Maryland PBHS Provider Billing Appendix

13.1 Billing Appendix Overview

This Maryland PBHS Provider Billing Appendix (Billing Appendix) is included in the Optum Maryland Provider Manual by reference in section 13 Claim Submission.

Note: Information contained in this Billing Appendix may be periodically updated or further explained through Provider Alerts.

13.2 General Claim Submission Guidelines

Claims may be submitted online using Provider Connect, through a clearinghouse using Electronic Data Interchange (EDI) with 837batch files or by U.S. Mail.

Online and Electronic Claim Submission

For Provider Connect: After logging into Provider Connect, use the Provider Connect User Guide for instructions on entering a claim or for submitting an electronic file of claims. The link to the Provider Connect guide is found at https://maryland.optum.com > Behavioral Health Providers.

For EDI/Electronic claims: Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a payer. You may choose any clearinghouse vendor to submit claims using EDI. For PBHS claim submissions, use **Payer ID OMDBH**. The link to the 837i and 837p companion guides is https://maryland.optum.com

Paper Claim Submission

For U.S. Mail (paper claims): Optum Maryland will accept paper CMS-1500 forms for practitioner/professional services or Uniform Billing (UB)-04 forms for inpatient and outpatient facility claims. The mailing address for completed claim forms and required attachments is:

<div align="center">

Optum Maryland
P.O. Box 30531
Salt Lake City, UT 84130

</div>

Please see the section on Paper claim submission for more specific instructions for use of CMS-1500 and UB-04 claim forms.

Customer Service Claims Assistance

Optum Maryland has a dedicated customer service department with staff available five days a week during regular business hours to assist you with questions related to general information, eligibility verification or the status of a claim payment. You may also visit Provider Connect to gather claim status information.

The Optum Maryland customer service phone number is: **1-800-888-1965.**

General Guidelines – Outpatient Professional Claims Submitted on CMS-1500

The provider shall submit claims using the current CMS-1500 form with applicable coding including, but not limited to, ICD-10, CPT, and HCPCS coding. The provider shall include on the claim the participant MA number or other participant identifier, provider's Federal Tax I.D. number, National Provider Identifier (NPI) as specified below and/or other identifiers requested by Optum Maryland.

- CMS-1500 claim submissions may not span dates. Submit each date of service on a separate line.
- Allowable HCPCS and CPT codes are found on the Optum Maryland Covered Services Grid at https://maryland.optum.com
- Authorization rules based on Level of Care guidelines are found on the Optum Maryland Covered Services Grid at https://maryland.optum.com. Claims will be denied if the service requires an authorization and an authorization has not been issued.
- Multiple units of the same service code/modifier on the same day must be submitted on ONE claim line.
- Certain provider types require that a Rendering provider must be referenced on the claim. At the time of implementation, those Provider Types (PT) include: Mental Health Groups (PT 27), Physician Groups (PT 20), FQHC (PT 34) and ABA (PT AB).,

General Guidelines – Facility or Institutional Claims Submitted on UB-04

The provider shall submit claims using a UB-04 claim form for Facility-based claims with applicable coding including, but not limited to, ICD-10 diagnosis code(s), CPT, Revenue and HCPCS coding.
- UB-04 outpatient claims may not span dates. Submit each date of service on a separate line.
- Allowable HCPCS and revenue codes are found on the Optum Maryland Covered Services Grid at https://maryland.optum.com
- Authorization rules based on Level of Care guidelines are found on the Optum Maryland Covered Services Grid at https://maryland.optum.com. Claims will be denied if the service requires an authorization and an authorization has not been issued.

- Bill Types must match the Facility Type. Bill types are provided on page 32 after the Paper Claim instructions within this document.
- Rendering provider and attending provider are required on all claims.
- Inpatient claims may not span the State Fiscal Year (June to July). A separate claim must be submitted. Optum Maryland will deny claims that span the months June to July.

13.3 Special Claim Submission Guidelines

Claims should be submitted to Optum Maryland only after each of the following is met:
- The individual is Medicaid-eligible
- An authorization has been issued
- A long-term care span has been secured through the Occupational Employment Statistics application process (OES 1000 form).
- A Federally Mandated CON (Certification of Need) is completed

One claim per month is allowed and the claim must not span months. If there is a resource/share amount associated with the participant, it is the facility's responsibility to collect those funds directly from the source. Optum Maryland will deduct the share amount, as indicated on the eligibility file, from the monthly per diem rate billed by the provider.

Rules for Long-Term Spans

When the participant is Medicaid eligible and meets the State's definition of institutionalized (participant is admitted to a facility for more than one calendar month), the provider is required to work with the State's Eligibility Determination Division to change the Medicaid eligibility from a community-based Medicaid Coverage Group to a Long Term Eligibility Group, and establish a Long Term Care Span. To do so, the provider must submit the following:

◈ **An OES 1000 form, available at:** https://mmcp.health.maryland.gov/longtermcare/SiteAssets/SitePages/Long%20Term%20Care%20Forms/OES%201000%20Updated.3-9-18.pdf

◈ **A 9708A Application, available at:** https://mmcp.health.maryland.gov/eid/Documents/9708A%20form.pdf

The OES 1000 is required to confirm the start date of the Long Term Care Span. It must be submitted to the Optum Maryland Clinical Director or designee. Once confirmed, the Clinical Director or designee will sign the form and return it to the RTC provider to be processed with the State. The 9708A application, which determines financial eligibility, must be submitted to the Eligibility and Determination Division of MDH.

Prior to payment, the State of Maryland requires Optum Maryland to confirm the participant has a Long Term care span established as indicated on the participant's eligibility. If the Long-Term care span is not established, the claim will be denied.

It is the responsibility of the facility to close the span when the participant leaves the facility. If the participant is transferred to another facility (regardless of the length of stay), the RTC must close the existing long-term care span and then re-open the span if the participant later returns to the RTC. Unless the span is closed, the other facility may not be able to bill Medicaid. Participants are not eligible for additional Medicaid services in the community while in Long Term Care.

