Section 6 Billing and Encounter Data Reporting

I. CMS-1500 BILLING INSTRUCTIONS

When filing a paper claim, providers must use original CMS-1500 forms available from the **Government Printing Office** at **202-512-1800**, the American Medical Association, and major medical-oriented printing firms.
See the following website for more information: *http://www.cms.hhs.gov/electronicbillingeditrans/16_1500.asp*

Blocks that refer to third party payers must be completed only if there is a third party payer other than Medicare or Medicaid. The Medical Assistance Program is by law the **"payer of last resort."** If a patient 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. Exceptions include claims for well child care and immunization, which can be billed without first billing the other third party insurer.

Proper Submission of the CMS 1500 Billing Form

The following table provides information on how to complete the required blocks on the CMS-1500 form. Please note that for the Medical Assistance claims processing, the top right side of the CMS-1500 must be blank. Notes, comments, addresses, or any other notations in this area of the form will result in the claim being returned unprocessed.

Block 1 – Show all type(s) of health insurance applicable to this claim by checking the appropriate box(es)

Block 1a – INSURED'S ID NUMBER

1. When billing a Managed Care Organization (MCO), enter the participant's unique MCO number. Please note that all MCOs have unique MCO numbers for their clients. If there is no unique MCO number for a particular participant, enter the participant's MA number in this box. At this point of time, MedStar Family Choice, United Healthcare, and Priority Partners are the only MCOs that have unique numbers. If you do not have the patient's unique number, call the MCO and get that number. All other MCOs accept the students MA number in this block.

2. When billing DHMH for a Fee-For-Service participant, no number is required in this box.

Block 2 – PATIENT'S NAME – (Last Name, First Name, and Middle Initial) – Enter the patient's name as it appears on the Medical Assistance card.

Block 3 – PATIENT'S BIRTH DATE/SEX – Enter the patient's date of birth and sex (Optional).

Block 4 – INSURED'S NAME – Enter name (Last Name, First Name, and Middle Initial) – If the patient has other third party insurance, enter the name of the person in whose name the third party coverage is listed (*No entry required when billing for a patient without third-party insurance*).

Block 5 –PATIENT'S ADDRESS – Enter the patient's complete mailing address with zip code and telephone number (Optional).

Block 6 – PATIENT'S RELATIONSHIP TO INSURED – Enter the appropriate relationship only when there is third party health insurance besides Medicare and Medicaid (*No entry required when billing for a patient without third-party insurance*).

Block 7 – INSURED'S ADDRESS – When there is third party health insurance coverage besides Medicare and Medicaid, enter the insured's address and telephone number (*No entry required when billing for a patient without third-party insurance*).

Block 8 – RESERVED FOR NUCC USE.

Block 9 – OTHER INSURED'S NAME – No entry required.

Block 9a – OTHER INSURED'S POLICY OR GROUP NUMBER – Enter the patient's ***eleven digit Maryland medical assistance number*** exactly as it appears on the Medical Assistance card. Check for transposition of numbers. The MA number must appear here regardless of whether or not a patient has other insurance. A patient's Medicaid eligibility should be verified on *each* date of service, *prior* to rendering service, by calling the EVS. EVS is operational 24 hours a day, 365 days a year at the following number: **1-866-710-1447** or online at *http://www.emdhealthchoice.org***.**

Block 9b – RESERVED FOR NUCC USE – No entry required.

Block 9c – RESERVED FOR NUCC USE – No entry required**.**

Block 9d – INSURANCE PLAN OR PROGRAM NAME – Enter the insured's group name and group number if the patient has health insurance besides Medicare/Medicaid (*No entry required when billing for a patient without third-party insurance).*

Block 10a thru 10c (Block 10d only for abortion-related billing) – IS PATIENT'S CONDITION RELATED TO – Check "Yes" or "No" to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in Item 24, if this information is known. If not known, leave blank.

