SUBSTANCE USE DISORDER SELF-REFERRAL MANUAL

Includes billing procedures for the following Community-Based Substance Use Disorder Services[1]*:*

Substance Use Disorder Assessment
Individual Outpatient Therapy
Group Outpatient Therapy
Intensive Outpatient
Methadone Maintenance

Effective January 1, 2010

Department of Health and Mental Hygiene
Medical Care Programs

Revised July 2014

[1] Formerly known as the Substance Abuse Improvement Initiative (SAII)

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I. GENERAL INFORMATION

A. INTRODUCTION

This manual is designed to assist community-based substance use disorder (SUD) providers to understand billing procedures for the Self-Referred SUD program for the following services:

- Comprehensive Substance Use Disorder Assessment
- Individual Outpatient Therapy
- Group Outpatient Therapy
- Intensive Outpatient
- Methadone Maintenance

Regulatory requirements for these services can be found in COMAR 10.09.80, COMAR 10.09.08.04, and COMAR 10.09.67.28.

PLEASE NOTE: These billing instructions do not affect the billing procedures for Federally Qualified Health Centers (FQHCs) when participants are enrolled in a HealthChoice Managed Care Organization (MCO). Additionally, FQHCs should continue to use their existing billing code (T1015) along with the SUD procedure codes that describe substance use disorder services for participants in HealthChoice.

This manual contains instructions for submitting claims using the revised CMS 1500 form (02-12) version or 837P electronic format. These instructions are for claims associated with participants enrolled in an MCO under HealthChoice and the Medicaid fee-for-service (FFS) system.

Although this manual provides information relating to MCO billing practices, it is not intended to replace the MCOs' Billing Instructions. Specific billing instructions can be found on each MCO's website or manual (see Attachment 1 for MCO website information). When billing for SUD services under the self-referred provisions outlined in COMAR 10.09.67.28, SUD programs must follow the specific instructions for billing and reporting encounters provided by the participant's MCO.

PLEASE NOTE: SUD programs may not bill the MA Program or HealthChoice MCOs for any services that are provided free of charge to participants without Medicaid coverage. This means that in order to bill Medicaid, providers either need to bill participants' respective third party insurance organizations or bill the participants based on a sliding fee scale.

B. HOW TO GET STARTED

To bill an MCO or the Medical Assistance (MA) program for community-based SUD services, certified SUD programs must take the following steps:

STEP 1: OBTAIN OFFICE OF HEALTH CARE QUALITY CERTIFICATION

In order to deliver SUD services, programs must be certified by the Office of Health Care Quality (OHCQ). To obtain information on OHCQ certification, call **877-402-8218**. Substance use disorder providers must attach their certificate to their MA provider application.

PLEASE NOTE: Programs with expired certification must obtain a letter of good standing from OHCQ.

STEP 2: APPLY FOR A NATIONAL PROVIDER IDENTIFIER (NPI)

The National Provider Identifier (NPI) is a Health Information Portability and Accountability Act (HIPAA) mandate requiring a standard unique identifier for health care providers. Substance use disorder programs or their parent organization must use this 10-digit identifier on all transactions.

When billing on paper, SUD programs must include both their NPI and their 9-digit Medicaid provider number in order to be reimbursed by the Medicaid fee-for-service program. Providers can find additional NPI information on the Center for Medicare and Medicaid Services (CMS) website:

https://nppes.cms.hhs.gov/NPPES/Welcome.do
Or for NPI assistance, call **1-800-465-3203**

STEP 3: APPLY FOR A MARYLAND MEDICAL ASSISTANCE PROVIDER NUMBER

PLEASE NOTE: If you are already enrolled as a provider type 32 or 50 you **do not** need to reapply.

In order to participate in the MA fee-for-service program, SUD programs must complete a provider application and agreement. Substance use disorder programs can obtain a provider application and agreement on the SUD Program website, access website here: **https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/HealthChoice%20Substance%20Use%20Disorder%20Program.aspx**

For application assistance or to determine the status of the application, call **Provider Application Support** at **410-767-5340.** Provider information and billing instructions are available at: ***https://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx***

In order to apply as a **COMMUNITY-BASED SUBSTANCE USE DISORDER TREATMENT PROVIDER**, SUD providers should select provider type “32” for Clinic, Drug Abuse (Methadone) or type “50” for OHCQ Certified Addictions Outpatient

Program.

Community-based providers should be familiar with the regulations in COMAR 10.09.36 and COMAR 10.09.80. In addition, methadone maintenance providers should review COMAR10.09.08.04. Providers who wish to become an OHCQ Certified Addiction Program should review COMAR 10.47.

Once a provider's Medical Assistance application is received by Provider Enrollment, community-based providers will be visited by a Medicaid site surveyor to complete an unannounced site review. Site visits are federally mandated and independent of any previous OHCQ site reviews conducted.

Providers must comply with COMAR and satisfy all requirements of the site review process in order to be approved as a Medicaid provider. If approved by Medicaid, providers will receive notification by mail of their Medical Assistance provider number.

STEP 4: SUBMIT INFORMATION TO BECOME AN MCO SELF-REFERRED PROVIDER

SUD providers are not required to contract with an MCO. However, OHCQ-certified SUD programs must be set up as non-contracted providers with HealthChoice MCOs in order to receive payment from these MCOs. To do so, SUD providers must submit the following information to the **Behavioral Health Division** at ***DHMH.MedicaidSUD@Maryland.gov***:

1. Full name of SUD program
2. SUD Program Practice Address
3. Name of Organization Contact Person
4. Contact Person's telephone number
5. 10-digit NPI number for SUD program
6. 9-digit legacy Medical Assistance (MA) number for SUD program
7. Email Address of Contact Person or Organization Email Address
8. Age or gender restrictions for program
9. Name of Billing entity if different from practice location
10. Tax ID number for Billing entity
11. "Pay-to" address
12. Telephone number for "Pay-to" address

STEP 5: FOLLOW HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PROTOCOL

The Administrative Simplification provisions of HIPAA require that a health plan, including private, commercial, Medicaid and Medicare, healthcare clearinghouses and healthcare providers use standard electronic health transactions. Additional HIPAA information is available online at: ***http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html***

STEP 6: BILL APPROPRIATE PARTY FOR SERVICES RENDERED

To ensure payment, SUD providers must determine the following before providing services to a Maryland Medicaid participant:

- The participant is eligible for Medical Assistance on the date of service. **Always** verify the participant's eligibility using the Eligibility Verification System (EVS) (see page 8 for details);

- The participant, as indicated by EVS is enrolled with a MCO and the services rendered are not free of charge. SUD provider must bill the MCO for services rendered (see Attachment 1: MCO Contact Information for Substance Use Disorder Providers);

- If a participant with Medical Assistance coverage also has other third party insurance the SUD provider must bill the other insurance for services rendered. Otherwise the SUD provider can submit claims to the participant's MCO or the Fee-For-Service system; and

- The service rendered is billable under the self-referral regulations for SUD providers. For example, mental health services are not billable under these provisions.

    - For more details on how to become a mental health provider, contact the **Provider Relations Unit** at **410-767-5340**.

STEP 7: FOLLOW AUTHORIZATION AND NOTIFICATION PROCEDURES

To ensure payment, all SUD providers must follow the authorization and notification procedures beginning on page 21 of this manual. The narrative includes information about the five self-referred services, and other Substance Use Disorder program services.

II. ELIGIBILITY VERIFICATION SYSTEM

Providers are responsible for confirming participants' eligibility on the date of service, prior to delivering services, by checking the Eligibility Verification System (EVS).

Before providing services, providers should use the participant's Medical Assistance member number (found on their Medical Assistance Program identification card) to verify eligibility using the EVS. If applicable, the EVS system will also provide information regarding a participant's MCO or third party insurance enrollment.

If the participant does not have their MA card, providers may also use the individual's Social Security Number to verify eligibility via EVS. Substance use disorder providers may search current eligibility (or past eligibility up to one year) by using a participant's Social Security Number or MA number and first two letters of the last name.

For additional information on eligibility verification, please call the **Provider Relations Unit** at **410-767-5503** or **800-445-1159**.

A. HOW TO USE WEB EVS

WebEVS is the quickest method for obtaining participant eligibility information. Providers must be enrolled in eMedicaid in order to access WebEVS. To enroll, go to the URL below, select "EVS Help," and follow the instructions: ***https://encrypt.emdhealthchoice.org/emedicaid/***

For assistance with enrolling in eMedicaid, please visit the website in section B or call **410-767-5340**.

B. HOW TO USE PHONE EVS

Call the EVS access telephone number at **1-866-710-1447** to verify participant eligibility by phone. For directions on how to use Phone EVS, access the EVS brochure at: ***https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/HealthChoice%20Substance%20Use%20Disorder%20Program.aspx***

III. BILLING INFORMATION

A. FILING STATUTES

For timely billing, programs must adhere to the following statutes:

- Managed Care Organization claims must be received within 180 days of the date of service.