The RTC daily rate is established according to federal guidelines and is intended to cover all services a participant may require, including but not limited to, psychological and other specific types of testing and forensic and psychosexual evaluations. Likewise, the occasional need for intensive supervision of some participants is included in the determination of the annual provider rate of care.

Emergency Department Services

Emergency Departments (EDs) regulated by the State of Maryland are eligible providers. Out-of-state EDs must be active Maryland Medicaid providers and have a signed provider agreement with Maryland Department of Health (MDH) in order to provide this service.

The Maryland Public Behavioral Health System (PBHS) does not cover services for participants presenting at an ED whose primary diagnosis is not a PBHS-covered diagnosis. A list of covered diagnoses is available on the Optum Maryland Covered Services Grid at https://maryland.optum.com.

Reimbursement for ED services pertaining to medical diagnoses for participants enrolled in HealthChoice is the responsibility of the Managed Care Organization (MCO) in which the participant is enrolled.

Licensed providers requesting reimbursement from PBHS will also need their own active Maryland Medicaid individual or group number. The provider, NOT the hospital, will be paid for services rendered.

Emergency Petition Billing

Optum Maryland will process and pay claims for services rendered to individuals who come into an emergency room with an emergency petition and who 1) do not have insurance or, 2) are not covered under Medicaid.

Submissions of claims/invoices may be made for the following:

- Emergency room services
- Emergency room evaluations by licensed consultant physicians
- Transportation to a designated emergency facility/or state hospital by ambulance, sheriff departments, and fire departments

The following rules apply:

1. Claims for services rendered under emergency petitions are processed in accordance with COMAR 10.21.15.
2. Claims will be paid as primary and there will not be coordination of benefits with commercial coverage or Medicare.
3. Services must be performed within five days of the approval date on the emergency petition.
4. Standard claim timely filing rules apply.

Claims from a Facility for Emergency Room Services

1. In accordance with COMAR 10.21.15.02, only designated emergency psychiatric facilities are eligible for reimbursement.
2. Designated emergency facility means a health care organization currently identified by the Maryland Department of Health (MDH) to perform the functions.

Claim Forms

1. Emergency facilities must submit claims for services on a UB-04 claim form.
2. Only one UB-04 claim per evaluee, per day, is payable to an emergency facility.
3. Medicaid rules covering the submission of hospital claims apply.

Procedure Codes

1. Only the basic emergency room fee is payable. All other services are non-covered services.
2. Payable revenue codes include 450, 451, and 452. Revenue code 450 is not payable with revenue codes 451 or 452; however, both 451 and 452 are payable for the same episode of service:
   a. 450 – General Classification (EMERG ROOM)
   b. 451 – EMTALA Emergency Medical Screening Services (ER/EMTALA)
   c. 452 – ER Beyond EMTALA Screening (ER/BEYOND EMTALA)

Rates

1. The procedure codes listed above are to be billed at the rate approved by the Health Services Cost Review Commission (HSCRC) for the specific facility.
2. Payment by Optum Maryland will be made at the current published percent of billed charges.

Required Documentation
Several documents must be submitted and completed in order for payment to occur. The forms can be found at https://maryland.optum.com. The forms include:
1. **Request for Reimbursement Form**
   a. Standard form is generated/designed by BHA "Request for Emergency Room Fee"
   b. Provider must complete all fields on the form

2. **Emergency Petition Form (Form DC-13)**
   a. Petitions must include the identity of the petitioner, identity of the evaluee, reason for petition, and signature of petitioner
   b. For petition requests by a lay petitioner (a family member or friend), the petition must be endorsed by the judge
   c. For petition request by professionals (e.g., physician, psychologist, social worker, health officer, peace officer), **Form DC-14** must be endorsed by a petitioner; if the petitioner is a health officer designee, the form must include a signature and date indicating the individual as the designated health officer

3. **Other documents that may be attached include:**

   a. A copy of the complete medical record listing the services performed. It should include the name of the evaluee, date of service, and facility's name

   b. Optum Maryland's Medical Director will only review emergency room rates when verifying the intensity of the care provided

   c. An explanation of benefits (EOB) from the evaluee's primary carrier is not needed. Optum Maryland will pay as primary and not coordinate benefits

Claims from a Physician for Emergency Room Evaluation Services

1. In accordance with COMAR 10.21.15.02, only consultant physicians are eligible for reimbursement.
2. "Consultant" means a physician, licensed by the State, who is not a salaried staff member of the emergency facility and who is authorized by the facility to perform an examination of an emergency evaluee.

Claim Forms
1. Physicians must submit claims for services on a CMS-1500 claim form.
2. Only one CMS-1500 claim per evaluee per day is payable to a physician.

Procedure Codes
1. Only the initial examination performed in the emergency room of a designated psychiatric facility by a consultant physician is payable. All other services are non-covered services.
2. Payable CPT codes include 99281, 99282, 99283, 99284, and 99285. Only one of these codes is payable per evaluee per day.
   a. 99281 – Emergency room visit for the evaluation and management of a patient. Usually presenting problems are self-limited or minor.
   b. 99282 – Emergency room visit for the evaluation and management of a patient, which requires the following three components:
      i. An expanded problem-focused history
      ii. An expanded problem-focused examination
      iii. A medical decision-making of low complexity
   Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

c. 99283 – Emergency room visit for the evaluation and management of a patient, which requires the following three components:
   i. An expanded problem-focused history
   ii. An expanded problem-focused examination
   iii. A medical decision-making of moderate complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.

d. 99284 – Emergency department visit for the evaluation and management of a patient, which requires the following three components:
   i. A detailed history
   ii. A detailed examination
   iii. A medical decision-making of moderate complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and require urgent evaluation.

e. 99285 – Emergency department visit for the evaluation and management of a patient, which requires the following three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:
   i. A comprehensive history
   ii. A comprehensive examination
   iii. A medical decision-making of high complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiological function
.