Block 11 – INSURED'S POLICY GROUP OR FECA NUMBER – If the patient has **other third-party insurance and the claim has been rejected by that insurance, enter the appropriate rejection code listed below:** For information regarding participant's coverage, contact Third Party Liability Unit at **410-767-1765** .

Code	Rejection Reasons
K	Services Not Covered
L	Coverage Lapsed
M	Coverage Not in Effect on Service Date
N	Individual Not Covered
Q	Claim Not Filed Timely (Required documentation, e.g., a copy of rejection from the insurance company)
R	No Response from Carrier Within 120 Days of Claim Submission (Requires documentation e.g., statement indicating a claim submission, but to response)
S	Other Rejection Reasons Not Defined Above (Requires documentation e.g., a statement on the claim indicating that payment was applied to the deductible)

For information regarding participant's coverage, contact Third Party Liability Unit at **410-767-1765** .

Blocks 11a – INSURED'S DATE OF BIRTH – (*No entry required when billing for a patient without third-party insurance).*

Block 11c – EMPLOYER'S NAME OR SCHOOL NAME – (*No entry required when billing for a patient without third-party insurance).*

Block 11c – INSURANCE PLAN OR PROGRAM NAME – (*No entry required when billing for a patient without third-party insurance).*

BLOCK 11d – IS THERE ANOTHER BENEFIT PLAN? – *(No entry required when billing for a patient that doesn't have another third party insurance in addition to the one already described in 11 above).*

Block 12 – PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – If the provider already has an authorized signature on file for the patient, this section should read "Signature on File" and include the billing date.

Block 13 – INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – If the provider already has an authorized signature on file for the patient, the section should read "Signature of File" and include the billing date. (*No entry required when billing for a FFS client or a client without third party insurance*.)

Block 14 – DATE OF CURRENT ILLNES, OR INJURY OR PREGNANCY

Block 15 – IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (OTHER DATE)

Block 16 – DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION – No entry required.

Block 17 – NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
Note: Completion of 17-17b is only required for Lab and Other Diagnostic Services.
Block 17 should be completed in cases where there is a referring physician**.** Completion is optional if a valid Medical Assistance individual practitioner identification number is entered in Block #17a. To complete, enter the full name of the ordering practitioner. Do not submit an invoice unless there is an order on file that verifies the identity of the ordering practitioner. **–** No entry required.

Block 17a (gray shaded area) – ID OF REFERRING PHYSICAIN – Enter the ID Qualifier **–1D (Medicaid Provider Number)** followed by the provider's 9-digit Medicaid Provider Number. **–** No entry required.

Block 17b – Enter the NPI of the referring, ordering, or supervising provider listed in Block 17.

Block 18 – HOSPITALIZATION DATES RELATED TO CURRENT SERVICES – No entry required.

Block 19 – ADDITIONAL CLAIM INFORMATION

Block 20 – OUTSIDE LAB – Check "no"

Block 21 – DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY –
Enter the 3, 4, or 5 alpha/numeric code from the ICD-9 related to the procedures, or services, listed in Block #24d. List the primary diagnosis on Line 1 and secondary diagnosis on Line 2. Additional diagnoses are optional and may be listed on Lines 3 and 4.

Note: Do not report ICD-10 codes for claims with dates of service prior to October 1, 2015. The Program will accept either ICD-9 or ICD-10 codes depending upon the dates of service on the revised form. REMINDER: ICD-9 and ICD-10 codes cannot be reported on the same claim form, ***providers must bill on separate claims and they cannot be combined****.*

REMINDER: ICD-9 and ICD-10 codes **cannot** be reported on the same claim form.

Block 22 – MEDICAID RESUBMISSION – No entry required.

Block 23 – PRIOR AUTHORIZATION NUMBER – For those services that require preauthorization, a preauthorization number **must** be obtained and entered in this Block.

