MARYLAND MEDICAL ASSISTANCE PROVIDER HANDBOOK

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Chapter 10 explains your obligations and rights as a Medical Assistance provider. The topics covered include civil rights, confidentiality, provider eligibility, enrollment changes, record keeping requirements and fraud/abuse review.

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Appendices

Appendix A describes various supplements available, including specific billing instructions and a third party carrier listing. Copies of several forms are reproduced in Appendix B. The Rare and Expensive Case Management Handbook is reproduced in Appendix C.

Glossary

The glossary is a list of terms used either in this handbook or by the Program along with their definitions. The terms are defined because the Maryland Medical Assistance Program may have special meanings for them.

MARYLAND MEDICAL ASSISTANCE PROVIDER HANDBOOK

Chapter 2 - The Medical Assistance Program

History of the Maryland Medical Assistance Program

The Medical Assistance Program (also referred to as Medicaid, the Program or Title XIX) is a federally and State funded program which entitles poor and medically needy persons to medical care and related services. The Program provides access to a broad range of health care services for eligible Maryland residents. The Medical Assistance Program provides eligible people with services to promote self-care.

Congress created the Medical Assistance Program in 1965 through Title XIX of the federal Social Security Act. Medical Assistance derives its legal authority from Title XIX, Section 1902 (a) of the Social Security Act and from Title 15 of the Health-General Article, Article 43, Section 42, of the Annotated Code of Maryland. State regulations pertaining to Medical Assistance are found in Title 10, Subtitle 09, of the Code of Maryland Regulations (COMAR).

The Maryland Medical Assistance Program began on July 1, 1966, during the administration of Governor J. Millard Tawes. It is administered by the Maryland Department of Health and Mental Hygiene (DHMH) Medical Care Programs, which consists of three administrations: Medical Care Finance and Compliance Administration (MCFCA), Medical Care Policy Administration (MCPA) and Medical Care Operations Administration (MCOA).

In order to receive federal funds, Maryland must comply with federal regulations. The federal regulations for Medicaid are located in Title 42 of the Code of Federal Regulations. The regulations provide two types of Medical Assistance services for the State: mandatory and optional. To receive federal financial participation, states are required to provide Medicaid coverage for most individuals receiving welfare, as well as for related groups not receiving cash payments. In addition, states must offer certain health care services such as inpatient and outpatient hospital services, physician services and nursing facility services. States may also receive federal funding if they elect to provide optional services such as clinic services, pharmacy services and dental services.

Program Administration

The Medical Assistance Program, has different levels of governmental involvement.

Federal	The U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) administers the Medical Assistance Program at the federal level.
State	The Maryland Department of Health and Mental Hygiene (DHMH) administers Medical Assistance at the State level.
Local	The Department of Human Resources and its Local Departments of Social Services and Local Health Departments determine Medical Assistance eligibility.

What Determines Eligibility

A person can qualify for Medical Assistance in several ways:

1. A person is eligible for health care coverage under Medical Assistance if he or she receives cash assistance under Temporary Assistance to Needy Families (TANF) or Supplemental Security Income (SSI).

2. A person may also qualify for federal Medical Assistance under one of the following categories: aged (age 65 or over), blind, disabled, caretaker relative of dependent child(ren) under 21 years old, children under age 21, pregnant women. If a person falls into one of these categories, the remaining qualifications for eligibility are based primarily on what the person has in the way of available income and assets. If both are within certain established levels, the person is financially eligible.

   Income for the above categories include both earned income and unearned income. Earned income includes wages, salaries, commissions and profit from self-employment. Unearned income includes Social Security benefits, dividend income, Veteran=s benefits and retirement benefits. Assets mean accumulated personal wealth over which a person has the authority or power to liquidate his/her interest. Assets include cash savings, savings accounts, checking accounts, stocks, bonds, etc.

. A person who is ineligible, because he/she has income which exceeds the income eligibility level, may be able to become eligible for a limited period of time by reducing his/her excess income with incurred medical expenses. This is called the Aspenddown≅ process. If a person applies, and is determined ineligible due to excess income, he/she will be provided information on how eligibility may be established through spenddown. The medical expenses used to establish eligibility under spenddown remain the person=s liability after eligibility for Medical Assistance is established. If a person is receiving certain services, such as nursing facility services, eligibility is determined on a different basis. The cost of the person=s care is taken into consideration, and the person is required to pay a fixed monthly amount towards his/her care. This amount is deducted from the Program=s payment.

3. The Maryland Children=s Health Program (MCHP) provides coverage to pregnant women and children with family incomes which do not exceed 200% of the federal poverty level. Only pregnant and postpartum women, and children, under age 19, are eligible. As of July 1, 2001, MCHP has expanded its program. This new expanded program is called “MCHP Premium”. The MCHP Premium will provide coverage to children under 19 with family incomes that exceed 200% but at or below 300% of the federal poverty level. Participation in the MCHP Premium will require a family contribution based on income.

   Pregnant women on MCHP receive all benefits covered under the regular Medical Assistance Program except for abortion. Children on MCHP receive all benefits. A woman delivering on MCHP receives family planning benefits through the Family Planning Program for 5 years following the birth of her child.

How Eligibility Is Established

Recipient eligibility for Medical Assistance is determined by the Local Departments of Social Services (LDSS) and Local Health Departments (LHDs) in accordance with criteria established by the Medical Assistance Program. (See Chapter 11 for a list of the locations of the LDSS and LHDs). In general, a person wishing to apply for Medical Assistance may do so at his/her local department of social services in his/her county of residence, or Baltimore City if he/she lives in Baltimore City. In addition, many of the acute care hospitals in Maryland also have eligibility workers who can take Medical Assistance applications. A written and signed application is required of each applicant for Medical Assistance. An applicant may be required, as part of the application process, to verify the information given on an application form.

Pregnant women of any age and children up to the age of 19 can apply for the Maryland Children=s Health Program at Local Health Departments, or Departments of Social Services. They may be eligible if the family income is at or below 200% of federal poverty level.

Providers, parents and pregnant women may contact their Local Health Department or DHMH at 1-800-456-8900 if they have further questions or need more information pertaining to the program. TDD for Disabled-Maryland Relay Service 1-800-735-2258.

A person may also apply for the Maryland Pharmacy Assistance Program (MPAP). To receive a MPAP card, the recipient ***MUST*** complete a Maryland Pharmacy Assistance Program Application form. The recipient must follow the instructions on the form and mail it to the address listed in Chapter 11. The recipient must provide proof of all sources of income and assets. If the recipient has no income or assets, he/she ***MUST*** provide a letter of support from his/her caregiver.

Persons who have Medicare as well as limited income and resources may qualify for participation as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI). These persons are eligible for assistance with their Medicare premium payments. Qualified Medicare Beneficiaries (QMB=s) also qualify for assistance with their Medicare deductibles and co-insurance. Individuals should contact the Local Department of Social Services in their county of residence (or Baltimore City) to find out if they are eligible for any of these programs or for regular Medical Assistance.

It is the provider=s responsibility to verify a recipient=s current eligibility each time service is provided. A patient=s Medical Assistance eligibility should be verified on each date of service prior to rendering service by calling the Eligibility Verification System (EVS) at the number listed in Chapter 11.

Eligibility of Newborns

With few exceptions, babies born to women with Medical Assistance coverage are automatically eligible for Medical Assistance for the first year of life. Hospitals are responsible for filling out a form called the 1184 and mailing it to the Medical Assistance Program so that a card can be issued. This means that newborns will receive a Medical Assistance card within two weeks of birth if the hospital has filled out the form promptly. The newborn=s Medical Assistance number will be on EVS. A child born to a mother enrolled in a MCO on the day of delivery will automatically be enrolled in that MCO at birth. Providers must bill for services to the newborn on the newborn=s card, not his/her mother=s card. If you have any questions or concerns about this process, please call the Outreach and Women=s Services Division as listed in Chapter 11.

Spenddown Process

When a person applies for Medical Assistance, the Program determines if the amount of countable income the applicant receives is within the Medical Assistance income eligibility standard. If the application is for multiple family members, their income may also be counted.

If the applicant=s income exceeds the Medical Assistance income eligibility standard, the Program determines the applicant ineligible for Medical Assistance because of excess income and tells the applicant that he/she may become eligible through the Aspenddown≅ process.

When the Program determines how much income the applicant receives, it also calculates the income the applicant will receive for a six-month period. The Program then compares that amount against the Medical Assistance eligibility standard for the same six-month period. The difference between the amount of income the applicant receives and the amount that is allowed is called *excess income*. If the applicant has excess income, the Program will hold his/her case open to allow the applicant to incur medical expenses and to use those expenses to reduce the amount of excess income to the Medical Assistance income eligibility standard. If the applicant succeeds in reducing the amount of excess income to the Medical Assistance income eligibility standard, at any time during the six-month period, the Program will make the applicant eligible for the time remaining in the six-month period. At the end of this eligibility period, the applicant must reapply for Medical Assistance and the whole process begins anew.

Only *medical* expenses can be used in the spenddown process. Medical expenses include hospital and doctor=s bills, prescription drugs, medical equipment, etc. Any medical expenses used to make the applicant eligible will remain his/her responsibility. Any expenses that are paid by someone else, such as an insurance company or Medicare, cannot be used in spenddown. A medical expense can only be used once for spenddown.

If you have any questions about the spenddown process, contact an eligibility policy specialist at the phone numbers listed in Chapter 11.

Recipient Participation

A person who has been determined eligible for Medical Assistance may participate in one of several programs. The next several pages describe such programs. For those programs which issue a unique identification card, the program is described and followed by a picture of the Medical Assistance identification card associated with that program. Several programs do not issue unique identification cards; these are also described in the following pages.

Each Medical Assistance recipient, when initially enrolled, is issued a red and white Medical Care Program identification card. Recipients enrolled in the Managed Care Program are also issued a distinctive Managed Care Organization (MCO) card by that particular MCO. Following is a list of cards issued by the ***Program:***

Card Color	**Issued For Recipients With**
Red and White	For both recipients enrolled in HealthChoice and for fee for service identification
Blue and White	Hospice Care
Brown and White	Maryland AIDS Drug Assistance Program (MADAP)
Yellow and White	Pharmacy Assistance Program (MPAP)
Gray and White	Qualified Medicare Beneficiary (QMB)
Purple and White	Family Planning Program

HealthChoice

In June, 1997, Maryland Medical Assistance began A*HealthChoice@* the Medicaid Managed Care Waiver Program. Medical Assistance capitates Managed Care Organizations (MCO=s), to provide care for most Medical Assistance recipients. This care includes provision and coordination of health care, and fiscal management of Medical Assistance benefits for these recipients. Some Medicaid recipients are excluded from *HealthChoice* and will continue with fee-for-service Medicaid. Those recipients are:

X those recipients who are dually eligible for *Medicare and Medicaid;*
X those recipients who are *institutionalized* in nursing homes, Chronic Hospitals, Institutions for Mental Diseases (IMDs) or Intermediate Care Facilities for the Mentally Retarded (ICF-MR);
X individuals who are eligible for Medical Assistance for a *short period of time;*
X those recipients in the *Model Waiver* program for children who are medically fragile; and
X persons receiving family planning services through the *Family Planning Waiver*.

Recipients who are part of the MCO program will receive information regarding changing their MCO, one time per year, on the anniversary date of their MCO linkage. Information regarding recipient eligibility or MCO linkages should be obtained using the Eligibility Verification System (EVS) at 410-333-3020 or 1-800-492-2134. In order to use this system, you must have an active Medical Assistance provider number. If you need assistance with understanding EVS, please contact the Medical Care Liaison Unit at 410-767-6024.

Providers wishing to participate with the MCO program, must contact the MCO=s directly using the list on the next page. If you are unable to obtain a contract with any of the MCO=s, please contact a member of our Policy Administration at 410-767-1482. However, please keep in mind that the most efficient way to gain *HealthChoice* provider status is to sign-up with the MCO.

Recipient Protection

DHMH understands the importance of protecting the recipient=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 DHMH has current addresses of recipients. As providers, you are in a unique position to inform recipients of the importance to pass on any new address information to DHMH. When possible, please inform recipients that they *must* give their correct address to their Department of Social Services. If recipients receive SSI, they will need to change their address with the Social Security office.

Managed Care Organizations

Amerigroup 857 Elkridge Landing Road Linthicum, MD 21090 (410)859-5800 Exec: Don Gilmore, COO	Mr. Paul Bechtold Director, Provider Relations (410)981-4004 Fax (410)981-4010	Baltimore City, A.A. Balto., Montgomery, and Prince George=s Counties
Chesapeake Family First (United Health Care of the Mid-Atlantic, Inc) 6300 Security Blvd. Baltimore, MD 21207 800-368-1680 Exec: Robert Sleshner	Ms. Barbara Spence (410)277-6226 Fax (410)277-6650	Statewide except Garrett
Helix Family Choice, Inc. 8094 Sandpiper Circle, Suite O Lutherville, MD 21093 (410)847-6700 Exec: Peter Mongroo, President	Lyse Wood Provider Relations (410)933-3066 Fax: (410)769-6007	Baltimore City, A.A. Baltimore, Carroll, Harford, Howard Counties.
JAI Medical Systems, Inc. 5010 York Rd. Baltimore, MD 21212 Exec: Hollis Seunarine, M.D.	David Burke Director, Provider Relations (410)433-2200 Fax: (410)532-7246	Baltimore City, Baltimore County.
Maryland Physicians Care MCO 7104 Ambassador Rd. Suite 100 Baltimore, MD 21244 (410)277-9710 CEO: Raymond Grahe	Mr. Tom Sommer (410)277-9712 Fax: (410)277-9722	Statewide except Caroline, Dorchester, Kent, Prince George's, Queen Anne's, Somerset, Talbot, Wicomico and WorcesterCountie
Priority Partners MCO Baymeadow Industrial Park 6701 Curtis Court Glen Burnie, MD 21060 (410)424-4400 COO: Cynthia Demarest	Ms. Denise Quandt VP of Provider Relations (410)424-4625 Fax: (410)424-4604	Statewide except Garrett County

Covered Services

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

X *Abortion Services* - MCO=s are responsible for related services performed as part of a medical evaluation prior to the actual abortion.

X *Aids Drug Therapies* - Limited to Protease Inhibitors, Non-nucleoside Reverse Transcriptase Inhibitors and viral load testing.

X *Healthy Start Case Management Services*

X *IEP/IFSP* - Individual Education Plan (IP) 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.

X *Medical Day Care Services*

X *Nursing Home/Long Term Care Facility Services* - After the first 30 consecutive days of care.

X *Personal Care Services*

X *Rare & Expensive Case Management Services (REM)* - Recipients are eligible based on one of the diagnoses listed in COMAR 10.09.69. ***(See REM information in Appendix C)*** Recipients receive all State Plan Medicaid services on a fee-for-service basis.

X *Specialty Mental Health Services* - Including inpatient admissions to Institutions for Mental Disease (IMD). These services are payable through the Administrative Services Organization, Maryland Health Partners. For information, call 1-800-565-9688.

X *Stop Loss Case Management (SLM)* - A recipient participating in a MCO which does not self insure becomes eligible for the Stop Loss Case Management Program when his or her paid inpatient hospital services exceed $61,000.00. At that point, the Program pays 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.

X *Transportation Services* - MCO=s may, however, be responsible for transportation services which are not covered by fee-for-service Medicaid.

Recipients are linked by their MCO to a primary care physician or clinic, and must obtain all services except the above through their MCO. The recipient=s primary care physician or clinic will give referrals for specialty care. However, the following services must be reimbursed by the MCO without a referral:

Self-referral services are defined in the HealthChoice regulations as Ahealth 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.@ Self-referral services include:

X *Child With Pre-Existing Medical Condition - Medical Services*

X *Child In State-Supervised Care - Initial Medical Exam*

X *Emergency Services*

X *Family Planning Services*

X *HIV/AIDS Annual Diagnostic and Evaluation Service Visit*

X *Newborn=s Initial Medical Examination In A Hospital*

X *Pregnancy-Related Services Initiated Prior To MCO Enrollment*

X *Renal Dialysis Services Provided In A Medicare Certified Facility*

X *School-Based Health Center Services*

X *Substance Abuse Assessment*

For additional information regarding the above self-referral services contact the Medical Care Policy Administration at 1-800-685-5861.

Billing

Providers should also contact the MCO=s 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, Medical Care Operations Administration, P.O. Box 1935, Baltimore, MD 21203.

Mental Health Services

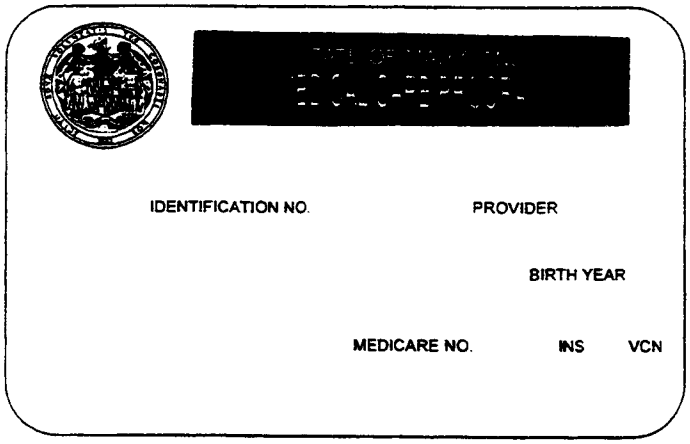
As part of the 1115 waiver process, specialty mental health services, those services provided by a mental health professional or a mental health service agency which are not performed as part of a primary practitioner=s office visit, were carved out into a separate managed fee-for-service system. This system, the Specialty Mental Health System (SMHS), is administered by the Mental Hygiene Administration (MHA), local Core Service Agencies (CSA=s), and an administrative services organization, which is currently Maryland Health Partners (MHP). MHP authorizes services and pays claims for the SMHS. Any claims for non-emergency specialty mental health services for both HealthChoice and non-HealthChoice recipients must be authorized and paid by MHP.

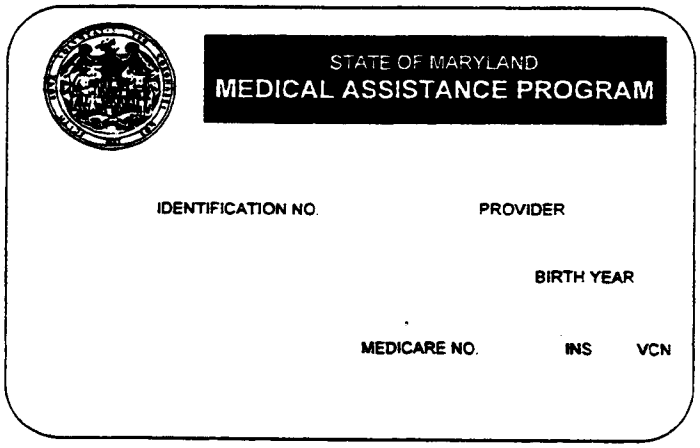
For some organizations and practitioners, all claims must be paid by MHP. These include special acute psychiatric facilities, both inpatient and outpatient services, special chronic psychiatric facilities, both inpatient and outpatient services, residential treatment center, psychologists, certified nurse psychiatric specialists, community mental health centers, psychiatric rehabilitation programs, mental health case management agencies, and mental health mobile treatment agencies. For other organizations and practitioners, only specific services rendered to recipients with defined diagnoses will be paid by MHP. These providers include acute hospital and acute rehab inpatient and outpatient psychiatric services, chronic and chronic rehab inpatient and outpatient services, special acute and special chronic inpatient and outpatient psychiatric services, psychiatrists, behavioral pediatricians, social workers, licensed professional counselors, local health departments, and FQHC's and MQHC's.

Practitioners who want to participate individually or as groups as specialty mental health providers must be appropriately licensed and must be able to provide services under their licensure. Organizations that want to participate as specialty mental health providers must be licensed or approved by the Office of Licensing and Certification. All providers, individuals, groups, or organizations, must be enrolled by both the Maryland Medical Assistance Program and by Maryland Health Partners. Further information about becoming a provider in the SMHS may be obtained from MHP's provider line at 1-800-565-9688.

Red and White Medical Care Program Card Used as Identification of Medical Assistance Recipients

This card is issued to recipients who have been determined eligible for Medical Assistance and is used for receiving medical services. (***Use the recipient number on this card to verify eligibility through EVS*** - See Chapter 4 for additional instructions). ***Please note that the red and white Medical Assistance Card may resemble either of the following cards - both are valid if eligibility is active.***

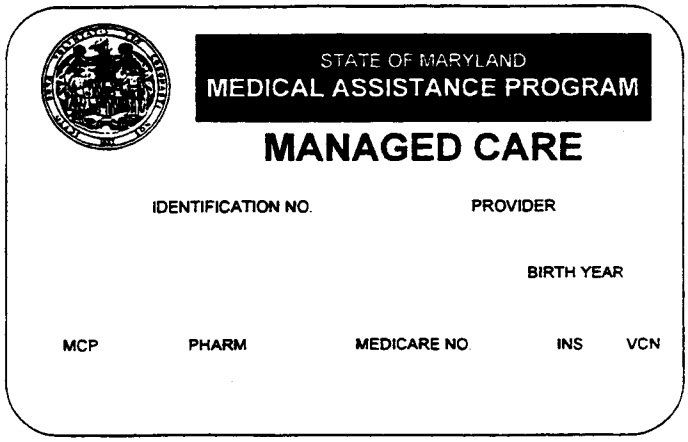




The red and white Medical Care Program card contains the following information:

Field	Description
IDENTIFICATION NO.	The recipient's 11-digit Medical Assistance Identification Number, First and Last Name appears here.
PROVIDER	The words "Call EVS" are imprinted on the card. To verify eligibility on a specific date, call the Eligibility Verification System.
BIRTH YEAR	The birth year of the recipient appears here.
MEDICARE NO.	If the Program knows the recipient's 10 - character Medicare Number it will be printed here.
INS	If the Program knows the recipient has third party insurance coverage, an insurance code indicator will be printed here.
VCN	The number of duplicate cards issued to a recipient will appear here.

Blue and White Medical Assistance Card Used as Identification for Hospice Care Program
This card is issued to recipients who have volunteered to be in the Hospice Care Program.

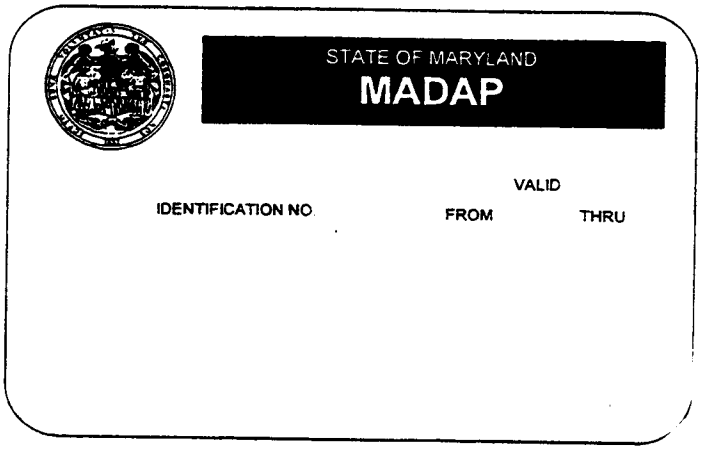


The blue and white Medical Assistance identification card contains the following information.