- Fee-For-Service (FFS) claims must be received within 12 months of the date of service.

Claims received after the deadlines will be denied. If the participant is enrolled in an MCO on the date of service, the MCO must be billed directly. Managed Care Organization billing information is available in Attachment 8.

Additionally, the MCO is a secondary payer to all other parties. If a participant is covered by other insurance or third party benefits such as Worker's Compensation, TRICARE or Blue Cross/Blue Shield, the provider must first bill the other insurance company before submitting claims to the MCO.

B. PAPER CLAIMS

If a community-based provider submits paper claims for SUD services, the program must use the revised CMS 1500 form (02-12). Providers can submit claims in any quantity and at any time within the filing time limitation. Medical Assistance processes claims on a weekly basis, but may take up to 30 business days to process a claim. Payment is issued weekly and mailed to the program's pay-to address.

For services rendered to Fee-For-Service participants (those not enrolled in an MCO), mail claims to the following address:

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

For MCO Paper Claims: Paper claims for participants enrolled in HealthChoice must be submitted to the appropriate MCO. Once a MCO receives a claim, they are required to process clean claims within 30 calendar days (or pay interest). Attachments 1 and 2 provide MCO contact information and billing addresses.

C. ELECTRONIC CLAIMS

If a SUD program chooses to submit claims electronically, HIPAA regulations require providers

to complete electronic transactions using ANSI ASC X12N 837P, version 5010A. Electronic claims are paid within two weeks of submission. **Before** submitting electronic claims directly or through a billing service, a provider must have a signed *Submitter Identification Form* and a *Trading Partner Agreement* on file. The *Submitter Identification Form* is available at: ***http://www.dhmh.maryland.gov/hipaa/pdf/Submitter-Identification-Form-005010.pdf***

The *Trading Partner Agreement* is available at:
http://www.dhmh.maryland.gov/hipaa/pdf/Trading-Partner-Agreement.pdf

Programs must also complete testing before transmitting such claims. Providers can find additional information regarding testing by visiting the DHMH website at: ***http://www.dhmh.maryland.gov/hipaa/SitePages/testinstruct.aspx*** or emailing ***DHMH.hipaaeditest@maryland.gov***.

Companion guides to assist providers with electronic transactions are available at:
http://www.dhmh.maryland.gov/hipaa/SitePages/transandcodesets.aspx

For MCO Electronic Claims: Each MCO will require separate testing. SUD programs should contact participant MCOs if interested in billing electronically (see Attachment 8: MCO/BHO Electronic Billing Information).

IV. CMS 1500 BILLING INSTRUCTIONS

When filing a paper claim, programs must use the revised CMS 1500 form (02-12) available from the **Government Printing Office** at **202-512-1800**, the American Medical Association, and major medical-oriented printing firms. See the following website for more information: ***http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html***

Blocks on the form that refer to third party payers must be completed only if there is a third party payer other than Medicare or Medicaid.

A. HOW TO COMPLETE THE CMS 1500 FORM

The table below provides information to complete the required blocks on the CMS 1500 form. All blocks not listed in this table may be left blank. For help completing the CMS 1500 form, please see mock-claims in Attachments 3 - 7.

PLEASE NOTE: When submitting Medical Assistance paper claims**, 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 Number	Title	Action
Block 1		Check appropriate box (es) for type(s) of health insurance applicable to this claim.
Block 1a	**INSURED'S ID NUMBER**	**1. When billing a MCO**, enter the participant's unique MCO number, if applicable. If you do not have the participant's unique number contact the participant's MCO for the number. ***Note: The following MCOs have unique numbers: MedStar Family Choice, United Healthcare, and Priority Partners. Other MCOs accept the member's MA number in this block.*** **2. When billing DHMH for a Fee-For-Service participant**, no number is required in this box.
Block 2	**PATIENT'S NAME**	(Last Name, First Name, Middle Initial) – Enter the participant's name as it appears on the Medical Assistance card.
Block 3	**PATIENT'S BIRTH DATE/SEX**	Enter the participant's date of birth and sex.

Block 4	**INSURED'S NAME**	(Last Name, First Name, Middle Initial) –When applicable, enter the name of the person who is listed on the third party coverage. ***Note: No entry required when billing for a participant with no third party insurance.***
Block 5	**PATIENT'S ADDRESS**	Enter the participant's complete mailing address with zip code and telephone number.
Block 6	**PATIENT'S RELATIONSHIP TO INSURED**	If the participant has other third party insurance, aside from Medicare, enter the appropriate relationship to the insured. ***Note: No entry required when billing for a participant without third party insurance.***
Block 7	**INSURED'S ADDRESS**	When the participant has third party insurance coverage aside from Medicare, enter the insured's address and telephone number. ***Note: No entry required when billing for a participant without third party insurance.***
Block 9a	**OTHER INSURED'S POLICY OR GROUP NUMBER**	Enter the participant's 11-digit Maryland Medical Assistance number. 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 web or phone EVS. EVS is operational 24 hours a day, 365 days a year at the following number: 1-866-710-1447 or online at http://www.emdhealthchoice.org
Block 10a through 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 *Block 24,* if this information is known. If not known, 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 insurer, enter the appropriate rejection code listed below: **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.) For information regarding participant's coverage, contact the Third Party Liability Unit at 410-767-1771.
Block 11a	**INSURED'S DATE OF BIRTH**	***No entry required when billing for a participant with no third party insurance.***
Block 11b	**EMPLOYER'S NAME OR SCHOOL NAME**	***No entry required when billing for a participant with no third party insurance.***
Block 11c	**INSURANCE PLAN OR PROGRAM NAME**	***No entry required when billing for a participant with no third party insurance.***
Block 11d	**IS THERE ANOTHER BENEFIT PLAN?**	***No entry required when billing for a participant that does not have third party insurance in addition to the one already described in Block 11 above.***
Block 12	**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**	For both MCOs and FFS, please write "**Signature on File**." Be sure to include the billing date.
Block 13	**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE**	***No entry required when billing for a FFS participant or a participant with no third party insurance.***
Block 14	**DATE OF CURRENT ILLNESS, or INJURY, or PREGNANCY**	Enter the date of the current illness, injury, or pregnancy.
Block 15	**OTHER DATE**	Enter the date if the participant has had the same or similar illness.
Block 17	**NAME OF**	*Block 17* should be completed in cases where there is

	REFERRING PHYSICIAN OR OTHER SOURCE	a referring physician.
Block 21	**DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY**	Enter the 3, 4, or 5 character code from the ICD-9 manual related to the procedures, services, or supplies listed in *Block 24d*. List the primary diagnosis on Line "A" and secondary diagnosis on Line "B". Additional diagnoses are optional and may be listed on Lines "C" and "D."
Block 23	**PRIOR AUTHORIZATION NUMBER**	For those services that require preauthorization, a preauthorization number **must** be obtained and entered in this Block.
Block 24 A-G	**NATIONAL DRUG CODE (NDC) (shaded area)**	Report the NDC/quantity when billing for drugs using the HCPCS J-code. 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. Without skipping a space or adding hyphens, enter the unit of measurement qualifier followed by the numeric quantity administered to the participant. Below are the measurement qualifiers when reporting NDC units: **<u>Measurement Qualifiers</u>** **F2 International Unit, GR Gram, ML Milliliter, UN Units** More than one NDC can be reported in the shaded lines of *Block 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 NDCs.

Block 24A	**DATE(S) OF SERVICE**	Enter each date of service as a 6-digit numeric date (e.g. June 1, 2009 would be 06/01/09) under the **FROM** and **TO** headings. Each date of service on which a service was rendered must be listed on a separate line. ***Note: Ranges of dates are not accepted on this form.***
Block 24B	**PLACE OF SERVICE**	For each date of service, enter the code to describe the site. ***Note: SUD Programs must enter Place of Service code "11".***
Block 24D	**PROCEDURES, SERVICES OR SUPPLIES**	Enter the five-character procedure code (H0001, H0004, H0005, H0015 or H0020) that describes the service provided.
Block 24E	**DIAGNOSIS POINTER**	Enter "**A**" or "**B**" to indicate the primary diagnosis or secondary diagnosis listed in *Block 21* that relates to the service being provided.
Block 24F	**CHARGES**	Enter the 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.
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.
Block 24J	**RENDERING PROVIDER ID # (shaded area)**	Enter the NPI number of the SUD clinic/program, not the participant provider number.
Block 25	**FEDERAL TAX I.D. NUMBER**	Enter the **Federal Tax ID number** for the billing provider entered in *Block 33*. ***Note: Be sure to check the box labeled "EIN" to identify this number as the Federal Tax ID number.***
Block 26	**PATIENT'S ACCOUNT NUMBER**	An alphabetic, alphanumeric, or numeric participant account identifier (up to 13 characters) used by the provider's office can be entered. ***Note: If participant's MA number is incorrect, this number will be recorded on the Remittance Advice.***