Block 24 (gray shaded area) - NATIONAL DRUG CODE (NDC) – Report the NDC/quantity when billing for drugs using the J-code HCPCS. Allow for the entry of 61 characters from the beginning of 24A to the end of 24G. Begin by entering the qualifier **N4** and then the 11-digit NDC number. It may be necessary to pad NDC numbers with left-adjusted zeroes in order to report eleven digits (5-4-2). Without skipping a space or adding hyphens, enter the unit of measurement qualifier followed by the numeric quantity administered to the patient. Below are the measurement qualifiers when reporting NDC units:

Measurement Qualifiers
F2 International Unit
GR Gram
ML Milliliter
UN Units (EA/Each)
ME Milligram

Example: NDC/Quantity Reporting

24A DATE(S) OF SERVICE		D. PROCEDURES, SERVICES	G. DAYS OR UNITS
FROM:	TO:	CPT/HCPCS	
MM DD YY	MM DD YY		
N400009737604ML1 (SHADED AREA)			
01 01 08	01 01 08	J1055	

More than one NDC can be reported in the shaded lines of Box 24. Skip three spaces after the first NDC/Quantity has been reported and enter the next NDC qualifier, NDC number, unit qualifier and quantity. This may be necessary when multiple vials of the same drug are administered with different dosages and NDC's.

Block 24a – DATE OF SERVICE – Enter each separate dates of service as a **six (6) digit numeric date (e.g. 03/31/14) 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 on this form.** If more than one type of billable service was rendered on a given day, each service should be billed on a separate line. Thus, one date of service may be used on more than one line.

Block 24b. – PLACE OF SERVICE – Enter 11 for Doctor's Office visits.

Block 24c. – EMG – No entry required.

Block 24d. – PROCEDURES, SERVICES OR SUPPLIES – List the appropriate five (5) character procedure code. The Physician Fee Schedule can be found at *www.dhmh.maryland.gov/providerinfo*.

Block 24e. – DIAGNOSIS POINTER – Enter a single or combination of diagnosis from Block #21 above for each line on the invoice.

Note: the Program only recognizes up to eight (8) pointers, A-H.

Block 24f. – CHARGES – Enter the usual and customary charges. Do not enter the Maryland Medicaid maximum fee unless that is your usual and customary charge. If there is more than one unit of service on a line, the charge for that line should be the total of all units.

Block 24g. – DAYS OR UNITS OF SERVICE – Enter the total number of units or service for each procedure. Multiple, identical services rendered on different days should be billed on separate lines.

Block 24h. – EPSDT FAMILY PLAN – No entry required.

Block 24i. – ID. QUAL. – Enter the ID Qualifier **1D (Medicaid Provider Number)**

Block 24j. (gray shaded area) RENDERING PROVIDER ID # – Enter the 9-digit MA provider number of the practitioner rendering the service. In some instances, the rendering number may be the same as the payee provider number in Block #33. Enter the rendering provider's NPI in the unshaded area.

Block 25 – FEDERAL TAX ID NUMBER

Block 26 – PATIENT'S ACCOUNT NUMBER – An alphabetic, alpha-numeric, or numeric patient account identifier (up to 13 characters) used by the provider's office can be entered. If recipient's MA number is incorrect, this number will be recorded on the Remittance Advice

Block 27 – ACCEPT ASSIGNMENT? – For payment of Medicare coinsurance and/or deductibles, this Block must be checked "Yes". Providers agree to accept Medicare and/or Medicaid assignment as a condition of participation.

Note: Regulations state that providers shall accept payment by the Program as payment in full for covered services rendered and make no additional charge to any participant for covered services.

Block 28 – TOTAL CHARGE – Enter the sum of the charges shown on all lines of Block 24f.

Block 29 – AMOUNT PAID – Enter the amount of any collections received from any third party payer, **EXCEPT Medicare**. If the recipient has third party insurance and the claim has been rejected, the appropriate rejection code shall be placed in Block # 11.

