Maryland Medicaid Claims Guide
United Behavioral Health

UBH processes claims by a mostly automated system. Due to strict oversight by federal Medicaid authorities, the claims adjudication process allows little leeway. For a claim to be paid, numerous requirements must be met, and any deviation causes the claim to be denied.

Most of the claims denials for Maryland Medicaid have been a result of the authorizations not matching the claims, either in terms of the provider type or the services authorized. Some of those mismatches were due to billing procedures, some to our data entry process, and some to the way the authorizations were worded.

Here is what Medicaid providers can do to avoid some of the problems inherent in the process:

When calling for an authorization, be sure the Care Manager understands that you are a Maryland Medicaid provider. We have notified our care managers of the special requirements of Maryland Medicaid, but it helps if you remind them. They normally deal with all types of services from several different states and might not recognize that your authorizations will be different.

- **Explain what type of service you will be providing.**

- **It is vital that our authorization matches the claims you are submitting.** If you will be billing with 90899-HG or –HQ, or if you are billing H-codes, let the Care Manager know so they can enter the auth appropriately.

- **Methadone maintenance providers:** Remind the Care Manager that in Maryland this is billed as one unit = one week, so the authorization can reflect that.

Key factors. Here is what you can do to assist data entry people to properly identify and enter the type of claim:

- **Identify the member with a complete name and address.** For the member identification number, either use the SSN alone, or if you use the entire member ID number, leave spaces or dashes between the elements (i.e., 09611-123456789-00).

- **If you are an Intensive Out-Patient programs use Place of Service Code 22.** This helps identify the claim as IOP and prevents the claim being automatically processed by the computer, since these claims require human intervention.

- **If you are billing IOP or OP on a UB-92 form, be sure to put both the Rev code and the CPT code.** For IOP programs, on both UB-92s and HCFA-1500s, put a description beside the CPT code, such as “Substance Abuse IOP” or something similar. This will help our data entry people identify the claim type and key it properly.

- **For IOP and other programs for which our contract is with the facility, do not enter the name of the individual clinician.** Claims with an individual clinician listed often get mis-keyed as normal outpatient claims, and those will not match the authorization to the facility, leading to either denial or incorrect payment.

- **For methadone maintenance**, be sure to list the start and end date of the week being billed, so that it is clear that you are billing for an entire week and not a single day.

- **Be sure that the procedure codes, number of visits, and dates being billed for are included on the authorization.** Any mismatch will probably cause the claim to deny.

Example: If the auth is for six visits starting October 1 through December 1, a 7th visit or a visit after December 1 will deny automatically.

- **If you know your UBH provider ID number, entering it on the claim may assist in getting the claim keyed correctly.** Your provider ID number should start with either 50- or 84-. The 50- number can only be used if you are billing on a UB-92. The 84- number can be used on either form. This number should be reflected on your authorization; if not, ask the care manager what provider number they are entering the auth under.

- **Submit claims at least once a month if at all possible.** If several months' worth of claims for a patient are submitted at one time, there is a strong possibility they will be processed out of date order, which will cause problems with linking the authorizations to the claims in the right sequence.

  Example: an auth may grant 8 units for July 1 through November 1, and a later auth grants 8 more units from September 1 through January 1. If claims for September are processed before claims from July and August, they will be linked to the first auth, and use those units, thus leaving insufficient units for the July and August claims, which cannot use the auth beginning in September.