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. ***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 participant for covered services.***
Block 28	**TOTAL CHARGE**	Enter the sum of the charges shown on all lines of *Block 24F* of the invoice.
Block 29	**AMOUNT PAID**	Enter the amount of any collections received from any third party payer, except Medicare. If the participant has a third party insurance and the claim has been rejected, the appropriate rejection code should be placed in *Block 11*.
Block 31	**SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS**	For participants enrolled in MedStar Family Choice, please give the actual name of the rendering provider. For all other MCOs/FFS, please write "**Signature on File**." In both cases, please include the date of submission. ***Note: The date of submission must be in Block 31 in order for the claim to be reimbursed.***
Block 32	**SERVICE FACILITY LOCATION INFORMATION**	Enter the complete name and address for the SUD clinic/program.
Block 32a	**NPI**	Enter the SUD program's group NPI number. This should be the same 10-digit number entered in *Block 24J*.
Block 32b	**ID QUALIFIER (shaded area)**	Enter the SUD provider's 9-digit Maryland **Medicaid number**, which must be prefixed with "**ID**' in order for the claim to be reimbursed (i.e. ID012345678).
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 ID number entered in *Block 25*.
Block 33a	**NPI**	Enter the NPI number of the "pay-to" billing provider in *Block 33*. ***Note: Errors or omissions of this number will result in non-payment of claims.***
Block 33b	**(shaded area)**	Enter the "pay-to" provider's 9-digit Maryland **Medicaid number**, which must be prefixed with "**ID**' in order for the claim to be reimbursed (i.e. ID012345678).

		Note: The MA number should be that of the provider listed in Block 33. Errors or omissions of this number will result in non-payment of claims.
NOTE: It is the provider's responsibility to promptly report all name changes, pay-to address, correspondence address, practice locations, tax identification number, or OHCQ certification to the Provider Master File in Provider Relations at 410-767-5340. SUD providers should also contact the Behavioral Health Division at DHMH.MedicaidSUD@Maryland.gov with any changes. Also, SUD providers should report any changes to MCOs they have contracts with.		

Mail completed claims to the following address:

Maryland Department of Health and Mental Hygiene Office of Systems, Operations and Pharmacy Claims Processing Division
P.O. Box 1935
Baltimore, MD 21203

B. REJECTED CLAIMS

Rejected claims are 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 specific to individual claims and provide detailed information about the claim. There are a few common reasons a claim may be rejected:

1. Data was incorrectly keyed or was unreadable on the claim:

- Typing or printing clearly will help to avoid errors when a claim is scanned. When a claim is denied, always compare data from the Remittance Advice with the file copy of your claim. If the claim was denied because of a keystroke or scanning error, resubmit the claim with the corrected data.

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

- Verify that you have not previously submitted the claim;
- If the Program has determined that a participant 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 has coverage through a HealthChoice MCO, you must bill that participant's MCO for services rendered.

For MCO-Rejected Claims: The information above applies to claims submitted to the Medical Assistance fee-for service system; each MCO sets its own rules for rejection of claims and provides varying information on the EOB. Providers have at least 90 business days from the date of claim

denial to file an appeal. See the MCO Provider manual for further information.

C. TROUBLESHOOTING INFORMATION

To ensure proper completion of a claim, please check the following information is entered correctly:

1. Appropriate pay-to provider information in Blocks 31 and 33.

- ✓ Block 24J and Block 32 should contain information for the SUD program; and
- ✓ Block 25 and Block 33 should contain information for the sponsoring/pay-to provider if it is different from the rendering program information.

2. Establish provider and/or participant eligibility on the dates of services.

- ✓ Verify that you did not bill for services provided prior to or after your program enrollment dates; and
- ✓ Verify that you entered the correct dates of service in Block 24a of the claim form. You **must** check EVS on the day you render service to determine if the participant is eligible on that date. If you have done this and your claim is denied because the participant is ineligible, double-check that you entered the correct dates of service.

3. Make sure the medical services are covered/authorized for the provider and/or participant.

- ✓ A valid 2-digit place of service code is required. SUD programs must use Place of Service "11";
- ✓ 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 the 11- digit participant MA number and procedure code on the claim form; and
- ✓ Verify that the services are covered for the participant's coverage type. Covered services vary by population and program. Refer to the regulations for each program type to determine the covered services for that program.

D. HOW TO FILE AN ADJUSTMENT REQUEST

If you have been paid incorrectly for a claim **or** received payment from a third party after Medical Assistance issued payment, you **must** complete and submit an Adjustment Request Form (DHMH 4518A) to correct the payment. If an incorrect payment was due to an 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. Additionally, please be aware that SUD provider charges may differ from reimbursement rates.

When completing the Adjustment Form, do not bill only for remaining unpaid amounts or units; bill for the **entire** amount(s). For example, if you submitted and received payment for three units, but should have billed for five units, **do not** bill for the remaining two units; bill for the **entire** 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 (e.g., none of the participants listed are your participants). When this occurs, send 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 a Remittance Advice that 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 only those claims 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 CMS1500 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**.

For MCO Adjustment Requests: The information above **only** applies to claims submitted to Medical Assistance fee-for service system; the Adjustment Request Form (DHMH 4518A) is **not** valid for MCOs. SUD providers will have to submit corrected claims or appeals to MCOs. For information on how to file an adjustment with an MCO, see the contact information provided in Attachment 1.

V. SELF-REFERRED SUBSTANCE USE DISORDER SERVICES

The HealthChoice Substance Use Disorder Program, formally known as the Substance Abuse Improvement Initiative (SAII), allows HealthChoice participants to self-refer to substance use disorder treatment providers that are not part of their MCO provider network. Providers who do not have contracts with a HealthChoice participant's MCO can receive reimbursed for SUD services provided to these participants.

The criteria used for SUD treatment is the American Society of Addiction Medicine's (ASAM) Participant Placement, which is a widely used and comprehensive national guideline for placement, continued stay, and discharge of participants with alcohol and other drug problems. It also provides a mechanism to evaluate level of care (LOC).

A. SUBSTANCE USE DISORDER PROGRAM

A HealthChoice participant can self-refer for a Substance Use Disorder Assessment (CSAA) to any appropriate, willing SUD provider. Substance use disorder providers may receive reimbursement for a CSAA under the self-referred protocol if the following conditions are met:

- The participant is not currently in substance use disorder treatment;
- The participant self-refers for an assessment once per calendar year per Health Care Quality (OHCQ) certified program, unless there is more than a 30 day break in treatment;
- The program providing the assessment is certified by the OHCQ and meets the requirements established by the Alcohol and Drug Abuse Administration (ADAA) as described in COMAR 10.47;
- The assessment is reviewed and approved by a licensed physician or licensed practitioner of the healing arts, within the scope of his or her practice under State law;
- The program does not need to be part of the participant's MCO/BHO network; and
- A provider is not required to accept the participant as an enrollee, but does have a professional obligation to refer the participant to another provider.

If the SUD program does not provide additional treatment following completion of the CSAA, they will receive payment for the service only if they have met the requirements above and the program:

- Does not offer the level of care the participant requires and the participant has to be referred to another program;
- Conducts the CSAA, but the participant does not return for treatment; or
- Determines the participant does not need treatment.

The self-referral notification protocols beginning on page 21 of this manual include preauthorized units of service, the notification process for each treatment modality, and other important information. When a HealthChoice participant requests SUD treatment, the provider should

identify the ASAM level of care and follow the provisions for the appropriate treatment modality. The authorization narrative includes information about the five self-referred services, in addition to other SUD program services not included in these billing instructions. **Familiarity with the entire protocol is crucial. Providers not following these procedures could lead to denied authorization and/or payment.**

B. SELF-REFERRED SUBSTANCE USE DISORDER CODES AND RATES

The Department has developed uniform codes and rates for the following self-referred services, effective January 1, 2010:

- Comprehensive Substance Use Disorder Assessment
- Individual Outpatient Therapy
- Group Outpatient Therapy
- Intensive Outpatient
- Methadone Maintenance

These codes are to be used by providers who bill with the CMS 1500 form and are certified by OHCQ to provide SUD treatment. To simplify billing, the HealthChoice program and the Medicaid FFS system use the same codes.

Service	Code	HCPCS Description	Unit of Service	Rate	Limitations
Substance Use Disorder Assessment (CSAA)	H0001	Alcohol and/or drug Assessment	Per assessment	$142	Can **only** be billed once per 12-months per participant per provider unless there is more than a 30 day break in treatment
Individual outpatient therapy	H0004	Behavioral health counseling and therapy	Per 15 minutes	$20	Cannot bill with H0015 or H0020
Group outpatient therapy	H0005	Alcohol and/or drug services; group counseling by a clinician	Per 60-90 minute session	$39	Cannot bill with H0015 or H0020
Intensive outpatient (IOP)	H0015	Alcohol and/or drug services; intensive outpatient, including assessment, counseling, crisis intervention, and activity therapies or education.	Per diem (minimum 2 hours of service per session) Maximum 4 days per week Minimum 9 hours of service per week	$125	Cannot bill with H0020, H0004, or H0005

Methadone maintenance	H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	Per week	$80	Cannot bill this code with H0004, H0005, or H0015

IMPORTANT NOTE ON H0020: Providers are encouraged to establish a standard day of the week to consistently bill for the Methadone Maintenance service (procedure code H0020) in order to prevent denials. To determine the best day of the week to submit claims for the Methadone Maintenance service providers should contact the participant's MCO (see Attachment 1 for MCO contact information).