Block 30 – RESERVED FOR NUCC USE – No entry required.

Block 31 – SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS – Please write "Signature on File" and include the date of submission.

Note: The date of submission must be in Block 31 in order for the claim to be reimbursed.

Block 32 –SERVICE FACILITY LOCATION INFORMATION – Complete only if billing for medical laboratory services referred to another laboratory or the facility where trauma services were rendered. Enter the name and address of facility.

Block 32a – NPI – Enter facility's NPI number.

Block 32b (gray shaded area) – Enter the ID Qualifier **1D (Medicaid Provider Number)** followed by the facility's 9-digit Maryland Medicaid provider number.

Note: The Program will not pay a referring laboratory for medical laboratory services referred to a reference laboratory that is not enrolled. The referring laboratory also agrees not to bill the recipient for medical laboratory services referred to a nonparticipating reference laboratory.

Block 33 – BILLING PROVIDER INFO & PH # – Enter the name, complete street address, city, state, and zip code of the provider. This should be address to which claims may be returned. The nine (9) digit Maryland Medical Assistance provider number to which payment is to be made must be entered in the lower right hand section of this block. Errors in this area are likely to result in denied or misdirected payment.

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

Block 33b (gray shaded area) – Enter the ID Qualifier 1D (Medicaid Provider Number) followed by the shaded area) 9-digit MA provider number of the provider in Block #33. Errors or omissions of this number will result in non-payment of claims.

Note: It is the provider's responsibility to promptly report all name changes, addresses, correspondence addresses, practice locations, tax identification number certification to the DHMH's Provider Master File via Provider Relations at 410-767-5340.

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Rejected Claims

Rejected claims will be listed on your Remittance Advice (RA) along with an Explanation of Benefits (EOB) code that provides the precise reason a specific claim was denied. EOB codes are very specific to individual claims and provide you with detailed information about the claim. There are several reasons a claim may be rejected:

Data was incorrectly keyed or was unreadable on the claim

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

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

- Verify that you have not previously submitted the claim;
- If the program determines that an enrollee has third party coverage that should be billed first, the claim will be denied. Submit the claim to the third party payer first; and
- If an enrollee has coverage through a HealthChoice MCO, you must bill that organization for services rendered.

For MCO Rejected Claims: The information above is true for claims submitted to Medical Assistance; each MCO sets its own rules for rejection of claims and provides varying information on the EOB (see MCO manuals for further information).

Adjustment Request

If you have been paid incorrectly for a claim **or** received payment from a third party after Medical Assistance has made payment, you **must** complete and submit an Adjustment Request Form (DHMH 4518A) to correct the payment. If an incorrect payment was due to an error made by Medical Assistance, or an incorrect number of units were inadvertently billed, complete an Adjustment Request Form following the directions on the back of the form. Additionally, please be aware that provider's charges may differ from reimbursement rates, and reimbursement rates may vary depending on the insurer.

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When completing the Adjustment Request Form, bill for the entire amount(s) due, rather than any unpaid amounts or units.

Example: You submitted and received payment for three units, but should have billed five units.
Do not bill for the remaining two units, bill for the **entire** five units.

Total Refunds – If you receive an incorrect payment, return the check issued by the Medical Assistance Program only when every claim payment listed on the Remittance Advice (RA) is incorrect (e.g., none of the enrollees listed are your patients). When this occurs, send a copy of the RA and the check with a complete Adjustment Request Form to the address on the bottom of the form.

Partial Refunds – If you receive a RA that lists correct and incorrect payment, do not return the Medical Assistance Program check. Deposit the check and file an Adjustment Request Form for those claims paid incorrectly.

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

Before mailing Adjustment Request Forms, be sure to attach any supporting documentation such as RAs and CMS-1500 claim forms. Adjustment Request Forms should be mailed to:

Medical Assistance Adjustment Unit
Box 13045
Baltimore, MD 21203