Rates

1. The procedure codes listed above are payable at the lesser of the amount billed or the statewide average of prevailing charges for an examination by a physician consultant based on Medicare's 75th percentile as determined according to 42 CFR §405.504.
2. The hospital's county, not the evaluee's county of residence, determines locality.

Required Documentation

Several documents must be submitted and completed in order for payment to occur. The forms can be found at https://maryland.optum.com. The forms include:

1. **Request for Reimbursement Form**
   a. Standard form is generated/designed by BHA "Request for Psychiatric Evaluation"
   b. Provider must complete all fields on the form
2. **Emergency Petition Form (Form DC-13)**
   a. Petitions must include the identity of the petitioner, identity of the evaluee, reason for petition, and signature of petitioner
   b. For petition requests by a lay petitioner (a family member or friend), the petition must be endorsed by the judge
   c. For petition request by professionals (e.g., physician, psychologist, social worker, health officer, peace officer), **Form DC-14** must be endorsed by a

petitioner; if the petitioner is a health officer designee, the form must include a signature and date indicating the individual as the designated health officer

3. Psychiatric Evaluation

    a. The psychiatric evaluation must contain the name of the evaluee, the date of service, and must be signed and dated by the physician

Claims for Transportation Services

1. In accordance with COMAR 10.21.15.02, only transportation provided by an emergency vehicle is eligible for reimbursement.
2. "Emergency vehicle" means:
   a. A vehicle operated by a law enforcement officer
   b. An ambulance regulated by the state

Claim Forms

1. Transportation providers must submit claims for services on a CMS-1500 claim form.
2. Two transportation bills can be paid for the same date of service.
   a. Transport to the designated emergency facility (ambulance or peace officer)
   b. For an evaluee involuntarily certified, from the designated emergency facility to the admitting facility (ambulance only)

Procedure Codes

1. Payable HCPCS codes for ambulance transportation include A0362 and A0380.
   a. A0362 – Ambulance services, BLS, emergency transport, mileage, and disposable supplies separately billed
   b. A0380 – BLS mileage (per mile)
2. Payable HCPCS codes for transportation by a peace officer include A0080 and A0170
   a. A0080 – Non-emergency transportation: per mile volunteer with no vested or personal interest
   b. A0180 – Non-emergency transportation: ancillary, parking fees, tools, other

Rates

1. The procedure codes listed above are payable at the lesser of the amount billed or the statewide average of prevailing charges for an ambulance based on Medicare's 75th percentile.
2. The procedure codes for mileage listed above are payable at the rate established for the county in which the transportation provider is located. Each county should supply their current rate.
3. The cost of the law enforcement officer's hourly wage for the number of hours, not to exceed 4 hours, required to transport the emergency evaluee.

Required Documentation

Several documents must be submitted and completed in order for payment to occur. The forms can be found at https://maryland.optum.com. The forms include:

1. Request for Reimbursement Form

    a. Standard form is generated/designed by BHA "Request for Transportation"
    b. Providers must complete all fields on the form

2. **Emergency Petition Form (Form DC-13)**
   a. Petition must include the identity of the petitioner, identity of the evaluee, reason for the petition, and signature of the petitioner
   b. For petition requests by a lay petitioner (a family member or friend), the petition must be endorsed by the judge
   c. For petition requests by professionals (physician, psychologist, social worker, health officer, peace officer), **Form DC-14** must be endorsed by the petitioner; if the petitioner is a health officer designee, the form must include a signature and date indicating the individual as the designated health officer
3. **Two certificates of involuntary admission and the application for involuntary admission (MDH 34)** are required for ambulance transportation from a designated emergency facility to the admitting facility.
4. **An Emergency Vehicle Certificate (MDH 210C)** is required for transportation by a peace officer to certify that the vehicle used to transport the evaluee contains health equipment.

Mobile Treatment Services/Assertive Community Treatment (MTS/ACT)

MTS/ACT are paid through a monthly rate with the below regulations:

- Only one monthly fee is reimbursable
- Providers are to bill with the first date of service the participant was seen
- Claims may not be submitted for the monthly fee until the calendar month has ended

Baltimore City Capitation Project

Providers submit claims on a monthly basis to Optum Maryland for services to clients who are enrolled in care. Providers are required to request and maintain uninsured eligibility through the ASO for all uninsured clients in the Capitation Project. A month of enrollment is defined as enrollment before the 16th of the month or disenrollment after the 15th of the month.

Providers are to bill G9010/G9011 with a HE modifier if the participant does not have Medicare and G9010/G9011 without a modifier if the participant does have Medicare because the providers are required to submit claims to Medicare for any mental health services that are eligible for reimbursement from Medicare.

No other Mental Health services are reimbursable from Optum Maryland. Optum Maryland will reimburse for other SUD services.

Supported Employment (SE)

- One unit is billed for each phase, except for the Intensive Job Coaching Phase
- The number of units billed for Intensive Job Coaching services is based on the actual number of units authorized with one unit equal to 15 minutes of service
- Claims submitted with date spans will be denied
- Visit data must be submitted to establish the actual number of Psychiatric Rehabilitation Program (PRP) services delivered for Psychiatric Rehabilitation Program- Supported Employment (PRP-SE)

- S9445 is the code for billing the PRP-SE monthly rate
- Only one unit of S9445 per participant/per provider may be billed each month
- The date of service for the monthly claim may be any date within the month, (i.e., the January monthly claim may have any date of service of January)
- The monthly claim may be billed, at the earliest, the first day of the month following the month of service being billed, (i.e. the January monthly claim may be billed no earlier than February 1) or the date the two visits for the month is achieved
- Visit claims should be submitted at the time the service is rendered or on the claim with the monthly rate
  - If submitted with the monthly rate, the monthly rate should be billed on claim line item 1 and the visits reported on an individual claim line with one unit per date of service
- Visit claims may not be submitted prior to the date of service of the visit
- Visit claims shall have one line per visit with one date of service and one unit
- Visit claims should be billed as H2016 U1 with a billed at amount of $1 and will be reimbursed at $0

A minimum of two visits counts per month must be submitted in order to be reimbursed for the monthly rate.

