front of the trauma registry number until you have a 6-digit number. For example, if there is only a 4- digit trauma registry patient number, fill in the first two positions with zeros. Please refer to the list on page 62 for Trauma Facility I.D. numbers.

4. Only the place of service codes -19 (off- campus outpatient hospital), -21 (inpatient), -22 (outpatient), -23 (emergency room), -61 (inpatient rehab hospital) can be reported in Block #24B (place of service field) for trauma services.

5. The modifier –**U1** must be reported in one of the modifier positions for the trauma service in Block #24D (modifier field). This modifier is being used to reimburse trauma providers for trauma services at the Medicare rate instead of the current Medicaid rate.

6. The 9-digit Medicaid provider number of the hospital where the trauma center is located must be reported in Block #32b (Service Facility Location Information). The number must be proceeded with the ID Qualifier, 1D. In Block #32a, indicate the trauma center's NPI number.

NOTE: *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, not for subsequent follow-up services.* ***All*** *reporting of the modifier –U1 will be subject to post-payment audit.*

If you have any questions regarding this Program or would like to request a copy of the fee schedule, email mdh.professionalservicespolicy@maryland.gov.

TRAUMA FACILITIES NAMES AND NUMBERS

FACILITY NAME	**TRAUMA CENTER ID** (Last two digits of the MIEMSS Facility ID # + Trauma Registry Number)
Primary Adult Resource Center	
R. Adams Cowley, Shock Trauma Center/University of Maryland Medical System, Baltimore	34 + six digit Trauma Registry Patient Number
Level I Trauma Center	
The Johns Hopkins Hospital Adult Trauma Center, Baltimore	04 + six digit Trauma Registry Patient Number Adult Trauma Center
Level II Trauma Centers	
The Johns Hopkins Bayview Medical Center, Baltimore	01 + six digit Trauma Registry Patient Number Adult Trauma Center
University of Maryland Capital Region Health/ Prince George's Hospital Center (UMCRH), Cheverly	32 + six digit Trauma Registry Patient Number Adult Trauma Center
Sinai Hospital (Lifebridge Health), Baltimore	10 + six digit Trauma Registry Patient Number Adult Trauma Center
Suburban Hospital (JHM), Bethesda	49 + six digit Trauma Registry Patient Number Adult Trauma Center
Level III Centers	
UPMC Western Maryland, Cumberland	20 + six digit Trauma Registry Patient Number Cumberland Memorial Trauma Center

TidalHealth Peninsula Regional, Salisbury	08 + six digit Trauma Registry Patient Number Adult Trauma Center
Washington County Hospital, Facility Name	89 + 6-Digit Trauma Registry Trauma Center ID (Last 2-Digits of the MIEMSS Facility ID#) + Trauma Registry #
Meritus Medical Center, Hagerstown	89 + six digit Trauma Registry Patient Number,
Pediatric Trauma Centers	
The Johns Hopkins Children's Center, Baltimore	05 + six digit Trauma Registry Patient Number Pediatric Trauma Center
Children's National Medical Center, Washington D.C.	17 + six digit Trauma Registry Patient Number Pediatric Trauma Center

H. PRIVATE DUTY NURSING (PDN)

Current procedure codes for Private Duty Nursing services are noted below. Only the Assessment (T1001) and RN Supervisory Visit (W1002) procedure codes are billed using the CMS 1500. These procedure codes do not require preauthorization., All other procedure codes for PDN are billed using the Maryland Long Term Services and Supports System (LTSS*Maryland*) - Electronic Visit Verification (EVV).

Service	Procedure Code	Description of Code
Assessment	**T1001**	**RN per Assessment**
Registered Nurse (RN) Supervisory Visit	**W1002**	**RN per Visit**

Information on preauthorizing other procedure codes for private duty nursing and shift home health aide services can be requested by contacting the Division of Nursing Services (DONS) at 410-767-1448 or via email: mdh.pdnpreauthorization@maryland.gov.

MDH- Division of Nursing Services
201 West Preston Street
Unit 79, Room 130
Baltimore, MD 21201

If you have any questions regarding these procedure codes or would like to request a list of covered services, please contact the Staff Specialist at 410-767-1448.

I. SCHOOL-BASED HEALTH CENTERS (SBHC)

COMPLETING THE CMS-1500 FORM AS AN SBHC

The following table provides information on how to complete the blocks specific to SBHCs on the CMS-1500 form. For CMS-1500 form blocks highlighted below, SBHCs must follow the instructions in the table to avoid claim denials.

Block 24B (Block 24C leave blank)	**PLACE OF SERVICE** – For each date of service, enter the code to describe the site. **Note: To bill as self-referred providers, SBHCs must use Place of Service code "03"- School.**
Block 24J (shaded area)	**RENDERING PROVIDER ID #** – **For FQHCs and physician and nurse practitioner group sponsoring agencies:** Enter the NPI number of the individual provider rendering care . **All FQHCs and physician and nurse practitioner groups must report an individual rendering provider, and the provider MUST be actively enrolled with Maryland Medicaid with a valid Provider ID.** Enter the individual, location specific, NPI number of the SBHC.
Block 25	**FEDERAL TAX I.D. NUMBER** – This block requires the Federal Tax I.D. number for the Billing Provider entered in Box 33.
Block 32b (shaded area)	Enter the ID Qualifier "**1D" (Medicaid Provider Number)** followed by the SBHC's 9-digit Maryland Medicaid (legacy) provider number. Note: Use the Medicaid Provider Number of each site location.
Block 33	**BILLING PROVIDER INFO & PH#** - Enter the name and complete address to which payment and/or incomplete claims should be sent. The billing provider should match the federal Tax I.D. number entered in Block 25.
Block 33a	**NPI** - Enter SBHC's NPI number. Errors or omissions of this number will result in non-payment of claims.

J. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

With only two exceptions, SBHC billing instructions **do not affect** the billing procedures for Federally Qualified Health Centers (FQHCs). FQHCs should continue to use their existing billing codes rather than those included in this manual. The only two billing requirements that apply to FQHCs are related to filling in the CMS-1500 form:

Change #1: Block 24B – All SBHCs must enter "03" as the "Place of Service Code"

Change #2: Block 32 – All SBHCs must enter the Name and Address of the SBHC

VIII. IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

The Department's website will contain up-to-date information relative to Maryland Medicaid Programs, physician's fee schedule and program transmittals. Providers can access the website via the following address: https://health.maryland.gov/mmcp/provider/Pages/contact.aspx

The Maryland Department of Health (MDH) has developed a new website called eMedicaid www.emdhealthchoice.org. This website is an interactive site that allows providers to:

- Enroll as a Medicaid Provider
- Add new providers to their practice
- Obtain payment information by downloading copies the remittance advices for up 2 years
- Access EVS to verify recipient eligibility
- Submit claims electronically for faster payment
- Check the status of claims

It is recommended that the office administrator register all users for this site.

Claims – Originals
P.O. Box 1935
Baltimore, MD 21203

Claims – Adjustments
P.O. Box 13045
410-767-5346
Baltimore, MD 21298

Eligibility Verification System (EVS)
1-866-710-1447

Forms – How to Order Forms
https://health.maryland.gov/mmcp/provider/Pages/ffsadjustments.aspx

Provider Relations
P.O. Box 22811
Baltimore, MD 21203

Baltimore Area
410-767-5503
Outside Baltimore Area
800-445-1159

Third Party Recovery
Division of Recoveries & Financial Services
P.O. Box 13045
Baltimore, MD 21298
410-767-1762

MEDICAID PROGRAM TELEPHONE NUMBERS

EPSDT Audiology Services		1-800-565-8190
EPSDT Therapy Services		1-800-565-8190
Electronic Billing		410-767-4682
Disposable Medical Supplies/ Durable Medical Equipment		410-767-7283
Emergency Service Transporters		410-767-7283
Healthy Kids Unit		410-767-1683
Health Choice Enrollment Line	Participant Provider	1-800-284-4510 1-800-766-8692
Private Duty Nursing		410-767-1448
Family Planning Program		410-767-6750
Free-Standing Clinics		410-767-5706
Healthy Start Program		410-767-6750
Home Health Services		410-767-1448
Managed Care Organizations MCO Provider Hotline		1-800-766-8692
Maryland Children's Health Program (MCHP)		1-800-456-8900
Maryland Pharmacy Assistance		410-767-1455

Medical Day Care Services – Adult		410-767-1739
Medical Laboratories		410-767-1426
Model Waiver for Medically Fragile Children		410-767-1448
Department on Aging/Senior Assisted Housing Waiver		410-767-1102
Oxygen and Related Respiratory Equipment Services		410-767-7283
Personal Care Services		410-767-1739
Pharmacy Services		410-767-1455
Professional Services		mdh.professionalservicespolicy@maryland.gov
Podiatry Services		mdh.professionalservicespolicy@maryland.gov
Pregnant Women and Children Medical Assistance		410-767-6750
Primary Adult Care (PAC)	Enrollment Hotline Provider Hotline	1-888-754-0095 1-800-766-8692
Rare and Expensive Case Management (REM)		1-800-565-8190
Targeted Case Management for HIV Infected Individuals		410-767-5220
Waiver Programs		410-767-1739

DIRECTORY OF LOCAL DEPARTMENTS OF HUMAN (SOCIAL) SERVICES

IX. FREQUENTLY ASKED QUESTIONS

1. When can a provider bill a recipient?

You can bill the recipient only under the following circumstances:

- If the service provided is not covered by Medical Assistance and you have notified the recipient prior to providing the care that the service is not covered; or
- If the EVS reported a message that the recipient is not eligible for Medical Assistance on the date you provided services.

2. Can a provider bill Maryland Medicaid participants for missed appointments?

No. Federal policy prohibits providers from billing Medicaid participants for any missed appointments.

3. Where can a provider call to check the status of claims?

Provider Relations is available Monday from 8:30 a.m. to noon.
Tuesday, Wednesday and Friday from 8:30 a.m. to 4 p.m.to assist providers with questions regarding the status of claims. To reach a representative, call 410-767-5503 or 1-800-445-1159. Providers can now check the status of claims on the eMedicaid website by visiting https://encrypt.emdhealthchoice.org/emedicaid/.

4. Where can a provider obtain a copy of a Remittance Advice (RA)?

Copies of RAs are available for up to two years by accessing the Program's website at ***www.emdhealthchoice.org,*** eMedicaid registration must be completed by an Administrator.

5. How can a provider request a check tracer?

mdh.medicaidchecktracing@maryland.gov

6. Can you check EVS for future dates?

No, however you can check EVS for past eligibility up to one year.

7. How long does a provider have to file a claim?

A provider has twelve months from the date of service to submit a claim for payment. For other time statutes, see page two.

8. Claims should be mailed to what address?

Claims Processing
P.O. Box 1935
Baltimore, MD 21203

9. How long should I wait before I check claim status?

Under normal conditions, if you have sent a paper claim, wait four to six weeks before calling Provider Relations. When billing electronically, please allow two weeks.

X. APPENDIX