CHAPTER 17

MARYLAND PROVIDER BILLING MANUAL

NOTE: Information contained in this manual may be periodically updated or further explained through Provider Alerts
http://maryland.valueoptions.com/provider/prv_alerts.htm

General Claims Submission Guidelines

NOTE: Claims submitted electronically are generally processed more quickly than paper claims.

For electronic claims:

- To learn how to create 837 batch files using free ValueOptions® software, please refer to the website:
- http://www.valueoptions.com/providers/Compliance/ediclaimslinkmanual.pdf
- For the ValueOptions® companion guide to 837 submissions please refer to the website:
- http://www.valueoptions.com/providers/Compliance/837_Companion_Guide.pdf

- For information on submitting claims directly through the web please refer to the website: http://www.valueoptions.com/providers/ProviderConnect/ProviderConnect_SCS_How_To_Less_Screen_Prints_Final.pdf

Or call the EDI Help Desk at 888-247-9311

For paper claims:

ValueOptions® Maryland will accept paper CMS-1500 forms or Uniform Billing (UB)-04 forms. Do not use discontinued HCFA-1500 or UB-94 forms. Claims billed on discontinued forms may be denied. Please use original forms with red ink.

- CMS-1500 forms are for professional/practitioner services
- UB-04 forms are for inpatient and outpatient facility claims

Claim Mailing Address:

Mail completed claim forms to:

ValueOptions Maryland

PO Box 1950

Latham, NY 12110

Timely Filing Guidelines Initial Submission

Claims must be submitted within 12 months of the first date of service on the claim. ValueOptions® Maryland will deny claims received more than 12 months after the date of service.

Denials

If the original claim was filed with ValueOptions® Maryland within 12 months of the date of service, the provider may resubmit the claim with additional information for consideration to ValueOptions® Maryland within that same 12 month period, or if after the 12 month period, within 60 days of the date of the ValueOptions® Maryland provider voucher which denied the claim. (COMAR 10.09.36.06 B (3)

When Commercial Insurance is Primary

The timely filing limit for claims is 60 days from the date of the other carrier's EOB, or 12 months from the first DOS, whichever is later. The provider must submit the claims to the primary carrier within the primary carrier's timely filing limit. ValueOptions® Maryland requires the other carrier's remittance advice as proof of timely filing.

When Medicare is Primary

If Medicare benefits are exhausted or if Medicare will deny benefits for another reason the provider must submit claims to Medicare within Medicare's timely filing limits and submit the paper claim and Explanation of Medicare benefits (EOMB) to ValueOptions® Maryland within 12 months of DOS or 120 days from EOMB, whichever is later) of Medicare's EOMB date. Authorizations are required for services not covered or exhausted by Medicare. COMAR 10.09.36.06 B (2) a -b

If the service is known not to be covered by Medicare, e.g. PRP, the provider does not need to submit to Medicare. Refer to the "EOP Required" grid on the ValueOptions® Maryland website to identify services for which a Medicare EOMB is not required. The direct link is:
http://maryland.valueoptions.com/provider/cliams_finance/EOP_Approved.pdf

For services and providers covered by Medicare, submit claims directly to Medicare following Medicare's timely filing guidelines. Claims covered by Medicare should not be sent to ValueOptions® Maryland.

When Medicaid Eligibility is Assigned Retroactively

Claims must be submitted to ValueOptions® Maryland within 12 months from the date of eligibility determination. The Department of Social Services Medical Assistance eligibility Determination Award Letter I (MA-81 letter of retro-eligibility) or a retro-eligibility timely filing waiver forms must be submitted with every claim. The Form can be downloaded at: http://maryland.valueoptions.com/, "For Providers", "Provider Forms", and Administrative Forms". Please include the Medical Assistance Eligibility Determination Letter, if available. COMAR 10.09.36.06 B (6-8)

- If a claim is submitted for which you do not receive a payment or a rejection within 90 days, please resubmit the claim.

Consumer/Recipient Eligibility

It is the provider's responsibility to confirm consumer eligibility. Before rendering services, providers should request the recipient's Medicaid identification card. See DHMH's instructions for verifying eligibility using the Eligibility Verification System (EVS) at https://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx

NPI – General Information

The National Provider Identifier (NPI) is a unique 10-digit numeric identifier for covered healthcare providers. The NPI must be used on all claims.