Outpatient Mental Health Services

- Date spans will not be accepted. Each date of service must be entered on a separate transaction line
- Billing under a private practitioner's or group practice's license for services provided by individuals who do not have their own Medicaid provider number will be denied
- Private practitioners of any discipline are not allowed to bill for services delivered by non- licensed/certified mental health professionals (e.g., students or interns). Only Outpatient Mental Health Clinics (OMHCs), Federally Qualified Health Centers (FQHCs), and hospitals with formal training programs and supervision may receive reimbursement for other types of licensed/certified mental health professionals and professional students who are in a formal training program
- Electroconvulsive Therapy (ECT) services are authorized to the facility or physician performing the service. The anesthesiologist charges related to the ECT do not require a separate authorization, and may be billed using CPT code 00104

Psychological Testing Services

- The number of units billed must equal the number of hours that testing was provided.
- A psychological associate, under the supervision of a clinical psychologist, may assist in administering a psychological evaluation. In these cases, the clinical psychologist should bill with CPT codes 96130/96131 or 96136/96137 as indicated and the associate should bill with CPT codes 96138/96139.

ASAM levels 3.1, 3.3, 3.5, 3.7 and 3.7WM

Only Provider Types (PT) 54 and 55 may bill for SUD residential services. The place of service (POS) 54 or 55 to be used is dependent on their classification. POS 54 is specific for Intermediate Care Facility (generally this is used for 16 beds or more); POS 55 is for Residential Substance Abuse Treatment Facility (generally used for under 16 bed facilities).

Please note rates for all residential SUD services are inclusive of drug screening and testing. PT 54, PT 55 and laboratories may not bill Medicaid separately for these services.

On the CMS-1500 form, providers may bill on the first line a daily rate for the ASAM Level to which the participant is admitted and bill on the second line the room and board code. Providers cannot bill date spans; all days must be billed individually.

H0001 for Alcohol and/or Drug Assessment may only be billed if the participant is NOT assessed ASAM Residential Levels of Care 3.3, 3.5, 3.7 or 3.7 WM. H0001 may not be billed within 7 days of W7310, W7330, W7350, W7370 or W7375.

HCPCS codes and billing rules are:

Service Code	Service Description	Combination of Service Rules
W7310	Services for ASAM Level 3.1	May not be billed with any community-based SUD codes with the exception of H0020 and H0047. May not be billed with any mental health community-based services except for date of admission or for services rendered by a community-based psychiatrist.
W7330	Services for ASAM Level 3.3	May not be billed with any community-based SUD codes with the exception of H0020 and H0047 billed by PT 32. May not be billed with any mental health community- based services except for date of admission or for services rendered by a community-based psychiatrist.
W7350	Services for ASAM Level 3.5	
W7370	Services for ASAM Level 3.7	
W7375	Services for ASAM Level 3.7WM	
RESRB	Room and Board	

For ASAM 3.7 Youth under the Age of 21 and provider type 55, claims should be submitted using UB-04 and the all-inclusive daily revenue code of 0100.

Withdrawal Management

- Claims by community-based providers are submitted electronically using the 837p or on a CMS-1500 paper form. Claims for acute general hospitals and ICF-As for individuals under 21 years are submitted electronically using an 837i format or on a UB-04 paper form. Both should use the appropriate billing codes
- Provider type 50 should use the ambulatory detoxification code H0014
- Provider type 32 should use:
  - H0016 - MAT Initial induction: Alcohol/Drug Services; Medical/Somatic (Medical Intervention in Ambulatory Setting)
  - H0020 - Methadone Maintenance
  - W9520 - Methadone guest dosing
  - H0047 - Ongoing services (Buprenorphine/Naloxone): Alcohol/Other Drug Abuse Services, Not Otherwise Specified
  - W9521 - Buprenorphine guest dosing
  - Appropriate E&M codes 99211 to 99215
- For provider type 55, this service is part of their all-inclusive daily rate and should be billed with revenue code 0100.
- Acute general hospital providers should bill for withdrawal in hospital inpatient detoxification beds using revenue codes 0116, 0126, 0136, or 0156 and the appropriate ICD-10-PCS code. If the patient is detoxified in a regular medical surgical bed, the hospital should bill the patients managed care organization (MCO).
- If the patient is seen in an emergency or outpatient unit of an acute general hospital, the hospital should bill using the appropriate revenue code in combination with a diagnosis code indicating that the patient is receiving withdrawal management.

SUD, Intensive Outpatient Treatment (ASAM Level 2.1)

The procedure code for intensive outpatient services is H0015.
- H0015 may be billed on a daily basis, up to four days per week. This code cannot be billed concurrently with Level 1 services (H0004, H0005, H0016, H0020, or H0047) or partial hospitalization (H2036).
- Intensive outpatient programs may also bill H0001 for the initial comprehensive assessment. H0001 can only be billed once per 12 months per provider unless there is more than a 30-day break in treatment.
- Intensive outpatient programs can bill up to five days of ambulatory detoxification using procedure code H0014.

Outpatient Individual, Group and Family Therapy

The claims submission guidelines are:

- Date spans will not be accepted. Each date of service must be entered on a separate transaction line.

Private practitioners of any discipline are not allowed to bill for services delivered by non-licensed/certified mental health professionals (e.g., students or interns).