For questions regarding covered services, or to request a copy of the fee schedule, please contact ***DHMH.MedicaidSUD@Maryland.gov***. A copy of the fee schedule is available at: ***https://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx***

C. LABORATORY AND PATHOLOGY SERVICES

All MCOs currently have contracts with LabCorp. Labs should not bill Medicaid FFS or the MCOs for basic drug testing related to methadone maintenance treatment. Drug testing is included in the $80/week bundled payment rate for methadone maintenance services and thus should **not** be billed separately by the Methadone Maintenance Clinic or an outside lab service. If the Methadone Maintenance Clinic sends labs to an outside service, the Methadone Maintenance Clinic must pay the lab provider themselves.

D. SELF-REFERRED NOTIFICATION PROTOCOL

The following section provides a narrative description of the notification and authorization requirements for self-referred services under HealthChoice. Self-referred protocols are listed by ASAM level. Please note these protocols do **not** address any benefit limitations; services beyond these are justified based on medical necessity according to ASAM criteria.

Comprehensive Substance Use Disorder Assessment (CSAA)

A MCO or the Behavioral Health Organization (BHO) will cover a Comprehensive Substance Use Disorder Assessment once per participant per provider per 12-month period, unless there is more than a 30-day break in treatment. If a participant returns to treatment after 30 days, the MCO/BHO will pay for another CSAA.

ASAM Level I.D – Ambulatory Detox

In regards to the self-referral option under HealthChoice, ambulatory detox refers to detox services provided in the community or in outpatient departments of hospitals or outpatient programs of intermediate care facilities-alcohol (ICF-A).

Provider Communication Responsibility

Provider must notify MCO/BHO and provide treatment plan (by fax or email) within one (1) business day of admission to ambulatory detox.

MCO/BHO Communication Responsibility

The MCO/BHO will respond to provider within one (1) business day of receipt with final disposition concerning ASAM criteria, including confirmation/ authorization number if approved.

Approval Protocol

1) If MCO/BHO **does not** respond to provider's notification, MCO/BHO will pay up to five (5) days.

2) If MCO/BHO responds by approving authorization, a LOS of five (5) days will automatically be approved. Additional days must be preauthorized as meeting medical necessity criteria.

3) If MCO/BHO determines participant does not meet ASAM LOC, the MCO/BHO will pay for care up to the point where they formally communicate their disapproval.

ASAM Level: I – Outpatient Services - Individual, family and group therapy

Self-referred individual or group therapy services must be provided in the community (not in hospital rate-regulated settings).[2] Hospital-based providers must seek preauthorization to be reimbursed for these services from an MCO/BHO.

Provider Communication Responsibility

Provider must notify (by fax or email) the MCO/BHO and provide initial treatment plan within three (3) business days of admission to Level I therapy services.

[2] Hospital rate regulated clinics must seek preauthorization to provide such services under HealthChoice.

MCO/BHO Communication Responsibility

The MCO/BHO must respond to a provider within two (2) business days of receipt with confirmation of receipt of notification.

Approval Protocol

The MCO/BHO will pay for 30 sessions (any combination of individual, group, and family therapy) within a 12-month period per participant (family sessions are billed under the participant's Medicaid number). The 30 sessions are not a benefit limitation. Rather, the provider must seek preauthorization for additional individual or group therapy services during the year. Medicaid MCOs will pay for additional individual and group counseling services as long as medical necessity has been met.

In order for a provider to bill for family counseling, the participant must be present for an appropriate length of time but does not need to be present for the entire counseling session. In some circumstances the counselor might spend part of the session with the family out of the presence of the participant.

ASAM Level: II.1 – Intensive Outpatient (IOP)

Self-referred intensive outpatient only applies to care delivered in a community-based setting. Providers must seek preauthorization to provide such services. In preauthorizing, MCOs may refer to in-network community providers if those providers are easily available geographically and without waiting lists.

Provider Communication Responsibility

The Provider must notify and provide treatment plan to MCO/BHO (by fax or email) within three (3) business days of admission to IOP. **If they do not notify the MCO/BHO, they will not be paid for services rendered.**

MCO/BHO Communication Responsibility

The MCO/BHO will respond to the provider (by fax or email) within two (2) business days with final disposition concerning ASAM criteria, including confirmation number if approved.

Approval Protocol

If the treatment plan is approved, MCO will pay for 30 calendar days. At the end of week three (3), for care coordination purposes, the provider must notify the MCO/BHO of discharge plan or need for remaining treatment. Continuing treatment beyond the 30 days must be preauthorized as being medically necessary.

If determined that a participant **does not** meet ASAM LOC, MCO/BHO will pay for all services delivered up until the point that they formally notify the provider of the denial. If the participant does not qualify for IOP, the MCO/BHO will work with the provider to determine the appropriate level of care.

ASAM Level: II.5 – Partial Hospitalization

This service is provided in a hospital or other facility setting.

Provider Communication Responsibility

By the morning of the second day of admission to this service setting, the provider will review the participant's Treatment Plan with the MCO/BHO by telephone. The Provider must submit a progress report **and** assessment for justification of continued stay beyond day five (5). The Provider obtains participant consent and submits progress report or discharge summary to PCP for their records and coordination of care within 10 days.

MCO/BHO Communication Responsibility

MCO/BHO will respond to providers within two (2) hours of review. Confirmation number will be provided. MCO/BHO must have 24/7 availability for case discussion with providers.

Approval Protocol

1) Two (2) day minimum guaranteed. If ASAM is met, MCO/BHO will authorize an additional three (3) days. Any additional days must be preauthorized by the MCO/BHO based on medical necessity.

2) If the MCO/BHO is **not available or does not respond** to the provider within two (2) hours, they will pay the extra three (3) days. Any additional days must be preauthorized by the MCO/BHO based on medical necessity.

Providers shall seek the least restrictive level of care for participants. If the participant does not qualify for partial hospitalization, the MCO/BHO will work with the provider to determine the appropriate level of care.

ASAM Level: III – Residential and Inpatient – ICF-A, (under 21 years)

ICF-A services are only available for children and adolescents under age 21 for as long as medically necessary and the participant is eligible for the service. Medicaid does not pay for services if they are not medically necessary, even if a Court has ordered them. HealthChoice MCOs do not cover other residential services.

Provider Communication Responsibility

Within two (2) hours, provider calls MCO/BHO for authorization.

MCO/BHO Communication Responsibility

MCO/BHO will respond to the provider within two (2) hours with a final disposition concerning ASAM criteria, including confirmation number if approved. MCO/BHO must have 24/7 availability for case discussion with the provider.

Approval Protocol

1) If MCO/BHO **does not** respond to urgent call, up to three (3) days will be paid. Additional days must be preauthorized.

2) If ASAM is met and MCO/BHO has authorized, a LOS of three (3) days will be approved. Additional days must be preauthorized.

3) If participant does not meet criteria, the MCO/BHO will work with the provider to determine appropriate level of care.

ASAM Level: Opioid Maintenance Treatment - Methadone

In regard to the self-referral option, methadone maintenance refers to services provided in the community or outpatient departments of hospitals.

Provider Communication Responsibility

Within five (5) calendar days of participant admission to methadone program, provider notifies MCO/BHO (by fax or email) and submits initial treatment plan.

After obtaining the participant's consent, the provider will also inform the participant's Primary Care Provider that this participant is in treatment.

The provider will submit an updated treatment plan to the MCO/BHO at the 12th week of service to promote the coordination of care. The next approvals for continued care will be at six-month intervals.

MCO/BHO Communication Responsibility

MCO/BHO will respond to provider within two (2) business days (by fax or email) with final disposition, including confirmation number if approved. The MCO/BHO will assist the provider with contact information concerning the participant's PCP.

Approval Protocol

If approved, MCO/BHO will pay for 26 weeks under the self-referral option. Medicaid coverage is determined by medical necessity. Unit of service is one week. Any care provided prior to a denial based on medical necessity will be paid by the MCO/BHO. Additional approvals for continued care beyond the first 26 weeks will be at six-month intervals.

ASAM Level: IV.D: Medically Managed Participants – Inpatient Detox in an Inpatient Hospital Setting or in an ICF-A Facility

This service is provided in a hospital or ICF-A setting.

Provider Communication Responsibility

Within two (2) hours, provider calls MCO/BHO for authorization.