For all claims, whether submitted electronically or on paper, the provider's billing and rendering NPI must be submitted. There are some exceptions to the rendering NPI requirement, based on provider type. Outpatient Mental Health Clinics (OMHC), Federally Qualified Health Centers (FQHC) and Psychiatric Rehabilitation Providers (PRP) are not required to include the rendering provider's NPI.

On all outpatient laboratory claims whether submitted electronically or on paper, the referring provider's NPI must be included.

On all institutional claims whether submitted electronically or on paper, the attending provider's NPI must be included.

Electronic Claims: see the HIPAA Implementation Guide for NPI placement. The HIPAA Implementation Guide can be purchased at http://www.wpc-edi.com/hipaa.

Paper CMS-1500 Forms:

- When submitting on paper, providers must use current CMS-1500 form (version 02/12) http://www.valueoptions.com/providers/Handbook/resource/CMS_1500_Claim_Form.pdf
- The CMS-1500 forms are available from the Government Printing Office can be reached at:
- http://bookstore.gpo.gov/catalog/government-forms-phone-directories
- or call 866-512-1800

NPI Information

ValueOptions® Maryland will accept NPI numbers that are registered with MMIS II. To update or clarify provider information (including, but not limited to, Tax Identification number, NPI, service location, and payment address), contact DHMH Provider Enrollment at 410-767-5340 or email to DHMH.BHenrollment@maryland.gov

Show the provider's Billing NPI in box 33a and Rendering NPI in box 32a on all CMS-1500 claims.

ValueOptions® Maryland will deny any claims that do not include valid billing and rendering NPI numbers.

- Exception: OMHC, FQHC, PRP providers may leave Box 32a blank (rendering NPI)
- Claims from outpatient laboratories must include the referring provider's NPI in box 17b.
- Multiple Services on a Single Claim
- The Dates of Service on a claim cannot span a calendar month. If billing for more than one calendar month, split onto separate claims
- Submit each date of service on a separate line
- Multiple units of the same service code/modifier on the same day must be submitted on ONE claim line.

Completing the Paper Form

The following information shows field by field description of required data elements in addition to the NPI requirements listed above. Please note that the terms "patient," "recipient," and "consumer" are used interchangeably.

Block 1

Show all type(s) of health insurance applicable to this claim by checking the appropriate box(es).

Block 1a

INSURED'S ID NUMBER –Claims must be submitted with either the consumer's Medicaid Identification Number or the ValueOptions® Maryland assigned Member Identification Number. Claims submitted with a Social Security Number, including claims for Uninsured Eligible participants, will be rejected.

Block 2

PATIENT'S NAME (Last Name, First Name, and Middle Initial) – Enter the patient's (recipient's) name as it appears on the Medical Assistance card.

Block 3

PATIENT'S BIRTH DATE/SEX – Enter the patient's (recipient's) birth date and gender. Use the eight digit format (MM|DD|CCYY) format for date of birth. Enter an X in the correct box to indicate the patient's gender. Only one box can be marked. If the gender is unknown, leave blank.

Block 4

INSURED'S NAME (Last Name, First Name, Middle Initial) – Enter the name of the person in whose name the third party coverage is listed, only when applicable.

Enter the insured's full last name, first name and middle initial. If the insured has a last name suffix (e.g., Jr., Sr.) enter it after the last name, but before the first name.

Block 5

PATIENT'S ADDRESS – Enter the patient's (or participants) complete mailing address with zip code and telephone number. On the first line, enter the street address (apartment number or Post Office Box number); the second line, the city and state; the third line, the ZIP code and phone number.

NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a nine-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number. If the patient is homeless, please indicate HOMELESS on the first line

Block 6

PATIENT'S RELATIONSHIP TO INSURED – Enter the appropriate relationship only when there is third party health insurance

Block 7

INSURED'S ADDRESS – When there is third party health insurance coverage enter the insured's address and telephone number.

Block 8

PATIENT STATUS - Check the appropriate box for the patient's marital status and whether employed or a student

Block 9

OTHER INSURED'S NAME - Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer.)