Field	Description
IDENTIFICATION NO.	The recipient's 11-digit Medical Assistance Identification Number, First and Last Name appears here.
PROVIDER	The words "Call EVS" are imprinted on the card. To verify eligibility on a specific date, call the Eligibility Verification System.
BIRTH YEAR	The recipient's year of birth appears here.
MCP	The name of the linked provider or hospice appears here.
PHARM	No information is printed here.
MEDICARE NO.	No information is printed here.
INS	If the Program knows the recipient has third party insurance coverage, an insurance code indicator will be printed here.
VCN	The number of duplicate cards issued to a recipient appears here. *Beneath the name of the provider or hospice is printed the associated phone number, followed by the words "Hospice Care".*

Brown and White Medical Assistance Card Used as Identification of Medical Assistance Recipients in the Maryland AIDS Drug Assistance Program (MADAP)

This card is issued to recipients by the Maryland AIDS Drug Assistance Program for prescription drug services.



The brown and white Medical Assistance identification card contains the following information:

Field	Description
IDENTIFICATION NO.	The recipient's 11-digit Medical Assistance Identification Number, First and Last Name appears here.
VALID FROM AND THRU	The recipient's Begin and End Date of certification appear here.

Pharmacy Assistance Program (MPAP)

The Maryland Pharmacy Assistance Program is 100% State funded and provides pharmacy services to persons who are not eligible for participation in the Medical Assistance Program, but who meet the eligibility requirements of the Pharmacy Assistance Program. Recipients are liable for a co-payment for each original prescription and refill.

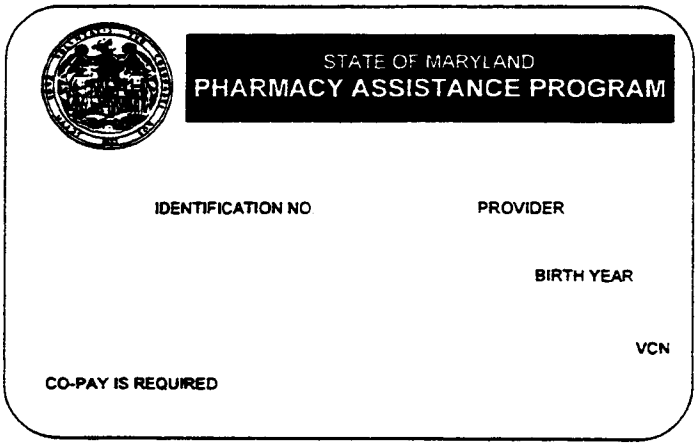
Eligibility for the Maryland Pharmacy Assistance Program is based on the size of the recipient=s household and the financial resources (total gross income and current assets) available to the family unit. The Program increases the maximum gross allowable income standards annually at the time Social Security benefits are increased, by the larger of either any Social Security cost-of-living percentage increase, not to exceed 8%, or the dollar amount which the Medical Assistance income standards are increased by the State.

MPAP is a program to help Maryland residents pay for certain maintenance drugs used to treat long term illnesses, anti-infective drugs such as AZT, insulin syringes and needles. Under the Program, the recipient pays $5 for each prescription and each of two refills and the State pays the rest.

For further information regarding the Maryland Pharmacy Assistance Program, call the number listed in Chapter 11.

Yellow and White Medical Assistance Card Used as Identification for Persons Eligible for the Maryland Pharmacy Assistance Program (MPAP)

This card is issued to recipients who have been determined eligible for the Maryland Pharmacy Assistance Program. Coverage is limited by the State to prescriptions for maintenance drugs and infectives. Cards are issued for a 12-month period. The recipient will receive a new application to submit 2 months before the current card expires.



The yellow and white Maryland Pharmacy Assistance Program identification card contains the following information:

Field	Description
IDENTIFICATION NO.	The recipient's 11-digit Pharmacy Assistance Identification Number, First and Last Name appears here.
PROVIDER	The words "Call EVS" are imprinted on the card. To verify eligibility on a specific date, call the Eligibility Verification System.
BIRTH YEAR	The recipient's year of birth appears here. *The words "Pharmacy Only" are imprinted on the card indicating that no Medical services are covered for this recipient.*
VCN	The number of duplicate cards issued to a recipient appears here.
CO-PAY IS REQUIRED	The words "Co-pay is required" are printed here.

Qualified Medicare Beneficiary

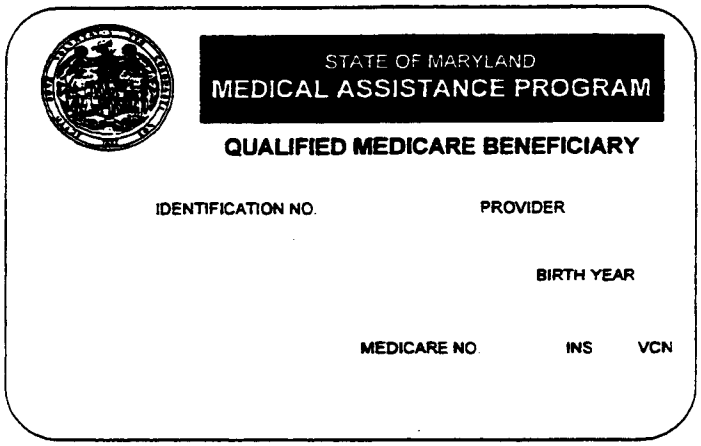
For recipients who qualify, participation in the Qualified Medicare Beneficiary (QMB) Program allows the Medical Assistance Program to pay the recipient=s Medicare medical insurance premium. In addition, the Program will also pay the Medicare deductibles and co-insurance.

Individuals who would be Qualified Medicare Beneficiaries except that their income is slightly above the national poverty level may qualify for help in paying their Part B (Medical insurance) premium under the Speficied Low-Income Medicare Beneficiary (SLMB) Program. This program does not cover Medicare co-pays and deductibles, and no identification card is issued to SLMB recipients.

Beginning in January 1998, the State pays either the full Medicare Part B premium or a portion of the Medicare Part B premium for Qualifying Individuals (QIs). The partial premium payment is refunded directly to the individual once a year. QIs are individuals whose income exceeds the levels for QMBs and SLMBs.

Gray and White Medical Assistance Card Used as Identification of Medical Assistance Recipients in the Qualified Medicare Beneficiary (QMB) Program

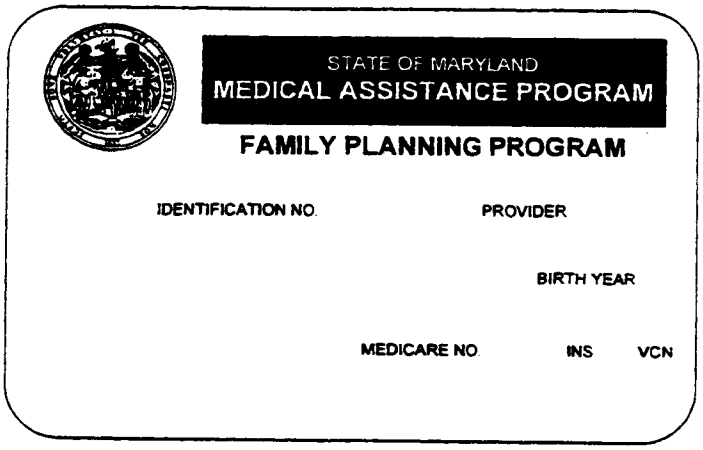
The QMB card is issued to recipients who qualify as a Qualified Medicare Beneficiary. The Part B premium is paid by the State which allows coverage for certain services such as outpatient services, etc. This card also covers Medicare deductibles and co-insurance.



The gray and white Medical Assistance identification card contains the following information:

Field	Description
IDENTIFICATION NO.	The recipient's 11-digit Medical Assistance Identification Number, First and Last Name appears here.
PROVIDER	The words "Call EVS" are imprinted on the card. To verify eligibility on a specific date, call the Eligibility Verification System.
BIRTH YEAR	The recipient's year of birth appears here.
MEDICARE NO.	The recipient's 10-character Medicare Number is printed here.
INS	If the Program knows the recipients has third party insurance coverage, an insurance code indicator will be printed here.
VCN	The number of duplicate cards issued to a recipient appears here.

Purple and White Medical Assistance Card Used as Identification for Family Planning Program
This card is issued to women who have delivered a baby while receiving coverage under the Maryland Children's Health Program (MCHP). Coverage is for family planning services only and gives eligibility for five (5) years.



The purple and white Medical Assistance identification card contains the following information:

Field	Description
IDENTIFICATION NO.	The recipient's 11-digit Medical Assistance Identification Number, First and Last Name appears here.
PROVIDER	The words "Call EVS" are imprinted on the card. To verify eligibility on a specific date, call the Eligibility Verification System.
BIRTH YEAR	The recipient's year of birth appears here.
MEDICARE NO.	If the Program knows the recipient's 10-character Medicare Number it will be printed here.
INS	If the Program knows the recipient has third party insurance coverage, an insurance code indicator will be printed here.
VCN	The number of duplicate cards issued to a recipient appears here.

In addition to the programs described above, recipients of Medical Assistance often are involved in the following programs for which the Medical Assistance Program does not issue unique identification cards.

Medicare

Who Must Enroll

Medical Assistance recipients or applicants who are eligible for Medicare must enroll in Medicare in order to participate in the Medical Assistance Program.

Enrollment in Parts A & B

Medicare is a federal health care insurance program for people who are 65 years and older and some people under 65 who are blind or disabled. Medicare has two parts. Part A covers hospitalization, dialysis services and post-hospital care in a skilled nursing facility. Part B covers other Medical services, including physicians= services, medical supplies, home health services and physical therapy.

The Medical Assistance Program pays the recipient=s deductible and co-insurance for both Part A and Part B. The Program will also pay the monthly Part A premium for people 65 and older with low income and limited resources who do not qualify for premium-free Part A. It also pays the monthly insurance premium for Part B. If a Medical Assistance recipient is enrolled in Medicare Part B, the Medicare identification number is shown on the recipient=s Medical Assistance card if the Program is aware of the enrollment.

Medical Assistance is Payer of Last Resort

The Medical Assistance Program is by law the payer of last resort. The Medicare carrier will process the invoice, pay the Medicare portion and then send the bill to Medical Assistance for payment of deductibles and co-insurance when the carrier has a crossover agreement with the State.

The provider must check the appropriate block on the Medicare form which indicates acceptance of assignment in order for the Medical Assistance Program to pay the deductible and co-insurance. In addition, the recipient=s Medical Assistance number must be entered in the appropriate space on the Medicare form. Medical Assistance sends a file of eligible recipients to some Medicare carriers, and that file is used to select the claims they pass to Medical Assistance.

Medicare Information Resources

For further information regarding Medicare, contact one of the carriers listed in Chapter 11.

Maryland Healthy Kids Program/EPSDT

The Maryland Healthy Kids Program, known on the federal level as the Early and Periodic Screening, Diagnosis and Treatment Program, offers comprehensive health care services which are designed to detect physical and mental problems and provide necessary follow-up care to Medical Assistance Recipients under 21 years of age. Children receive a more comprehensive service package than adults with Medical Assistance coverage.

Healthy Kids services are provided by the primary care medical provider for the child. The providers practice in many settings including private practice settings, health maintenance organizations, Federally Qualified Health Centers, Maryland Qualified Health Centers, Rural Health Centers, hospital outpatient departments and local health department clinics. The Healthy Kids Program provides reimbursement for: physical examinations; laboratory tests; immunizations; hearing, vision, developmental, speech and language screenings; dental services; and various other screening procedures. Diagnostic and treatment services may be delivered by the screening provider or by another health care provider who participates in the Maryland Medical Assistance Program.

Federal regulations require that certain administrative services be performed, such as outreach and case management, to ensure all eligibles are informed about Healthy Kids services and receive assistance in obtaining the necessary services. Program management services provided by local health departments are offered to ensure that eligibles receive support services such as appointment scheduling, transportation assistance, assessment of health needs to identify at-risk children and initiation of treatment for identified problems.

Waiver Programs

Home and Community-Based Services Medical Assistance Waivers

These waivers enable States to cover a broad array of home and community-based services (HCBS) for targeted populations as an alternative to institutionalization. Waiver services may be optional State Plan services which either are not covered by a particular State or which enhance the State=s coverage. Waivers also may include services not covered through the State Plan such as respite care, environmental modifications, or family training.

Each waiver has a target population defined by the State. Participants must be medically qualified, certified for the waiver=s institutional level of care, choose to enroll in the waiver as an alternative to institutionalization, cost Medicaid no more in the community under the waiver then they would have cost Medicaid in an institution, and be financially eligible based on their income and assets.

Mentally Retarded/Developmentally Disabled Waiver

The Home and Community-Based Services Waiver for Mentally Retarded/Developmentally Disabled Individuals, began in February of 1984, to provide services for developmentally disabled individuals, who meet an ICF-MR (Intermediate Care Facility for the Mentally Retarded) level of care, as an alternative to institutionalization in an ICF-MR. Since November, 1990, the waiver has also been used to divert individuals from institutionalization. Covered services under the waiver include day habilitation, residential option services, respite care, services coordination, environmental modifications, assistive technology and adaptive equipment.

Model Waiver for Disabled Children

This Model Waiver which became effective in January 1985, targets medically fragile, including technology dependent individuals, who before the age of 22, would otherwise be hospitalized and are certified as needing hospital or nursing home level of care. Through the waiver, services are provided to enable medically fragile children to live and be cared for at home rather than in a hospital. Model Waiver services provide case management, private-duty nursing, home health aide assistance, physician participation in the Plan of Care development, and durable medical equipment and supplies. The number of participants of a model waiver is capped at 200 slots.

Senior-Assisted Housing Waiver

The Maryland Department of Aging/Senior Assisted Housing waiver for eligible recipients who reside in group homes that are certified by the Maryland Department of Aging was implemented in July 1993. This waiver is targeted to individuals aged 62 and over who are certified for nursing facility level-of-care and are being discharged or diverted from a nursing home. The waiver provides

Medicaid reimbursement for senior-assisted housing services, previously funded with all State dollars, as an alternative to seniors being institutionalized in a nursing home. The waiver services include assisted-living services, environmental assessment, environmental modifications, assistive equipment, behavior consultation and Senior Center Plus. *For further information regarding the waiver programs, call the number listed in Chapter 11.*

Case Management Services

There are five targeted case management programs covered by Maryland=s Medical Assistance Program. Case management is designed to assist a target group of recipients in gaining access to needed services.

Targeted Case Management for HIV Infected Individuals

Targeted Case Management for HIV infected individuals is a voluntary fee-for-service program. The client is given an assessment and a plan of care is developed by a Diagnostic Evaluation Services (DES) multidisciplinary team. AIDS management services are provided by licensed physicians, physician assistants, advanced practice nurses, social workers, or other individuals who are appropriately trained, experienced, and supervised by a licensed practitioner. The client may then elect to receive monthly case management services and select a case manager.

Mental Health Case Management

The Mental Health Case Management Program became effective in January 1992. The program allows for an annual assessment and reassessment of each recipient enrolled in the Mental Health Case Management Program. Ongoing Case Management services are also reimbursed.

Maryland Medical Assistance in conjunction with the Department of Health and Mental Hygiene=s Mental Hygiene Administration (MHA), administers the program through the Core Services Agencies. Covered services are pre-authorized. *For further information regarding this program, call the number listed in Chapter 11.*

Case Management for Individuals with Developmental Disability

This program which became effective in June, 1992, assists individuals with developmental disabilities to live in the community in the least restrictive environment available. This is accomplished by the case manager=s linking the participant with the services and community resources necessary to meet the participants personal goals. Eligibility for the program requires individuals to be certified for, and receiving, Medical Assistance benefits as well as to be determined eligible to receive this service by the Developmental Disabilities Administration or it=s designee.

Case Management for Children Diverted or Returned from Out-Of-State Residential Treatment Facilities

Case Management for Children Diverted or Returned from Out-of-State Residential Treatment Facilities began in February of 1993.

Services are provided to Medicaid-eligible recipients who are under age 21, determined eligible by the Local Coordinating Council for out-of-state placement and suitable for alternative community placement. Recipients are eligible for this program if they have emotional, behavioral, or mental disorders, or are developmentally disabled. These recipients are provided with an initial assessment, development of an interagency service plan and monthly ongoing case management.

Service Coordination for Children with Disabilities

This program which became effective in June of 1993, implements service coordination for Medical Assistance recipients aged 2 through 20 years old, who have been determined through assessment, as having temporary or long-term special education needs arising from cognitive, emotional, or physical factors, or any combination of these. *For further information on this program, call the number listed in Chapter 11.*

Chapter 4 - Steps To Take Before Providing Services

It is the provider=s responsibility to verify a recipient=s current eligibility each time service is provided. This chapter tells you how to determine if your patient is eligible and if the service is covered by Medical Assistance.

If you follow the procedures in this chapter you will:

- T save time when you complete your Medical Assistance claim, and
- T avoid claims that Medical Assistance must deny or send back to you for more information.

Actions for Determining Eligible Recipients and Services
Follow these steps to determine if your patient and the service you plan to provide is covered by Medical Assistance. This section first presents steps and then breaks them into separate tasks.

Step	Action
1	Ask how the patient will pay for your services.
2	If the patient says he/she is eligible for Medical Assistance, request the Medical Care Program identification card.
3	Verify that the recipient is eligible on the date the service is to be provided by calling the Eligibility Verification System (EVS).
4	Determine if the services to be provided are Medicaid covered services.
5	Check to see if you must get preauthorization before providing this service.
6	Check to see if your patient is covered by other insurance.

The following section presents tasks you must complete for several of the above steps.

If your patient says he/she is eligible for Medical Assistance, request identification
A recipient may present a Medical Care Program Identification Card as identification; there are illustrations of each of these cards in Chapter 3. Alternatively, the recipient may simply give you a Medical Assistance Identification Number or a Social Security Number which you may use to verify eligibility by calling the Eligibility Verification System (EVS) at the number listed in Chapter 11. ***Always*** call EVS to verify the recipient is eligible for services on a specific date.

Verify that the recipient is eligible on the date the service is to be provided by calling the Eligibility Verification System (EVS)

The EVS tells providers whether a particular patient is eligible for Medical Assistance; it will tell you if the patient is eligible on the day you are calling and can also give you information on past eligibility. If a patient is not eligible for Medical Assistance on the day you render service, the Medical Assistance Program will not reimburse you.

EVS gives providers information on whether a particular patient is part of the Managed Care Program-AHealthChoice≅. This information is communicated on EVS with the message *A**HealthChoice**@*, followed by the name and telephone number of one of the approved Medical Assistance MCOs. When you hear this message, you should contact that MCO and follow their guidelines for services.

When a patient reports his/her Medical Assistance card lost or stolen to the local Department of Social Services, the information is passed to the Department of Health and Mental Hygiene which issues a new card. The *A**VCN**@* field in the lower right corner of the card shows how many duplicate cards the Department has issued to that recipient. The EVS also will tell you the valid card number. (If no duplicate card has been issued, there will be no valid card message.) If the number in the *A**VCN**@* field on the card does not match the number stated on EVS, that card is not valid , and you must verify the identity of the recipient through alternate means.

EXAMPLE: The EVS message may say, AValid Card Number 3.≅ If any number below 3 (including no number) appears in the *A**VCN**@* field, the card is invalid.

To report suspected abuse to the Program, contact the Division of Recipient Services at 1-888-767-0013.

Determine if the services to be provided are covered services

Read the regulations that apply to your program to determine if the services you plan to provide are covered services. If you require assistance, refer to the phone numbers provided in Chapter 11 to determine the appropriate policy division to contact.

Check to see if you must get preauthorization before providing this service

If the procedure you intend to provide requires preauthorization, you must obtain this by calling the Preauthorization Unit at the number listed in Chapter 11.

Check to see if your patient is covered by other insurance

Information about third party coverage appears on the Medical Assistance Identification Card. If you need information or wish to verify the insurance coverage on file, you should call the Division of Medical Assistance Recoveries/Insurance Recovery Section at the telephone numbers listed in Chapter 11. If the recipient shows you additional insurance information, you should ask him/her if the other insurance might help to pay for your services. You should then call the Insurance Recovery Section to inform it of the insurance carrier=s name and policy name. ***Medical Assistance is the payer of last resort.***

Chapter 5 - Preparing Claims and Forms

To receive payment from Medical Assistance for providing covered services to eligible recipients you must complete the appropriate claim form.

Billing Time Statute
You must submit a *clean* claim to the Maryland Medical Assistance Program within *nine months of the date of service* (for acute hospitals -- date of discharge). A clean claim is an original, correctly completed claim that is ready to process.

Submit claims immediately after providing services. If a claim is denied, you then have time to correct any errors. Be sure to resubmit the corrected claim within the time statute.

Exceptions to Time Statute
Exceptions to the claim submission statute can be made under the following circumstances:

X	The claim was filed within statute previously but denied by the Program due to provider error.	Corrected claim must be received within *60* days of the last rejection.	Resubmit the corrected claim through normal claims processing channels.
X	Retroactive eligibility is determined by the local Department of Social Services.	Claim must be received within *9* months of the eligibility decision date.	Submit the claim through normal claims processing channels, including documentation of retro-active eligibility.
X	A claim was submitted to Medicare as the primary payer.	Claim must be received within *120* days from the date of Medicare EOMB.	Submit the claim with a copy of the Medicare EOMB through normal claims processing channels. Be sure to place recipient and provider #=s in required Medicaid fields.

NOTE: Whenever a claim is past the 9 month from date of service statute, documentation AMUST@ be attached. If this is not done, the system automatically rejects that claim

Use of Proper Claim Form

Providers must submit the appropriate claim form corresponding to the services provided to eligible recipients. The Maryland Medical Assistance Program accepts the following forms:

Form Number	*Form Name*	*Used by the Following Programs*
DHMH 248	Community Based Services	Diagnostic Evaluation Services Providers EPSDT Private Duty Nursing HIV Targeted Case Management Home Health Medical Day Care Providers Model Waiver Home Health Aides Model Waiver Private Duty Nursing MR/DDA Providers MR/DDA TCM Providers Dept. of Aging Assisted Living Providers Dept. of Aging Behavior Consultation Providers Dept. of Aging Senior Center Plus Providers Personal Care Providers - *these claims must be submitted by the case monitoring agency* STEPS Case Management Targeted Case Management for Children Diverted/Returned from Out of State Residential Treatment Center Facilities Targeted Case Management Provider (Johns Hopkins) for Pregnant Substance Abusing Women
DHMH 234	Dental Services	Dental Services, including orthodontic treatment
HCFA-1500	HCFA-1500	Ambulatory Surgical Centers Audiology Services Clinic Services DMS/DME Model Waiver DMS/DME Providers Emergency Service Transporters EPSDT Referred Services Provided by: < Chiropractors < Nurse Psychotherapists < Occupational Therapists < Psychologists < Social Workers < Speech Therapists

Form Number	*Form Name*	*Used by the Following Programs*
HCFA-1500 (Continued)		Free Standing Dialysis Centers Healthy Start Case Management Halfway Houses (TCA) IDEA Transportation Individual Educational Plan Case Management Infants and Toddlers Case Management Laboratory Services Mental Hygiene Target Case Management Providers Model Waiver for Physician Participation in Plan of Care Office on Aging Environmental Assessment Services Providers Oxygen Therapy Services Physical Therapy Services Physician Services Podiatry Providers Psychiatric Rehab Providers Registered Nurse Anesthetists Registered Nurse Midwives Registered Nurse Practitioners School Health Providers Therapeutic Community Providers (TCA)
DHMH 263	Long Term Care Services	Nursing Facility Providers Transitional Care/Sub Acute
HCFA-1491	Medicare Ambulance Services	Ambulance Services
UB-92	UB-92	Hospice Hospitals Intermediate Care Facilities-Addictions Residential Treatment Centers

Billing Instructions
Supplements to this handbook have been developed which provide detailed billing instructions for each type of claim form. Please refer to these supplements for specific information. You may obtain these billing instruction supplements by contacting either Provider Relations at 410-767-5370 or the Medical Care Liaison Unit at 410-767-6024.