MCO/BHO Communication Responsibility

MCO/BHO will respond to provider within two (2) hours with a final authorization or disposition, including confirmation number if approved. MCO/BHO must have 24/7 availability.

Approval Protocol

1) If ASAM is met and MCO/BHO authorizes, a LOS of three (3) days will be approved. Additional days must be preauthorized based on medical necessity.

2) If participant **does not** meet criteria, the MCO/BHO will work with provider to determine appropriate level of care.

3) If MCO/BHO **does not** respond to the provider's authorization call, up to three (3) days will be paid. Additional days must be preauthorized based on medical necessity.

ATTACHMENT 1
MCO CONTACT INFORMATION FOR SUBSTANCE USE DISORDER PROVIDERS

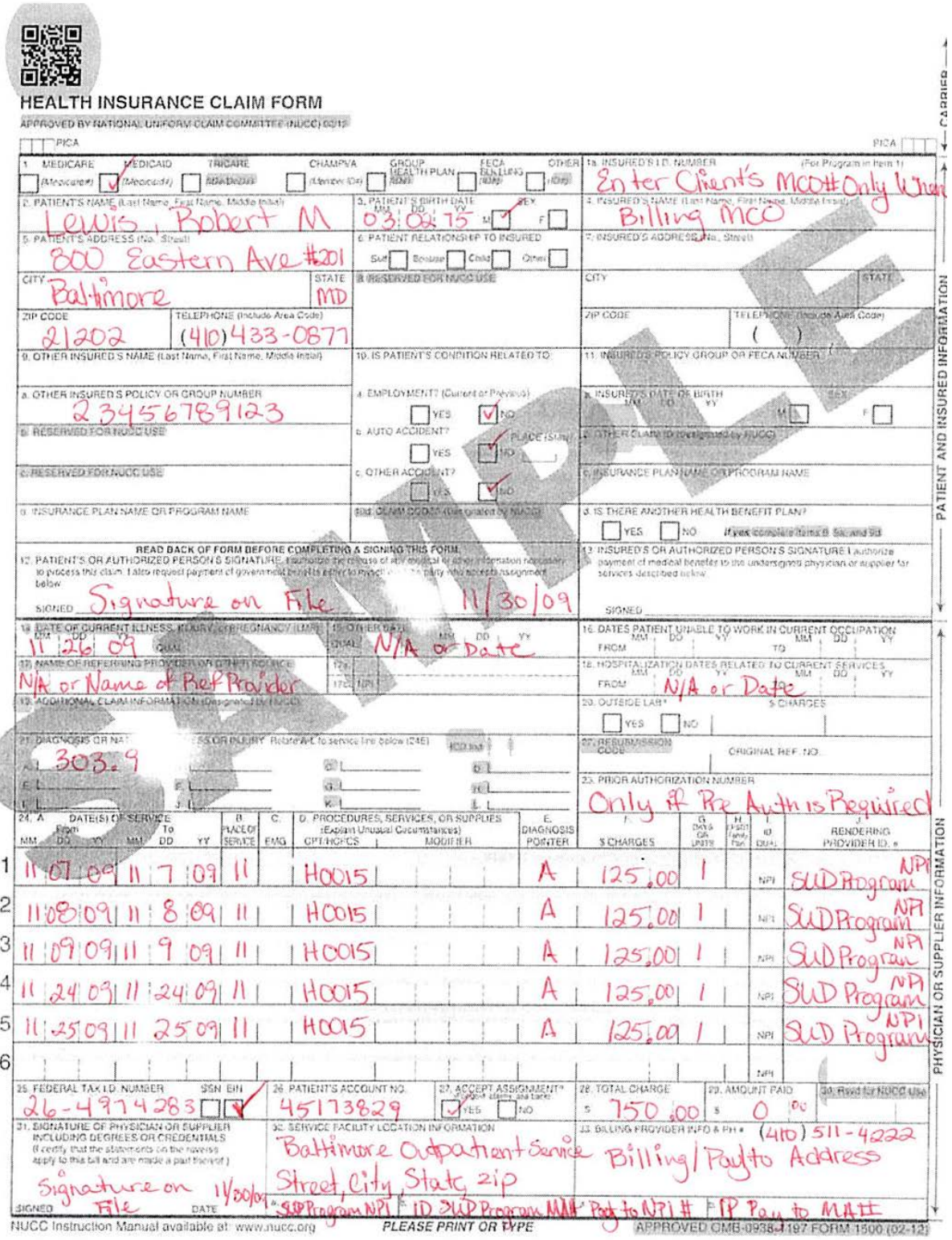
Managed Care Organization Behavioral Health Organization (BHO)	Authorization/ Notification Both in- & out-of-network	MCO Problem/Concern Contact Call numbers to the left first	Provider Relations	Claims	Special Needs Coordinator
Amerigroup Community Care www.amerigroup corp.com	Providers: 1-800-454-3730 (have AMERIGROUP provider ID number or NPI number to more easily navigate system) Members: 1-800-600-4441 Fax: 1-800-505-1193	Sarah Bradley Phone: 1-410-981-4051 Sarah.bradley@amerigroup.com	Provider Service Unit: 1-800-454-3730	Provider Service Unit: 1-800-454-3730	Monique Anthony Phone: 410-981-4060 Fax: 866-920-1867 Email: manthony@amerigroup.com
Jai Medical Systems www.jaimedical systems.com/	Jemma Chong Qui Phone: 1-888-JAI-1999 Fax: 410-327-0542 Email: Jemma@jaimedical.com	Jemma Chong Qui Phone: 1-888-JAI-1999	Kristin Yursha Phone: 1-888-JAI-1999 Fax: 410-433-4615 Email: kristin@jaimedical.com	Provider Relations Department: 1-888-JAI-1999	Chardae Buchanan, RN Phone: 410-433-5600 option 7 Fax: 410-433-8500 E-mail: chardae@jaimedical.com
Maryland Physicians Care www.maryland physicianscare.com/	Phone: 1-800-953-8854 option 7 Fax: 860-907-2649	Linda Dietsch 410-401-9452 Fax: 860-907-2684 Email: linda.dietsch@ marylandphysicianscare.com	Susan Rewers-Green Phone: 410-401-9457 Fax: 860-907-2736 Email: susan.green@ marylandphysicianscare.com	All Authorizations Fax: 860-907-2649 Claims Inquiry-Research Phone: 1-800-953-8854	Shannon Jones Phone: 410-401-9443 Fax: 860-970-2710 Email: shannon.jones@ marylandphysicianscare.com
MedStar Family Choice www.medstar familychoice.net **BHO: Value Options**	Phone: 1-800-496-5849	Jennifer Hale, Sr. Acct. Exec. Jennifer.Hale@ValueOptions.com Phone: 740-389-5132 Secondary Phone: 518-271-2126	Phone: 1-800-397-1630	Phone: 1-800-496-5849	Laura Trembly Phone: 410-933-2241
Priority Partners www.ppmco.org/	Phone: 1-800-261-2429 Option 2 Fax: 410-424-4891	Thomas Taylor Phone: 1-800-261-2429 Secondary Phone: 410-762-5225 Fax: 410-424-4891 Email: TTaylor@jhhc.com	Dina Goldberg, Director Phone: 410-424-4634 Fax: 410-424-4604 Email: dgoldberg@jhhc.com	Provider Customer Service Phone: 410-424-4490 Secondary Phone: 1-800-819-1043	James Tisdale Phone: 1-800-261-2396 Secondary Phone: 410-424-4915 Fax: 410-424-4887 Email: JTisdale@jhhc.com
Riverside Health of Maryland www.myriverside health.com/ **BHO: Value Options**	Phone: 1-877-813-5706	Jennifer Hale, Sr. Acct. Exec. Phone: 740-389-5132 Email: Jennifer.Hale@ValueOptions.com	Phone: 1-877-813-5706, press 4 Or ValueOptions Provider line: 1-800-397-1630	Phone: 1-877-813-5706	Kimberly Morrill, LCSWC Phone: 443-552-3278 Fax: 410-779-9336 E-mail: kmorrill@myriversidehealth.com
UnitedHealthcare www.uhccommunity plan.com **BHO: United Behavioral Health**	Phone: 1-888-291-2507 Fax: 1-855-250-8159	Alicia McKnight Account Director Phone: 615-941-1249 Email: alicia.s.mcknight@optum.com	Katie Hinkle Network Manager Phone: 612-642-7606 Fax: 215-832-4707 Email: Katie.hinkle@optumhealth.com	Phone: 1-888-291-2507	Brenda McQuay Phone: 410-379-3434 Fax: 410-540-5977 E-Fax: 1-855-273-1594 Email: brenda_e_mcquay@uhc.com