Block 9a

OTHER INSURED'S POLICY OR GROUP NUMBER - Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's policy or group number or the insured's identification number.

Block 9b

OTHER INSURED'S DATE OF BIRTH— Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the eight-digit date of birth in MM/DD/CCYY format and enter an "X" to indicate the sex of the other insured. Only one box can be marked. If gender is unknown, leave blank.

Block 9c

EMPLOYER'S NAME OR SCHOOL NAME –Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's employer's name or school.

Block 9d

INSURANCE PLAN OR PROGRAM NAME – Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or program name.

Block 10a thru 10c

IS PATIENT'S CONDITION RELATED TO - Check "Yes" or "No" Place an "X" in the box dictating whether or not the condition for which the patient is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question. NOTE: The state postal code must be shown if "yes" is marked in 10b for "auto accident". Any item marked yes indicates there may be other applicable insurance coverage that would be primary such as automobile liability insurance. Primary insurance information must then be shown in item 11.

Block 10d

RESERVED FOR LOCAL USE – Leave blank.

Block 11

INSURED'S POLICY GROUP OR FECA NUMBER – Enter the Insured's policy or group number as it appears on the insured's health care identification card.

Block 11a

INSURED'S DATE OF BIRTH – Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the eight-digit date of birth in MM/DD/CCYY format and enter an "X" to indicate the sex of the other insured. Only one box can be marked. If gender is unknown, leave blank.

Block 11b

EMPLOYER'S NAME OR SCHOOL NAME – Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's employer's name or school.

Block 11c

INSURANCE PLAN OR PROGRAM NAME – Required if Field 11d is yes. Enter the other insured's insurance company or program name.

Block 11d

IS THERE ANOTHER BENEFIT PLAN? – Place an "X" in the box indicating whether there may be other insurance involved in the reimbursement of this claim.

Block 12

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – The patient must sign and date the claim if authorizing the release of medical information. If "signature on file" is indicated, the provider must maintain a signed release form or CMS-1500 (formally HCFA 1500). The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment on the claim.

Block 13

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – The signature in this item authorizes payment of benefits to the physician or supplier. Signature on file, SOF, or the legal signature is acceptable. If there is no signature on file leave this item blank or enter "no signature on file".

Block 14

DATE OF CURRENT ILLNESS, INJURY, PREGNANCY – Optional.

Block 15

IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS – Optional.

Block 16

DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION– Optional.

Block 17

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE – required for outpatient laboratory claims.

Block 17a

ID NUMBER OF REFERRING PHYSICIAN – Enter the ID Qualifier.

Block 17b

Enter the NPI of the referring, ordering, or supervising provider listed in Block 17. This field is required for outpatient laboratory claims.

Block 18

HOSPITALIZATION DATES RELATED TO CURRENT SERVICES – Required if this claim includes charges for services rendered during an inpatient admission. Enter dates in MMDDYY format.

Block 19

RESERVED FOR LOCAL USE – No entry required.

Block 20

OUTSIDE LAB – Optional.

Block 21

DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY – Enter a valid ICD-9 diagnosis code, coding to the highest level of specificity (include fourth and fifth

digits if applicable) that describes the principal diagnosis for services rendered. Enter up to four codes in priority order (primary, secondary, etc.) The primary diagnosis must be a PBHS Specialty Mental Health Diagnosis. See link for the list of covered diagnosis: http://maryland.valueoptions.com/provider/clin_ut/PMHS_Diagnosis.pdf.

Block 22

MEDICAID RESUBMISSION – List the original reference (claim) number for resubmitted claims.

Block 23

PRIOR AUTHORIZATION NUMBER – Optional. Not required for claims processing.

Block 24a

DATE(S) OF SERVICE – Enter each separate date of service as a 6-digit numeric date (e.g. June 1, 2010 would be 06/01/10) under the FROM heading. Leave the space under the TO heading blank. Each date of service on which a service was rendered must be listed on a separate line. Ranges of dates are not accepted.

Block 24B

PLACE OF SERVICE – For each date of service, enter the appropriate 2 digit place of service code.

Block 24C

EMG – Leave blank.