Electronic Claims Submission
Submitting your claims via electronic media offers the advantage of speed and accuracy in processing. You may submit your claims through an electronic medium yourself or choose from several firms that offer electronic claim submission services for a small per-claim fee.

The Medical Assistance Program accepts both magnetic tapes and direct, electronic submissions via modem. If you are interested in submitting claims via electronic media, contact the Systems Liaison Unit at the address and phone number listed in Chapter 11.

Other Forms Necessary for Payment
In addition to the claim form (invoice), the provider may be required to submit additional forms, such as a certification for abortion, hysterectomy or sterilization, preauthorization, adjustment or inquiry forms.

Special Billing for Spenddown Recipients
Providers rendering services to recipients who are in a spenddown situation may submit the UB-92 claim form via electronic submission. *The claim must be coded correctly and the spenddown dates and amounts must exactly match the information in MA eligibility files.* If a provider submits their spenddown claim electronically and has coded their UB92 appropriately but receives a denial, they should resubmit a paper claim and attach a 216 form to the claim.

Providers rendering services to recipients who are in a spenddown situation must submit the DHMH 216 form with the UB-92 claim form.

Special Billing Instructions for Pharmacy Services
Claims for pharmacy services, with the current exception of nursing home pharmacy, ***must*** be billed via the Program=s on-line pharmacy point of sale network. Claims for pharmacy services rendered to residents of nursing homes may be billed via magnetic tape through the pharmacy on-line claims processing vendor. Billing instructions for both point of sale and magnetic tape pharmacy claims may be obtained by contacting First Health at the phone number listed in Chapter 11.

Third Party Billing
A third party is another insurance company or agency that may be responsible for paying all or part of the cost for medical services provided to a Medical Assistance recipient. Some examples of third parties are Medicare, CHAMPUS, CHAMPVA, major medical insurance, cancer insurance, automobile (PIP) insurance and Worker=s Compensation.

The Medical Assistance Program is by law the *Apayer of last resort@.* Therefore, if a recipient 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 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. On the remittance advice, the Medical Assistance Program will give you the name, address and policy number so that you can bill the third party before resubmitting your claim.

If the recipient has health or dental insurance which may cover or partially cover the services you plan to provide, please take the following steps:

Step **Action**

1. Locate the potential payer=s address and telephone number in the supplemental third party 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.

   X 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.

   X 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 (*refer to next page to determine if documentation is required).* Mail it to the same address to which you submit all other claims.

   a. If payment is made by the other payer, indicate the other payment in the appropriate field on the claim form.

   b. 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 billing instructions to complete the claim by entering the appropriate code.

c. If you receive a denial from the other payer, follow the billing instructions to complete the claim by entering the appropriate rejection code.

Definition	UB-92 Code	Other Forms Code
Service Not Covered	61	K
Coverage Lapsed	62	L
Coverage Not in Effect on Service Date	63	M
Individual Not Covered	64	N
Claims Not Filed Timely (Requires Documentation)	65	Q
No Response from Carrier (Requires Documentation)	68	R
Other Rejection Reason Not Defined Above (Requires Documentation)	69	S

If you prefer, or if the carrier advises, file a claim with the carrier even if the services will be denied. You will then receive an official denial from the carrier which you can send with the invoice to the Medical Care Operations Administration.

4. Notify the Division of Medical Assistance Recoveries in writing when you receive a denial of third party responsibility due to policy coverage termination. (See address in Chapter 11.)

If payment of a claim is made by both the Medical Assistance Program and a third party (i.e. insurance carrier or other 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 made payable to the Division of Medical Assistance Recoveries and mailed to the address listed in Chapter 11. For further information regarding third party recoveries and reimbursement, contact the Division of Medical Assistance Recoveries, Third Party Recovery Section.

Medicare/Medical Assistance Billing

Crossover providers have to bill Medicare first for their services to Medical Assistance recipients. Exceptions to this are listed in the regulations that apply to your program. After Medicare has paid, Medical Assistance pays 100% of the deductible and coinsurance (except for the HSCRC-approved hospital discount rate). If a Medical Assistance recipient is also enrolled in Medicare Part B, specific billing procedures should be followed.

1. The provider must first determine whether or not the Medical Assistance recipient is enrolled in Medicare Part B. All Part B enrollees are issued a red, white and blue Medicare card. However,individuals often lose these cards and are uncertain as to their Part B enrollment. If the Medical Assistance Program is aware of a recipient=s enrollment in Medicare Part B, the recipient=s Medicare claim number will be printed on the Medical Assistance card. (This is a 10 to 12-position number and alpha value.) Providers may also use the Eligibility Verification System (EVS) to verify if a recipient is Medicare eligible.

   NOTE: With the exception of aliens who have not been in the United States for 5 years, all individuals who are age 65 or older and are eligible for Medical Assistance are *eligible* for Medicare Part B. However, not all of these individuals are automatically *enrolled* in Medicare since they must complete an application for Medicare in order to be enrolled. In addition, certain blind or disabled individuals are also eligible for Medicare Part B.

2. If the patient does *not* have a Medicare card, and the Medicare claim number is *not* printed on theMedical Assistance card, you must bill the Medical Assistance Program directly on the appropriate form. (Individuals over 65 who do not have a Medicare card should be encouraged to apply for Medicare at their Social Security District office.)

3. If the recipient does have dual Medicare/Medical Assistance coverage:

   X Bill the Medicare carrier *first*
   X Use the appropriate Medicare form.
   X Be sure to enter the patient=s Medicare claim number on the Medicare form.
   X Enter the patient=s Maryland Medical Assistance number on the Medicare form.
   X Check the appropriate block on the Medicare form which indicates acceptance of assignment. (Failure to accept assignment will result in a denial of payment by the Medical Assistance Program for the Medicare deductible and coinsurance).
   X Use the correct billing address for Medicare, as listed in Chapter 11.
   X Bill any other responsible third parties. If the recipient has third-party insurance coverage in addition to Medicare, you must bill the other carrier as well before billing Medical Assistance.

The Medical Assistance Program will handle Medicare/Medical Assistance claims as follows:

1. If Medicare makes a payment on every line item of a claim and the provider has entered the recipient=s Medical Assistance number on the Medicare form and has accepted assignment, most Medicare carriers will pass the claim to the Medical Assistance Program for payment of the deductibles and/or coinsurance.

2. If Medicare rejects every line item of a claim, the provider must bill the Medical Assistance Program for all of the Medicare-rejected services which Medical Assistance covers on the appropriate billing form and must attach the Medicare Rejection Notice (EOMB). If appropriate, the preauthorization form or number, or any other necessary documentation, must be attached.

3. If Medicare makes a payment on some of the line items of a claim and rejects others, and the provider has entered the recipient=s Medical Assistance number on the Medicare form and has accepted assignment, the Medicare carrier will pass the claim to the Medical Assistance Program. The Medical Assistance Program will process the items for which Medicare *has* made payment (i.e. pay coinsurance and/or deductibles).

   The provider must bill the Medical Assistance Program for all of the Medicare-rejected services, which Medical Assistance covers, on the appropriate form and must attach the Medicare Rejection Notice (EOMB). However, if the claim fails to meet Medicare=s requirements, i.e., the claim was submitted after the filing time limits, the Medical Assistance Program will also deny the claim. If appropriate, the preauthorization form or number, or any other necessary documentation, must be attached. The denied services should be highlighted on the EOMB.

4. When Medicare crosses over a claim to the Medical Assistance Program, the claim only carries the Medicare provider number. This claim must be matched to a Medical Assistance provider number. If a match cannot be made, the claim will be returned to the provider for entry of his/her Medical Assistance provider number. In order to be added to the crossover file, providers should contact the Crossover File Section at the address listed in Chapter 11.

5. If 3 weeks have elapsed since payment was received from Medicare and a Medical Assistance payment or rejection has not been received, the provider should send the EOMB and the Medicare billing invoice to the Medical Assistance Program. The Medical Assistance provider number and the Medical Assistance recipient number must be entered on the Medicare billing invoice in the appropriate section. (Refer to Billing Supplement for Provider Type).

Submission Tips

Claims submitted via electronic media are processed more quickly and accurately. For further information on electronic billing, refer to Chapter 11 for the address and telephone number.

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* presented in the appropriate supplement? Some fields on Medical Assistance forms are not self-explanatory or may be used for other purposes.

Did you enter your *provider name and number* ? We do not know who to pay without them.

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? Current addresses for submission are listed in Chapter 11.

Do you have any questions not answered in this handbook? If so, please contact either Provider Relations or the Medical Care Liaison Unit for assistance. Refer to Chapter 11 for the addresses and telephone numbers.

Mailing Tips

Use the following checklist before mailing your claims to the Medical Assistance Program for reimbursement.

CHECKLIST

Did you enclose only one claim type per envelope? For example, claims and adjustment requests should be sent separately because they are processed separately.

Did you address the envelope to the correct Post Office Box and corresponding ZIP code for each claim type being mailed? Typewritten or machine-printed addresses speed up processing by the U.S. Postal Service.

If you need to mail claims in a large envelope or Aflat≅, did you mark the envelope AFirst Class≅ and pay for the first class postage? If AFirst Class≅ is not specified, the Postal Service will send large envelopes as third class mail. This will delay delivery of your claims to the Medical Assistance Program.

MARYLAND MEDICAL ASSISTANCE PROVIDER HANDBOOK

Chapter 6 - How You Will Get Paid

This chapter tells you how Medical Assistance pays for the services you provide to eligible recipients.

Payment Acceptance
When you agree to accept Medical Assistance, you agree to submit a claim to the Program and to accept the Program=s payment as payment in full. You cannot routinely bill the recipient for covered services. You cannot collect payment from the recipient and then refund that money to him/her only after the claim has been paid by Medical Assistance. No person or entity, except a third party source or a recipient who has failed to pay the co-payment, has available income or must fulfill resource requirements, can be billed, in part or in full, for covered Medical Assistance services rendered and paid under the Medical Assistance Program. If you miss the billing time limits or bill the Program incorrectly, you cannot bill the recipient.

Conditions for Payment
All of these conditions must be met before Medical Assistance will pay.

1. Your patient must be eligible for Medical Assistance on the date of service. Chapter 4 tells you how to determine if your patient is eligible.

2. Your enrollment as a Medical Assistance provider must be effective on the date of service.

3. You must agree to accept Medical Assistance as payment in full for your services.

4. The services you provide must be covered by Medical Assistance.

5. The services you provide must be determined medically necessary. Preauthorization must be obtained for certain services, as identified in the regulations that apply to your program.

6. Do not bill Medical Assistance prior to rendering services.

7. Your patient must not have exceeded the service limitations for your program areas. Refer to the regulations that apply to your program for more information.

8. You must bill all applicable third party sources (other insurance, Medicare, etc.) before Medical Assistance. The supplemental billing instructions tell you how to list other carriers= payments on the claim form. A supplement is available which lists all insurance carriers currently known to provide health coverage to Maryland Medical Assistance recipients.

Payment Procedures

Invoices may be submitted in any quantity and at any time within the billing time frame. There are limits on the number of claims for a specific recipient that can be submitted in one electronic file. For more information, contact the Systems Liaison Unit listed in Chapter 11 under Electronic Media.

Invoices are processed on a weekly basis. Payments and remittance advices are issued once a week and mailed to the provider=s Apay-to≅ address.

If an invoice is not paid due to a provider error, the appropriate Explanation of Benefits code will appear on the remittance advice. Claims with incorrectly completed attachments may be returned to the provider; these include claims with attachments for hysterectomies, abortions and sterilizations as well as administrative days (DHMH 1288) and spenddown (DHMH 216). The provider should correct the errors and resubmit the invoice to the Medical Assistance Program within the original 9-month period or within 60 days of rejection, whichever is longer.

Method of Payment

Medical Assistance will pay the *lower* of:

1. The Medical Assistance fee or rate; or

2. Your usual and customary charge - the amount that you normally charge a private paying patient.

Medical Assistance will pay only for procedures listed in the regulations that apply to your program. You must use the claim forms and procedure codes referred to in this handbook and supplements.

The Medical Assistance Program pays providers *only.* The Program *never* pays recipients. Medical Assistance recipients cannot submit claims to the Program.

If a patient=s Medical Assistance eligibility was established retroactively and you have already collected payment from the recipient, you may refund the patient=s payment and then bill the Program. If the services provided were nursing facility services, you must refund the patient=s payment before billing the Program.

Payments to Managed Care Organizations

The Medical Assistance Program contracts with Managed Care Organizations (MCOs) to provide provision and coordination of health care and reimburse for services to most of the Medical Assistance population. MCOs are reimbursed a monthly capitation fee for each enrolled recipient.

All MCO-enrolled recipients are provided an identification card by their respective MCO. MCO enrollees *must* obtain all MCO-covered services through their MCO. Medical Assistance services for which MCOs are not responsible, are available through any appropriate, participating Medical Assistance provider.

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 for payment your rendering of the 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. For further information regarding these services, call the number listed in Chapter 11.

NOTE: If the recipient-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.

MARYLAND MEDICAL ASSISTANCE PROVIDER HANDBOOK

Chapter 7 - How The Program Processes And Responds To Your Claim

After you send your Medical Assistance claim to the Program, you should receive a response within 4 to 6 weeks. This chapter explains the processing of your claim and what happens once a decision is made.

When Your Claim is Received

When your claim is received by the Medical Assistance Program=s Claims Control Section, it is screened for missing information (such as the provider number) or necessary attachments. If required information is *missing,* the claim may be returned to you and does not enter the claims processing system and is *Anot@* considered a submission for purposes of the billing statute of limitations. You must correct the error or attach the missing document to the claim and return the original for processing.

From time to time, there may be other reasons why a claim(s) are returned to you. A return notice will accompany claim(s) that are returned and will state the reason the claim(s) were rejected. Once the problem is corrected, return the claim(s) to the Medical Assistance Program for processing.

Each claim that passes this initial screening is microfilmed and either scanned or keyed by staff.
The Medical Assistance Program=s computer system then analyzes the claim information and determines the status or disposition of the claim, that is, whether the claim is to be:

Paid payment is approved in accordance with program criteria,

Suspended the claim is put on A*hold@* so it can be analyzed in more detail by the Medical Assistance Program, or

Denied payment cannot be made because the information supplied indicates the claim does not meet program criteria, or information necessary for payment was either erroneous or missing.

How Long the Process Takes

Claims are processed daily. Checks are printed on a weekly basis. Under normal conditions a claim can be processed from receipt to payment within 4 weeks. Electronic claims are normally processed within 2 weeks.

Your Remittance Advice

The remittance advice displays the disposition of all claims processed during the claims cycle. A remittance advice is mailed each week if we processed any of your claims. A check is mailed in a separate envelope from the remittance advice if claims were approved for payment.

The remittance advice contains one or more of the following sections, depending on the type of claims you file, the disposition of those claims and any new billing or policy announcement.

Remittance Newsletter
Whenever the Medical Assistance Program discovers billing problems encountered by all provider types or selected providers, or when policy announcement must be made, a Remittance Newsletter page is printed. Suggestions for avoiding problems or explanations of new or changed policy are described. Information regarding provider training seminars, etc. are also announced on the Remittance Newsletter page. A newsletter may not be printed with every remittance advice; however, when present, it will appear as the first page.

Grouping of Claim Information
Immediately following the remittance advice cover page, automatic recoupments will be listed.Following this, information will be grouped by claim type. Within each claim type, claims are grouped by disposition category. For example, paid, suspended, and denied claims as well as adjustments are listed in separate sections. All paid, suspended, and denied claims and claim adjustments are itemized in alphabetic order by recipient last name.

Claims Total Section
This sections reports the number of claim transactions and the total payment or check amount. If your account with the Medical Assistance Program shows a prior negative balance, it will be carried forward from week to week until eliminated.

How to Read Your Remittance Advice
The remittance advice plays an important communications role between the Medical Assistance Program and you. It tells you what happened to the claims you submitted for payment - whether they were paid, suspended or denied. When a claim is suspended or denied, the remittance advice gives you a three digit code which explains the reason for suspension or denial. If the claim has been *A**denied**@*, using the denial information, correct the error and resubmit the claim.

When Your Patient Has Other Insurance
If a recipient has other insurance coverage according to Medical Assistance records, payment will be denied unless you report the coverage on your claim. Medical Assistance is always the payer of last resort. To help you file with the other carrier, you receive the following information on the remittance advice, directly underneath the denied claim.

- X Insurance carrier name,
- X Name of insured,
- X Policy number,
- X Insurance carrier address,
- X Group number, if applicable, and
- X Group employer name and address, if applicable.

A supplement is available which contains a listing of all known insurance carriers who cover Medical Assistance recipients. Each carrier entry includes the address and telephone number. In

many cases, the contact person=s name is also present. The listing does not include policy numbers for individual recipients. Record other insurance coverage information reported on the remittance advice in your recipient=s file for future use.

How Adjustments Appear on the Remittance Advice

Adjustment requests are printed on your remittance advice as two different claim entries:

1. The incorrectly paid claim is listed exactly as it was when it was originally reported. The ICN for this entry is not that of the original claim. Instead, the system assigns a unique Acredit≅ ICN. In this step, the original payment to you is credited back to Medical Assistance=s account. A minus A-≅ symbol appears just to the right of the incorrectly paid amount.

2. The adjustment request is printed directly following the original claim entry. Claim information which was wrong on the original now shows as corrected. The difference between these two entries is the ANET≅ amount on the remittance advice. For your information, as Adjustment Reason Code (ADJ-R) and the ICN of the claim being adjusted are listed following the two claim entries.

Adjustment requests which result in a complete void of the original claim are printed as <u>*one*</u> claim entry. The entire claim is displayed and the payment amount is returned to Medical Assistance. (The symbol A-≅ appears next to the amount.)

If the adjustment results in a difference in payment from the original, the net amount is added to or reduced from your check amount for that claims cycle. If the adjustment results in a deduction against a zero or insufficient check amount for that week, the negative balance will be carried over to the next claims cycle.

How to Call for Help

For the most expeditious handling of your claims, please read and follow these guidelines.

Claims Processing

Claims Processing handles:

1. <u>Original submissions</u> of claims.

2. <u>Timely resubmissions</u> when:

   a. Sixty days have elapsed and you have not seen the claim reported on a remittance advice (RA) as paid, suspended, or denied. (This is an indication that your claim may not have been received.) Resubmit the claim, <u>*do not*</u> attach any form of inquiry letter.

b. You are correcting a previously-rejected claim. Corrections must be resubmitted within *60* days of latest rejection or *9* months from date of service, whichever is longer. ***If claim is older than 9 months, attach a copy of RA page showing timely submission.***

3. Medicare as primary payer: Medical Assistance secondary,
If you have billed Medicare and are in possession of its EOMB showing payment made, allow 3-4 weeks from your receipt of EOMB for Medical Assistance payment. If you do not receive Medical Assistance payment within this time, the claim may not have *Acrossed over@*. You must submit the following:

a. A copy of the HCFA-1500 or UB-92. Remember to change all fields as required by the Medical Assistance Program. For example, the correct Medical Assistance recipient and provider numbers must appear on the claim form in the Medical Assistance required fields.

b. A copy of the Medicare EOMB with the specific claim information highlighted.

If Medicare has denied payment and the claim is for a Medical Assistance-covered service, submit:

a. The appropriate Medical Assistance invoice, e.g., HCFA-1500, DHMH 248, depending upon services provided;

b. Copy of Medicare EOMB showing the highlighted denial of payment.

Provider Relations
Provider Relations handles problem claims when:

1. Ninety days have elapsed since a claim appeared as Asuspended≅ on a remittance advice, the claim has not appeared as denied on a subsequent RA and payment has not been made.Call Provider Relations for instructions. Have the RA showing the Asuspended≅ status available when you call. You will be given instructions as to how to solve the problem with the claim. Resubmission may not be necessary.

2. You continually receive a rejection for AThird-Party Insurance Coverage≅ and the recipient *no longer* has that coverage. Submit to the Division of Medical Assistance Recoveries a letter of explanation, including the expiration/cancellation date of the policy and the recipient=s Medical Assistance 11-digit identification number. However, send the claim with appropriate insurance rejection code, as listed on Page 36, to Claims Processing.

3. Duplicate payment errors reported on a remittance advice may indicate a near, suspect or exact duplicate of a previously-paid or in-process claim. Examples of why these errors occur when you have not been previously paid are:

a. another provider was paid for the same service on the same day;

b. a modifier was omitted from your claim or another provider=s claim;

c. you billed for the same procedure code for the same date of service as two separate line items.

Check your previously-received RAs and other records to ascertain if you did, in fact, receive payment. If you did not receive payment, call Provider Relations for assistance. In many cases, writing for help provides you with more detailed information about your claims. In addition, written responses can be kept as permanent records for future reference.

Medical Care Liaison Unit

The Medical Care Liaison Unit is available to answer other questions about the proper filing of claims, and to provide Medical Assistance training if required. Refer to Chapter 11 for the address and telephone number of this unit.

Institutional Services Unit

The Institutional Services Unit is available to Hospital and Nursing Home providers to answer questions about the proper filing of claims, and to provide Medical Assistance training in these areas if required. Refer to Chapter 11 for the address and telephone number of this unit.

How to Resubmit a Claim

Please check your remittance advice before submitting a second request for payment. Claims may be resubmitted only for one of the following reasons:

1. The claim has not appeared on a remittance advice as paid, suspended or denied after waiting *60* days since you submitted it, or

2. The claim was denied due to incorrect or missing information or lack of a required attachment.

Please do not resubmit a claim denied because of Medical Assistance Program limitations or policy regulations, i.e., the claim was not originally submitted within the *9* month statute, or the Program does not reimburse for services provided. ***Computer edits ensure that it will be denied again.***

You may resubmit a claim on a new claim form or a legible photocopy *after correcting any error or attaching requested documentation.* Claims and attachments which cannot be clearly microfilmed or photocopied will be returned. Do not attach any form of an inquiry letter, as it will not be responded to using this mechanism.

How to Resubmit a Claim

Refer to the following for a checklist of steps to take when resubmitting claims.

Did you wait *60* days after your original submittal, without getting a response from us, before resubmitting a claim?

If you chose to fill out a new invoice, did you type or print your form in black ink? Remember, typing your claim form will speed up the process.

If you have corrected or changed the original claim form, have strikeovers been corrected on each copy?

Have you stapled to the claim form all attachments and requested documentation, if required?

If your claim is being filed more than *9* months from the date of service, have you attached documentation showing previous timely submittals and routine follow-up every *60* days?.

Do you have the correct P.O. Box number and corresponding ZIP code for mailing your resubmittals? Resubmittals should be sent to the same P.O. Box as the original claim.

Do you have any questions about resubmittals that are not answered in this handbook? If so, please contact either Provider Relations or Medical Care Liaison Unit for assistance. Refer to Chapter 11 for the address and telephone number.

How to File an Adjustment Request

From time to time, you may receive an inaccurate payment for a claim or payment from a third party after Medical Assistance has made payment. If you discover the liability of another payer after Medical Assistance paid you or you believe an adjustment is needed, you **MUST** complete and submit an Adjustment Request Form (ARF) to correct the payment. See Chapter 9 for instructions on ordering forms.

If you believe a Medical Assistance Program keying error caused the incorrect payment, complete an Adjustment Request Form following the directions on the back of the form. However, please be sure that it was a keying error that caused an unexpected payment. In some cases, claim payment is Acut back≅ due to service limitations. If you were not paid the maximum allowable amount, you are notified on the remittance advice in the AEOB≅ column as to the reason. All EOB codes are translated at the end of the remittance advice in the Claims Total Section.