ATTACHMENT 2

MCO Billing Addresses

MCO (BHO)	Billing Address
AMERIGROUP	Amerigroup PO Box 61010 Virginia Beach, VA 23466-1010
JAI MEDICAL SYSTEMS	Jai Medical Systems Attention: Claims Department 5010 York Road Baltimore, MD 21212
MD PHYSICIANS CARE	Maryland Physicians Care MCO Claims P.O. Box 61778 Phoenix, AZ 85082-1778
MEDSTAR FAMILY CHOICE (Value Options)	MedStar Family Choice P.O. Box 383 Latham, NY 12110
PRIORITY PARTNERS	Johns Hopkins Health Care Attn: Priority Partners Claims 6704 Curtis Court Glen Burnie, MD 21060
RIVERSIDE HEALTH OF MARYLAND (Value Options)	Riverside Health P.O. Box 383 Latham, NY 12110
UNITEDHEALTHCARE (United Behavioral Health)	United Behavioral Health P.O. Box 30757 Salt Lake City, UT 84130-0757

ATTACHMENT 3
MOCK UP OF CMS 1500 FORM FOR A PARTICIPANT RECEIVING INTENSIVE OUTPATIENT THERAPY



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) ✓ | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Enter Client's MCO# Only When

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Lewis, Robert M

3. PATIENT'S BIRTH DATE: 03 02 75 SEX: M ✓ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Billing MCO

5. PATIENT'S ADDRESS (No., Street): 800 Eastern Ave #201

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Baltimore | STATE: MD

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 21202 | TELEPHONE (Include Area Code): (410) 433-0877

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 2345678912 3

a. EMPLOYMENT? (Current or Previous): YES | NO ✓

a. INSURED'S DATE OF BIRTH: MM DD YY | SEX: M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO ✓ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO ✓

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File 11/30/09

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY 11 26 09 QUAL.

15. OTHER DATE: QUAL. MM DD YY N/A or Date

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: N/A or Name of Ref Provider

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM N/A or Date

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.

A. 303.9 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Only if Pre Auth is Required

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 07 09	11 7 09	11		H0015		A	125.00	1		NPI	SUD Program NPI
2 11 08 09	11 8 09	11		H0015		A	125.00	1		NPI	SUD Program NPI
3 11 09 09	11 9 09	11		H0015		A	125.00	1		NPI	SUD Program NPI
4 11 24 09	11 24 09	11		H0015		A	125.00	1		NPI	SUD Program NPI
5 11 25 09	11 25 09	11		H0015		A	125.00	1		NPI	SUD Program NPI
6										NPI	

25. FEDERAL TAX I.D. NUMBER: SSN | EIN ✓ 26-4974283

26. PATIENT'S ACCOUNT NO.: 45173829

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ✓ | NO

28. TOTAL CHARGE: $ 750.00

29. AMOUNT PAID: $ 0.00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File DATE 11/30/09

32. SERVICE FACILITY LOCATION INFORMATION: Baltimore Outpatient Service Street, City State, zip

a. SUD Program NPI | b. ID SUD Program MAA#

33. BILLING PROVIDER INFO & PH #: (410) 511-4222 Billing/Pay to Address

Pay to NPI # | Pay to MAA#

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

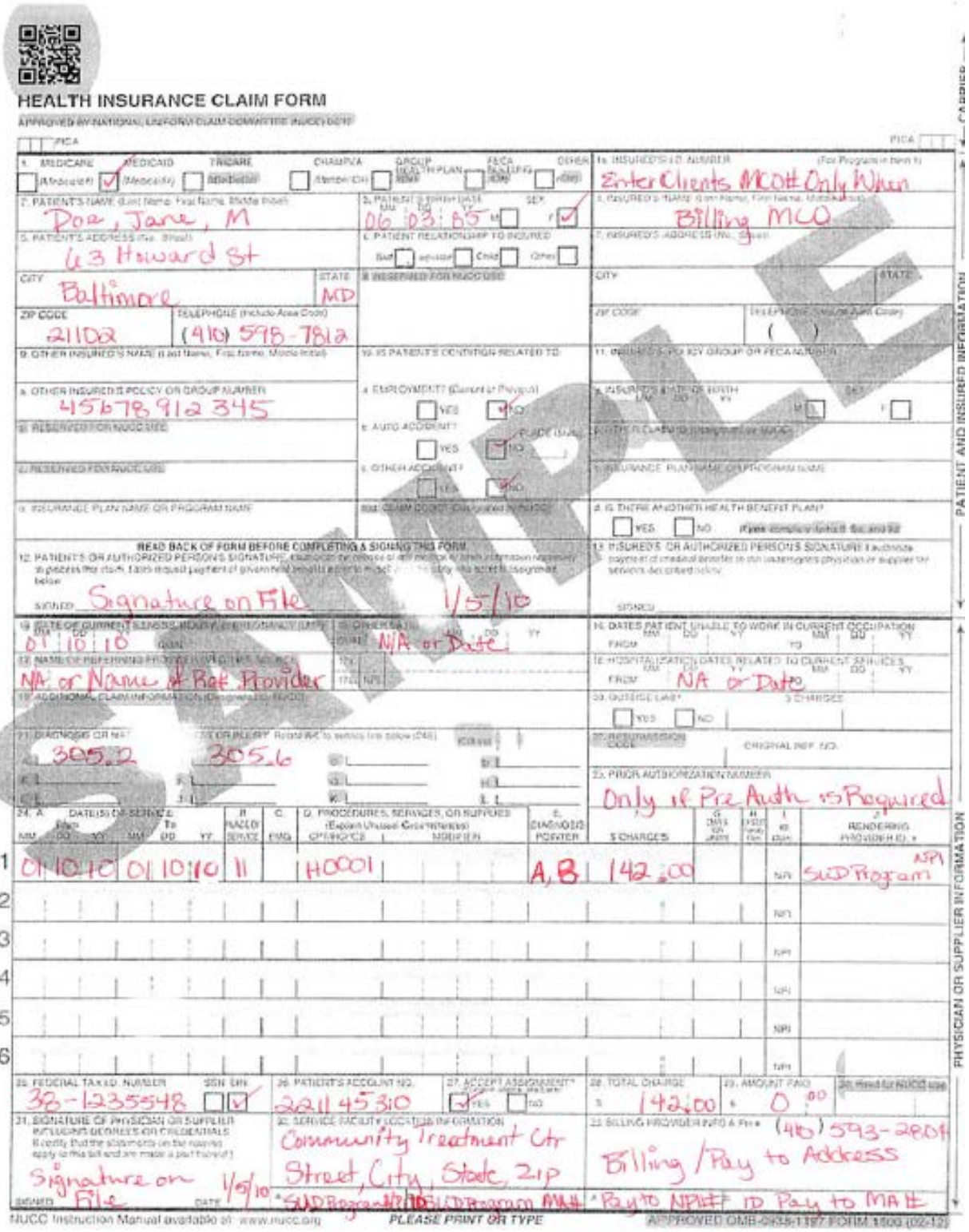
APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

ATTACHMENT 4
MOCK UP OF CMS 1500 FORM FOR A PARTICIPANT
RECEIVING A SUBSTANCE USE DISORDER ASSESSMENT



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) ✓ | TRICARE (ID/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Enter Clients MCO# Only When

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane, M

3. PATIENT'S BIRTH DATE: 06 03 85 SEX: M ☐ F ✓

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Billing MCO

5. PATIENT'S ADDRESS (No., Street): 43 Howard St

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Baltimore

STATE: MD

8. RESERVED FOR NUCC USE

CITY:

STATE:

ZIP CODE: 21102

TELEPHONE (Include Area Code): (410) 598-7812

ZIP CODE:

TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 456 78 912 345

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ✓

a. INSURED'S DATE OF BIRTH: MM DD YY SEX: M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ✓ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ✓

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE: 1/5/10

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 01 10 10 QUAL.

15. OTHER DATE: QUAL. NA or Date

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: NA or Name of Ref. Provider

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM NA or Date TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E)

ICD Ind.