Providers may not bill for:

- Services provided at no charge to the general public
- More than one comprehensive substance use assessment for a participant per provider per 12 month period unless the participant was discharged from treatment with that provider for more than 30 days.
- More than one Level I group counseling session per day per participant
- More than six Level I individual counseling units as measured in 15-minute increments per day per participant
- More than four sessions of intensive outpatient treatment per week
- Services rendered but not appropriately documented
- Services rendered by mail, telephone, or otherwise not one-to-one, in person
- Completion of forms or reports
- Broken or missed appointments
- Travel to and from site of service

Opioid Treatment including Medication Assisted Treatment (MAT) Services

Provider Types 32 OTP, 50 SUD program licensed by BHA, 54 IMD, 55 ICF-A
Please refer to the SUD Fee schedules for specific codes and regulations by Provider Type that are allowed for SUD services

General Rules
- Date spans will not be accepted
    - Each date of service must be entered on a separate transaction line
    - In order to ensure that weekly claims are paid appropriately, OTPs should use one day of the week as the start date (example Monday)
    - Optum Maryland will pay for the first week even if it begins mid-week
- Routine drug screens are built into the bundled rates. Claims for routine drug tests will be denied
- Providers may bill for individual and group counseling, and E&M codes for medication management
- Providers may bill the induction code for the first week an individual receives buprenorphine or methadone or naltrexone
- Claims must specify an approved substance use disorder

Partial Hospitalization (PHP)*

*MH PHP also known as Psychiatric Day Treatment Program (PDTP)

Claim processing rules are:
- Provider Type 50 Programs should submit claims electronically using the 837p format or on a CMS-1500 paper form
- Hospital-based programs should submit claims electronically using the 837i format or on a UB-04 paper form

The Billing codes for Partial hospitalization are:
Community-based Programs:

- The procedure code for a Provider Type 50 community-based program service is H2036; it is a daily rate

- Sessions must by a minimum of two hours per day
- This code cannot be billed concurrently with Level 1 services (H0004, H0005, H0015, H0016, H0020, or H0047)
- Partial hospitalization providers may also bill H0001 for the initial comprehensive assessment
    - This code can only be billed once per 12 months per provider unless there is more than a 30-day break in treatment
- Partial hospitalization providers may bill up to five days of ambulatory detoxification using procedure code H0014

Hospital-based programs:
- Hospital-based programs should use revenue code 0912 or revenue code 0913.

Psychiatric Rehabilitation Program/Residential Rehabilitation Program (PRP/RRP)

The monthly billing/payment code for either PRP or RRP therapeutic services is H2018 along with the appropriate modifier based on the level of service. The modifiers are:

Modifier	Description
U2	PRP for all children (up to the age of 18) adults ages 18-21 in a TAY-designated PRP, or adults with a legal guardian 　　Legal guardians are appointed through the legal system Note: A participant who still lives with his parents at the age of 18 (or older) but there is no legal guardian is an adult (use U3)
U3	PRP for adults with no legal guardians
U4	A RRP client in the general level of care who is either on or off-site
U5	A RRP client in the intensive level of care who is either onsite or off-site
U6	A RRP client in the general level of care who receives services from a provider who has the capacity to render services in onsite and off-site capacity
U7	A RRP client in the intensive level of care who receives services from a provider who has the capacity to render services in an onsite or off-site capacity

Providers should choose the appropriate modifier when submitting the requests for authorization and use that same modifier on the monthly billing.

The visit code for either PRP or RRP therapeutic services is H2016. The visit codes have minimum visits per month and are to be billed at $1.00 and paid at $0. These minimum service visits along with the place of service billed is used to calculate the fee to be paid on the monthly claim. The PBHS PRP Billing Cascade fee schedule is found at https://maryland.optum.com.

The rules for submitting claims are:

- H2018 is the code for billing the PRP monthly rate
- H2018 must be billed with the appropriate modifier consistent with the authorization
- Only one unit of H2018 per participant/per provider may be billed each month
- The date of service for the monthly claim may be any date within the month, (i.e., the January monthly claim may list any date of service in January)
- The monthly claim may have POS 49 for Blended, POS 52 for Onsite, or POS 15 for Offsite
- The monthly claim may be billed, at the earliest:
  - the first day of the month following the month of service being billed, (i.e., the January monthly claim may be billed no earlier than February 1), or
  - the day the minimum visits for the month is achieved
- Visit claims should be submitted at the time the service is rendered or on the claim with the monthly rate
  - If submitted with the monthly rate, the monthly rate should be billed on claim line item 1 and the visits reported on an individual claim line with one unit per date of service
- Visit claims may not be submitted prior to the date of service of the visit
- Visit claims shall have one line per visit with one date of service and one unit
- Visit claims do not have a modifier
- The charge submitted for the monthly service should equal the amount shown on the cascade fee schedule for the modifier and place of service, with visit units rounding down to the nearest count
- Claims will be reimbursed based on the count of the visit claims received prior to, or with, the monthly claim. If the provider visit data was excluded in its H2016 claim submission, the provider must submit a CORRECTED claim to void the original H2018 claim and resubmit an updated H2018 claim that includes the missing H2016 visit data
- Providers must obtain an authorization for this service. Claims without an authorization will be denied

Medically Managed Intensive Inpatient Services (ASAM Level 4.0) in Institutions for Mental Diseases (IMDs)

- The primary diagnosis billed must be for substance use disorders. The mental health diagnosis is listed as the secondary diagnosis
- Claims must reflect revenue code 0124 (for the bed type) for reimbursement
- Claims for administrative days must use revenue code 0169

Out-of-State Psychiatric Hospitals

Out-of-state psychiatric hospitals are paid at a Host State Medicaid Rate.   It is the responsibility of the facility to update MDH when a rate change occurs so that claims are paid at the correct amount. The rate is supplied to Optum Maryland by MDH.

Federally Qualified Health Centers (Provider Type 34)

A Mental Health Service and an SUD Service are allowed on the same day.