DO NOT BILL ONLY FOR REMAINING UNPAID AMOUNTS OR UNITS

For example, you submitted and received payment for 3 units of a revenue code and you should have billed for 5 units. Do not bill for the remaining 2 units; bill for the full 5 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 recipients listed are your patients. In this situation, return the remittance advice and check with a completed Adjustment Request Form to the Division of Medical Assistance Recoveries at the address listed in Chapter 11.

Partial Refunds. If you receive a 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 for each individual claim paid incorrectly. Each adjustment request should be submitted on a separate Adjustment Request Form.

Complete an Adjustment Request Form following the directions printed on the back of the form. Adjustments are processed as replacement claims. In processing, the original payment is completely deducted and the adjustment is processed as a regular claim. The net result is a transaction which will increase or decrease your check amount.

Provider-requested adjustment (underpayments) must be received by the Medical Assistance Program within the billing statute of limitations.

Since the Medical Assistance Program processes an adjustment request as a replacement to the original erroneously paid claim, it is vital that all claim items on the Adjustment Request Form are completed correctly.

For overpayments or refunds, the provider may issue and submit one check to cover more than one Adjustment Request Form.

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Chapter 8 - Trouble-Shooting Guide

This guide provides information about the most common billing errors encountered when providers submit claim forms to the Medical Assistance Program. It can help when you are just starting to bill by providing information about the most common errors and how to avoid them. Preventing errors on the claim form 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 which provides the precise reason a specific claim was denied. EOB codes are very specific to individual claims and provide you with the most information about a specific 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.*

X Verify that your *9*-digit Medical Assistance provider number is entered in the appropriate block. *Do not* use your PIN or tax identification number.

X Verify that a valid *9*-digit provider number for the requesting, referring or attending provider is entered in the appropriate block and each provider is correctly identified.

X Verify that the *9*-digit provider number you entered in the block reserved for the rendering provider number is, in fact, for a rendering provider. If you enter a group provider number in the block for the rendering provider the claim will deny because group provider numbers cannot be used as rendering provider numbers. The same applies for pay-to provider numbers.

X When billing for preauthorized 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.

X Verify that the recipient=s *11*-digit Medical Assistance identification number is entered in the appropriate block.

X Verify that the recipient=s name is entered in the appropriate block as last name and then first name.

X When billing for preauthorized procedures, verify that the *11*-digit recipient number entered on the claim form is the same *11*-digit recipient number that was authorized to receive the services.

X 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 service covered by the claim.*

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

   X Verify that you entered the correct dates of service in the appropriate blocks of the claim form. You ***MUST*** call the Eligibility Verification System (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 in the appropriate block on the claim form.

   X Verify that the recipient is not part of the Medical Assistance Managed Care Program. If you determine that the recipient services are covered by Managed Care, contact the appropriate Managed Care Organization.

   X Verify that the recipient is not covered by Medicare. If you determine that the recipient is covered by Medicare, bill the appropriate Medicare carrier. If you have already billed Medicare, follow the procedures described in Chapter 5.

   X When billing for preauthorized procedures, verify that the dates of service entered on the claim are the same dates of service that were authorized.

3. *Preauthorization is required.*

   X Certain procedures require preauthorization. If you obtained preauthorization, verify that you entered the number correctly on the claim form. If you did not obtain preauthorization, remove the unauthorized procedure from the claim and resubmit the claim to receive payment for the procedures which did not require preauthorization.

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

   X 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.

   X For some claims, a valid *2*-digit place of service code is required. Medical Assistance uses the same 2-digit place of service codes used by Medicare.

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

   X 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. This also applies to surgical and other procedures.

X MMIS-II performs multiple utilization review and other edit checks for each claim. Claims will be denied if the procedure cannot be performed on the listed recipient because of gender, age, prior procedure or other medical criteria conflicts. Verify that you entered the correct *11*-digit recipient identification number, procedure code and modifier on the claim form.

X Verify that the billed services are covered for the recipient=s coverage type. Covered services vary by program type. For example, some recipients 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. Several types of programs are described in Chapter 3. Refer to regulations for each program type to determine the covered services for that program.

X Some providers are authorized to bill for certain services only based on their provider type or specialty. For example, some providers are authorized to bill for Medicare services only. Verify that you entered the correct *9*-digit Medical Assistance provider number, procedure code and modifier on the claim form and that you are eligible to provide these services.

X 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.

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

X If the Program has determined that a recipient has third party coverage that will pay for medical services, the Program will deny the claim except in the case of prenatal care and EPSDT well-child services. Follow the procedures described in Chapter 5 above to bill the third party.

X If a recipient is enrolled in an MCO, you must bill that organization for services rendered. Verify that the recipient=s *11*-digit Medical Assistance number is entered correctly on the claim form.

6. Required attachments are not included.

X If you bill for an abortion, hysterectomy or sterilization, the appropriate form must be completed *accurately and completely.* **Verify that this has been done.**

X 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.

X If you bill a usual and customary charge that is over the maximum allowed amount and did not obtain prior authorization, the invoice must be reviewed before the claim can be paid. Verify that you have the appropriate documentation to justify your pricing, attach it to the claim form and then resubmit the claim.

Some errors occur simply because the data entry operators have incorrectly keyed or been unable to read data from your claim. This can also occur when the claim is scanned, if your claims information is not clearly typed or printed. For a denied claim, always compare data from the remittance advice with file copies of your claims. If the claim denied because of a keying or scanning error, resubmit the claim following the procedures described in Chapter 7.

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Chapter 9 - How To Order Forms

Supplies of ***State*** invoices and most other Medical Assistance forms are available from the Department of Health and Mental Hygiene through the local Health Departments. The following two pages contain the names, addresses and telephone numbers for the forms distribution contact persons at the local Health Departments throughout the State.

A list of ***State*** forms and reproductions of forms used for various purposes can be found in Appendix B, beginning on Page 80.

If your local Health Department cannot provide you with ***State*** invoices or other Medical Assistance forms, call Provider Relations at the number listed in Chapter 11.

NOTE:

X HCFA-1490, HCFA-1491 and HCFA-1500 are federal forms used by providers to bill Medical Assistance for some of their services. These forms must be obtained other than through Medical Assistance.

X Preauthorization forms are not available through local Health Departments. To obtain preauthorization forms, complete an order form (DHMH 4129) and send it to the address listed in Chapter 11.

Directory of Local Health Departments - Contacts for Obtaining MA Forms

Allegany Co. Health Department
12500 Willowbrook Road
Cumberland, MD 21502
Att: Linda Curry
301-777-5660

Anne Arundel Co. Health Department
3 Harry S. Truman Parkway
Annapolis, MD 21401
Att: Mike Barnes
410-222-7129

Baltimore City Health Department
1601-1631 McCulloh Street
Baltimore MD 21217
Att: Patricia Jefferson
410-396-4008

Baltimore Co. Health Department
Eastern Family Resource Center
9100 Franklin Square Drive
Baltimore, MD 21237
Att: Steve Cline or Diana Macri
410-887-0416

Calvert Co. Hea1th Department
975 Solomons Island Rd., North
Prince Frederick, MD 20678
Att: Denise Wilkins
410-535-5400 Ext. 301

Caroline Co. Health Department
403 South Seventh St.
Denton, MD 21629
Att: Sylvia Trice
410-479-0556

Carroll Co. Health Department
290 S. Center St.
P.O. Box 845
Westminster, MD 21158
Att: Wilma Lough
410-876-2152

Cecil Co. Health Department
401 Bow Street
Elkton, MD 21921
Att: Betty Morris
410-996-5550

Dorchester Co. Health Department
751 Woods Road
Cambridge, MD 21613
Att: Betty Camper
410-228-3223

Frederick Co. Health Department
350 Montevue Lane
Frederick, MD 21702
Att:Deanna Casto
301-631-3124

Garrett Co. Health Department
2008 Maryland Highway
Mt. Lake Park, MD 21550
Att: Karen Otto
301-334-1599

Harford Co. Health Department
119 Hays Street
Bel Air, MD 21014
Att: Brenda Hinton
410-638-8400

Howard Co. Health Department
6751 Columbia Gateway Drive, 3rd Flr.
Columbia, MD 21046
Att: Debbie Donlan
410-313-6306

Kent Co. Health Department
125 S. Lynchburg St.
Chestertown, MD 21620
Att: Jane Lane
410-778-7035

Montgomery Co. Health Department
(Receiving and Supply)
2000 Dennis Avenue
Silver Spring, MD 20902
Att: Karen Anderson
240-777-1842

Prince George=s Co. Health Department
9314 Piscataway Road
Clinton, MD 20735
Att: Iris Kent
301-856-9606

Charles Co. Health Department
4545 Crain Highway
White Plains, MD 20695
Att: Irene Shymansky
301-609-6920

Somerset Co. Health Department
7920 Crisfield Highway
Westover, MD 21871
Att: Sandy Leatherbury
410-651-5600

St. Mary=s Co. Health Department
21580 Peabody Street
Leonardtown, MD 20650
Att: Gail Lawrence/Patricia Norris
301-475-4072

Talbot Co. Health Department
100 S. Hanson Street
Easton, MD 21601
Att: Lisa Dobson
410-819-5600

Queen Anne=s Co. Health Department
206 North Commerce Street
Centreville, MD 21617
Att: Karen Griscom
410-758-0720 Ext. 363

Washington Co. Health Department
1302 Pennsylvania Avenue
Hagerstown, MD 21742
Att: Jennifer Smith
301-791-3228

Wicomico Co. Health Department
108 E. Main Street
Salisbury, MD 21801
Att: Ava Brice
410-749-1244

Worcester Co. Health Department
6040 Public Landing Road, Route 365
Snow Hill, MD 21863
Att: Aggie Parks
410-632-1100

MARYLAND MEDICAL ASSISTANCE PROVIDER HANDBOOK

Chapter 10 - Provider Participation

General Provider Requirements

In order to participate in the Maryland Medical Assistance Program, a practitioner or facility must be licensed and legally authorized to practice the appropriate medical services in the state in which the service is provided. The provider must not knowingly employ or contract with any person, partnership or corporation who has been disqualified from the Program unless written approval has been granted by the Program to provide services to Medical Assistance recipients.

The provider must insure that all equipment has been inspected and meets the standards established by the state in which the service is provided.

Specific provider requirements are explained during the provider application process and detailed in the provider agreement. Refer to the regulations for your program for additional details. If you have questions regarding requirements specific to your provider type, contact the Provider Master File at the phone number listed in Chapter 11.

Provider Requirement for Clinical Laboratory Services

Clinical laboratory services, that may be reimbursed by the Maryland Medical Assistance Program, can be provided by institutions, facilities, laboratories, practices and practitioners that have demonstrated the required Clinical Laboratory Improvement Amendments (CLIA) and, if necessary, Maryland State certification.

CLIA, the Clinical Laboratory Improvement Amendments of 1988, was promulgated as Public Law 100-578 and established federal registration for all facilities and practitioners performing clinical laboratory services in the United States, effective September 1, 1992. Registration is required *even* if only basic tests such as dipstick urinalysis, pregnancy tests, hemoglobin by copper sulfate, spun microhematocrits and fecal occult bloods are performed. CLIA has *no effect on the ability of an authorized ordering practitioner to order* laboratory services performed by another facility or *obtain and forward* specimens. **TO BE REIMBURSED FOR CLINICAL LABORATORY SERVICES, ALL PROVIDERS MUST SUPPLY A COPY OF A CLIA CERTIFICATE FOR EACH AND EVERY SITE AT WHICH CLINICAL LABORATORY SERVICES ARE PERFORMED.**

Maryland State laboratory certification is required for all institutions, facilities, laboratories, practices and practitioners that are located in or that receive specimens originating in the State of Maryland. If an out-of-state provider does not have Maryland laboratory certification and wishes to be reimbursed for clinical laboratory services, then the provider must supply a signed statement attesting to the fact that they do not receive specimens originating in Maryland as well as the CLIA certification. **TO BE REIMBURSED FOR CLINICAL LABORATORY SERVICES, ALL PROVIDERS, IF REQUIRED TO BE STATE CERTIFIED, MUST SUPPLY A COPY OF THEIR STATE CERTIFICATION FOR EACH AND EVERY SITE AT WHICH CLINICAL LABORATORY SERVICES ARE PERFORMED.**

Civil Rights

There are two federal laws about civil rights. The first is the Civil Rights Act of 1964. This law prohibits discrimination on the basis of race, creed, color or national origin. The second is Section 504 of the Rehabilitation Act of 1973. This law prohibits discrimination on the basis of handicap. If you do not comply with these two laws, you cannot participate in the Medical Assistance Program.

Provider Eligibility

The Department of Health and Mental Hygiene determines the eligibility of each Medical Assistance provider. In order to enroll in the Maryland Medical Assistance Program, a provider must:

1. meet federal and State standards for enrollment;

2. complete and sign an application and provider agreement approved by the Department of Health and Mental Hygiene; and

3. comply with applicable federal and State regulations. Providers are deemed responsible for reading and adhering to Program regulations set forth in this handbook and the provider agreement.

Complete and return the application to the Provider Master File Unit with the information requested in the enrollment packet. Those who are applying to provide services to waiver participants must supply additional information and submit it to the address given for Medical Care Policy Administration in Chapter 11. After your application is approved, the Program will send you a 9-digit Medical Assistance provider number. You will use this number to bill Medical Assistance; this number should also appear on any correspondence sent to the Program. The Program will then pay you for covered services that you furnish to eligible Medical Assistance recipients during the dates your provider enrollment is effective.

Regulations specify the following participation requirements for Medical Assistance providers. Each provider must:

1. complete and sign an enrollment application and provider agreement as specified by the Medical Assistance Program;

2. maintain such records as are necessary to document fully the services provided and make them available, upon request, to the Department or its designee. The records must be retained for 6 years. If an audit is in process at the end of 6 years, the records must be retained until the audit is completed and every exception is resolved;

3. consider the fee paid by the Medical Assistance Program in accordance with State maximum allowable limits as payment in full. *Providers are prohibited by law from requesting or receiving additional payment from the recipient or responsible relatives, except when specifically allowed by regulations.* The provider must agree that if the Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary or preauthorized, he/she may not seek payment for that service from the recipient;

4. place no restrictions on the recipient=s right to select providers of his/her choice. A recipient enrolled in an MCO is required to obtain services from that organization, except for some specified services. For additional information, refer to Chapter 3.

5. furnish services to Medical Assistance recipients in full compliance with Title VI of the Civil Rights Act of 1964, the Maryland statutes and other laws and regulations which prohibit discrimination.

Out-of-state providers that provide services to Maryland Medical Assistance recipients must enroll in the Maryland Medical Assistance Program through the same enrollment process as Maryland in-state providers. All participating out-of-state providers are subject to the same program regulations and procedures that apply to participating in-state providers.

Continuing Enrollment

Providers are required to promptly report any and all change of status such as address, licensing, certification, board specialties, corporate name or ownership in writing to the Provider Master File Unit at the address listed in Chapter 11. In some instances, i.e., change in ownership, a new application is required. If you change your Federal Tax Identification Number, you must *re-enroll* in the Program. Questions concerning specific requirements should be directed to Provider Master File at the phone number listed in Chapter 11.

Record Keeping

You must retain records on services provided to each Medical Assistance patient and make these records available to the Medical Assistance Program on request. Keep the records for a period of 6 years from the date of service.

Examples of the types of Medical Assistance records that must be retained are;

1. medical records showing services to each Medical Assistance recipient, including signature of the recipient where required;
2. treatment plans and utilization review worksheets;
3. all preauthorization information;

4. a record of all prescriptions, equipment, referrals and ancillary services which are prescribed, ordered or authorized by you;

5. Medical Assistance claim forms and any supporting documentation;

6. any third party claim information; and

7. fiscal records such as cost reports, purchase invoices, inventory records and necessary supporting documentation.

You are required to make these records available to authorized State and federal staff, and their authorized representatives, upon request. You may convert your records to microfilm or microfiche. *You may also convert your records to optical disc as long as an exact image of the medical record is transferred and there are safeguards to prevent editing of the image file.* Any medical records converted to microfilm, microfiche or *optical disc* must be legible when printed or viewed. *Use of other electronically stored image systems require prior written authorization from* the Department or a superseding transmittal which authorizes the use of *other electronic* record(s) keeping.

Confidentiality

Names, treatments, payments and other information about Medical Assistance patients are confidential. Confidential means that information cannot be released without written consent from the recipient.

You *do not* have to get your patient=s consent if you are;

- X billing another insurance carrier;
- X releasing information to your billing agent;
- X releasing information to the patient=s managed care provider; or
- X releasing information to authorized representatives of the Medical Assistance Program. If someone asks you for such information saying he/she represents the Medical Assistance Program, ask for his/her Medical Assistance Program identification.

Rights

When you enroll as a Medical Assistance provider, it means that you are willing to accept Medical Assistance patients. You are not required to provide services to every recipient who comes to your practice, except in cases of emergency. However, you may not deny services based on race, color, age, sex, national origin, marital status or physical or mental handicap.

Medical Assistance Payments

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

You *cannot* bill your 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 Medical Assistance denies your claim because of billing errors you made such as:
   - X wrong procedure and diagnosis codes,
   - X lack of preauthorization
   - X invalid consent forms,
   - X unattached necessary documentation,
   - X incorrectly completed claim form,
   - X filing after the time limitations, or
   - X 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 recipient=s medical records to another health care provider;

6. when services were determined to not be medically necessary; or

7. for hospitals, the difference in your charges for a private room and what Medical Assistance paid when there was no semi-private room available or when a private room was used by a recipient because of medical necessity at the physician=s orders.

8. for nursing facilities, additional charges for a private room.

You *can* bill the recipient under the following circumstances:

1. if the service provided is not covered by Medical Assistance and you have notified the recipient prior to providing the serviced that the service is not covered; or

2. if the recipient is not eligible for Medical Assistance on the date you provided the services.

Fraud and Abuse
It is illegal to submit reimbursement requests for:

- X 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 payor;
- X services which are either not provided, or not provided in the manner described on the request for reimbursement. In other words, 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;
- X any procedures other than the ones you actually provided;
- X multiple, individually described or coded procedures if there is a comprehensive procedure which could be used to describe the group of services provided;
- X unnecessary, inappropriate, non-covered or harmful services, whether or not you actually provided the service;
- X items or services which are performed without the required referrals or preauthorizations; or
- X services for which you have received full payment by another insurer or 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.

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; and
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 recipients *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:

X refuses to allow authorized auditors or investigators reasonably immediate access to records substantiating the provider=s Medical Assistance billings;

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

X furnishes a recipient goods or services that are determined to be:
1. in excess of the recipient=s needs,
2. harmful to the recipient,
3. of inferior quality, or
4. insufficient to meet the recipient=s needs;

X fails to provide necessary access to medical care for recipients 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 recipient=s medical condition or need for referred or emergency care, either to the Program or to another provider.

X provides misleading or false information to the Medical Assistance Program, or to its authorized representatives or delegates;

X demands, bills or accepts payments from recipients or others for services covered by Medical Assistance;

X has been indicted for, convicted of, or pled guilty to Program related offenses, or is suspended or terminated from the Medicare Program; or;

X does not have all required professional licensure and certifications necessary for the services he/she is performing.

Appeal Procedure

Appeals that are authorized by Medical Assistance regulations are conducted under the authority of COMAR 10.09.36.09 and in accordance with State Government, Sections 10-201 et seq. And Health-General, Sections 2-201 through 2-207 of the Annotated Code of Maryland and COMAR 10.01.03 and 28.02.01.

To initiate an appeal, follow the procedures described in the Annotated Code and COMAR. Appeals must be filed within 30 days of receipt of a notice of administrative decisions.

MARYLAND MEDICAL ASSISTANCE PROVIDER HANDBOOK

Chapter 11 - Important Phone Numbers And Addresses

Claims - Originals
P.O. Box 1935
Baltimore, MD 21203
410-767-5347

Claims - Pharmacy
Point of Sale Claims
First Health Help Desk
800-884-3238

Paper Claims (Compounds and Home IVs)
P.O. Box 2158
Baltimore, MD 21203
410-767-6028

Policy/Coverage Questions
410-767-1455

The Web Site will contain information relative to the Maryland Medicaid Program, and will include the latest Provider Manual and Provider Bulletin. Providers can access the Web site via the following address: www.dhmh.state.md.us.mcoa

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

Compliance Administration
Medical Care Finance and Compliance Administration
201 W. Preston Street
Baltimore, MD 21201
410-767-5204

Electronic Media Submittal
Tape Billing
Production Control
201 W. Preston Street, Room SS-3A
Baltimore, MD 21201
410-767-5983

Dial-Up Billing
Systems Operator
201 W. Preston Street, Room SS-3A
Baltimore, MD 21201
410-767-5863

For technical problems concerning electronic media submittal, contact the DMIS Technical Team at 410-767-5977. To inquire about rejected claims, contact Provider Relations.

Eligibility Verification System
Baltimore Metro Area 410-333-3020
Outside Baltimore Metro Area 800-492-2134

EPSDT Unit
Medical Care Policy Administration
201 W. Preston Street
Baltimore, MD 21201
410-767-1485

Forms - How to Order Forms
For Preauthorization Forms ***ONLY***, (using DHMH 4129) write:
Medical Care Operations Administration
201 West Preston Street, Room SS-12
Baltimore, MD 21201
410-767-5180

All other State forms, including State claim forms, must be ordered through your local Health Department. Refer to Page 56.