Block 24D

PROCEDURES, SERVICES OR SUPPLIES – Enter a valid CPT or HCPCS code for each service rendered. Enter a valid CPT or HCPCS code modifier, as applicable, for each service entered.

Block 24E

DIAGNOSIS POINTER – Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line. When multiple services are performed, the primary reference number for each service, 1, 2, 3 or 4, is shown. Do not enter the ICD-9 diagnosis code.

Block 24F

CHARGES – Enter the provider's usual and customary charges. Do not enter the Maryland Medicaid maximum fee unless that is the provider's usual and customary charge. (PRP claims should bill the cascade rate schedule, see link for reference http://maryland.valueoptions.com/provider/cliams_finance/PMHS_PRP_Cascade.pdf

If there is more than one unit of service on a line, the charge for that line should be the total of all units.

Block 24G

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

Block 24H

EPSDT FAMILY PLAN – Leave blank.

Block 24I

ID QUAL. – Enter the ID Qualifier 1D (Medicaid Provider Number) – used if the provider does not have a NPI, enter the appropriate qualifier and identifying number in the shaded area. Providers who do not have an NPI will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported. – Optional

Block 24J

RENDERING PROVIDER ID # – Enter the NPI number in the un-shaded area of the field. All claims must include rendering provider NPI except those from OMHC, FQHC, and PRP providers.

Block 25

FEDERAL TAX I.D. NUMBER – Enter the nine-digit Employee Identification Number (EIN) or Social Security Number under which payment for services is to be made for reporting earnings to the IRS. Enter an "X" in the appropriate box that identifies the type of ID number used for services rendered. Claims with an incorrect or missing Tax ID number will be denied.

Block 26

PATIENT'S ACCOUNT NUMBER – Enter the unique number assigned by the provider for the patient. If entered, the patient account number will be returned to the provider on the Provider Summary Voucher. – Optional

Block 27

ACCEPT ASSIGNMENT? – Enter an "X" in the appropriate box. NOTE: Providers must accept payment by the Program as payment in full for covered service

(in addition to applicable copay). No additional charge to any recipient may be made for covered services.

Block 28

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

Block 29

AMOUNT PAID – Enter the amount of any collections received from any third party payer or the patient. If the recipient has third party insurance and the claim has been rejected, the appropriate rejection code shall be placed in Block # 11. Entering an amount in this field does not eliminate the need to attach the paper EOB from the primary carrier. If there is other insurance, an EOB from the primary carrier must be submitted with the claim. If an EOP is not required for the service, it not necessary to bill the primary carrier. See the list of service codes that don't require a primary carrier EOB at the following site: http://maryland.valueoptions.com/provider/cliams_finance/EOP_Approved.pdf

Block 30

BALANCE DUE – (Box 28 minus Box 29 equals Box 30 "balance due").

Block 31

SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS – this is the rendering provider's signature and degree/license level.

Block 32

SERVICE FACILITY LOCATION INFORMATION – Facility where services were rendered.

Block 32a

NPI – Enter the NPI of the service facility.

Block 32b

May be left blank.

Block 33

BILLING PROVIDER INFO & PH# – Enter the name, complete street address, city, state, and zip code of the provider. This is the address to which payment should be made.

Block 33a

NPI – Enter the NPI number of the billing provider in Block # 33. Error or omission of this number will result in non-payment of claims.

Block 33b

May be left blank.

Facility Billing: UB-04 Claims

See the DHMH UB04 Hospital Billing Instructions at: https://mmcp.dhmh.maryland.gov/Documents/UB04%20HOSPITAL%20INSTRUCTIONS%20AND%20REVENUE%20MATRIX%20-%201014.pdf

See type of bill instructions at the end of this section

NOTE: Only one date of service may be billed per claim for outpatient facility services. If submitting on paper, providers must use UB-04 claim forms. UB-92

forms may be rejected. A copy of a UB-04 form is shown at the end of the field instructions.

Paper UB-04 forms:

- Providers must use current UB-04 forms. UB-92 forms will not be accepted.
- Show the billing NPI in box 56 and the attending NPI in box 76.
- The attending physician's NPI must be included on all UB-04 claims.

