THE MARYLAND DEPARTMENT OF HEALTH

Health Homes

Billing Instructions

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I. GENERAL INFORMATION

A. Introduction

Health Homes offer enhanced services and supports for participants with serious and persistent mental illness (SPMI), serious emotional disturbance (SED), and opioid substance use disorders. Health Homes aim to improve somatic and behavioral health outcomes by incorporating a whole-person approach to behavioral health care, removing barriers to accessing physical health care, and improving self-management capacity while reducing avoidable emergency room visit and hospital admissions.

Provider types eligible to become Health Homes include Psychiatric Rehabilitation Programs (PRP), Mobile Treatment (MT) programs, and Opioid Treatment Programs (OTP).

These billing instructions are designed to help Health Home providers understand the proper billing procedures for Health Home services. Instructions include information about the processes required to become a Health Home provider and the procedures involved for enrolling participants and submitting claims.

B. Getting Started

Health Home providers submit claims directly to the Maryland Departments of Health's Fee-For-Service system. Before billing for Health Home services, providers must ensure they have completed the steps below.

Providers already operating as an active PRP, MT, or OTP enrolled with Maryland Medical Assistance may begin at **step iv**.

i. Obtain Required OHCQ Certification or Deemed Status

Health Homes must have the appropriate certification or approval as a PRP, MT, or OTP provider from the Office of Health Care Quality (OHCQ) or the Behavioral Health Administration (BHA), as appropriate.

- PRP providers should refer to:
  - COMAR 10.21.21 or COMAR 10.63.03.09 for adults
  - COMAR 10.21.29 or COMAR 10.63.03.10 for minors
- MT providers should refer to: COMAR 10.21.19 or COMAR 10.63.03.04
- OTP providers should refer to: COMAR 10.09.80 or COMAR 10.63.03.19

ii. Apply for a National Provider Identifier

Health Home providers must obtain a National Provider Identifier (NPI), a unique 10-digit identifier that health care providers must use on all transactions as mandated by the Health

Information Portability and Accountability Act (HIPPA). Maryland Medicaid requires that all providers have a unique NPI for each line of business they offer. For example if you are a PRP and a MT provider, you will need a separate NPI for each service. Additional NPI information can be found on the Center for Medicare and Medicaid Services (CMS) website at https://nppes.cms.hhs.gov/NPPES/Welcome.do or by calling the NPI assistance phone line at 1-800-465-3203.

iii. Apply for a Medical Assistance Provider Number

In order to participate as a Health Home, providers must complete a Medicaid (MA) provider application and provider agreement to become a PRP, MT, or OTP. Once the application is approved, providers will receive a MA provider number. Health Home providers who wish to enroll with more than one provider type must submit a separate MA application with a distinct NPI for each. Health Homes will use their MA provider number(s) to bill for services and to access the Health Home portal where services must be documented.

For assistance with this process please email mdh.bhenrollment@maryland.gov.

iv. Apply as a Health Home

Providers must complete a Health Home Provider Application with the required materials and obtain approval from the Department before billing for Health Home services. The provider application and instructions can be found at https://mmcp.health.maryland.gov/Pages/Health-Home-Requirement-Information.aspx. All completed applications should be submitted to mdh.healthhomes@maryland.gov.

If you need assistance please email mdh.healthhomes@maryland.gov

v. Register with eMedicaid

All Health Homes must use their MA provider number specific to their PRP, OTP, or MT program to register with eMedicaid at https://encrypt.emdhealthchoice.org/emedicaid/. eMedicaid gives providers access to the eligibility verification system, the electronic claims submission system, and the eMedicaid Health Home portal where providers must document all provided services. For more information about registering or for troubleshooting, please visit the eMedicaid User's Guide at https://encrypt.emdhealthchoice.org/emedicaid/eDocs/eMedicaid_web.pdf.