HealthChoice Enrollment Line
1-800-977-7388

HealthChoice Action Line (Information & Complaints)
Recipient 1-800-284-4510
Provider 1-800-766-8692

Maryland Pharmacy Assistance Program
P.O. Box 386
Baltimore, MD 21203-0386
410-767-5394/1-800-492-1974

Medical Care Liaison Unit
201 W. Preston Street, Room L-4
Baltimore, MD 21201
410-767-6024

Institutional Services Unit *(Hosp./Nursing Homes)*
201 W. Preston Street, Room L-4
Baltimore, MD 21201
410-767-5457 (or) 410-767-5361

Medicare Billing Addresses

Part A Services
Maryland Blue Cross/Blue Shield
1946 Greenspring Drive
Timonium, MD 21093
410-252-5310

Medical Supplies and Equipment
DMERC (Administar)
P.O. Box 7078
Indianapolis, IN 46207-7078
877-299-7900

Part B Services
TrailBlazer Health Enterprises, Inc.
Executive Plaza III
11350 McCormick Rd.
Hunt Valley, MD 21031
866-539-5591
All of Maryland, alsoD.C. Metropolitan Area

Medicare Crossover Section
P.O. Box 1935
Baltimore, MD 21203

Policy Administration and Divisions
Medical Care Policy Administration
201 W. Preston Street
Baltimore, MD 21201

Please refer to the following matrix to determine the appropriate phone number to call:

Title	Regulation	Division	Phone Number
Ambulance Services	10.09.13	Division of Grants, Regulations, and TransportationServices	410-767-1436
Case Management for Children Diverted/Returned from Out-of-State Residential Treatment Facilities	10.09.49	Waiver Programs	410-767-5220

Title	Regulation	Division	Phone Number
Case Management for Individuals with Developmental Disabilities	10.09.48	Waiver Programs	410-767-5220
Dental Services	10.09.05	Children=s Services	410-767-1485
Disposable Medical Supplies/ Durable Medical Equipment	10.09.12	Long Term Care Services	410-767-1474
Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)	10.09.23	Children=s Services	410-767-1485
Early Intervention Services Case Management	10.09.40	Children=s Services	410-767-1485
Eligibility - Medical Assistance	10.09.24	Eligibility Services	410-767-1463
Emergency Service Transporters	10.09.31	Div. Of Grants, Regulations and Transportation	410-767-1436
EPSDT - Private Duty Nursing	10.09.53	Children=s Services	410-767-1485
EPSDT Audiology Services	10.09.51	Children=s Service	410-767-1485
EPSDT School Health-Related or Health-Related Early Intervention Services	10.09.50	Children=s Services	410-767-1485
Expanded EPSDT Referred	10.09.37	Children=s Services	410-767-1485
Family Planning Program	10.09.58	Outreach & Women=s Services	410-767-6750
Free-Standing Clinics	10.09.08	Medical Services	410-767-1455
Free-Standing Dialysis Facility Services	10.09.22	Medical Services	410-767-1455

Title	Regulation	Division	Phone Number
Free-Standing Medicare - Certified Ambulatory Surgical Centers	10.09.42	Medical Services	410-767-1455
Health Maintenance Organizations Establishment, Operation and Authority for Medical Assistance	10.09.16	Managed Care	410-767-1482
Healthy Start Program 6750	10.09.38	Outreach & Women=s Services	410-767-
Home Health Services	10.09.04	Long Term Care Services	410-767-1474
Hospice Care	10.09.35	Long Term Care Services	410-767-1474
Hospital Services	10.09.06	Medical Services	410-767-1455
Hospital Services, State-Only	10.09.34	Medical Services	410-767-1455
IDEA Transportation	10.09.25	Div. of Grants, Regulations and Transportation	410-767-1436
Managed Care Organizations Establishment, Operation and Authority for Medical Assistance		Managed Care	410-767-1482
Maryland Pharmacy Assistance Program - Eligibility	10.45.01	Eligibility Services	410-767-1463
Maryland Pharmacy Assistance Program - Services	10.45.02	Medical Services	410-767-1455
Medical Day Care Services - Adults	10.09.07	Long Term Care Services	410-767-1444
Medical Laboratories	10.09.09	Medical Services	410-767-1455
Mental Health Case Management	10.09.07	Waiver Programs	410-767-5220

Title	Regulation	Division	Phone Number
Mentally Retarded/Developmentally Disabled Waiver	10.09.26	Waiver Programs	410-767-5220
Model Waiver for Medically Fragile Children	10.09.27	Waiver Programs	410-767-5220
Nurse Anesthetist Services	10.09.39	Medical Services	410-767-1455
Nurse Midwife Services	10.09.21	Medical Services	410-767-1455
Nurse Practitioner Services	10.09.01	Medical Services	410-767-1455
Nursing Facility Services	10.09.10	Long Term Care Services	410-767-1444
Dept. on Aging/Senior Assisted Housing Waiver	10.09.54	Waiver Programs	410-767-5220
Oxygen and Related Respiratory Equipment Services	10.09.18	Long Term Care Services	410-767-1474
Partially Capitated Programs	10.09.57	Managed Care	410-767-1482
Personal Care Services	10.09.20	Long Term Care Services	410-767-1444
Pharmacy Services	10.09.03	Medical Services	410-767-1455
Physical Therapy Services	10.09.17	Long Term Care Services	410-767-1474
Physician=s Services	10.09.02	Medical Services	410-767-1455
Podiatry Services	10.09.15	Medical Services	410-767-1455
Pregnancy Women and Children-Medical Assistance	10.09.28	Outreach & Women's Service	410-767-6570
Provider Participation Criteria-General Medical Assistance	10.09.36	Administrative Services	410-767-1436

Title	Regulation	Division	Phone Number
Rare & Expensive Case Management	10.09.69		1-800-565-8190
Rehabilitative Services-Mental Health	10.09.59	Medical Services	410-767-1455
Residential Treatment Center Services	10.09.29	Medical Services	410-767-1455
Service Coordination for Children with Disabilities	10.09.52	Children=s Services	410-767-1485
Statewide Evaluation & Planning Services (STEPS)	10.09.30	Long Term Care Services	410-767-6767
Stop Loss	10.09.65		410-767-5445
Targeted Case Management for HIV Infected Individuals	10.09.32	Waiver Programs	410-767-5220
Transportation Grants	10.09.19	Div. of Grants, Regulations and Transportation	410-767-1436
Vision Care Services	10.09.14	Medical Services	410-767-1455

Preauthorizations

Medical Care Finance and Compliance Administration
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201

General Information		410-767-1693
Preauthorization Requests		
X Audiology	?	Medical Care Operations Administration
X Dental	?	Division of Claims Processing
X DMS/DME	?	P.O. Box 17058
X	PDN	Baltimore, MD 21201
EPSDT - Private Duty Nursing (PDN)		410-767-1814
Home Health Services		410-767-1820
Nutritional Supplements		410-767-1693

Pharmacy Services - Telephone number given on-line by First Health

Vision Services	Baltimore Area	410-767-1693
	Outside Baltimore Metro Area	800-492-6006

Only needed for services after the coverage limitation has been met and for services indicated on the Vision Care Fee Schedule

Provider Master File Unit (*formerly* Provider Enrollment Unit)
Medical Care Operations Administration
P.O. Box 17030
Baltimore, MD 21203
410-767-5340

Provider Relations
Medical Care Operations Administration

P.O. Box 22811	Baltimore Area	410-767-5503
Baltimore, MD 21203	Outside Baltimore Metro Area	800-445-1159

Systems Liaison Unit
Medical Care Operations Administration
201 W. Preston Street
Baltimore, MD 21201
410-767-6940

Third Party Recovery
Medical Care Finance and Compliance Administration
Division of Medical Assistance Recoveries
P.O. Box 13045
Baltimore, MD 21298
410-767-1764 - 410-767-1773 or 410-767-1771

Directory of Local Health Departments

Allegany County Health Department
P.O. Box 1645, Willowbrook Road
Cumberland, MD 21502
301-777-5600

Anne Arundel County Health Department
3 Harry S. Truman Parkway
Annapolis, MD 21401
410-222-7095

Baltimore City Health Department
210 Guilford Avenue, 3rd Flr.
Baltimore, MD 21202
410-396-4398

Baltimore County Health Department
Investment Building
1 Investment Place, 11th Flr.
Towson, MD 21204
410-887-3740

Calvert County Health Department
P.O. Box 980
Prince Frederick, MD 20678
410-535-5400

Caroline County Health Department
Box 10, 403 South 7th Street
Denton, MD 21629
410-479-8030

Carroll County Health Department
Box 845, 290 S. Centre Street
Westminster, MD 21157
410-876-2152

Charles County Health Department
Box 640, Garrett Street
LaPlata, MD 20646
301-609-6900

Dorchester County Health Department
3 Cedar Street
Cambridge MD 21613
410-228-3223

Frederick County Health Department
350 Montevue Lane
Frederick, MD 21702
301-694-1029

Garrett County Health Department
1025 Memorial Drive
Oakland, MD. 21550
301-334-7777

Harford County Health Department
119 South Hays Street, Box 797
Bel Air, MD 21014
410-879-2404

Howard County Health Department
6751 Columbia Gateway drive
Columbia, MD 21046
410-313-6300

Kent County Health Department
125 South Lynchburg Street, Box 359
Chestertown, MD 21620
410-778-1350

Cecil County Health Department
John M. Byers Health Center
401 Bow Street
Elkton, MD 21921
410-996-5550

Montgomery County Health Department
401 Hungerford Drive, 5th Floor
Rockville, MD 20850
240-777-1245

Prince George=s County Health Department
1701 McCormick Drive
Largo, MD 20774
301-883-7879

Talbot County Health Department
100 South Hanson Street
Easton, MD 21601
410-819-5600

Queen Anne=s County Health Department
206 North Commerce Street
Centreville, MD 21617
410-758-0720

Washington County Health Department
1302 Pennsylvania Avenue
P.O. Box 2067
Hagerstown, MD 21742
301-791-3200

St. Mary=s County Health Department
Peabody Street, P.O. Box 316
Leonardtown, MD 20650
301-475-4330

Wicomico County Health Department
108 East Main Street
Salisbury, MD 21801
410-749-1244

Somerset County Health Department
7920 Crisfield Highway
Westover, MD 21871
410-651-5600

Worcester County Health Department
P.O. Box 249
Snow Hill, MD 21863
410-632-1100

Directory of Local Departments of Social Services

Allegany County DSS
1 Frederick Street
Cumberland, MD 21502
Mail-P.O. Box 1420
Cumberland, MD 21502-1420
301-784-7000

Anne Arundel County DSS
80 West Street, 2nd Floor Deck
Annapolis, MD 21401
410-269-4504

Baltimore City DSS
2000 North Broadway
Baltimore, MD 21213-1447
410-361-4602

Baltimore County DSS
Investment Building
620 York Road
Towson, MD 21204-4150
410-887-2520

Calvert County DSS
Goldstein Building
200 Duke Street
Prince Frederick MD 20678
Mail-P.O. Box 100
Prince Frederick, MD 20678-0100
410-286-2100

Caroline County DSS
207 S. 3rd Street
Denton, MD 21629
Mail-P.O. Box 100
Denton, MD 21629-0100
410-479-5900

Carroll County DSS
10 Distillery Drive
Westminster, MD 21157-5045
410-848-8880

Cecil County DSS
Multi-Service Building
170 E. Main Street
Elkton, MD 21921-5941
Mail-P.O. Box 1160
Elkton, MD 21922-1160
410-996-0100

Charles County DSS
Southern MD Trade Center
101 Catalpa
LaPlata, MD 20646
Mail-P.O. Box 1010
LaPlata, MD 20646-1010
301-932-6433

Dorchester County DSS
627 Race Street
Cambridge, MD 21613
Mail-P.O. Box 217
Cambridge, MD 21613-0217
410-901-4100

Frederick County DSS
100 E. All Saints Street
Frederick, MD 21701
Mail-P.O. Box 237
Frederick, MD 21701-0237
301-694-4575

Garrett County DSS
12578 Garrett Highway
Oakland, MD 21550-1159

Harford County DSS
2 South Bond Street, 3rd Floor
Bel Air, MD 21014
410-836-4787

Howard County DSS
7121 Columbia Gateway Drive
Columbia, MD 21046-2151
410-872-4200

Kent County DSS
350 High Street
Chestertown, MD 21620
Mail-P.O. Box 670
Chestertown, MD 21620-0670
410-810-7600

Montgomery County DSS
1301 Piccard Drive
2nd Floor
Rockville, MD 20850
240-777-4600

Germantown 240-777-3420
Silver Spring 240-777-3000

Prince George=s County DSS
6505 Belcrest Road
Hyattsville, MD 20782
Mail-Centre Pointe
805 Brightseat Road
Landover, MD 20785-4723
301-209-5000

Queen Anne=s County DSS
120 Broadway
Centreville, MD 21617-1089
410-758-8000

St. Mary=s County DSS
Carter Building
23110 Leonard Hall Drive
Leonardtown, MD 20650
Mail-P.O. Box 509
Leonardtown, MD 20650-0509
240-895-7000

Somerset County DSS
30397 Mt. Vernon Road
Princess Anne, MD 21853
Mail-P.O. Box 369
Princess Anne, MD 21853-0369
410-677-4200

Talbot County DSS
10 S. Hanson Street
Easton, MD 21601
Mail-P.O. Box 1479
Easton, MD 21601-1479
410-822-1617

Washington County DSS
122 N. Potomac Street
Hagerstown, MD 21741
Mail-P.O. 1419
Hagerstown, MD 21741-1419
240-420-2100

Wicomico County DSS
201 Baptist Street
3rd Floor
Salisbury, MD 21802-4966
Mail-P.O. Box 2298
Salisbury, MD 21802-2298
410-543-6900

Worcester County DSS
299 Commerce Street
Snow Hill, MD 21863
Mail-P.O. Box 39
Snow Hill, MD 21863-0039
410-677-6800

MARYLAND MEDICAL ASSISTANCE PROVIDER HANDBOOK

Appendix A: Available Supplements

Billing Instructions
Contact the First Health Help Desk for billing instructions for pharmacy.

Contact Staff Specialist, Pharmacy Services, Medical Care Policy Administration, for billing instructions for home infusion therapy services.

Contact Provider Relations if you would like a copy of any of the following supplements:

- X Community Based Services
- X Dental
- X HCFA-1491
- X HCFA-1500
- X Long Term Care
- X UB-92
- X Vision

Third Party Carrier Listing
Contact Medical Care Finance and Compliance Administration for a third party carrier listing.

MARYLAND MEDICAL ASSISTANCE PROVIDER HANDBOOK

Appendix B: Medical Assistance Forms

The following pages are copies of various forms referenced throughout this handbook, and used by Maryland Medical Assistance providers.

The forms are reproduced for your information, and are not intended to be photocopied for various reasons.

The actual forms may be obtained by using the process described in Chapter 9.

MARYLAND MEDICAL ASSISTANCE FORMS

Send Order To: Provider Number: Return To:

_____

Address (Include Zip Code)

_____

_____

_____

Phone Number: _____

Please use a street address. We cannot deliver forms to a post office box.

_____

The following forms are <u>only</u> available from your local Health Department.

Quantity	**Form Number**	**Description**
_____	DHMH 11	Specialist Referral Form - Case Management Program
_____	DHMH 234	Dental Report and Invoice
_____	DHMH 242	Hospital Inpatient-Outpatient Report to Receipts Not Previously Reported for State Patient
_____	DHMH 245	Appeal for Medical Assistance Hearing
_____	DHMH 248	Community Based Service Invoice
_____	DHMH 253	Preauthorization Request for Podiatry Services
_____	DHMH 254	Annual Podiatric Evaluation Report-Nursing Home Patients
_____	DHMH 257	Long Term Care Patient Activity Notification
_____	DHMH 259	Certification for Extended Care Facility
_____	DHMH 263	Long Term Care Report and Invoice
_____	DHMH 282	Physical Therapy Preauthorization
_____	DHMH 302	Personal Care Services Application and Plan of Care
_____	DHMH 302(A)	Request for Level 2/ Level 3 Personal Care Services
_____	DHMH 303	Physician Letter
_____	DHMH 304	Medical Assistance Personal Care Program AFACTS≅
_____	DHMH 306	Case Manager=s Services Agreement
_____	DHMH 307	Personal Care Services Agreement
_____	DHMH 310	Provider Instructions
_____	DHMH 311	Provider=s Record
_____	DHMH 313	Personal Care Service 60 Day Case Review
_____	DHMH 314	Notice of Termination
_____	DHMH 318	Personal Care Provider Application
_____	DHMH 321	Intake for Personal Care Services
_____	DHMH 325	Incident Report
_____	DHMH 328	Contact Sheet

Quantity	Form Number	Description
_____	DHMH 329	Provider Evaluation
_____	DHMH 521	Certification for Abortion
_____	DHMH 1184	Hospital Report of Newborns
_____	DHMH 1288R	Report of Administrative Days
_____	DHMH 1295	Authorization for Leave of Absence
_____	DHMH 1321	Nursing Facility Request for Reimbursement for Bed Reservations During Acute Hospitalization
_____	DHMH 1471	Voluntary Consent to Transfer
_____	DHMH 2129	Report of Administrative Days in Long Term Facilities
_____	DHMH 2989	Sterilization Consent Form
_____	DHMH 2990	Document for Hysterectomy
_____	DHMH 3423	General Instructions Medical Day Care Health Care Audit/Utilization Review Procedure
_____	DHMH 3767	Receipt for Patient Allowance Returned Upon Discharge to Community
_____	DHMH 3806	Referral for Audiological Evaluation
_____	DHMH 3808	Request for Admission and Length of Stay Certification
_____	DHMH 3871	Medical Eligibility Review Form (N.H.)
_____	DHMH 4129	Order Form
_____	DHMH 4518A	Adjustment Request Form
_____	DHMH 4519	Medical Claim Problem Form

_____

The following Pre-Authorization Forms are only available from:
Medical Care Operations Administration, Room SS-12, 201 West Preston St., Balto., Md. 21201

Quantity	Form Number	Description
_____	DHMH 4523	Physician Services Pre-Authorization
_____	DHMH 4524	Dental Services Pre-Authorization
_____	DHMH 4525	Audiology Services Pre-Authorization
_____	DHMH 4526	Vision Services Pre-Authorization
_____	DHMH 4527	Durable Equipment Pre-Authorization

DO NOT WRITE HERE

ELIGIBILITY DATES FROM THRU

RESUBMITTAL ☐

(4) PAYEE PROVIDER NO.

(1) PATIENT'S LAST NAME | FIRST NAME OR INITIALS | TYPE

(5) NAME

(2) ADDRESS

(6) ADDRESS

(3) IDENTIFICATION NUMBER

PATIENT IDENTIFICATION | **PROVIDER IDENTIFICATION**

PROVIDER IS RESPONSIBLE FOR CHECKING MA ELIGIBILITY. PAYMENT WILL BE DENIED IF RECIPIENT IS NOT ELIGIBLE ON DATE SERVICE IS COMPLETED.

STATE OF MARYLAND - DEPARTMENT OF HEALTH AND MENTAL HYGIENE - MEDICAL ASSISTANCE PROGRAM

DENTAL REPORT AND INVOICE

(7) REFERRING PROVIDER NO.

(8) REFERRING PROVIDER NAME

(9) PRIOR AUTHOR. NO.

(10) MA PROVIDER NO. OF DENTIST RENDERING SERVICE (IF DIFFERENT FROM PAYEE)

(11) EMERGENCY YES ☐ NO ☐

(12) EPSDT RELATED YES ☐ NO ☐

(13) DUE TO ACCIDENT YES ☐ NO ☐

(14) DUE TO EMPLOYMENT YES ☐ NO ☐

(15) THIRD PARTY POTENTIAL YES ☐ NO ☐

TPL - OVR (15a) ☐

(15b) ATCH - IND YES ☐ NO ☐

(16) PROVIDER'S PATIENT I.D. NO. (OPTIONAL)

(17) NAME OF POTENTIAL THIRD PARTY PAYOR

(18) 3RD PARTY I.D. NO., IF ANY

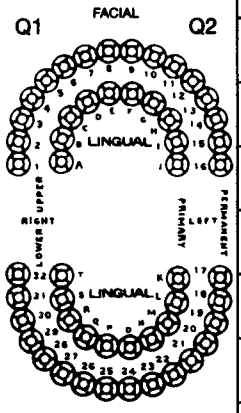
(19) NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

(20) FACILITY PROVIDER NO.

QUADRANTS, ITEM 23

CODE QUADRANT(S)

0 = N/A Neither tooth nor quadrant related
1 = 1
2 = 2
3 = 3
4 = 4
5 = 1 and 3
6 = 1 and 4
7 = 2 and 3
8 = 2 and 4
9 = 1, 2 and 3
A = 1, 2 and 4
B = 1, 3 and 4
C = 2, 3 and 4
D = Upper (1 and)
E = Lower (3 and 4)
F = Full Mouth



INDICATE MISSING TEETH WITH AN "X"

SURFACES

O - OCCLUSAL D - DISIAL
I - INCISAL L - LINGUAL
M - MESIAL B - BUCIAL OR LABIAL

LINE NO.	(21) TOOTH NO. OR LETTER	(22) SURFACES O I M D L B	(23) QUADRANT(S)	(24) DESCRIPTION OF SERVICE	(25) FUTURE USE	(26) UNITS OF SERVICE	(26) DATE OF SERVICE MO.	DAY	YR.	(27) PLACE OF SERVICE	(28) PROCEDURE CODE (ADA)	(29) CHARGES
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												
11.												
12.												
13.												
14.												

(40) TOTAL CHARGE

(41) COLLECTIONS

(42) NET AMOUNT CLAIMED

MAIL TO:

OFFICE OF OPERATIONS & ELIGIBILITY
STATE DEPARTMENT OF HEALTH & MENTAL HYGIENE
P.O. BOX 1935
BALTIMORE, MARYLAND 21203

TO BE PAYABLE THIS INVOICE MUST BE RECEIVED WITHIN NINE (9) MONTHS OF THE DATE ON WHICH SERVICES WERE RENDERED.

I do solemnly declare and affirm under the penalties of perjury that the contents of the foregoing document are true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws. I certify that the services shown on this report were rendered and that no charge has been or will be made for payment from the patient, the patient's family or other source, except as authorized by the Program. I certify further that all reasonable measures to identify and recover third party liabilities to the patient have been taken and all such collections therefrom have been or will be reported to the State. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to Title XIX recipients and to furnish information regarding any payments claimed for providing such services as the State may request for five years from the service date. Payment is hereby requested.

(43)

DATE _____ SIGNED _____ D.D.S.

DOCUMENT CONTROL NO. - DO NOT WRITE HERE

DO NOT WRITE HERE

DHMH 234 (REV. 6/95)

STATE COPY

DO NOT WRITE HERE

ELIGIBILITY DATES FROM | THRU

RESUBMITTAL ☐

(4) PAYEE PROVIDER NO.

(1) PATIENT'S LAST NAME | FIRST NAME OR INITIALS | TYPE

(5) NAME

(2) ADDRESS

(6) ADDRESS

(3) IDENTIFICATION NUMBER

PATIENT IDENTIFICATION | **PROVIDER IDENTIFICATION**

PROVIDER IS RESPONSIBLE FOR CHECKING MA ELIGIBILITY. **PAYMENT WILL BE DENIED IF RECIPIENT IS NOT ELIGIBLE ON DATE SERVICE IS COMPLETED.**

STATE OF MARYLAND - DEPARTMENT OF HEALTH AND MENTAL HYGIENE - MEDICAL ASSISTANCE PROGRAM

COMMUNITY BASED SERVICES INVOICE

(7) | (8) PRIOR AUTHOR. NO. | (9) DUE TO ACCIDENT YES ☐ NO ☐ | (10) DUE TO EMPLOYMENT YES ☐ NO ☐ | (11) THIRD PARTY POTENTIAL YES ☐ NO ☐ | (12) TPL - OVR ☐

(13) PROVIDER'S PATIENT I.D. NO. (OPTIONAL) | (14) NAME OF POTENTIAL THIRD PARTY PAYOR | (15) 3RD PARTY I.D. NO., IF ANY

(16) ATTENDING PHYSICIAN PROVIDER NO. | (17) ATTENDING PHYSICIAN NAME | (17a) ATCH - IND YES ☐ NO ☐

(18) I C D DIAG. CODE | (19) PRINCIPAL DIAGNOSIS

(20) I C D DIAG. CODE | (21) OTHER DIAGNOSIS

LINE NO.	(22) DATE OF SERVICE MO.	DAY	YR.	(23) PROCEDURE CODE *	(24) UNITS OF SERVICE	(25) DESCRIPTION OF SERVICE	(26) CHARGES
1.							
2.							
3.							
4.							
5.							
6.							
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9.							
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13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							

* SEE INVOICE PREPARATION INSTRUCTIONS FOR APPROPRIATE PROCEDURE CODES AND DESCRIPTIONS.

(27) TOTAL CHARGE	
(28) COLLECTIONS	
(29) RESOURCES	
(30) NET AMOUNT CLAIMED	

MAIL TO:
OFFICE OF OPERATIONS & ELIGIBILITY
STATE DEPARTMENT OF HEALTH & MENTAL HYGIENE
P. O. BOX 1935
BALTIMORE, MARYLAND 21203

TO BE PAYABLE THIS INVOICE MUST BE RECEIVED WITHIN NINE (9) MONTHS OF THE DATE ON WHICH SERVICES WERE RENDERED.

I do solemnly declare and affirm under the penalties of perjury that the contents of the foregoing document are true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws. I certify that the services shown on this report were rendered and that no charge has been or will be made for payment from the patient, the patient's family or other source, except as authorized by the Program. I certify further that all reasonable measures to identify and recover third party liabilities to the patient have been taken and all such collections therefrom have been or will be reported to the State. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to Title XIX recipients and to furnish information regarding any payments claimed for providing such services as the State may request for five years from the service date. Payment is hereby requested.