SUD Diagnosis Claim submission rules:
- The available "H" codes and associated Modifier are:
  - H0001-SC: Alcohol and/or drug assessment
  - H0004-SC: Behavioral Health counseling and therapy, per 15 minutes
  - H0005-SC: Alcohol and/or drug services, group counseling by a clinician
  - H0015-SC: Alcohol and/or drug services, intensive outpatient
  - H0016-SC: Alcohol and/or drug services, medical somatic
- Each code + modifier combination is billed at the same FQHC rate per provider
- If only a SUD group therapy session is rendered, bill using H0005-SC using the currently published fee schedule rate, not the FQHC rate
- If SUD group therapy H0005 SC plus another SUD service is rendered, the individual service "H code" should be billed on the first line of the claim at the FQHC rate and H0005-SC should be billed on second line at $0 and with 1 unit
- All other Combination of Service rules apply

MH Diagnosis Claim submission rules:

- If only an MH group therapy session is rendered, bill using 90853 using the currently published fee schedule rate, not the FQHC rate
- If an MH group therapy plus another MH service is rendered, bill using T1015 with published FQHC rate and list the CPT codes of services rendered with $0 and 1 unit
  - The claim will reject if the services rendered are not indicated
- The same date of service should be used on the claim for all claim lines
- A Mental Health Service and an SUD Service are allowed on the same day

13.4 Coordination of Benefits (COB)

When Commercial Insurance is Primary

Some participants are eligible for coverage of allowable expenses under one or more additional health benefit plans. In these circumstances, payment for allowable expenses shall be coordinated with the other plan(s). Providers should submit claims to the commercial carrier first.

- Providers must submit their claim to the Primary Commercial Insurance within their Timely Filing Guidelines

- Providers will submit their claim (on approved paper form or through Provider Connect or EDI) to Optum Maryland with a Copy of the Explanation of Benefits from the Commercial Payer
- Providers must submit claims to Optum Maryland within 12 months of the first Date of Service or 120 days from the Commercial Carrier's EOB whichever is later
- Pre-Authorization is not required when Optum Maryland is paying as Secondary
- Providers will be reimbursed by Optum Maryland for the difference between the Commercial Payment up to the Medicaid Allowed amount
- Providers may not bill participant for the difference between the usual and customary charges and the amount paid by the primary plan(s) and Optum Maryland

Medicaid is always the payer of last resort. However in some cases Optum Maryland will pay as primary when the provider has received a rejection from the commercial carrier. Pre-authorizations for services are required for those services requiring Pre-Authorization. The circumstances in which Optum Maryland will pay as primary are:
1. Coverage has terminated at the Commercial Carrier
2. Service is not a Covered Benefit or Benefits have exhausted under the Commercial plan
3. The service does not meet the primary payer's Medical Necessity Criteria but meets the PBHS Medical Necessity Criteria
4. The provider has demonstrated due diligence in assuring the participant was Medicaid-eligible by checking EVS and after date of service learned the individual had third party insurance

Optum Maryland will not pay as primary for the following reasons:

1. The claim was denied by the commercial carrier for failure to meet timely filing requirement
2. The claim was denied by the commercial carrier for no authorization
3. The claim was denied by the commercial carrier because the provider is not participating with the carrier unless there is justification of a low health care shortage area

When Medicare is Primary

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

The following rules apply regarding Medicare coverage.

Medicare Benefits Exhausted or Terminated

- Optum Maryland is Primary Payer for both Outpatient and Inpatient Charges
- Providers should submit claim to Medicare directly to receive a benefits exhausted denial

- Providers should submit claims to the Optum Maryland and provide a copy of the Explanation of Medicare Benefits (EOMB)

- Providers should submit claims to Medicare within Medicare's timely filing limits and submit the paper or electronic claim to Optum Maryland within 12 Months of the Date of Service or 120 Days from the EOMB date, whichever is later
- Optum Maryland will process and pay the Medicaid Allowed amount
- Pre-Authorization is required per standard Optum Maryland authorization rules

Medicare Non-Covered Service

- Providers are not required to submit claims to Medicare for known Non-Covered Services. The list of services not covered by Medicare are found at https://maryland.optum.com
- Providers should submit their claim to Optum Maryland for payment as the primary payer
- Pre-Authorization is required per standard Optum authorization rules
- Optum Maryland will process and pay up to the Medicaid Allowed amount

Medicare Part A is Exhausted and Part B is Active

- Optum Maryland is the primary payer for Room & Board, admission, and laboratory charges
- Providers should submit their claim to Optum Maryland
- The UB-04 must list Occurrence Code A3 in FL31a-34a and the date Medicare benefits were exhausted in FL31b-34b
- 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
- Optum Maryland will process and pay up to the Medicaid Allowed amount

Medicare Part A is Exhausted and Participant does not have Part B Coverage

- Optum Maryland is the primary payer for both outpatient and inpatient charges
- Pre-Authorization is required per standard Optum authorization rules
- The UB-04 must be submitted with Occurrence Code A3 in FL31a-34a and the date Medicare benefits were exhausted in FL31b-34b
- Providers must attach a copy of the Medicare EOMB stating that coverage is exhausted
- Optum Maryland will process and pay up to the Medicaid Allowed amount

Medicare Part A is Active and Participant does not have Part B Coverage

- Optum Maryland is primary for outpatient charges
- Inpatient charges should be submitted directly to Medicare in compliance with their timely filing guidelines
- Pre-Authorization is required per standard Optum authorization rules
- Optum Maryland will process and pay up to the Medicaid Allowed amount

13.5 Timely Filing Guidelines

Initial Submission

Claims must be submitted and received within 12 months of the earliest date of service on the claim, or if the service was a hospital inpatient service, the date of discharge, or if the service was provided in a nursing or rehabilitation facility, the month of service. Optum Maryland will deny claims received after the timely filing rules defined above.