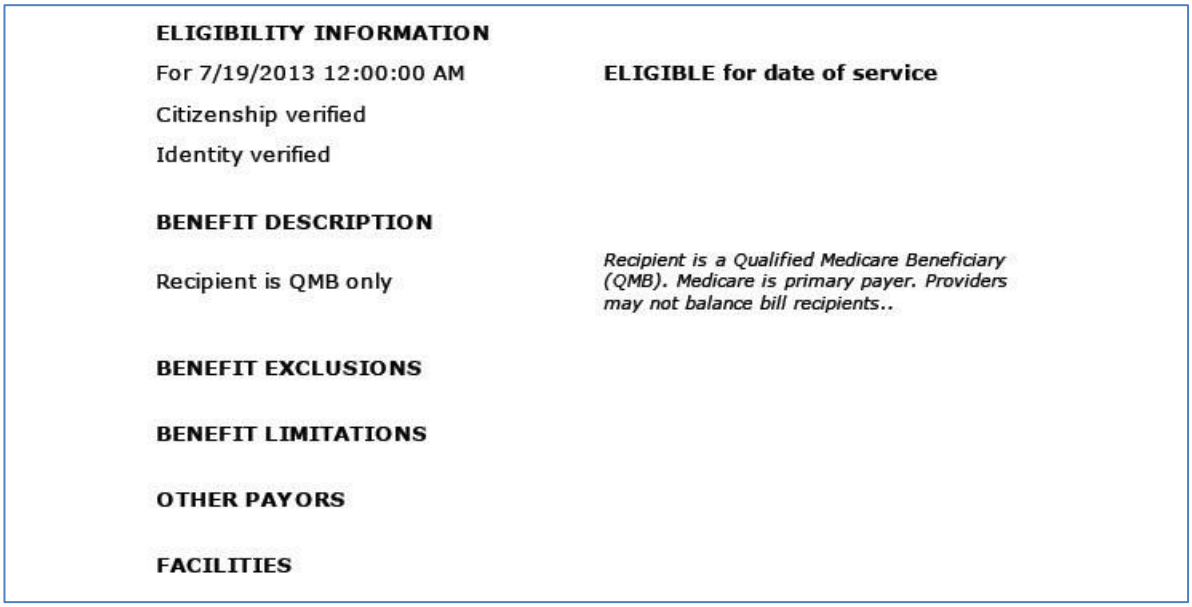
Instructions for eMedicaid's Health Home system are available at: https://health.maryland.gov/bhd/Documents/HH%20eMedicaid%20Instructions%20(Updated%202.21.14)%20(2).pdf

II. VERIFYING PARTICIPANT ELIGIBILITY

Before rendering a service, providers should verify the participant's MA eligibility on the date of service through the Eligibility Verification System (EVS). Providers may access EVS online through eMedicaid or by calling the automated phone line at 1-866-710-1447. To check a participant's eligibility, providers will need the participant's MA member number or Social Security number.

In order to be eligible, a recipient's eligibility information status must read "*Eligible for date of service*" and the benefit description must reflect full Medicaid benefits.

Only full Medicaid recipients are eligible to receive Health Home services. For example, the image below is a screenshot of an EVS message for an individual who is **ineligible** for Health Homes. Although the Eligibility Information reads "*Eligible for date of service*," the Benefit Description specifies that the individual is a Qualified Medicare Beneficiary (QMB), which is a recipient who is not eligible for full Medicaid.



Examples of Benefit Descriptions for individuals who are NOT eligible for Health Homes include:

- *Recipient is SLMB only.*
- *Recipient is QMB only.*
- *Recipient's benefits are limited to family planning services only.*

For more information about EVS, visit the online user's guide at https://encrypt.emdhealthchoice.org/emedicaid/eDocs/eMedicaid_web.pdf.

III. HEALTH HOME SERVICES

Providers may be reimbursed for the following two types of Health Home services:

A. The Health Home Intake Process: Providers must complete the initial intake process when enrolling a new participant in the Health Home. The intake process includes an assessment, an explanation of the purpose of the Health Home, obtaining participant consent, assigning a care manager, and reporting information into the eMedicaid system. Providers complete the eMedicaid intake process, which authorizes Health Home services therefore any Health Home claims with a date of service prior to the intake will be denied.

The date of service for the intake claim should be the date the intake was submitted to eMedicaid, and NOT the date of the assessment. The intake procedure code may be billed only once per participant. However, if a participant is discharged from a Health Home and later re-enrolls with the same Health Home, 90 days must have passed since discharge in order to bill for a new intake process. If a client transfers Health Homes, the new provider may bill the intake if at least 6 months have passed since the original intake, or the client has been discharged from the first Health Home for at least 90 days.

Service	Procedure Code	Unit of Service	Rate
Health Home Intake	W1760	Per Assessment	$106.46

B. Health Home Monthly Services: Providers may bill this code once per calendar month. Payment for this monthly rate is dependent upon the provider meeting the minimum service provision requirements of two services per month, and documenting those services in eMedicaid.

Each individual service is reported in eMedicaid with the date delivered. When submitting a claim, providers should use the date of service of the last service delivered in the month as the claim's date of service.