(31)

DATE _____ SIGNED _____

(AUTHORIZED SIGNATURE)

DOCUMENT CONTROL NO. - DO NOT WRITE HERE

DO NOT WRITE HERE

DHMH 248 (REV. 6/95)

STATE COPY

Medical Care Transaction Form

TO: Department of Health & Mental Hygiene
Program Systems and Operations Administration
201 West Preston Street, SS 12
Baltimore, Maryland 21201

⑤ Re: Name: _____

M.A. No. _____

⑨ * UCA USE ONLY

Level of Care Eff. _____ (Mo. / Day / Yr.)

☐ Intermediate ☐ Skilled

☐ Chronic

Utilization Control Agent

Authorized Signature _____ Date

① FROM: _____
Nursing Home / Chronic Facility

② _____ MMIS Provider ID ③ _____ CARES Vendor ID

④ _____
Street Address

City State Zip Code

⑥ Cancel Pay Effective _____ (Mo. / Day / Yr.)

☐ Discharge to Medicare
☐ Expiration of Bed Reservation
☐ No longer Intermediate or Skilled Care
☐ No longer Chronic Care

⑦ Begin Pay Effective _____ (Mo. / Day / Yr.)

☐ Medicare Co-pay
☐ *Medicare Ended, Begin Full M.A.
☐ *Readmitted after Expiration of Bed Reservation
☐ *Admitted to Chronic Care
☐ *Admitted to Skilled or Intermediate Care
☐ Bed hold during Medicare period (complete ⑥ and ⑦)

⑧ _____ Signature of Facility Administrator _____ Date _____ Telephone Number

DHMH 259 (Rev. 9/96)

PSOA

DO NOT WRITE HERE	④Payee Provider No.
① Patient's Last Name / Patient's First Name	⑤ Name
② Address	⑥ Address
③ Identification Number	
PATIENT INFORMATION	**PROVIDER INFORMATION**

PROVIDER IS RESPONSIBLE FOR CHECKING MA ELIGIBILITY. **PAYMENT WILL BE DENIED IF RECIPIENT IS NOT ELIGIBLE ON DATE OF SERVICE**

STATE OF MARYLAND - DEPARTMENT OF HEALTH AND MENTAL HYGIENE - MEDICAL ASSISTANCE PROGRAM

LONG TERM CARE INVOICE

⑦ DHMH 2129 Administrative Days ☐	⑧ Administrative Days this Month	⑨Death/Discharge Date / /	⑩ Invoice Covers Month From / / Thru / /	⑪Provider's Patient ID No. (Opt'l)
⑫Facility Admission Date / /	⑬Third-Party Potential? Yes ☐ No ☐	⑭Third-Party ID No., if any	⑮Name of Potential Third-Party Payer	⑯Amount Paid by Third-Party Payer

⑰ Diagnosis Code	Diagnosis Code	⑱Origin of Patient - New Adission Only ☐ 1 - HOME 2 - ACUTE HOSPITAL 3.- OTHER NH 4.- OTHER_____	⑲Patient Status - Enter One 0 - STILL PATIENT 1 - DISC. HOSPITAL 2 - DISC./TRANS SNF 3 - DISC./TRANS. ICF 4. - DISC.TRANS. OTHER INST 5. - DISC. HOME/SELF CARE 6 - DIED	⑳TPL-OVR ☐

LINE NO.	PROCEDURE CODE	㉑ DAYS OF SERVICE	DESCRIPTION OF SERVICE	LINE NO.	PROCEDURE CODE	㉒ DAYS OF SERVICE	DESCRIPTION OF SERVICE
1	N0010		Days of Care - Light	22	N0090		Oxygen / Aerosol Care
2	N0015		Days of Care - Light Behavioral Mgmt.	23	N0100		Peripheral Intravenous Care
3	N0020		Days of Care - Moderate	24	N0110		Suctioning / Tracheostomy
4	N0025		Days of Care - Moderate Behavioral Mgmt	25	N0115		Ventilator Care
5	N0030		Days of Care - Heavy	26	N0200		Physical Therapy 1/4 hour
6	N0040		Days of Care - Heavy Special	27	N0205		Physical Therapy 1/2 hour
7	N0120		Days of Care - Medicare	28	N0210		Physical Therapy 3/4 hour
8	N2200		ICF - MR	29	N0215		Physical Therapy 1 hour
9	N0005		Hospital Leave	30	N0300		Occupational Therapy 1/4 hour
10	N0006		Therapeutic Leave	31	N0305		Occupational Therapy 1/2 hour
				32	N0310		Occupational Therapy 3/4 hour
11	N0042		Decubitus Ulcer Care	33	N0315		Occupational Therapy 1 hour
12	N0043		Turning and Positioning	34	N0400		Speech Therapy 1/4 hour
13	N0044		Tubefeeding	35	N0405		Speech Therapy 1/2 hour
14	N0045		Medicare Tubefeeding	36	N0410		Speech Therapy 3/4 hour
15	N0046		Communicable Disease Care	37	N0415		Speech Therapy 1 hour
16	N0048		Central Intravenous Line	38			
17	N0051		Class A Support	39			
18	N0052		Class B Support	40			
19	N0060		Single Injections	41			
20	N0070		Multiple Injections	42			
21	N0080		Ostomy Care	43			

MAIL TO: MEDICAL CARE OPERATIONS ADMINISTRATION
STATE DEPARTMENT OF HEALTH & MENTAL HYGIENE
P.O. BOX 1935
BALTIMORE, MARYLAND 21203

TO BE PAYABLE THIS INVOICE MUST BE RECEIVED WITHIN NINE (9) MONTHS OF THE DATE OF WHICH SERVICES WERE RENDERED.

DO NOT WRITE HERE

DOCUMENT CONTROL NO. - DO NOT WRITE HERE

I do solemnly declare and affirm under the penalties of perjury that the contents of the foregoing document are true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable Federal and State laws. I certify that the services shown on the report were rendered and that no charge has been or will be made for payment from the patient, the patient's family or other sources, except as authorized by the program. I certify further that all reasonable measures to identify and recover third party liabilities to the patient have been taken and all such collections there from have been or will be reported to the State. I hereby agree to keep such reports as are necessary to disclose fully the extent of services provided to Title XIX recipients and to furnish information regarding any payments claimed for providing such services as the State may request for five years from the service date. Payment is hereby requested.

㉓ DATE _____ SIGNED _____

DHMH 263 (Rev. 10/99) **STATE COPY**

MARYLAND MEDICAL ASSISTANCE PROGRAM

CERTIFICATION FOR ABORTION

A COPY OF THIS FORM MUST BE ATTACHED TO ALL INVOICES FOR ABORTION SERVICES.

Please Print or Type

PATIENT'S NAME

PHYSICIAN COMPLETING FORM

PATIENT'S ADDRESS

PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER

PATIENT'S ADDRESS

PLACE OF SERVICE

PATIENT'S MEDICAL ASSISTANCE NUMBER

DATE OF SERVICE

PART I - Check one of the blocks if applicable and sign the certification.

☐ G. I certify that this abortion is necessary because the life of the mother would be endangered if the fetus were carried to term.

DATE

PHYSICIAN'S SIGNATURE

☐ I. Attached is a document submitted by an official of a law enforcement agency or public health service where the rape or incest was reported. The document includes the following information:

1. Name and address of victim;
2. Name and address of person making the report (if different from the victim);
3. Date of the rape or incest incident;
4. Date of the report (may not exceed 60 days after the incident);
5. Statement that the report was signed by the person making it;
6. Name and signature of person at law enforcement agency or public health service who took the rape or incest report.

DATE

PHYSICIAN'S SIGNATURE

PART II - You must check one of the following blocks and sign the certificate, unless you have checked "I" in Part I, above.

☐ R. I certify that this abortion is necessary because, based on my professional judgement, continuation of the pregnancy is likely to result in the death of the woman.

DATE

PHYSICIAN'S SIGNATURE

☐ S. I certify that, within a reasonable degree of medical certainty, based on my professional judgement, termination of pregnancy is medically necessary because there is substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.

DATE

PHYSICIAN'S SIGNATURE

☐ T. I certify that, in my professional judgement, there exists medical evidence that continuation of the pregnancy is creating a serious effect on the woman's present mental health and, if carried to term, there is substantial risk of a serious or long lasting effect on the woman's future mental health.

DATE

PHYSICIAN'S SIGNATURE

☐ V. I certify that, within a reasonable degree of medical certainty, based on my professional judgement, this abortion is necessary because the fetus is affected by genetic defect or serious deformity or abnormality.

DATE

PHYSICIAN'S SIGNATURE

☐ W. I certify that this procedure is necessary for a victim of rape, sexual offense, or incest, and the incident has been reported to a law enforcement agency or to a public health or social agency.

DATE

PHYSICIAN'S SIGNATURE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MARYLAND MEDICAL ASSISTANCE PROGRAM

HOSPITAL REPORT OF NEWBORNS

DHMH USE ONLY
Date Received: _____
Date Processed _____
Processed By: _____

FAX FORM IMMEDIATELY TO:
Recipient Master File Unit
410-333-7012
or
MAIL FORM TO:
Recipient Master File Unit
201 West Preston Street, Room SS7C
Baltimore, Maryland 21201

Mother's Name: _____ DOB: __/__/__
(Last) (First) (M.I.)

Mother's Medical Assistance Number: __/__/__/__/__/__/__/__/__/__/__/__/__/

Address: _____ S.S.#: ___ ___ ___/___ ___/___ ___ ___ ___

Full Name of Newborn(s) Last	First	M.I.	Birth Date Mo/ Day/ Yr	Sex M or F	DHMH Use Only MA Number Assigned
			/ /		
			/ /		

Name of Mother's MCO: _____

Complete Name of Hospital: _____

Address: _____ Telephone #: _____

Printed Name of Person Completing Form | Signature of Person Completing Form | Date of Completion

Optional

Has parent selected pediatrician for ongoing care after discharge? Yes ☐ No ☐

Name: _____ Practice Name: _____

Address: _____

Note: Automatic eligibility for the newborn(s) is dependent on the mother being eligible for and receiving Medical Assistance at the time of the child's or children's birth and the child living with the mother. It is advisable to confirm the mother's eligibility status on the date of delivery by using the Eligibility Verification System (EVS). Do not submit this form if the child will not be discharged to the mother.

Department of Health and Mental Hygiene

Medical Care Programs

Medical Care Compliance Administration

REPORT OF ADMINISTRATIVE DAYS

1. Patient: _____ 2. Medical Assistance #: _____
3. Hospital: _____ 4. Admission Date: _____
5. Diagnosis: (Adm.) _____ (Disch.) _____
6. Date eligible for other Level of Care: _____ 7. Level of Care requested: _____
8. Other reasons for Extended Stay: _____

_____

9. Completion of Referral:
   a. Date social worker became active in case: _____
   b. Date UCA notified by hospital of initiation of Discharge Planning _____
   c. Level of Care received: (1) Date: _____
      (2) Method (check one) ❑ 256R ❑ 257 ❑ phone call

10. Placement Efforts (use extra sheet if necessary).

DATE	FACILITY	RESULTS

11. Discharge date and name of facility to which discharged: _____

_____

12. Total Length of Stay: _____ 13. Total Administrative Days: _____

14. Review Coordinator Signature: _____ Date: _____

For Utilization Control Agent (UCA) Use Only

Dates UCA reviewed Continuation of Administrative Days: _____

Days approved: _____ Days denied: _____

UCA signature: _____ Date: _____

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a												A
b												B
												C

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT	
	a	.		.		.	a
	b	.		.		.	b
	c	.		.		.	c
	d	.		.		.	d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1						.	.		1
2						.	.		2
3						.	.		3
4						.	.		4
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19						.	.		19
20						.	.		20
21						.	.		21
22						.	.		22
23						.	.		23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
A					.	.		A
B					.	.		B
C					.	.		C
57		**DUE FROM PATIENT ▶**			.	.		

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	
A					A
B					B
C					C

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		

	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID	
	C		D		E		A	a
								b
							OTHER PHYS. ID	a
							B	b

a	84 REMARKS	85 PROVIDER REPRESENTATIVE X	86 DATE
b			
c			
d			

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.
   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

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

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

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 _____ DATE _____

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID 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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

MARYLAND MEDICAL ASSISTANCE PROGRAM
STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____. When I first asked for
(doctor or clinic)
the information I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a_____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
Month Day Year

I, _____, hereby consent of my own free will to be sterilized by _____
(doctor)
by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date: _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
name of individual
consent form, I explained to him/her the nature of the sterilization operation _____ the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ on _____
Name of individual to be sterilized *Date of sterilization*
_____, I explained to him/her the nature of the
operation
sterilization operation _____, the fact that
specify type of operation
it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery:

(describe circumstances):

_____
Physician

*Date*_____

DHMH-2989

MARYLAND MEDICAL ASSISTANCE PROGRAM

DOCUMENT FOR HYSTERECTOMY

A COPY OF THIS FORM MUST BE ATTACHED TO ALL INVOICES FOR HYSTERECTOMIES.

Please Print or Type

PATIENT'S NAME

PATIENT'S ADDRESS

PATIENT'S MEDICAL ASSISTANCE NUMBER

PHYSICIAN COMPLETING FORM

PHYSICIAN'S MEDICAL ASSISTANCE NUMBER

PLACE OF SERVICE

DATE OF SERVICE

SECTION I - To be signed by physician and patient or patient's representative when patient has been informed of the service.

A. I have performed a hysterectomy on _____ (NAME OF PATIENT) . I hereby certify that the following conditions do not apply to this hysterectomy.

1. It was performed solely for the purpose of rendering the individual permanently incapable of reproducing; or
2. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

I have informed the patient and her representative, if any, orally and in writing, that the hysterectomy will make the patient permanently incapable of reproducing.

DATE

SIGNATURE OF PHYSICIAN

B. Receipt of Hysterectomy Information

I, _____ (NAME OF PATIENT) have been informed by _____ (NAME OF PHYSICIAN) , that the hysterectomy to be performed will render me permanently incapable of reproducing.

DATE

SIGNATURE OF PATIENT OR REPRESENTATIVE

SECTION II - To be signed by physician. No patient signature is needed because the individual:

A. Was already sterile before the hysterectomy due to _____ (CAUSE OF STERILITY) ; or

B. Required a hysterectomy performed under a life-threatening emergency situation in which prior acknowledgement was not possible. (Describe the nature of the emergency.)

_____

_____

_____

DATE

SIGNATURE OF PHYSICIAN

DHMH 2990 (Rev. 10/82)
(10/82/10,000)

DOCUMENT NUMBER

Maryland Medical Assistance Program
ADMISSION AND LENGTH OF STAY CERTIFICATION

1) _____ HOSPITAL (Print or Type) _____ Medical Records Number

2) ☐☐☐☐☐☐☐☐☐ HOSPITAL PROVIDER NO.

3) Patient: _____ LAST NAME (Print or Type) FIRST

4) ☐☐-☐☐☐☐☐☐☐-☐☐☐ PATIENT MEDICAID NO.

5) Date of Birth: _____ 6) Category: ☐ F ☐ S 7) Sex: ☐ M ☐ F

8) Type of Admission ☐
(Select Appropriate No. 1-3)

9) Actual admission date: _____ Actual discharge date: _____

10) Admission: ☐☐-☐☐-☐☐ Month Day Year

11) REQUEST APPROVAL/CERTIFICATION FOR (Check one):
☐ 1. elective admission ☐ 2. emergency admission ☐ 3. retroactive admission

12) Discharge: ☐☐-☐☐-☐☐ Month Day Year

13) PRINCIPAL DIAGNOSIS: _____

14) PRINCIPAL ☐☐☐☐-☐☐
(One ICD-9CM Code)

15) SECONDARY DIAGNOSIS: _____
(COMORBIDITY)

16) SECONDARY ☐☐☐☐-☐☐
(One ICD-9CM Code)

17) SECONDARY ☐☐☐☐-☐☐
(One ICD-9CM Code)

18) SECONDARY ☐☐☐☐-☐☐
(One ICD-9CM Code)

19) PROCEDURES AND DATES: 1. _____
2. _____
3. _____

20) 1st ICD-9CM ☐☐-☐☐
Procedure Code

21) 2nd ICD-9CM ☐☐-☐☐
Procedure Code

22) 3rd ICD-9CM ☐☐-☐☐
Procedure Code

23) HOSPITAL COURSE: _____

24) DISCHARGE STATUS ☐☐
(Same as Codes on Invoice UB-92)

ATTACH ADDITIONAL SHEET(S) IF NECESSARY

25) DRG ☐☐☐

REQUESTOR'S NAME AND TITLE _____ DATE _____ TELEPHONE

FOR AGENT USE ONLY

Returned without UCA Action for: _____

Preadmission Review (check one):
☐ not obtained ☐ approved

Approved for (circle): 1. 2. 3.

Denied for (circle): 1. 2. 3.

MAC? ☐ yes ☐ no

DCP? ☐ yes ☐ no

SSO: emergency ☐ obtained ☐ waived ☐

Acute days approved: ☐☐☐

Acute days denied: ☐☐☐

Days not covered: ☐☐☐

Adm. days approved: ☐☐☐

Adm. days denied: ☐☐☐

Reason for denial: _____

Authorized Signature _____ Date _____

DHMH 3808 (REV 7/95)

Maryland Medical Assistance Program

Medical Eligibility Review Form

Please print or type

Level of Care/Services Requested (Applications for rehab hospitals must be accompanied by a plan of care from admitting hospital) (Please check)
[] NF [] Medical Day Care [] Rehab Hospital
[] Chronic Hospital [] Other ______________________
(e.g. Waiver)

Application Date: ______________________

Financial Eligibility Date: ______________________

Social Security #: ______________________

Medical Assistance #: ______________________

Part A: Patient Demographics

Patient's Last Name: ______________________ First Name: ______________________

Date of Birth ____________ Sex _____ Adm. Date ________ Verbal Level of Care Given: ______________
LOC

Permanent Address ______________________

____

____________ by ______________________
Date Utilization Control Agent

Present Location of Patient: (if different from above)

____

____

Name of Last Provider (Hospital, Long Term Care Facility, Institution): ______________________

Admission Date ______________________

Discharge Date ______________________

Patient Representative Name ______________________

Relationship ______________ Phone # ______________

Address ______________________

Is language a barrier to communication ability []Yes []No

* *

Part B: Physician's Plan of Care (Must be completed by physician or designee)
Please fill out accurately and completely

Physician Name: ______________ Telephone #: ____________ Address: ______________

Primary Diagnoses which Relate to Need for Level of Care: ______________________

Secondary/Surgical Diagnoses Currently Requiring M.D. and/or Nursing Intervention which Relate to Level of Care:

______________________ Date: ________

______________________ Date: ________

Other pertinent findings (ex. signs and symptoms, complications, lab results, etc.)

____

____

____

Is patient free from infectious TB? []Yes []No Determined by []Chest XRay []PPD Date ____________

T ________ P ________ R ________ B/P ________ HT ________ WT ________

Have any of the above vital signs undergone a significant change? [] Yes [] No

If yes, explain: ______________________

Diet (include supplements and tubefeeding solution) ______________________

Medications Which Will Be Continued

Medications	Dosage	Frequency*	Route	*If PRN, avg frequency actually given

Medical Eligibility Review Form - p. 2

PATIENT'S NAME ______________________

Treatments Which Will Be Continued: Description Frequency Durati (if tempo:

[] Ventilator: ______________________

[] O^2 (as well as sats and frequency): ______________________

[] Monitor [apnea/bradycardia (A/B), other]: ______________________

[] Suctioning: ______________________

[] Trach Care: ______________________

[] IV line/fluids (indicate central or peripheral): ______________________

[] Tube feeding (specify type of tube): ______________________

[] Colostomy/ileostomy care: ______________________

[] Catheter/continence device (specify type): ______________________

[] Frequent labs related to nutrition/meds (describe): ______________________

[] Decubitus (include size, location, stage, drainage, and signs of infection, also Tx regimen): ______________________

[] Other (specify): ______________________

Have any of the medications or treatments recently been implemented, discontinued, and/or otherwise changed? Explain:

____

Impairments/Devices (check all that apply)

[] Speech [] Sight [] Hearing [] Other (specify) ______________________

[] Devices/Adaptive Equipment ______________________ [] No Impairm

Active Therapies	Plan	Frequency	Est. Duration	Goal
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Respiratory				
Others				

Rehabilitation Potential: ______________________

Discharge Plan: ______________________

*If requesting a level of care for rehab hospital, please answer the following questions:

1. Preexisting condition related to current physical, behavioral and mental functions and deficits: ______________________

2. Reason for out-of-state placement (if applicable): ______________________

Is patient Comatose? Yes [] No [] If yes, skip Parts C through E and go directly to Part F.

PLEASE NOTE: For other adult applicants, complete Parts C and D, skip E. For applicants under age 21, skip Parts C and D, complete E.

* *

PATIENT'S NAME ______________________________

Part C: Functional Status (use one of the following codes) (if assistive device (e.g., wheelchair, walker) used, note functional ability while using device)

0-Little or no difficulty (completely independent or setup only needed)
1-Supervision/verbal cuing
2-Limited physical assistance by caregiver
3-Extensive physical assistance by caregiver
4-Total dependence on others

___ Locomotion (if using adaptive/assistive device, specify type) ______________

___ Transfer bed/chair

___ Reposition/Bed mobility

___ Medication self-administration

___ Dressing

___ Bathing

___ Eating

Appetite (check one) ☐ Good ☐ Fair ☐ Poor

Other functional limitations (describe) ______________________________

Incontinence Management (Circle applicable choices in each category)
(Note status with toileting program and/or continence device, if applicable)

Is patient maintained on a toileting schedule? Yes ☐ No ☐

Bladder	Bowel	
0	0	Complete control, or infrequent stress incontinence.
1	1	Usually continent - accidents once a week or less
2	2	Occasionally incontinent, accidents 2+ weekly, but not daily
3	3	Frequently incontinent - accidents daily but some control present
4	4	Incontinent - multiple daily accidents

* *

Part D: Cognitive/Behavioral Status

1. Memory/orientation Y = yes N = no

Yes	No	
☐	☐	Can recall after 5 minutes
☐	☐	Knows current season
☐	☐	Knows own name
☐	☐	Can recall long past events
☐	☐	Knows present location
☐	☐	Knows family/caretaker

2. Cognitive skills for daily decision making and safety (check one)

☐ Independent/decisions consistent and reasonable
☐ Modified/some difficulty in new situations only
☐ Moderately impaired/decisions requires cues/supervision
☐ Severely impaired/rarely or never makes decisions

3. Communication 0=Always, 1=Usually, 2=Sometimes, 3=Rarely/Never

	Always	Usually	Sometimes	Rarely/Never
Ability to understand others	☐	☐	☐	☐
Ability to make self understood	☐	☐	☐	☐
Ability to follow simple commands	☐	☐	☐	☐

4. Behavior issues (enter one code from A and B in the appropriate column)

A. Frequency
1=Occasionally
2=Often, but not daily
3=Daily

B. Easily Altered?
1=Yes
2=No

Description of Problem Behaviors	A	B

5. Most recent mini-mental score: ______________ Date: ______________

Previous mini-mental score (if available): ______________ Date: ______________

* *

PATIENT'S NAME ____________________

Part E: Functional/Cognitive Status - Pediatric

	Age Appropriate	Functioning Level	Adaptive Equipment	
Cognition			Wheelchair	
Social/Emotional			Splints/Braces	
Behavior			Side Lyer	
Communication			Walker	
Gross Motor Abilities			Adaptive Seating	
Fine Motor Abilities			Comunication Devices	
Feeding			Other	
Toileting				
Self Care				

* *

Part F: Physician's Certification for Level of Care

This patient is certified as in need of the following services (check one):

[] NF [] Medical Day Care [] Chronic Hospital [] Rehabilitation Hospital

Other information pertinent to need for long term care: ____________________

Physician Signature: ____________________ Date: __________

Other than physician completing form: ____________________
Signature Title Phone Date

* *

This area is for Agent determination only. Do not write in this area.