A. 305.2 B. 305.6 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: Only if Pre Auth is Required

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 10 10	01 10 10	11		H0001		A, B	142.00			NPI	SUD Program NPI
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 38-1235548 SSN EIN ✓

26. PATIENT'S ACCOUNT NO.: 221 45 310

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ✓ NO ☐

28. TOTAL CHARGE: $ 142.00

29. AMOUNT PAID: $ 0.00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File DATE: 1/5/10

32. SERVICE FACILITY LOCATION INFORMATION: Community Treatment Ctr Street, City, State, ZIP

SUD Program NPI ID SUD Program MAI

33. BILLING PROVIDER INFO & PH #: (410) 593-2801

Billing / Pay to Address

Pay to NPI ID Pay to MAI

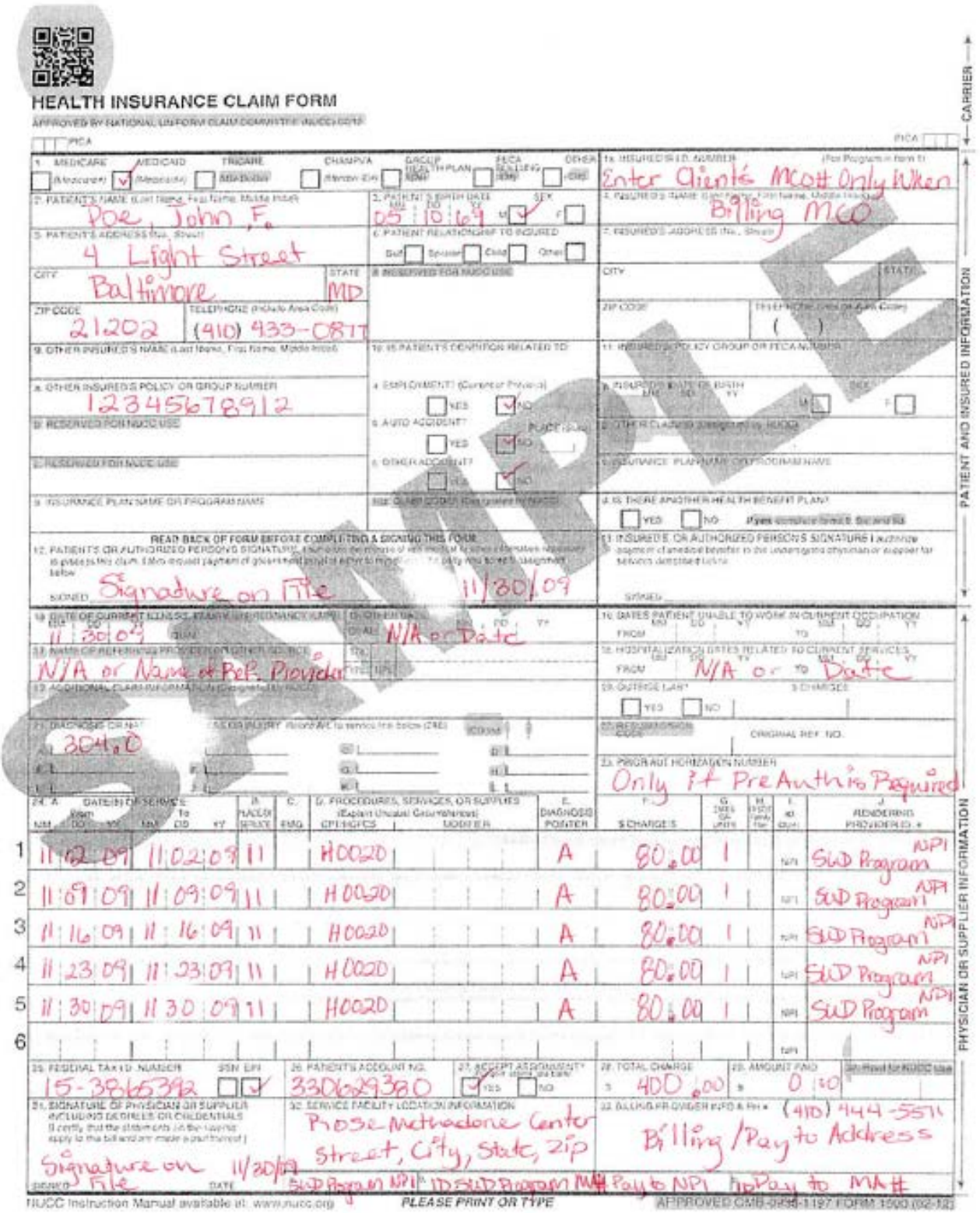
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

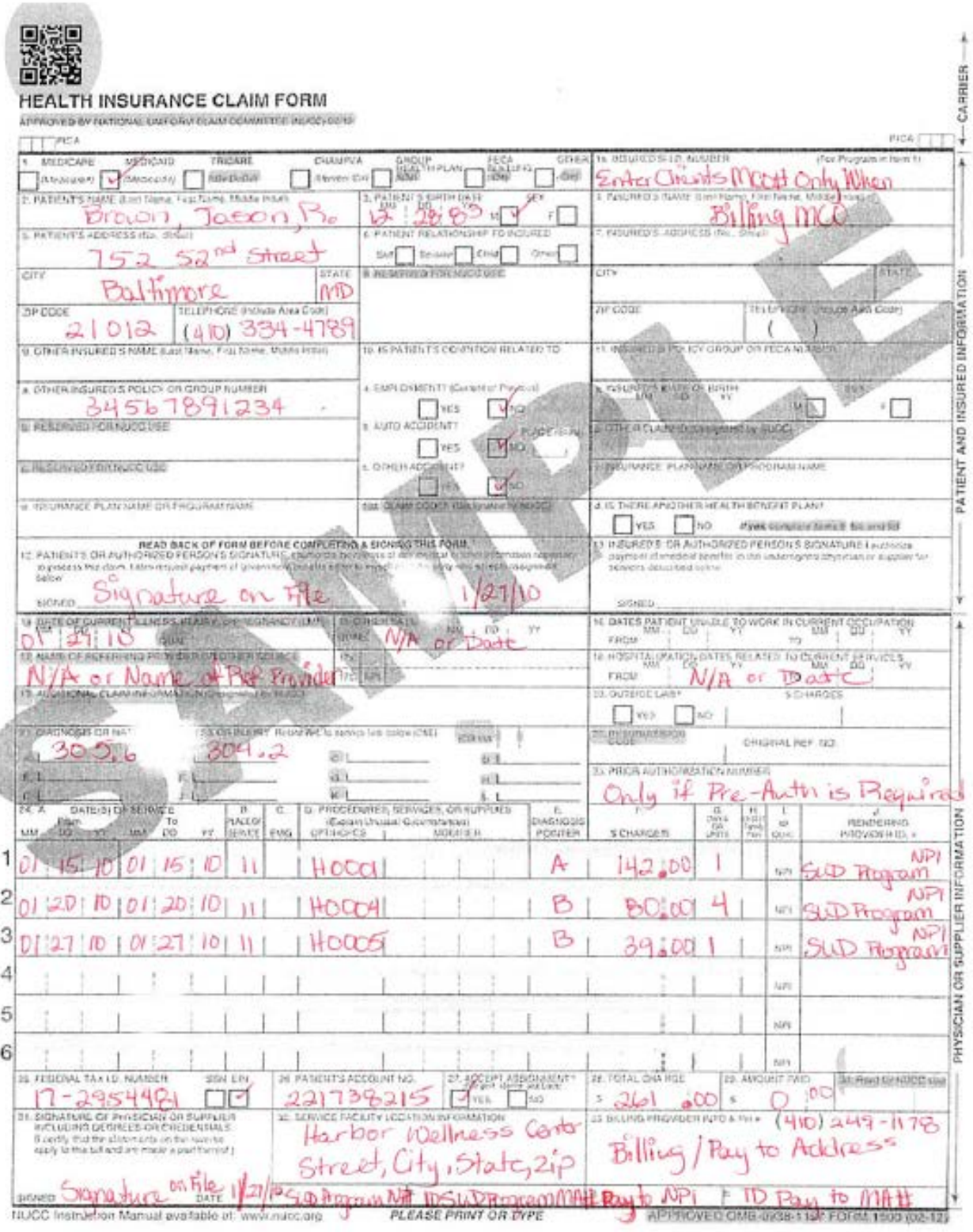
PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

ATTACHMENT 5
MOCK UP OF CMS 1500 FORM FOR A PARTICIPANT RECEIVING METHADONE MAINTENANCE THERAPY



ATTACHMENT 6
MOCK UP OF CMS 1500 FORM FOR A PARTICIPANT
RECEIVING CSAA, INDIVIDUAL AND GROUP OUTPATIENT THERAPY



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) ✓ | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Enter Client's Medi Only When Billing MCO

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Brown, Jason, Bo

3. PATIENT'S BIRTH DATE: 12 28 85 — SEX: M ✓ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Billing MCO

5. PATIENT'S ADDRESS (No., Street): 752 52nd Street

6. PATIENT RELATIONSHIP TO INSURED: Self ✓ Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Baltimore — STATE: MD

8. RESERVED FOR NUCC USE

CITY — STATE

ZIP CODE: 21012 — TELEPHONE (Include Area Code): (410) 334-4789

ZIP CODE — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 3456789 1234

a. EMPLOYMENT? (Current or Previous): YES ✓ NO

a. INSURED'S DATE OF BIRTH: MM DD YY — SEX: M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ✓ NO — PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ✓ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete items 9, 9a, and 9d.)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File — 1/27/10

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY — QUAL. — 01 29 10

15. OTHER DATE: MM DD YY — QUAL. — N/A or Date

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: N/A or Name of Ref Provider — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM N/A or ID date TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) — ICD Ind.