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

When Commercial Insurance is Primary

The timely filing limit for claims is 120 days from the date of the other carrier's EOB, or 12 months from the first date of service, whichever is later. The provider must submit the claims to the primary carrier within the primary carrier's timely filing limit. Optum Maryland requires the other carrier's remittance advice as proof of timely filing.

When Medicare is Primary

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 Optum Maryland. 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 claim and Explanation of Medicare benefits (EOMB) to Optum Maryland within 12 months of date of service or 120 days from the Medicare remittance date as shown on the EOMB, whichever is later. Authorizations are required for services not covered or exhausted by Medicare for those services that typically require an authorization (COMAR 10.09.36.06 B (2) a –b).

When Medicaid Eligibility is Assigned Retroactively

Claims must be submitted to Optum Maryland within 12 months from the date of eligibility determination when Medicaid eligibility is assigned retroactively.

13.6 Participant Eligibility

It is the provider's responsibility to confirm participant eligibility. Before rendering services, providers should request the participant's Medicaid identification card. See instructions from MDH for verifying eligibility using the Eligibility Verification System (EVS) at https://mmcp.health.maryland.gov/docs/EVS_Brochure_July2017.pdf

13.7 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, the provider's billing NPI must be submitted. Additionally, certain provider types require that a Rendering provider be referenced on the claim. At the time of implementation, those Provider Types (PT) include: Mental Health Groups (PT 27), Physician Groups (PT 20), FQHC (PT 34) and ABA (PT AB

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. HIPAA implementation guides can be purchased at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.
Paper Claims: Show the provider's Billing NPI in box 33a and Rendering NPI in box 32a on all CMS-1500 claims. Optum Maryland will deny any claims that do not include valid billing and rendering NPI numbers.

- Exception: OMHC, PR providers may leave box 32a blank (rendering NPI)
- Outpatient laboratory claims must include the referring provider's NPI in box 17b

13.8 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 https://maryland.optum.com.
  - To submit corrected claims on paper, write "CORRECTED CLAIM" at the top of the CMS-1500 or UB-04 form. Please include the original Optum Maryland claim number on the corrected claim.
- **Inquiry through Provider Connect**
  - See: https://maryland.optum.com for directions on how to submit an inquiry through Provider Connect.

13.9 Late Charge Claims

Medicaid does not accept Late Charge claims. If a charge has changed after a claim is submitted, the provider must submit a corrected claim to Optum Maryland. A full retraction will occur, and repayment in full will be made.

13.10 Refunds

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

Optum Maryland
P.O. Box 30532
Salt Lake City, UT 84130

13.11 Provider Information Update Guidelines

To update or clarify provider information, including, but not limited to, Tax Identification number, NPI, service location, and payment address, contact MDH Provider Enrollment.

Providers will need to make these changes using e-Prep online, to log in go to https://eprep.health.maryland.gov/sso/login.do. Please allow appropriate time for your information to be updated.

For assistance, the vendor is AHS (Automated Health Services) and can be reached by calling 1-844-4MD-PROV (1-844-463-7768) or by sending an email message to MDProviderRelations@automated-health.com.

13.12 Completing the Paper CMS-1500 Form

The following information shows field by field description of required data elements in addition to the NPI requirements listed above.

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

Block 1a: INSURED'S ID NUMBER: **Required**: Claims must be submitted with either the participant's Medicaid Identification Number or the Optum 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): **Required**: Enter the participant's name as it appears on the Medical Assistance card.

Block 3: PATIENT'S BIRTH DATE/SEX: **Required**: Enter the participant'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): **Optional**: 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: **Required**: Enter the patient's (or participant's) 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: **Optional**: Enter the appropriate relationship should be entered only when there is third party health insurance

Block 7: INSURED'S ADDRESS: **Optional:** Enter the insured's address and telephone number when there is third party health insurance coverage.

Block 8: PATIENT STATUS: **Optional:** 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: **Conditional**:   Check "Yes" or "No". Place an "X" in the box indicating 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: **Not Required**. N/A

Block 11: INSURED'S POLICY GROUP OR FECA NUMBER: **Not Required**: 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: **Not Required.** Enter the eight-digit date of birth in MM/DD/CCYY format.

Block 11b: EMPLOYER'S NAME OR SCHOOL NAME: **Not Required.** Enter the other insured's employer's name or school.

Block 11c: INSURANCE PLAN OR PROGRAM NAME: **Not Required.** Enter the other insured's insurance company or program name.

Block 11d: IS THERE ANOTHER BENEFIT PLAN?: **Conditional:** 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: **Required:** 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. 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: **Conditional:** 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.** Enter the date of the participant's current illness, injury or pregnancy.

Block 15: IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: **Optional**. Enter the date the participant first had the same or similar illness.

Block 16: DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: **Optional.** Enter the dates the participant was unable to work in their current occupation.

Block 17: NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: **Required for outpatient laboratory claims:** Enter the name of the referring physician.

Block 17a: ID NUMBER OF REFERRING PHYSICIAN: **Conditional**: Enter the ID Qualifier.

Block 17b: NPI OF REFERRING PHYSICIAN: **Required for outpatient laboratory claims**: Enter the NPI of the referring, ordering, or supervising provider listed in Block 17.

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: **Not required**. N/A

Block 20: OUTSIDE LAB: **Optional**. Enter the name of the outside laboratory.

Block 21: DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY: **Required:** Enter a valid ICD-10 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 Diagnosis Listing. The Diagnosis Listing can be found on the Covered Services Grid at http://maryland.optum.com.

Block 22: MEDICAID RESUBMISSION CODE AND ORIGINAL REF. NO.: **Conditional**: Enter the Medicaid Resubmission code and list the original reference (claim) number for resubmitted claims.

Block 23: PRIOR AUTHORIZATION NUMBER: **Optional.** Enter the prior authorization number.

Block 24a: DATE(S) OF SERVICE: **Required**: Enter each separate date of service as a 6-digit numeric date (e.g. June 1, 2020 would be 06/01/20) 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: **Required:** For each date of service, enter the appropriate 2 digit place of service code.