Service	Procedure Code	Unit of Service	Rate
Health Home Monthly Services	W1761	Per Month	$106.46

IV. Submitting Claims

A. Filing Statutes

Health Home providers submit claims directly to the Department's Fee-For-Service system either electronically or with the CMS 1500 form. Health Homes must comply with the following:

1. Before submitting a claim, providers must confirm that the participant has received the minimum of two Health Home services in the stated month, which have been documented in eMedicaid.

2. Providers may not designate as a Health Home service any activity that has already been billed to or counted towards a service requirement for another Medical Assistance Program or any other program.
    a. For example, if a PRP service can reasonably be categorized as either a PRP or Health Home service, the provider must decide to which program the service will be attributed and recorded.

3. Providers must submit claims within 30 days of the end of the month in which the service was provided.
    a. Providers who fail to submit claims within this timeframe may be subject to a 10% sanction on payment.
    b. Claims that are not submitted within 12 months of the date of service **will not be paid**.

B. Electronic Claims

Providers who wish to submit claims electronically may do so using one of the two options listed below.

1. HIPAA 837 Claims Files
   Providers may choose to submit Health Home claims electronically using HIPAA 837 claims files. These claims must be submitted in the ANSI ASC X12N 837P format, version 5010A. Prior to using the electronic submission process, a signed Submitter Identification Form and Trading Partner Agreement must be submitted, and testing must be completed before transmitting such claims. Testing information can be found on the MDH website at: https://health.maryland.gov/HIPAA/Pages/testinstruct.aspx

   For questions regarding HIPAA testing, please email mdh.hippaedittest@maryland.gov

   Companion guides to assist providers for electronic transactions can be found on the MDH Website at https://health.maryland.gov/hipaa/Pages/home.aspx

2. eClaims
   Claims may be submitted electronically through the eClaims system within eMedicaid. This online service allows providers that bill using the CMS 1500 to submit their claims electronically

and receive payment sooner than submitting through paper claims. For instructions on registering as an eClaim user, please reference the eClaims Overview document on the eMedicaid homepage at: https://encrypt.emdhealthchoice.org/emedicaid/.

Authorized users will see a link to "eClaim" on their eMedicaid homepage that leads to the "Claim Home" page. There, a provider can submit a new claim, view recently submitted claims, or search the claim history. For more detailed information and instructions, please reference the eClaims Tutorial document on the eMedicaid homepage. Additional questions may be directed to Call 410-767-5503, Option 2.

Note: To review claims submitted through the eClaims system, select the Claim Look up feature on the eMedicaid Service homepage.

C. Paper Claims

Providers may also submit paper claims using the CMS 1500 form. A sample form and detailed instructions for filling out the form as a Health Home provider is available on the Health Homes website. The Department encourages the use of electronic claim submission when possible as the speed of processing claims is faster. Electronic claims can take as little as two weeks to process while paper claims can take up to 30 business days to process.

Completed claims may be mailed to the following address:

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

D. Rejected Claims

Rejected claims are listed on the provider's Remittance Advice along with an Explanation of Benefits (EOB) code with the precise reason a specific claim was denied. The most common reasons a claim may be rejected include:

1. Data was incorrectly keyed or was unreadable on the claim, or
2. The claim is duplicative or has previously been paid.

E. Remittance Requests

If a provider is paid incorrectly for a claim, an Adjustment Request Form must be submitted to correct the payment. An incorrect payment should be returned only when every claim payment listed on the Remittance Advice is incorrect. If this occurs, send a copy of the Remittance Advice and the check with a

complete Adjustment Request Form to the MA Adjustment Unit. If a payment is only partially incorrect, deposit the check and file an Adjustment Request Form for only those claims paid incorrectly.

Before mailing Adjustment Request Forms, be sure to attach any supporting documentation such as remittance advices and CMS 1500 claim forms. Adjustment Request Forms should be mailed to the following address:

Medical Assistance Adjustment Unit
P.O. Box 13045
Baltimore, MD 21203

For questions or concerns regarding incorrect payment, please email mdh.healthhomes@maryland.gov

F. Troubleshooting for Health Home Billing Issues

Before you contact the Health Home program to assist you with resolving billing problems, be sure to first check the following:

1. Verify that you are using the correct provider number (MA) and NPI number for your Health Home.
2. Verify that you are using the correct primary address and pay-to address.
3. Verify that the Health Home recipient is Medicaid eligible for the proposed date of service by checking the Eligibility Verification System.
4. Review the Health Home Billing Instructions and Manual.