Completing the UB04 (CMS1450) Claim Form:

Field	Field Description	Field Type	Instructions
1	Provider Name, Address, Telephone Number, and Country Code: **Required:** This field contains the complete Service address (the address where the services are being performed/rendered) and the telephone and/or fax number.		
2	Pay-to Name and Address: **Required**: This field contains the address to which payment should be sent if different from the information in Field 1.		
3a	Patient Control Number: **Optional**: Complete this field with the patient account number that allows for the retrieval of individual patient financial records. If completed, this number will be included on the Provider's Summary Voucher.		
3b	Medical/Health Record Number: In this field, report the patient's medical record number as assigned by the provider.		
4	Type of Bill: **Required**: The type of bill code indicates the facility type, whether the claim is inpatient or outpatient, and the bill frequency. See the references at the end of this section for acceptable Bill Type codes.		

5 Federal Tax Number: **Required**: Enter the number assigned by the Federal Government for tax reporting purposes. This may be either the Tax Identification Number (TIN) or the Employer Identification Number (EIN). Affiliated subsidiaries are identified using Federal Tax Sub-IDs.

6 Statement covers Period "From" and "Through": **Required**: Use this field to report the beginning and end dates of service for the period reflected on the claim in MMDDYY format.

7 Reserved for Assignment by NUBC: **Not Required**: N/A

8a Patient Identifier: **Required**: This field is for the patient's identification number.

8b Patient Name: **Required**: This field is for the patient's last name, first name and middle initial.

9a Patient Address: **Required**: This field is for entering the patient's street address.

9b (unlabeled field): **Required**: This field is for entering the patient's city.

9c (unlabeled field): **Required**: This field is for entering the patient's state code.

9d (unlabeled field): **Required**: This field is for entering the patient's ZIP code.

9e (unlabeled field): **Required**: This field is for entering the patient's Country code.

10 Patient Date of Birth: **Required**: This field includes the patient's complete date of birth using the eight-digit format MMDDCCYY.

11 Sex: **Required**: Use this field to identify the sex of the patient.

12 Admission Date/State of Care Date: **Required**: Enter the date care begins. For inpatient care, it is the date of admission. For all other services, it is the date care is initiated.

13 Admission Hour: **Required**: Enter the hour in which the patient is admitted for inpatient or outpatient care.

NOTE: Enter using Military Standard Time (00-23) in top-of-the-hour times only. See valid hours at the end of this section.

14 Priority (Type) of Visit: **Required**: Enter the appropriate code for the priority of the admission or visit. See valid codes at the end of this section.

15 Source of Referral for Admission or Visit: **Required**: This field indicates the source of the referral for the visit or admission (e.g., physician, clinic, facility, transfer, etc.). See valid codes at the end of this section.

16 Discharge Hour: **Conditional**: This field is used for reporting the hour the patient is discharged from inpatient care.

NOTE: Enter using Military Standard Time (00-23) in top-of-the-hour times only. See valid hours at the end of this section.

17 Patient Discharge Status: **Required**: Use this field to report the status of the patient upon discharge – required for institutional claims. See valid codes at the end of this section.

18-28 Condition Codes: **Conditional**: Use these fields to report conditions or events related to the bill that may affect the processing of it. See valid codes at the end of this section.

29 Accident State: **Conditional**: When appropriate, assign the two-digit abbreviation of the state in which an accident occurred.

30 Reserved for Assignment by NUBC: **Not Required**: N/A

31-34 Occurrence Codes and Dates: **Conditional**: The occurrence code and the date fields associated with define a significant event associated with the bill that affects processing by the payer

35-36 Occurrence Span Codes and Dates: **Conditional**: This field is for reporting the beginning and the end dates of the specific event related to the bill.

37 Reserved for Assignment by NUBC: **Not Required**: N/A

38 Responsible Party Name and Address: **Required**: This field is for reporting the name and address of the person responsible for the bill.

39-41 Value Codes and Amounts: **Required**: These fields contain the codes and related dollar amounts to identify the monetary data for processing claims. This field is required by all payers.

42 Revenue Code: **Required**: Enter the applicable revenue code for the services rendered. There are 22 lines available and should include the total line for revenue code 0001.

43 Revenue Description: **Optional**: This field is used to report the abbreviated revenue code categories included in the bill.