[] Medical Eligibility Established MD Advisor: []

[] Medical Eligibility Denied

Effective Date: ____________________

Type of Service: ____________________

Certification Period:
from: __________ to: __________

Agent Signature: ____________________

Date: ____________________

Renewal

[] Medical Eligibility Established MD Advisor: []

[] Medical Eligibility Denied

Effective Date: ____________________

Type of Service: ____________________

Certification Period:
from: __________ to: __________

Agent Signature: ____________________

Date: ____________________

MARYLAND MEDICAL ASSISTANCE PROGRAM
ADJUSTMENT REQUEST FORM

Remittance Advice **MUST** Be Attached

1. Provider Name **Provider #** Provider Address (Street or Box No.) (City, State, ZIP Code)	**2. Check One:** ◯ Initial Request ◯ Follow-up Request **5. Number of Claims:** _____ (this form) **Total Number of Claims:** _____	**3. If One Check Enclosed** Check No. _____ Check Amt. _____ ◯ More Than One (1) Check Enclosed **6. Check One:** ◯ Medicaid ◯ Medicare Crossover	**4. Claim Type** ◯ Home Health ◯ HCFA 1500 ◯ Pharmacy ◯ Vision ◯ Dental ◯ Nursing Home ◯ UB92 ◯ Other _____

7.A. Invoice Control #	**B. Date of Service**	**C. Check One:** If Provider Underpaid _____ If Provider Overpaid _____	**D. Adjust Reason Code:**	**E. Complete One:** Amount Due Prov. _____ Amount Due State _____	**F. Enter the Corrected Proc. Code, Units, Modifier, $ Amt., TPL $ Amt., Recipient #, Resource $ Amt., or Prov. #:**
G. Recipient Name (Last, First)	**H. Recipient I.D. #**	**I. Prior Authorization #:** (If applicable)	**J. Check Amount $** _____	**K. Check #:** (if enclosed)	

8.A. Invoice Control #	**B. Date of Service**	**C. Check One:** If Provider Underpaid _____ If Provider Overpaid _____	**D. Adjust Reason Code:**	**E. Complete One:** Amount Due Prov. _____ Amount Due State _____	**F. Enter the Corrected Proc. Code, Units, Modifier, $ Amt., TPL $ Amt., Recipient #, Resource $ Amt., or Prov. #:**
G. Recipient Name (Last, First)	**H. Recipient I.D. #**	**I. Prior Authorization #:** (If applicable)	**J. Check Amount $** _____	**K. Check #:** (if enclosed)	

Adjustment Reason Codes *	
01 Incorrect Procedure	08 Outpatient Adm. Hospital
02 Incorrect Units of Service	79 TPL Payment Wrong **
03 Incorrect Modifier	80 Recip Did Not Receive Service
04 Incorrect $ Amount Charged	83 Change in Recip Eligibility
05 Wrong Provider Paid	87 Change in Patient Resource **
06 Duplicate Payment	BN Pt. Assess. Unbilled Verified **
07 Other Insurance Paid **	CG Incorrect Date Of Service

* **If uncertain, leave Section D Blank**

** **Additional Documentation Required** (See Instructions on Back)

REMARKS:

Name of MCOA Representative/Section: **Telephone No:** **Date:**

STATE COPY DHMH 4518A (7/98) DISTRIBUTION: The Original and Green copies are to be sent to the Adjustment Section, Medical Care Programs Administration, P.O. Box 13045, Baltimore, MD 21203 (410) 767-5346

Maryland Medical Assistance Program
Medical Claim Problem Form

INSTRUCTIONS: Use this form to inquire about problem claims. **All supporting documentation, claims, and remittance advice statements must be attached.** Mail this completed form with attachments to Provider Relations, P.O. Box 22811, Baltimore, Maryland 21203.

Do not use this form to request an adjustment to a paid claim. For adjustments, use DHMH 4518A, Maryland Medical Assistance Program Adjustment Request Form.

Do not use this form to submit corrected claims for service dates within the billing statute of limitations (9 months from date of service or 60 days from last rejection). Corrected claims are to be mailed to Claims Processing, P.O. Box 1935, Baltimore, Maryland 21203.

1.	Date

2. Claim Type (Check one)	3. Provider Information	Provider No.:
o HCFA-1500 o UB92 o Vision o Dental o Community Base Service o Nursing Home o Other_____	Name_____ Street Address _____ City, State, ZIP Code _____ Contact Person _____ Telephone ( ) _____	

4. Claim Information

Invoice Control #:	Recipient Name:	Recipient M.A. I.D. #	Date of Service:
Remarks:			

Invoice Control #:	Recipient Name:	Recipient M.A. I.D. #	Date of Service:
Remarks:			

Invoice Control #:	Recipient Name:	Recipient M.A. I.D. #	Date of Service:
Remarks:			

DHMH Use Only

Response

___ (1) The claims(s) in question has/have been reviewed and forwarded for payment. You should expect to see it/them reported on a remittance advice within six weeks.

___ (2) We are returning claim(s) to you for reason(s) checked on return notice(s) attached to claim(s).

___(3) Other_____

Reviewer:_____ Date:_____

Distribution: Return original and pink copy to Provider Relations, P.O. Box 22811, Baltimore, Maryland 21203. Retain yellow copy for your records.

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
PHYSICIAN SERVICES

SECTION I - Patient Information

Medicaid Number |_|_|_|_|_|_|_|_|_|_|_|_|

Name _____ DOB _____ Sex ___ Telephone (___)_____
(Last) (First) (MI)

Address _____

SECTION II - Preauthorization General Information

Pay to Provider Number |_|_|_|_|_|_|_|_|_| Request Date _____

Name _____

Address _____ Telephone (___) _____

Contact _____

Provider's Signature _____

SECTION III - Additional Preauthorization Information

Referring Provider
|_|_|_|_|_|_|_|_|_|_|

Name _____

Address _____

Rendering Provider
|_|_|_|_|_|_|_|_|_|_|

Name _____

Address _____

Telephone (___) _____

Dates of Service: From: _____ Thru: _____

Diagnosis Codes: 1_____ 2_____ 3_____ 4_____

SECTION IV - Preauthorization Line Item Information

CODE	MOD1	MOD2	REQUESTED UNITS

DEPARTMENT USE ONLY

SECTION V - Specific Program Preauthorization Information

Please attach correspondence which includes but is not limited to the following:
A. Complete Narrative Justification for procedure(s)
B. Brief history and physical examination
C. Result of pertinent ancillary studies if applicable
D. Pertinent medical evaluations and consultations if applicable

PREAUTHORIZATION NUMBER
|_|_|_|_|_|_|_|_|_|_|_|_|

SUBMIT TO: Program Systems and Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

DOCUMENT CONTROL NUMBER
(STAMP HERE)

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
DENTAL SERVICES/ORTHODONTIC SERVICES

SECTION I - Patient Information

Medicaid Number |_|_|_|_|_|_|_|_|_|_|_|_|

Name _____ DOB _____ Sex ___ Telephone (___)_____
(Last) (First) (MI)

Address _____

SECTION II - Preauthorization General Information

Pay to Provider Number |_|_|_|_|_|_|_|_|_| Request Date_____

Name _____

Address _____ Telephone (___)_____

Contact _____

SECTION III - Additional Preauthorization Information

Referring Provider

|_|_|_|_|_|_|_|_|_|

Name _____

Address _____

Telephone (___) _____

If Requested Service Has Been Provided:

Dates of Service:
From: _____ Thru: _____

Preauthorization Request for:
Dental Yes ___ No ___
Orthodontic Yes ___ No ___ Records _____

Permanent Definition ___ Mixed Definition ___

Orthodontic Diagnosis: Cleft Palate ___

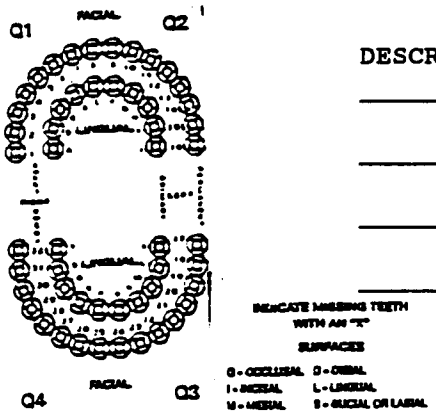
Severe Handicapping Malocclusion ___

Other (Explain) _____

Previous Orthodontic Treatment? Yes ___ No ___

Last Orthodontic Treatment Authorized _____

SECTION IV - Preauthorization Line Item Information



DESCRIPTION OF SERVICE	PROC CODE	TOOTH NO/SURF/Q	REQUESTED UNITS	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT
_____	____	__/__/__	_____		_____	$_____
_____	____	__/__/__	_____		_____	$_____
_____	____	__/__/__	_____		_____	$_____
_____	____	__/__/__	_____		_____	$_____

PLEASE COMPLETE SECTION V ON REVERSE SIDE

PREAUTHORIZATION NUMBER

|_|_|_|_|_|_|_|_|_|_|_|_|

DOCUMENT CONTROL NUMBER

(STAMP HERE)

DHMH 4524 Rev. 3/97

SUBMIT TO:

Program Systems and Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
DENTAL SERVICES/ORTHODONTIC SERVICES

SECTION V - Specific Program Preauthorization Information

ATTENDING CLINICIAN'S REPORT

Diagnosis: _____

Symptoms: _____

Benefits of Planned Treatment: _____

Condition of Remaining Teeth: Good ___ Fair ___ Poor ___

Condition of Periodontal Tissues: Good ___ Fair ___ Poor ___

Identify Other Teeth Requiring Extraction or Endodontics:

ADDRESS ALL QUESTIONS: Treatment Related to Accident or Injury? Yes ____ No ____

Insurance Coverage? Yes ____ No ____

Treatment Result of EPSDT Screen? Yes ____ No ____

Models Enclosed? Yes ___ No ___ Radiographs Enclosed? Yes ____ No ____

If appliance theraphy is required,is this initial placement? Yes ____ No ____

PROVIDER'S SIGNATURE _____

DATE _____

Reserved for Department of Health and Mental Hygiene's Report

Signature of Consultant, DHMH _____

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
AUDIOLOGY SERVICES

SECTION I - Patient Information

Medicaid Number |_|_|_|_|_|_|_|_|_|_|_|_|

Name _____ DOB _____ Sex ___ Telephone (___)_____
(Last) (First) (MI)

Address _____

SECTION II - Preauthorization General Information

Pay to Provider |_|_|_|_|_|_|_|_|_|
(Hearing Aid Dealership)

Name _____ Request Date _____

Address _____

Contact _____ Telephone (___) _____

Provider's Signature _____

SECTION III - Additional Preauthorization Information

Prescribing Audiologist
Provider Number |_|_|_|_|_|_|_|_|_|_|

Name _____ Telephone (___) _____

Address _____

SECTION IV - Preauthorization Line Item Information

DESCRIPTION OF SERVICE	PROCEDURE CODE	MOD	REQUESTED UNITS	REQUESTED AMOUNT	DATES OF SERVICE FROM	DATES OF SERVICE THRU	AUTHORIZED UNITS	AUTHORIZED AMOUNT
_____	___	___	_____	$_____	__/__/__	__/__/__	_____	$_____
_____	___	___	_____	$_____	__/__/__	__/__/__	_____	$_____
_____	___	___	_____	$_____	__/__/__	__/__/__	_____	$_____
_____	___	___	_____	$_____	__/__/__	__/__/__	_____	$_____
_____	___	___	_____	$_____	__/__/__	__/__/__	_____	$_____
_____	___	___	_____	$_____	__/__/__	__/__/__	_____	$_____

PREAUTHORIZATION NUMBER

|_|_|_|_|_|_|_|_|_|_|_|_|

DOCUMENT CONTROL NUMBER
(STAMP HERE)

DHMH 4525 Rev. 3/97

SUBMIT TO: Program Systems and Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

SEE REVERSE SIDE

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
AUDIOLOGY SERVICES

SECTION V - Specific Program Preauthorization Information

Patient Location: Home ___ Nursing Home ___ Hospital In-Patient ___ Discharge Date _____

Address where equipment will be used (if different from above): Period of time required:

_____ _____

_____

_____

MFGR	MODEL/PRODUCT NUMBER	SINGLE UNIT PRICE	AMT. PKG
____	_____	$_____	_____
____	_____	$_____	_____
____	_____	$_____	_____
____	_____	$_____	_____
____	_____	$_____	_____

Diagnosis and Present Physical Condition _____

_____

Prognosis _____

_____

Treatment Plan _____

_____

Expected Therapeutic Effect _____

_____

SECTION VI (DHMH Use Only)

_____ Approved _____ Denied _____ Returned

REASON(s) _____

_____

Medical Consultant's Signature _____ Date _____

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
VISION CARE SERVICES

SECTION I - Patient Information

Medicaid Number |_|_|_|_|_|_|_|_|_|_|_|_|

Name _____ DOB _____ Sex ___ Telephone (___) _____
(Last) (First) (MI)

Address _____

SECTION II - Preauthorization General Information

Pay to Provider Number |_|_|_|_|_|_|_|_|_|_|

Name _____ Date Service Requested by Provider _____

Address _____

Contact _____ Telephone (___) _____

Provider's Signature _____

SECTION III - Additional Preauthorization Information

Give Reason(s) for Requested Service

_____

_____

SECTION IV - Preauthorization Line Item Information

DESCRIPTION OF SERVICE	PROCEDURE CODE	REQUESTED UNITS	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT
			$		$
			$		$
			$		$
			$		$
			$		$

PREAUTHORIZATION NUMBER

|_|_|_|_|_|_|_|_|_|_|_|_|

DOCUMENT CONTROL NUMBER
(STAMP HERE)

SUBMIT TO: Program Systems and Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

SEE REVERSE SIDE

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
VISION CARE SERVICES

SECTION V - Specific Program Preauthorization Information

New Prescription: O.D. _____ Best Visual Acuity _____

O.S. _____ Best Visual Acuity _____

CONTACT LENS REQUESTS:

Health Condition of each eye: O.D. _____ O.S. _____

Date of Surgery: O.D. _____ O.S. _____

Best visual acuity with contact lenses: O.D. _____ O.S. _____

Advantage of contact lenses over glasses: _____

_____

SECTION VI (DHMH Only)

_____APPROVED _____DENIED _____RETURNED

REASON(s) _____

MEDICAL CONSULTANT'S SIGNATURE: _____ DATE_____

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM

☐ DURABLE MEDICAL EQUIPMENT ☐ DISPOSABLE MEDICAL SUPPLIES
☐ OXYGEN & RELATED RESPIRATORY EQUIPMENT ☐ INITIAL REQUEST ☐ FOLLOW-UP

SECTION I - Recipient Information

Medicaid Number |_|_|_|_|_|_|_|_|_|_|_|_|

Name _____ DOB _____ Sex ___ Telephone (___) _____
(Last) First) (MI)

Address _____

SECTION II - Preauthorization General Information

Pay to Provider Number |_|_|_|_|_|_|_|_|_|

Name _____

Address _____

Request Date _____ Contact _____ Telephone (___)_____

SECTION III - Additional Preauthorization Information

Prescribing Provider |_|_|_|_|_|_|_|_|_|

EPSDT (Y/N)? ___ PDN (Y/N) ___ WAIVER (Y/N)___

Name _____ Rental Extension (Y/N)? ___

Address _____ Initial Date of Rental __/__/__

_____ Period of Time Required _____

If Oxygen/Respiratory Equipment

Telephone (___)_____ Initial Request Recertification

Physician's Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN:

Diagnosis and Present Physical Condition _____

_____

Medical Justification _____

_____

Prognosis _____

Date last seen by Physician: _____

- If Oxygen request, please attach pertinent laboratory/pulmonary function test results: ABG's, sleep apnea studies or PFT's
- If Oxygen request, duration and liter flow per minute; for 02 recertification, please resubmit ABG's on room air by: _____

AUTHORIZATION NUMBER

|_|_|_|_|_|_|_|_|_|_|_|_|

DOCUMENT CONTROL NUMBER
(STAMP HERE)

SUBMIT TO: Program Systems and Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

COMPLETE REVERSE SIDE

DHMH 4527

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM

Patient Location: Home ___ Nursing Home ___ Hospital In-Patient___ Discharge Date ___/___/___

SECTION IV - Preauthorization Line Item Information

	NAME OF ITEM	PROCEDURE CODE	DATES OF SERVICE FROM	DATES OF SERVICE THRU	REQUESTED UNITS	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT
1.	_____	___	__/__/__	__/__/__	___	$_____	___	$ _____
2.	_____	___	__/__/__	__/__/__	___	$_____	___	$ _____
3.	_____	___	__/__/__	__/__/__	___	$_____	___	$ _____
4.	_____	___	__/__/__	__/__/__	___	$_____	___	$ _____
5.	_____	___	__/__/__	__/__/__	___	$_____	___	$ _____
6.	_____	___	__/__/__	__/__/__	___	$_____	___	$ _____

SECTION V - DETAILED ITEM Information

	MFGR	MODEL/PRODUCT NUMBER	SINGLE UNIT PRICE	AMT PER PKG (IF DMS)
1.	____	_____	$ _____	_____
2.	____	_____	$ _____	_____
3.	____	_____	$ _____	_____
4.	____	_____	$ _____	_____
5.	____	_____	$ _____	_____
6.	____	_____	$ _____	_____

All equipment purchased by the Department for the patient's use remains the property of the Department of Health and Mental Hygiene. Patient is requested to contact the Medical Assistance Program when equipment is no longer needed.

Item Received by _____ Date _____
Signature of Recipient or his Agent

PLEASE CHECK REQUESTED ACTION:
[ ] CERTIFICATION OF INSTITUTIONALIZATION & HEALTHCHOICE DISENROLLMENT
[ ] NOTIFICATION OF DISCHARGE FROM LONG-TERM CARE

TO: DHR/LDSS/LHD Case Manager
District Office: _____
Address: _____
_____

TO: DHMH HealthChoice
Enrollment Section, Room L-9
201 W. Preston Street
Baltimore, Maryland 21201

Part 1. Recipient Identification

Last Name _____ First _____ M.I. ___ D.O.B. _____
M.A. Number _____ Social Security Number _____ - ____ - _____
Date of Admission to the Facility _____

Part II. Facility Identification

Name _____ CARES Vendor ID Number _____
Address _____ MMIS Provider ID Number _____
_____ Facility Phone Number _____
_____ Facility Contact Person _____

Part III. Recipient Under 21 Years Old

To be completed after ***one full calendar month*** in the facility.
This certifies that this individual has been admitted to the above facility. The first full month of institutionalization began on _____ / 1 / _____.

Part IV. Recipient Aged 21 Through 64

To be completed after ***the 30th consecutive day*** in the institution **or** after the ***60th cumulative day during a calendar year*** in an institution.
This certifies that this individual has been institutionalized in the above facility
[ ] For 30 consecutive days, effective _____
[ ] For 60 days during the calendar year, effective _____

Part V. Recipient 65 Years Old or Older

To be completed after ***the 30th consecutive day*** in the facility.
This certifies that this individual was admitted to the above facility on _____ and is considered institutionalized on that date.

Part VI. Discharge Information For Recipients Under 21 & Over 65 Years of Age

To be completed ***upon discharge from the facility.***
This certifies that this individual was ***discharged from the above facility*** on _____ to
[ ] Home _____
[ ] LTCF _____
[ ] Other _____

Facility Certification: Signature _____ **Date** _____ **Phone** _____

Administrative Services Organization Authorization:

Signature _____ **Date** _____ **Phone** _____

DES 1000

LDSS

INSTRUCTIONS

Facility:

1. Complete Part I and II for all Medical Assistance recipients admitted to your facility.
2. Follow the instructions in section III, IV and V to determine *when* to complete and submit this form for each recipient.
3. The facility's authorized representative ***must*** sign and date the form.
4. Submit the entire, completed, signed form to the Administrative Services Organization (ASO) for their signature.
5. When the ASO returns the signed form to you:
   a. Send original to the Medical Assistance Case Manager
   b. Send the second copy to the DHMH HealthChoice Enrollment Section
   c. Retain the last copy for your files.

Administrative Services Organization:

1. Review form to determine that the period from the date of admission through the effective dates specified in the certification (Part III, IV, or V) is an authorized inpatient stay at this facility.
2. If the period is fully authorized, sign the form, retain the last copy for your files, and return the original and all other copies to the facility.
3. If any portion of the period from admission to date specified in the certification section is not authorized by your organization, do not sign the form, but return it to the facility, noting the discrepancy.

Case Manager:

1. Check the date specified in Part III, IV, or V against the admission date in Part 1.
2. Redetermine eligibility based on the recipient's institutionalized status.
   a. For recipients younger than 21 or 65 or older, redetermine eligibility in a long-term care coverage group (T track or L track) effective the date specified in the certification (Part III or V).
   b. For medically needy recipients aged 21 through 64, ***cancel*** eligibility with timely notice due to residency in an institution for mental disease.
3. Retain the original form in the case record.
4. Take ***no action*** for recipients of ***SSI or TANF.***

HealthChoice Enrollment Section:

1. Disenroll the recipient from HealthChoice effective the date specified in the certification section (Part III, IV or V).
   a. For Part III or V, use disenrollment code C8.
   b. For Part IV, use disenrollment code B2 or B1, as appropriate.
2. Retain form for your files.

Discharge Notification - To Be Completed By The Facility:

1. Complete Parts I and II. Indicate the date of discharge and destination in Part VI.
2. The facility's authorized representative must sign and date the form.
3. For recipients under 21 years old, send the original to:
   Ms. Nellie Allen, Supervisor, MA Waiver Unit
   St. Paul Street, Room 400
   Baltimore, Maryland 21202
4. For recipients over 65 years old, send the original to the Financial Agent or respective local department of social services.
5. Send the second copy to the DHMH HealthChoice Enrollment Section.
6. Retain the last copy for your files.

HEALTHCHOICE DISENROLLMENT FORM
(LONG TERM CARE)

Recipient M.A. ID: _____

Social Security Number: ___ ___ _____

DOB: M / D / Y

___ / ___ / ___

Last Name: _____

First Name: _____

M.I. _____

Sex: M_____ F_____

MCO Provider Name: _____

MCO Provider No: _____

Long Term Care Facility Information

Name:

Address:

Telephone Number:

Admission Date:

Anticipated discharge date, if any:

MCO Official Signature: _____

Date: _____

Phone: _____

Title:

Disenrollment Date: ___ / ___ / ___
(To be determined by Department)

Please attach the Utilization Control Agent (Delmarva Foundation) certification of medical eligibility for LTCF services (from the DHMH 3871)

Send to: HealthChoice Long Term Care Disenrollment
DHMH
201 West Preston Street, Room L-9
Baltimore, Maryland 21201

DHMH INTERNAL USE ONLY:

Competed by DHMH
___ / ___ / ___

Initials: _____

MARYLAND MEDICAL ASSISTANCE PROVIDER HANDBOOK

Appendix C: Rare and Expensive Case Management

The following pages contain the referral form and the disease list for the Rare and Expensive Case Management Program. **To obtain more information on this program, call 1-800-565-8190.**

The Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
http://www.charm.net/~cpi9/

Health Choice

Rare and Expensive Case Management (REM)
The Referral Process

The REM Program
University of Maryland, Baltimore County
Center for Health Program Development and Management
1000 Hilltop Circle, SS-309
Baltimore, MD 21250
1-800-565-8190
http://www.umbc.edu/chpdm

INSTRUCTIONS FOR COMPLETION OF REM INTAKE/REFERRAL FORM

Page 1 Please complete all requested information in ink.