A. 309.6 — B. 309.2 — C. — D. — E. — F. — G. — H. — I. — J. — K. — L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Only if Pre-Auth is Required

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 15 10	01 15 10	11		H0004		A	142.00	1		NPI	SUD Program NPI
2 01 20 10	01 20 10	11		H0004		B	80.00	4		NPI	SUD Program NPI
3 01 27 10	01 27 10	11		H0005		B	39.00	1		NPI	SUD Program NPI
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 17-2954981 — SSN EIN ✓

26. PATIENT'S ACCOUNT NO.: 2217382215

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ✓ NO

28. TOTAL CHARGE: $ 261.00

29. AMOUNT PAID: $ 0.00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: Signature on File — DATE: 1/27/10

32. SERVICE FACILITY LOCATION INFORMATION: Harbor Wellness Center Street, City, State, Zip — SUD Program NPI — ID SUD Program MAT# — Pay to NPI — ID Pay to MAT#

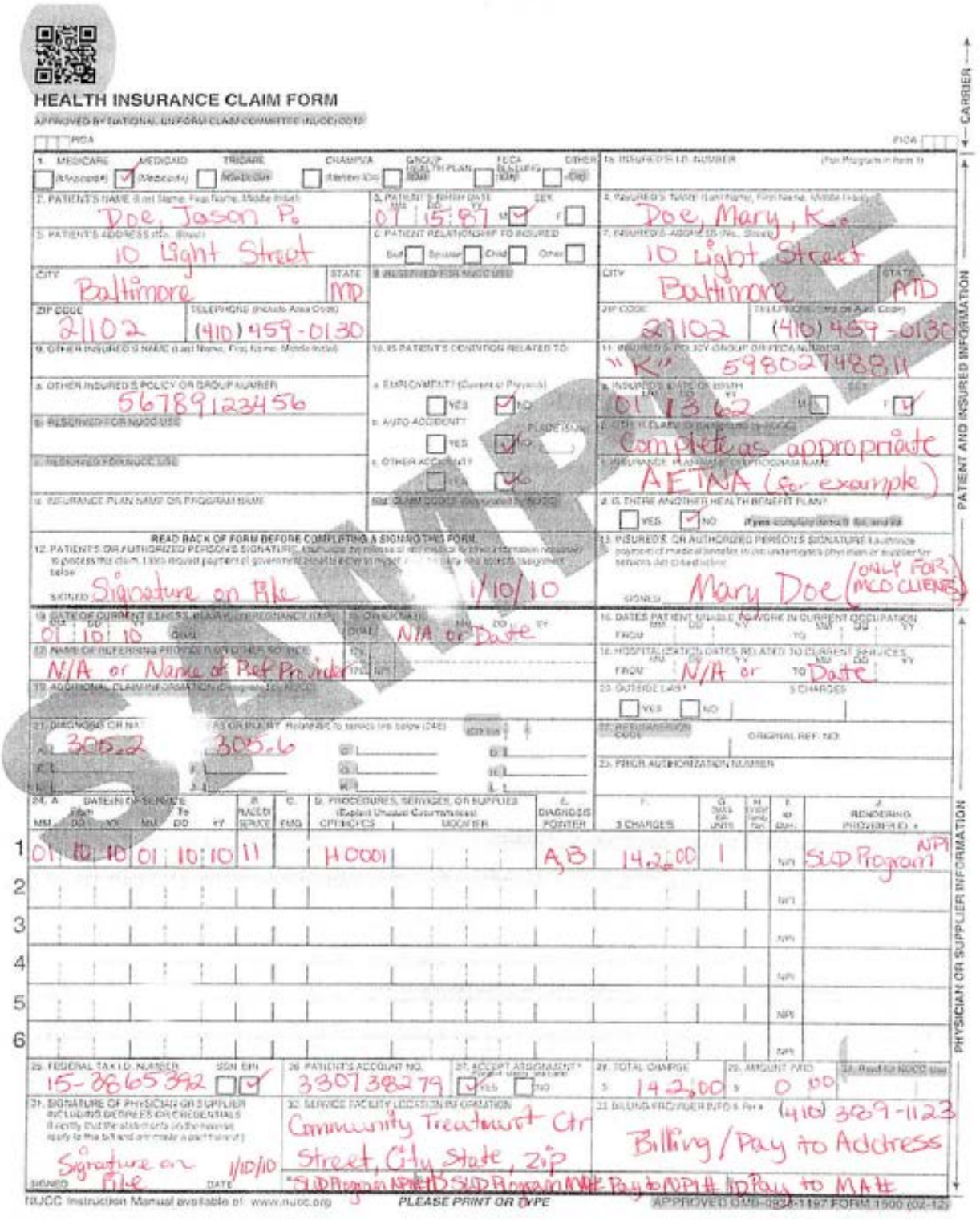
33. BILLING PROVIDER INFO & PH #: (410) 249-1178 Billing / Pay to Address

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

SAMPLE

ATTACHMENT 7
MOCK UP OF CMS 1500 FORM FOR A PARTICIPANT RECEIVING CSAA, GROUP AND INDIVIDUAL OUTPATIENT THERAPY WITH THIRD PARTY INSURANCE



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) ☑ | TRICARE (ID/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jason P.

3. PATIENT'S BIRTH DATE: 01 15 87 SEX: M ☑ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Mary, K.

5. PATIENT'S ADDRESS (No., Street): 10 Light Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 10 Light Street

CITY: Baltimore | STATE: MD

8. RESERVED FOR NUCC USE

CITY: Baltimore | STATE: MD

ZIP CODE: 21102 | TELEPHONE (Include Area Code): (410) 459-0130

ZIP CODE: 21102 | TELEPHONE (Include Area Code): (410) 459-0130

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: "K" 598027488,11

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 567891234 56

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☑

11a. INSURED'S DATE OF BIRTH: 01 13 62 SEX: M ☐ F ☑

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☑ PLACE (State)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☑

11c. INSURANCE PLAN NAME OR PROGRAM NAME: Complete as appropriate

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☑ (If yes, complete items 9, 9a, and 9d.)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File | DATE: 1/10/10

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Mary Doe (ONLY FOR MCO CLIENTS)

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 01 10 10 QUAL.

15. OTHER DATE: QUAL. N/A or Date

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: N/A or Name of Ref. Provider

17a. ID NUMBER OF REFERRING PROVIDER

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM: N/A or TO: Date

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind.

A. 305.22 B. 305.6 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 10 10	01 10 10	11		H0001		A,B	142.00	1		NPI	SUD Program NPI
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 15-8665382 SSN EIN ☑

26. PATIENT'S ACCOUNT NO.: 330738279

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☑ NO ☐

28. TOTAL CHARGE: $ 142.00

29. AMOUNT PAID: $ 0.00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File DATE: 1/10/10

32. SERVICE FACILITY LOCATION INFORMATION: Community Treatment Ctr Street, City State, Zip "SUD Program NPI# SUD Program NAME Pay to NPI# Pay to NAME

33. BILLING PROVIDER INFO & PH #: (410) 329-1123 Billing / Pay to Address

PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

ATTACHMENT 8
MCO/BHO ELECTRONIC BILLING INFORMATION

MCO (BHO)	Status/Procedure
AMERIGROUP	Available with no transaction costs, but setup fees might be charged. Following is contact information to obtain software. Emdeon (formerly WebMD) 1-877-469-3263 Option 3 - AMERIGROUP Payor ID: 27517 MedAdvant (formerly ProxyMed) 1-800-586-6870 - AMERIGROUP Payor ID: 28807 For issues with electronic transmission from a Clearinghouse to AMERIGROUP, call AMERIGROUP's EDI Support line at 1-800-590-5745
JAI MEDICAL SYSTEMS	Electronic billing is available through ClaimsNet. Please visit the ClaimsNet website at www.claimsnet.com/jai to register. If you have any technical problems, please contact helpdesk@claimsnet.com. Payor ID: JAI01
MD PHYSICIANS CARE	Emdeon WebMD 800-735-8254, Ext. 17903 MD Physicians Care Payor ID: 22348 ProxyMed 888-894-7888 MD Physicians Care Payor ID: 00247
MEDSTAR FAMILY CHOICE (Value Options)	Providers can access the electronic data interchange (EDI) by downloading the software from www.valueoptions.com/providers/ProCompliance.htm or requesting a CD through VO's EDI Helpdesk 1-888-247-9311 or email: e-supportServices@ValueOptions.com
PRIORITY PARTNERS	JHHC accepts claims from Emdeon (WebMD) and Payer Path (Relay Health). If interested in submitting electronically to JHHC, please contact ProviderRelations@jhhc.com. Upon receipt of your interest e-mail, a member of the EDI Task Force will contact you.
RIVERSIDE HEALTH OF MARYLAND (Value Options)	Providers can access the electronic data interchange (EDI) by downloading the software from www.valueoptions.com/providers/ProCompliance.htm or requesting a CD through VO's EDI Helpdesk 1-888-247-9311 or email: e-supportServices@ValueOptions.com
UNITEDHEALTHCARE (United Behavioral Health)	Network providers can submit bills and members can submit claims on line at ***www.ubhonline.com***. Facilities and large groups can submit electronically via third party vendors such as WebMD, etc.

Office of Health Services
Department of Health and Mental Hygiene
February 25, 2014