44 HCPCS/ Tate/ HIPPS Code: **Conditional**: This field is used to report the appropriate HCPCS codes corresponding to the revenue codes.

45 Service Date:**Conditional**: Indicates the date the outpatient service was provided and the date the bill was created using the six- digit format MMDDYY.

46 Service Units: **Required**: In this field, units such as pints of blood used, miles traveled and the number of inpatient days are reported.

47 Total Charges: **Required**: This field reports the total charges--covered and non-covered--related to the revenue code.

48 Non-Covered Charges: **Conditional**: This field indicates charges that are non-covered charges by the payer as related to the revenue code.

49 Reserved for Assignment by NUBC: **Not Required**: N/A

51a, b, c Health Plan Identification Number: **Not Required**: This field includes the identification number of the health insurance plan that covers the patient and from which payment is expected.

52a, b, c Release of Information Certification Indicator: **Required**: Enter the appropriate code denoting whether the provider has on file a signed statement form the member to release information. Refer to Attachment B for valid codes.

53a, b, c Assignment of Benefits Certification Indicator: **Required**: Enter the appropriate code to indicate whether the provider has a signed form authorizing the third party insurer to pay the provider directly for the service rendered.

54a, b, c Prior Payments: **Conditional**: Enter any prior payment amounts the facility has received toward payment of this bill for the payer indicated in Field 50 lines a, b, c.

55a, b, c Estimated Amount Due: **Not Required**: Enter the estimated amount due from the payer indicated in Field 50 lines a, b, c.

56 National Provider Identifier-Billing Provider: **Required**: Enter the Facility's billing NPI.

57 Other Provider Identifier-Billing Provider: **Not Required**: The unique provider identifier assigned by the health plan is reported in this field.

58a, b, c Insured's Name (last, first name, middle initial): **Required**: The name of the individual who carries the insurance benefit is reported in this field. Enter the last name, first name and middle initial.

59a, b, c Patient's Relationship to Insured: **Required**: Enter the applicable code that indicates the relationship of the patient to the insured.

60a, b, c Insured's Unique Identification: **Required**: This is the unique number the health plan assigns to the insured individual. The ID Number from the Member's Insurance Card should be entered.

61a, b, c Group Name: **Required**: Enter the group or plan name of the primary, secondary and tertiary payer through which the coverage is provided to the insured.

62a, b, c Insurance Group Number: **Conditional**: Enter the plan or group number for the primary, secondary, and tertiary payer through which the coverage is provided to the insured.

63a, b, c Treatment Authorization Codes: **Optional**: Enter the authorization number assigned by the payer indicated in Field 50, if known. This indicates the treatment has preauthorized.

64a, b, c Document Control Number: **Not Required**: from the Provider this number is assigned by the health plan to the bill for their internal control.

65a, b, c Employer Name (of the Insured): **Conditional**: Enter the name of the primary employer that provides the coverage for the insured indicated in Field 58.

66 Diagnosis and Procedure Code Qualifier ICD Version Indicator: **Required**: This qualifier is used to indicate the version of ICD-9-CM being used. A"9" is required in this field for the UB- 04.

67 Principal Diagnosis Code: **Required**: Enter the valid ICD-9-CM diagnosis code (including fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered.

67 a-q Other Diagnosis Codes/Present on Admission Indicator (POA): **Conditional**: This field is for reporting all diagnosis codes in addition to the principal diagnosis that coexist, develop after admission, or impact the treatment of the patient or the length of stay. The present on admission (POA) indicator applies to diagnosis codes (i.e., principal, secondary and E codes) for inpatient claims to general acute-care hospitals or other facilities, as required by law or regulation for public health reporting. It is the eighth digit attached to the corresponding diagnosis code.

68 Reserved for Assignment by NUBC: **Not Required**: N/A

69 Admitting Diagnosis: **Required**: Enter a valid ICD-9-CM diagnosis code (include the fourth and fifth digits if applicable) that describes the diagnosis of the patient at the time of admission.

70 a-c Patient's Reason for Visit: **Conditional**: The ICD-9-CM codes that report the reason for the patient's outpatient visit is reported here.