Block 24C: EMG (emergency indicator): **Not required**.

Block 24D: PROCEDURES, SERVICES OR SUPPLIES: **Required:** 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: **Required:** 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-10 diagnosis code.

Block 24F: CHARGES: **Required:** 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.

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: **Required**: 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: **Not required**.

Block 24I: ID QUAL.: **Optional**: Enter the ID Qualifier 1D (Medicaid Provider Number). If the provider does not have a NPI, enter the appropriate qualifier and identifying number in the shaded area. Providers who do not have a NPI will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.

Block 24J: RENDERING PROVIDER ID #: **Required**: Enter the NPI number in the unshaded area of the field. Please refer to section 13.7 regarding NPI rules for rendering providers.

Block 25: FEDERAL TAX I.D. NUMBER: **Required**: 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: **Optional**: 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.

Block 27: ACCEPT ASSIGNMENT?: **Required**: 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: **Required**: Enter the sum of the charges shown on all lines of Block #24F of the invoice.

Block 29: AMOUNT PAID: **Required if there is third party liability**: 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 EOB 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: https://maryland.optum.com

Block 30: BALANCE DUE: (Block 28 minus Block 29 equals Block 30 "balance due": **Required if there is third party liability:** Enter the difference between Block 28 and Block 29.

Block 31: SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS: **Required:** Enter the rendering provider's signature and degree/license level.

Block 32: SERVICE FACILITY LOCATION INFORMATION: **Conditional**: Facility where services were rendered.

Block 32a: NPI: **Conditional:** Enter the NPI of the service facility.

Block 32b: **Not required**.

Block 33: BILLING PROVIDER INFO & PH#: **Required:** 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: **Required**: 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: **Not required**.

13.13 Facility Billing: UB-04 Claims

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.

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 UB-04 Claim Form:

The following information shows field by field description of required data elements in addition to the NPI requirements listed above and required rendering/attending provider information.

1   Provider Name, Address, Telephone Number, and Country Code: **Required:** Enter 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**: Enter the address to which payment should be sent if different from the information in Field 1.

3a   Patient Control Number: **Optional**: Enter the patient account number that allows for the retrieval of individual patient financial records.

3b   Medical/Health Record Number: **Optional**: 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 and Bill Frequency 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).

6   Statement covers Period "From" and "Through": **Required**: Enter 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**: Enter the patient's identification number.

8b   Patient Name: **Required**: Enter the patient's last name, first name and middle initial.

9a   Patient Address: **Required**: Enter the patient's street address.

9b   (unlabeled field): **Required**: Enter the patient's city.

9c   (unlabeled field): **Required**: Enter the patient's state code.

9d   (unlabeled field): **Required**: Enter the patient's ZIP code.

9e   (unlabeled field): **Required**: Enter the patient's Country code.

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

11   Sex: **Required**: Enter 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.

14   Priority (Type) of Visit: **Required**: Enter the appropriate code for the priority of the admission or visit.

15   Source of Referral for Admission or Visit: **Required**: Enter the source of the referral for the visit or admission (e.g., physician, clinic, facility, transfer, etc.).

16   Discharge Hour: **Conditional**: Enter the hour the patient is discharged from inpatient care. NOTE: Enter using Military Standard Time (00-23) in top-of-the-hour times only.

17   Patient Discharge Status: **Required**: Enter the status of the patient upon discharge.

18-28 Condition Codes: **Conditional**: Enter any conditions or events related to the bill that may affect the processing of it.

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**: Enter 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**: Enter 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**: Enter the name and address of the person responsible for the bill.

39-41 Value Codes and Amounts: **Required**: Enter 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: **Required if billing a drug code for outpatient and inpatient claims**: Enter the National Drug Code (NDC) – Medicaid Drug Rebate Reporting.

44 HCPCS/ Tate/ HIPPS Code: **Conditional**: Enter the appropriate HCPCS codes corresponding to the revenue codes.

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

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

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

48 Non-Covered Charges: **Conditional**: Enter the 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

50a, b, c   Payer Name: **Optional:** Enter the name of the payer.

51a, b, c   Health Plan Identification Number: **Not Required**: Enter 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.

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**: Enter 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**: Enter 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**: Enter 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, enter the number 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-10-CM being used. A"0" is required in this field for the UB- 04.

67   Principal Diagnosis Code: **Required**: Enter the valid ICD-10-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**: Enter 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-10-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**: Enter the ICD-10-CM codes that report the reason for the patient's outpatient visit.

71   Prospective Payment System (PPS) Code: **Not Required**: Enter the 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, enter the appropriate ICD-10-CM diagnosis code this field.

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

74   Principal Procedure Code and Date**: Conditional**: Enter the principal ICD-10-CM procedure code covered by the bill and the related date.

74 a-e   Other Procedure Codes and Dates: **Conditional**: Enter additional ICD-10-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**: Enter the NPI of the attending provider is required.

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

78-79   Other Provider Names and Identifiers: **Conditional**: Enter the names and identification numbers of individuals that correspond to the provider type category.

80   Remarks Field: **Not Required**: Enter additional information necessary to process the claim.

81 a-d Code-Code Field: **Conditional**: Enter 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.

7   Replacement of Prior Claim: This code is to be used when a specific bill has been issued for a specific provider, patient, payer, insured and "statement covers period" and it needs to be restated in its entirety, except for the same identity information. In using this code, the payer is to operate on the principal that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill. This code is not intended to be used in lieu of a Late Charge(s) Only claim.

8   Void/Cancel of Prior Claim: This code reflects the elimination in its entirety of a previously submitted bill for a specific provider, patient, insured and "statement covers period" dates. The provider may wish to follow a Void Bill with a bill containing the correct information when a Payer is unable to process a Replacement to a Prior Claim. The appropriate Frequency Code must be used when submitting the new bill.