Referral Source:

Referral source name, address, phone number and fax number.

Patient Information:

Patient's last name, first name, and M.I.
Patient's complete address, including apartment number, if applicable.
Patient's telephone number
Medical Assistance Number
Social Security Number
Managed Care Organization (MCO) information. This should include the name of the MCO, the name of a contact person and phone number at the MCO.
Patient contact is the responsible party, next of kin, guardian, or significant other. Please include the contact's complete address, phone number, and relation to the patient.

Attending Physicians:

Provide the name of the referring physician. Include the physician's specialty, license number, and phone number. The referring physician's signature is **required**. Include any consulting physicians with their specialties, phone numbers, and license numbers.

Page 2 Complete patients name and date of birth at the top of page 2.

Clinical Information:

Provide the primary and secondary diagnoses including the ICD-9 codes. These are necessary to verify eligibility for REM enrollment.

Supporting Information:

This section will require specific information pertaining to each REM diagnosis. The Medical Intake Authorization Unit will indicate what information is needed to determine eligibility. Please refer to the diagnostic guidelines as a reference, or call REM for assistance (**1-800-565-8190**). Copies of this requested information **must** be sent in order to review this application.

PLEASE NOTE:

A physician's signature is required at the bottom of page 2. Please fax this completed form and supporting clinical information to the REM Medical Intake and Referral Unit at **410-455-1194**.

Or mail to:

REM Medical Intake and Authorization Unit-CHPDM
University of Maryland Baltimore County
1000 Hilltop Circle, SS 309
Baltimore, Maryland 21250

For questions please call the Medical Intake and Authorization Unit 1-800-565-8190

July 9, 1998

Intake/Referral Form

Rare and Expensive Case Management

Questions call - 1-800-565-8190
Fax (410) 455-1194

Mail or Fax To:

Medical Intake and Authorization Unit
University of Maryland, Baltimore County - CHPDM
1000 Hilltop Circle, SS-309
Baltimore, MD 21250

C:\FY99\REM\AREM\evalrevwnew1pg.wpd February 9, 1999

CHPDM USE ONLY	
CM Agency/Person:	
Date Assigned:	County:
BEGIN REM:	END REM:
Original MA#:	
Current MA #:	
MA # Elig. Span	
Coverage Group	
Faxed to DHMH	
Screener	Date:
Date File Complete:	Decision Date:
Enrolled	Not Enrolled

Referral Source: Address:	
Phone: ( )	Fax: ( )

Patient Information

Patient Name			MA #:	
Address				Home Phone ( ) -
Apt. #			DOB:	Work Phone ( ) -
City	State	Zip	Sex: M F	S S #:

MCO	Contact Person
	Phone ( ) -

Patient Contact	Contact Phone ( ) -	
Address	Relationship to Patient	
Apt. #	State	Zip Code

Referring Physician	**Signature:**	Date:
Name	Phone ( ) -	
Speciality	License #	
PCP		
Name	Phone ( ) -	
Speciality	License #	
Consulting Physician		
Name	Phone ( ) -	
Speciality	License #	

Page 1 of 2.

REM Intake/Referral Form

Patient Name: _____ **DOB:** _____

Clinical Information			
Primary Diagnosis		**Secondary Diagnoses:**	
ICD-9 Code		ICD-9 Code	
			1
			2
			3
			4

Supporting Information (Attach Copies)	
History	
Physical	
Laboratory/Pathology	
Radiology	
Consultations	
Comments	
MD Signature	Date

Rare and Expensive Disease List as of July 1, 1998

ICD-9 Code	Disease	Age Group	Guidelines
042. x all	Symptomatic HIV disease/AIDS (pediatric)	0-20	(A) A child <18 mos. who is known to be HIV seropositive or born to an HIV-infected mother **and:** * Has positive results on two separate specimens (excluding cord blood) from any of the following HIV detection tests: --HIV culture (2 separate cultures) --HIV polymerase chain reaction (PCR) --HIV antigen (p24) N.B. Repeated testing in first 6 mos. of life; optimal timing is age 1 month and age 4-6 mos. **or** * Meets criteria for Acquired Immunodeficiency Syndrome (AIDS) diagnosis based on the 1987 AIDS surveillance case definition
V08	Asymptomatic HIV status (pediatric)	0-20	(B) A child >18 mos. born to an HIV-infected mother or any child infected by blood, blood products, or other known modes of transmission (e.g., sexual contact) who: * Is HIV-antibody positive by confirmatory Western blot or immunofluorescense assay (IFA) **or** * Meets any of the criteria in (A) above
795.71	Infant with inconclusive HIV result	0-12 months	(E) A child who does not meet the criteria above who: * Is HIV seropositive by ELISA and confirmatory Western blot or IFA and is 18 mos. or less in age at the time of the test **or** * Has unknown antibody status, but was born to a mother known to be infected with HIV
270.0	Disturbances of amino-acid transport Cystinosis Cystinuria Hartnup disease	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
270.1	Phenylketonuria - PKU	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required. Lab test: high plasma phenylalanine and normal/low tyrosine
270.2	Other disturbances of aromatic-acid metabolism	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
270.3	Disturbances of branched-chain amino-acid metabolism	0-20	
270.4	Disturbances of sulphur-bearing amino-acid metabolism	0-20	
270.5	Disturbances of histidine metabolism Carnosinemia Histidinemia Hyperhistidinemia Imidazole aminoaciduria	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
270.6	Disorders of urea cycle metabolism	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.

270.7	Other disturbances of straight-chain amino-acid Glucoglycinuria Glycinemia (with methylmalonic acidemia) Hyperglycinemia Hyperlysinemia Pipecolic acidemia Saccharopinuria Other disturbances of metabolism of glycine, threonine, serine, glutamine, and lysine	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
270.8	Other specified disorders of amino-acid metabolism Alaninemia Ethanolaminuria Glycoprolinuria Hydroxyprolinemia Hyperprolinemia Iminoacidopathy Prolinemia Prolinuria Sarcosinemia	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
271.0	Glycogenosis	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
271.1	Galactosemia	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
271.2	Hereditary fructose intolerance	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
272.7	Lipidoses	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
277.0	Cystic fibrosis	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
277.00	Cystic fibrosis w/o ileus	0-64	
277.01	Cystic fibrosis with ileus	0-64	
277.2	Other disorders of purine and pyrimidine metabolism	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required. Demonstration of deficient enzyme such as: alpha-L-Idurondase, Iduronosulfate sulfatase, Heparan sulfate sulfatase, N-Acetyl-alpha-D-glucosaminidase, Arylsulfatase B, Beta-Glucuronidase, Beta-Galactosidase, N-Aacetylhexosaminidase-6-S04 sulfatase.
277.5	Mucopolysaccharidosis	0-64	
277.8	Other specified disorders of metabolism	0-64	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
284.0	Constitutional aplastic anemia	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
286.0	Congenital factor VIII disorder	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
286.1	Congenital factor IX disorder	0-64	
286.2	Congenital factor XI deficiency	0-64	

286.3	Congenital deficiency of other clotting factors	0-64	
286.4	von Willebrand's disease	0-64	
330	Cerebral degenerations in childhood	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
330.0	Leukodystrophy	0-20	
330.1	Cerebral lipidoses	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
330.2	Cerebral degenerations in generalized lipidoses	0-20	
330.3	Cerebral degeneration of childhood in other diseases classified	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
330.8	Other specified cerebral degeneration in childhood	0-20	
330.9	Unspecified cerebral degeneration in childhood	0-20	
331.3	Communicating hydrocephalus	0-20	Clinical history and physical exam; imaging studies supporting diagnosis. Subspecialist consultation note may be required.
331.4	Obstructive hydrocephalus	0-20	
333.2	Myoclonus	0-5	Clinical history and physical exam. Subspecialist consultation note may be required.
333.6	Idiopathic torsion dystonia	0-64	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
333.7	Symptomatic torsion dystonia	0-64	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
333.90	Unspecified extrapyramidal disease and abnormal movement disorder	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
334	Spinocerebellar disease	0-20	Clinical history and physical exam. Neurology consultation note.
334.0	Friedreich's ataxia	0-20	
334.1	Hereditary spastic paraplegia	0-20	
334.2	Primary cerebellar degeneration	0-20	
334.3	Cerebellar ataxia NOS	0-20	
334.4	Cerebellar ataxia in other diseases	0-20	
334.8	Other spinocerebellar diseases NEC	0-20	
334.9	Spinocerebellar disease NOS	0-20	
335	Anterior horn cell disease	0-20	Clinical history and physical exam. Neurology consultation note.
335.0	Werdnig-Hoffmann disease	0-20	
335.1	Spinal muscular atrophy	0-20	
335.10	Spinal muscular atrophy NOS	0-20	
335.11	Kugelberg-Welander disease	0-20	
335.19	Spinal muscular atrophy NEC	0-20	
335.2	Motor neuron disease	0-20	
335.20	Amyotrophic lateral sclerosis	0-20	
335.21	Progressive muscular atrophy	0-20	
335.22	Progressive bulbar palsy	0-20	
335.23	Pseudobulbar palsy	0-20	
335.24	Primary lateral sclerosis	0-20	
335.29	Motor neuron disease NEC	0-20	

335.8	Anterior horn disease NEC	0-20	
335.9	Anterior horn disease NOS	0-20	
341.1	Schilder's disease	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
343.0	Diplegic infantile cerebral palsy	0-20	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
343.2	Quadriplegic infantile cerebral palsy	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
344.0	Quadriplegia	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
359.0	Congenital hereditary muscular dystrophy	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
359.1	Hereditary progressive muscular dystrophy	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
359.2	Congenital myotonic dystrophy (Steinert's only)	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
437.5	Moyamoya disease	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
579.3	Short gut syndrome	0-20	Clinical history and imaging studies supporting diagnosis. Gastrointestional subspecialist consultation note may be required.
582	Chronic glomerulonephritis	0-20	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
582.0	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis	0-20	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
582.1	Chronic glomerulonephritis with lesion of membranous glomerulonephritis	0-20	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
582.2	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis	0-20	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
582.4	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis	0-20	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
582.8	Chronic glomerulonephritis with other specified pathological lesion in kidney	0-20	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
582.81	Chronic glomerulonephritis in diseases classified elsewhere	0-20	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
582.89	Other Chronic glomerulonephritis with lesion of exudative nephritis interstitial (diffuse) (focal) nephritis	0-20	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
582.9	With unspecified pathological lesion in kidney Glomerulonephritis: NOS specified as chronic hemorrhagic specified as chronic Nephritis specified as chronic Nephropathy specified as chronic	0-20	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
585	Chronic renal failure A) diagnosed by a pediatric nephrologist	0-20	Clinical history, laboratory evidence of renal disease. Pediatric nephrology subspecialist consultation note required.
585, V45.1	B) with dialysis and documented rejection from Medicare	21-64	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
741	Spina bifida	0-64	Clinical history and physical exam. Imaging studies supporting diagnosis. Subspecialist consultation note may be required.
741.0	Spina bifida with hydrocephalus	0-64	

741.00	Spina bifida with hydrocephalus NOS	0-64	
741.01	Spina bifida with hydrocephalus cervical region	0-64	
741.02	Spina bifida with hydrocephalus dorsal region	0-64	
741.03	Spina bifida with hydrocephalus lumbar region	0-64	
741.9	Spina bifida without hydrocephalus	0-64	
741.90	Spina bifida unspecified region	0-64	
741.91	Spina bifida cervical region	0-64	
741.92	Spina bifida dorsal region	0-64	
741.93	Spina bifida lumbar region	0-64	
742.0	Encephalocele Encephalocystocele Encephalomyelocele Hydroencephalocele Hydromeningocele, cranial Meningocele, cerebral Menigoencephalocele	0-20	Clinical history and physical examination, radiographic or other neuroimaging studies. Neurology or neurosurgery consultation note may be required.
742.1	Microcephalus Hydromicrocephaly Micrencephaly	0-20	Clinical history and physical examination, radiographic or other neuroimaging studies. Neurology or neurosurgery consultation note may be required.
742.3	Congenital hydrocephalus	0-20	Clinical history and physical examination, radiographic or other neuroimaging studies. Neurology or neurosurgery consultation note may be required.
742.4	Other specified anomalies of brain	0-20	Clinical history and physical examination, radiographic or other neuroimaging studies. Neurology or neurosurgery consultation note may be required.
742.5	Other specified anomalies of spinal cord	0-64	Clinical history and physical examination, radiographic or other neuroimaging studies. Neurology or neurosurgery consultation note may be required.
742.59	Other specified anomalies of spinal cord Amyelia Congenital anomaly of spinal meninges Myelodysplasia Hypoplasia of spinal cord	0-64	Clinical history and physical examination, radiographic or other neuroimaging studies. Neurology or neurosurgery consultation note may be required.
748.1	Nose anomaly - cleft or absent nose ONLY	0-5	Clinical history and physical examination. Radiographic or imaging studies and specialist consultation note (ENT, plastic surgery) may be required.
748.2	Web of larynx	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
748.3	Laryngotracheal anomaly NEC- Atresia or agenesis of larynx, bronchus, trachea, only	0-20	
748.4	Congenital cystic lung	0-20	Clinical history and physical exam; imaging studies supporting diagnosis. Subspecialist consultation note may be required.
748.5	Agenesis, hypoplasia and dysplasia of lung	0-20	
749 except 749.1x	Cleft palate and cleft lip	0-20	Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.
749.0	Cleft palate	0-20	Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.
749.00	Cleft palate NOS	0-20	
749.01	Unilateral cleft palate complete	0-20	
749.02	Unilateral cleft palate incomplete	0-20	
749.03	Bilateral cleft palate complete	0-20	
749.04	Bilateral cleft palate incomplete	0-20	
749.2	Cleft palate with cleft lip	0-20	

749.20	Cleft palate and cleft lip NOS	0-20	
749.21	Unilateral cleft palate with cleft lip complete	0-20	
749.22	Unilateral cleft palate with cleft lip incomplete	0-20	
749.23	Bilateral cleft palate with cleft lip complete	0-20	
749.24	Bilateral cleft palate with cleft lip incomplete	0-20	
749.25	Cleft palate with cleft lip NEC	0-20	
750.3	Congenital tracheoesophageal fistula, esophageal atresia and stenosis	0-3	Clinical history, physical examination; imaging studies supporting diagnosis. Subspecialist consultation note may be required.
751.2	Atresia large intestine	0-5	Clinical history and physical exam; laboratory or imaging studies suporting diagnosis. Subspecialist consultation note may be required.
751.3	Hirschsprung's disease	0-15	
751.61	Biliary atresia	0-20	
751.62	Congenital cystic liver disease	0-20	
751.7	Pancreas anomalies	0-5	
751.8	Other specified anomalies of digestive system NOS	0-10	
753.0	Renal agenesis and dysgenesis, **bilateral only** Atrophy of kidney: congenital infantile Congenital absence of kidney(s) Hypoplasia of kidney(s)	0-20	Clinical history, physical examination, radiographic or other imaging studies. Subspecialist consultation note may be required.
753.1	Cystic kidney disease, **bilateral only**	0-20	Clinical history, physical examination, radiographic or other imaging studies. Subspecialist consultation note may be required.
753.12	Polycystic kidney, unspecified type, **bilateral only**	0-20	Clinical history, physical examination, radiographic or other imaging studies. Subspecialist consultation note may be required.
753.13	Polycystic kidney, autosomal dominant, **bilateral only**	0-20	Clinical history, physical examination, radiographic or other imaging studies. Subspecialist consultation note may be required.
753.14	Polycystic kidney, autosomal recessive, **bilateral only**	0-20	Clinical history, physical examination, radiographic or other imaging studies. Subspecialist consultation note may be required.
753.15	Renal dysplasia, **bilateral only**	0-20	Clinical history, physical examination, radiographic or other imaging studies. Subspecialist consultation note may be required.
753.16	Medullary cystic kidney, **bilateral only**	0-20	Clinical history, physical examination, radiographic or other imaging studies. Subspecialist consultation note may be required.
753.17	Medullary sponge kidney, **bilateral only**	0-20	Clinical history, physical examination, radiographic or other imaging studies. Subspecialist consultation note may be required.
753.5	Exstrophy of urinary bladder	0-20	Clinical history, physical examination, radiographic and/or other imaging studies. Subspecialist consultation note may be required.

756.0	Musculoskeletal--skull and face bones Absence of skull bones Acrocephaly Congenital deformity of forehead Craniosynostosis Crouzon's disease Hypertelorism Imperfect fusion of skull Oxycephaly Platybasia Premature closure of cranial sutures Tower skull Trigonocephaly	0-20	Clinical history, physical examination; imaging studies supporting diagnosis. Subspecialist consultation note may be required.
756.4	Chondrodystrophy	0-1	Clinical history and physical exam; imaging studies supporting diagnosis. Subspecialist consultation note may be required.
756.50	Osteodystrophy NOS	0-1	Clinical history and physical exam; imaging studies supporting diagnosis. Subspecialist consultation note may be required.
756.51	Osteogenesis imperfecta	0-20	Clinical history, physical examination, radiologic studies. Specialist consultation report (genetics, orthopedics) may be required.
756.52	Osteopetrosis	0-1	Clinical history and physical exam; imaging studies supporting diagnosis. Subspecialist consultation note may be required.
756.53	Osteopoikilosis	0-1	
756.54	Polyostotic fibrous dysplasia of bone	0-1	
756.55	Chondroectodermal dysplasia	0-1	
756.56	Multiple epiphyseal dysplasia	0-1	
756.59	Osteodystrophy NEC	0-1	
756.6	Anomalies of diaphragm	0-1	Clinical history and physical exam; imaging studies supporting diagnosis. Subspecialist consultation note may be required.
756.7	Abdominal wall anomalies	0-1	Clinical history and physical exam.
759.7	Multiple congenital anomalies NOS	0-10	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
V46.1	Dependence on respirator	1-64	Clinical history and physical exam. Specialist consultation note required.
V46.9	Machine dependence NOS	1-64	

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January 4, 1999

Glossary

This glossary contains words used in the text of this handbook that may have unique meanings for Medical Assistance.

Adjustment
Correction to a mispaid claim, which would result in a partial refund to Medical Assistance or additional reimbursement to you.

Claim
A request for Medical Assistance to pay for health care services.

Crossover Claim
A claim electronically submitted (A*crossed-over*≅) from a Medicare carrier to Medical Assistance for the payment of deductibles and/or Part B coinsurance.

Deny
To refuse to pay a claim as submitted.

Department
The Department of Health and Mental Hygiene. It is the State agency that administers the Medical Assistance Program and formulates policy to conform with State and federal requirements. This Department also monitors providers= compliance with policy.

DX Code
Diagnosis Code

Emergency Services
Those services which are provided in hospital emergency facilities after the onset of a medical condition manifesting itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent layperson, possessing an average knowledge of health and medicine, to result in:

- X placing health in jeopardy;
- X serious impairment to bodily functions;
- X serious dysfunction of any bodily organ or part; or
- X development or continuance of severe pain.

EOMB
Explanation of Medicare Benefits

EPSDT/MARYLAND HEALTHY KIDS PROGRAM
Early and Periodic Screening, Diagnosis, and Treatment. A Program which provides health screens for children through age 20. Referrals are often made to other providers for treatment.

FQHC
Federally Qualified Health Center

HCFA
Health Care Financing Administration: The agency within the federal Department of Health and Human Services responsible for the regulation of the various states= Medical Assistance programs.

HCPCS
HCFA Common Procedure Coding System

ICN
Invoice Control Number. An internal control number assigned to each claim as it is received by the Medical Assistance Program for processing.

Inpatient Hospital Services
Preventive, diagnostic, therapeutic, rehabilitative or palliative services furnished:

X in a hospital for the care and treatment of inpatients under the direction of a physician or dentist;
X in an institution which:
a. is licensed or formally approved as a hospital by the Office of Licensure and Certification;
b. meets requirements for participating in Medicare;
c. has in effect a utilization review plan, applicable to all Medical Assistance patients.

Inpatient hospital services *do not* include SNF or ICF services furnished by a hospital with a swing-bed approval.

JCAHO
The Joint Commission on the Accrediation of Healthcare Organizations

MCO
Managed Care Organization

MQHC
Maryland Qualified Health Center

Medical Assistance Program
The Program of comprehensive medical and other health-related care for indigent and medically indigent persons.

Medical Care
Those medically necessary procedures provided in the course of diagnosis and treatment of an illness or injury.

Necessary
Directly related to diagnostic, preventive, curative, palliative or rehabilitative treatment.

Outpatient
A patient with a known diagnosis who enters a hospital for a specific minor surgical procedure or other treatment that is expected to keep him in the hospital for less than 24 hours. He/she is considered an outpatient if he/she does stay less than 24 hours, whether or not he/she used a bed, whether or not he/she remained in the hospital past midnight.

Outpatient Hospital Services
Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished:

- X to outpatients;
- X by or under the direction of a physician or dentist;
- X by an institution that:
  a. is licensed or formally approved as a hospital by the Office of Licensure and Certification,
  b. meets the requirements for participation in Medicare.

Participating Hospital
A hospital which has signed an agreement with Maryland Medical Assistance to participate in the Medical Assistance Program on a continuing basis. This type of hospital may accept Medical Assistance recipients for covered hospital services for both non-emergency and emergency conditions.

Per Diem Rate
A daily rate based upon a facility=s submitted cost report or the Department=s fee structure.

Preauthorization
A request submitted to the Medical Assistance Program for permission to perform one or more specific procedures.

Primary Care
Medical care which addresses a patient=s general health needs including the coordination of the patient=s health care, with the responsibility for the prevention of disease, promotion and maintenance of health, treatment of illness and referral to other specialists for more intensive care when appropriate.

Provider
An individual, association, partnership, corporation or unincorporated group licensed or certified to provide health care services for recipients and who, through appropriate agreement with the Department, has been identified as a Program provider by the issuance of an individual account number.

Psychiatric Services
Services covered under the branch of medicine which treats mental and neurotic disorders and the pathologic or the psychopathologic changes associated with them.

Recipient
A person who is certified as eligible for, and is receiving, Medical Assistance benefits.

RA
Remittance Advice. A statement from the Medical Assistance Program summarizing the status of and payment amounts for claims filed.

Screening
A medical examination provided to Medical Assistance patients under the EPSDT Program designed to detect physical and mental conditions for the provision of treatment and other corrective health measures.

Service Limit
Allowed time intervals for provision of certain services. Also referred to as Acaps≅

Suspended Claim
A claim in the system awaiting final adjudication.

TCA
Temporary Cash Assistance

Third Party
Any individual, entity or program that is or may be liable to pay all or part of the expenses for medical services.

Title IV-E
The title of the Social Security Act that enables foster care and adoption subsidy children to receive assistance through the Aid to Families with Dependent Children-Foster Care Program. If these Maryland children reside out-of-state, they are covered under the Medical Assistance Program of their state of residence.

Title XVIII
The title of the Social Security Act which authorizes Medicare.

Title XIX
The title of the Social Security Act which authorizes Medical Assistance

TPL
Third Party Liability. Any entity other than the recipient, or his/her responsible party, that is liable to pay all or part of the cost of medical care.

Utilization Review
A regular prescribed program for the review of each recipient=s need for services to ensure that efficient and appropriate care is provided.