71 Prospective Payment System (PPS) Code: **Not Required**: This code identifies the DRG based on the grouper software.

72 External Cause of Injury (ECI) Code: **Not Required**: In the case of external causes of injuries, poisonings, or adverse effects, the appropriate ICD-9-CM diagnosis code is reported in this field.

73 Reserved for Assignment by NUBC: **Not Required**: N/A

74 a-e Other Procedure Codes and Dates: **Conditional**: This field is used to report the principal ICD-9-CM procedure code covered by the bill and the related date.

75 Reserved for Assignment by NUBC: **Not Required**: N/A

76 Attending Provider Names and Identifiers: **Required**: The NPI of the attending provider is required.

77 Operating Physician Name and Identifiers: **Conditional**: Report the name and identification number of the physician responsible for performing surgical procedure in this field.

78-79 Other Provider Names and Identifiers: **Conditional**: This field is used for reporting the names and identification numbers of individuals that correspond to the provider type category.

80 Remarks Field: **Not Required**: This field is used to report additional information necessary to process the claim.

81 a-d Code-Code Field: Conditional: This field is used to report codes that overflow other fields and for externally maintained codes.

Type of Bill Description Inpatient/Outpatient General Designation

011x Hospital Inpatient (including Medicare Part A): IP

012x Hospital Inpatient (Medicare Part B ONLY): OP

013x Hospital Outpatient: OP

015x Chronic Hospitals, Chronic Rehabilitation Hospitals, Specialty Chronic Hospitals: IP

021x Intermediate Care Facility - Mental Retardation: IP

021x Skilled Nursing-Inpatient (including Medicare Part A): IP

Nursing Home Claims

022x Skilled Nursing-Inpatient (Medicare Part B): IP

Nursing Home Therapy

033x Home Health – Outpatient (plan of treatment under Part A, including DME under Part A): OP

Home Health Agency

065x Intermediate Care Facility – Addictions: IP

072x Clinic- Hospital Based or Independent Renal Dialysis Center: OP

Free-Standing Dialysis

081x Specialty Facility- Hospice Facility Services: IP

082x Specialty Facility- Hospice Nursing Home Room and Board Services: IP

086x Specialty Facility- Residential Treatment Center: IP

Type of Bill Frequency Codes

1 Admit Through Discharge Claims: The provider uses this code for a bill encompassing an entire inpatient confinement for which it expects payment from the payer

2 Interim Billing- First Claim: This code is to be used for first (admit) of an expected series of bills for the same confinement or course of treatment for which the provider expects payment from the payer. FL 17 should equal "30."

3 Interim Billing- Continuing Claim: This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted for which payment is expected from the payer. FL 17 should equal "30."

4 Interim Billing- Last Claim: This code is to be used for the last (discharge) of a series of bills for the same confinement or course of treatment for which payment is expected from the payer.

5 Late Charge(s) Only Claim: This code is to be used for submitting additional charges to the payer which were identified by the provider after the admit through discharge claim or the last interim claim has been submitted. This code is not intended for use in lieu of an adjustment claim or a replacement claim.

See note on late charges below.

OXX 7 Replacement of Prior Claim

OXX 8 Replacement of Prior Claim

(5) Late Charge(s) Only Claim:

- FL 6 "Statement Covers Period" on the late charge claim must be the same as the dates of the original claim to which the last charge refers. In addition, all "general information" must be the same on the late charge claim and the original claim.
- Late charges are subject to the 12 month statute of limitations.
- Late charges will be allowed one time only for each patient bill or outpatient bill with which the late charges are associated. COMAR 10.09.36.06 (7) a-b (8)

Other Insurance Coverage

The Medical Assistance Program is the payer of last resort. If a recipient is covered by other insurance or third party benefits such as Worker's Compensation, CHAMPUS or Blue Cross/Blue Shield, the provider must first bill the other insurance company before Medical Assistance will pay the claim. If the primary denies the claim, the provider must exhaust all available levels of appeal and provide corresponding documentation.

When Medicare is Primary

If both Medicare Part A and Part B are active for the consumer ValueOptions® Maryland does not coordinate benefits with Medicare. When Medicare is primary, providers must send their claims directly to DHMH in compliance with their timely filing guidelines.

Certain Services that are not covered by Medicare may be billed to Medicaid. See Provider Information for current list of covered service codes: http://maryland.valueoptions.com/provider/cliams_finance/EOP_Approved.pdf.

If Medicare Part A is exhausted but Medicare Part B is active:

- ValueOptions is the primary payer for Room & Board, admission, and laboratory charges. Providers should submit their paper claim to ValueOptions. The UB-04 must list occurrence code A3 with the date Medicare benefits were exhausted. Providers must attach a copy of the

Medicare EOMB stating that coverage is exhausted.

- Providers should submit all other ancillary charges to Medicare Part B for payment and to Maryland Medical Assistance for payment of any co-pay and/or deductibles. ValueOptions® Maryland will not process these claims.

If Medicare Part A is exhausted and Consumer does not have Medicare Part B:

- ValueOptions® Maryland is the primary payer for both outpatient and inpatient charges.
- Pre-authorizations are required for all services, as indicated by the plan
- The UB-04 must be submitted on paper and list occurrence code A3 with the date Medicare benefits were exhausted. Providers must attach a copy of the Medicare EOMB stating that coverage is exhausted.

If Medicare Part A is active but Medicare Part B is terminated or there is no Part B coverage:

- ValueOptions® Maryland is primary for outpatient charges.
- Inpatient charges should be submitted directly to Medicare in compliance with their timely filing guidelines.
- Pre-authorizations are required for all services, as indicated by the plan.

Commercial Insurance is Primary

- When commercial insurance is a consumer's primary coverage, submit claims to the commercial carrier first. Submit the commercial insurance's explanation of benefits to ValueOptions® Maryland with the claim. These claims can be submitted electronically or on paper. If the primary denies the claim, the provider must exhaust all available levels of appeal and provide corresponding documentation.

- Medicaid is always the payor of last resort. However, in some cases the PMHS will pay as primary for services rendered to Medicaid recipients who also have commercial coverage when the provider has received a rejection from the commercial carrier:

- Preauthorization by ValueOptions® Maryland is required.

- The coverage is not in effect on the service date

- The service does not meet the primary payor's Medical Necessity Criteria, but meets the PMHS Medical Necessity Criteria. The provider shall submit supporting documentation of denial of the claim by the primary carrier.

- The provider has demonstrated due diligence in assuring the consumer was Medicaid eligible by checking EVS and after date of service learned the individual had third party insurance.

- Medicaid will not pay as primary for the following:

- The claim was denied by the primary carrier for failure to meet timely filing requirement.

- The claim was denied because the provider is not participating with the primary carrier unless there is justification of a low health care shortage area.
- The claim was denied for no authorization by the primary carrier.
- To submit primary carrier payment information electronically, see the Companion Guide at: http://valueoptions.com/providers/Compliance/ediclaimslinkmanual.pdf
- When benefits have been exhausted by the primary carrier, the claim must be submitted on paper with a copy of the primary carrier's EOB for the same date of service as the claim.

Claim Adjustments/Corrections

A claim adjustment is performed when a paid claim is determined to have been incorrectly processed, either due to an error or when updated information is provided. An adjustment means the paid claim is reversed (and dollars paid are backed-out) and a new claim is processed with the correct information. If the new claim results in a lesser payment than the original paid claim, or is denied, then the provider's account is in a negative balance. Future payments to the provider will be used to offset a negative balance.

Providers can request a claim adjustment using one of the following methods:

- Submit a corrected claim:

To electronically submit corrected claims, please refer to the 837 Companion Guide at:

http://www.valueoptions.com/providers/Compliance/837_Companion_Guide.pdf.

- To submit corrected claims on paper, indicate CORRECTED CLAIM at the top of the CMS-1500 or UB-04 form. Please indicate the original ValueOptions® Maryland claim number on the corrected claim.
- Inquiry through ProviderConnect:

See: http://www.valueoptions.com/providers/Provider_Connect.htm for directions on how to submit an inquiry through ProviderConnect.

Refunds

To refund ValueOptions® Maryland for an overpayment, please send a copy of the associated provider summary voucher, and explanation of the overpayment with the check to:

ValueOptions® Maryland

P.O. Box 1950

Latham, NY 12110