

Health Homes

Billing Instructions

Maryland Medical Assistance

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I. GENERAL INFORMATION

A. Introduction

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

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

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

B. Getting Started

Health Home providers submit claims directly to the Department of Health and Mental Hygiene's (DHMH) Fee-For-Service system. Before billing for Health Home services, providers must ensure they have completed the steps below.

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

i. Obtain Required OHCQ Certification or Deemed Status

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

❖ PRP providers should refer to:

- [COMAR 10.21.21](#) or [COMAR 10.63.03.09](#) for adults
- [COMAR 10.21.29](#) or [COMAR 10.63.03.10](#) for minors

❖ MTS providers should refer to: [COMAR 10.21.19](#) or [COMAR 10.63.03.04](#)

❖ OTP providers should refer to: [COMAR 10.09.80](#) or [COMAR 10.63.03.19](#)

ii. Apply for a National Provider Identifier

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

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

iii. Apply for a Medical Assistance Provider Number

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

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

iv. Apply as a Health Home

Providers must complete a Health Home provider application with the required materials and obtain approval from the Department before billing for Health Home services. The provider application and instructions may be found at http://dhmh.maryland.gov/bhd/Documents/HH_ProviderApplication_10_2_13.pdf and submitted via email to dhmh.healthhomes@maryland.gov. If you receive a message saying “Please wait...” try downloading the PDF and opening it in your documents.

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

v. Register with eMedicaid

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

Instructions for eMedicaid’s Health Home system are available at: [http://dhmh.maryland.gov/bhd/Documents/HH%20eMedicaid%20Instructions%20\(Updated%202.21.14\)%20\(2\).pdf](http://dhmh.maryland.gov/bhd/Documents/HH%20eMedicaid%20Instructions%20(Updated%202.21.14)%20(2).pdf).

II. VERIFYING PARTICIPANT ELIGIBILITY

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

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

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

ELIGIBILITY INFORMATION	
For 7/19/2013 12:00:00 AM	ELIGIBLE for date of service
Citizenship verified	
Identity verified	
BENEFIT DESCRIPTION	
Recipient is QMB only	<i>Recipient is a Qualified Medicare Beneficiary (QMB). Medicare is primary payer. Providers may not balance bill recipients..</i>
BENEFIT EXCLUSIONS	
BENEFIT LIMITATIONS	
OTHER PAYORS	
FACILITIES	

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

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

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

III. HEALTH HOME SERVICES

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

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

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

Service	Procedure Code	Unit of Service	Rate
Health Home Intake	W1760	Per Assessment	\$100.85

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

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

Service	Procedure Code	Unit of Service	Rate
Health Home Monthly Services	W1761	Per Month	\$100.85

IV. Submitting Claims

A. Filing Statutes

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

1. Before submitting a claim, providers must confirm that the participant has received the minimum of two Health Home services in the stated month, which have been documented in eMedicaid.
2. Providers may not designate as a Health Home service any activity that has already been billed to or counted towards a service requirement for another Medical Assistance Program or any other program.
 - a. For example, if a PRP service can reasonably be categorized as either a PRP or Health Home service, the provider must decide to which program the service will be attributed and recorded.
3. Providers must submit claims within 30 days of the end of the month in which the service was provided.
 - a. Providers who fail to submit claims within this timeframe may be subject to a 10% sanction on payment.
 - b. Claims that are not submitted within 12 months of the date of service **will not be paid**.

B. Electronic Claims

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

1. HIPAA 837 Claims Files

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

<http://dhmh.maryland.gov/HIPAA/Pages/testinstruct.aspx>.

For questions regarding HIPAA testing, please email:

DHMH.HIPAAEDITEST@MARYLAND.GOV. Companion guides to assist providers for electronic transactions can be found on the DHMH Website at

<http://dhmh.maryland.gov/hipaa/Pages/home.aspx>.

2. eClaims

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

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

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

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

C. Paper Claims

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

Completed claims may be mailed to the following address:

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

D. Rejected Claims

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

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

E. Remittance Requests

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

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

A blank Adjustment Request Form can be found at the end of this document for your convenience.

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

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

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

F. Troubleshooting for Health Home Billing Issues

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

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

INSTRUCTIONS FOR COMPLETING THE ADJUSTMENT REQUEST FORM (ARF)

1 Provider Name - Enter the name of the provider who actually received the Medicaid payment.

Provider Number - Enter the nine (9) digit State Medicaid Provider number assigned to the individual provider who received the Medicaid payment.

Provider Address - Enter the complete mailing address: including city, state, and ZIP code of the provider who received the Medicaid payment.

2. Check One - All adjustment requests on each DHMH 4518 must be an initial request. follow-up request.

Initial Request - Check "initial request" if a DHMH 4518 has not previously been submitted for the payment(s) in question.

Follow-up Request - If a request has been previously submitted check the "follow-up request" block in red on a photostatic copy of the original DHMH 4518. Do not complete a second DHMH 4518.

3. If One Check Enclosed - Complete this block when reimbursing DHMH if only one check is submitted. One check may be used to cover more than one adjustment, provided all of them are included in the same submission. If the check covers paid services for more than one patient, complete items affected showing the amounts refunded for each recipient.

Check Number- Enter the number of the check enclosed

Check Amount - Enter the total dollar amount of the check enclosed.

More Than One Check Enclosed - Complete this block if separate checks are enclosed for each recipient. Enter the check amounts for each recipient in Claim I.D. Fields 7 and 8. Do not enter any check numbers.

4. Claim Type- Indicate the type of claim originally submitted. If adjustments are to be requested for more than one type of claim, separate request forms must be submitted.

5. Total Number of Claims- Enter the number of claims submitted on this form. If the total number of claims exceeds (2), additional request forms must be submitted with the total number of claims involved entered on each form. Example: A request for 18 claims adjustments would require (9) forms and the number 18 would be entered in the total number of claims line on each form.

NOTE: If more than one ARF is used, complete Page _of_ in the upper right corner of the form.

6. Check One - Check the appropriate block to indicate whether the request involves either Medicaid or Medicare Crossover Claims. Do not include both types on the same submission.

INDIVIDUAL CLAIM INFORMATION

For HCFA 1500, Vision, Home Health, and Dental Claims - each individual line item on the form is considered a claim. If, for example, a document has three line items for payment, and line one was paid correctly but lines two and three were not, then line two and three should be reported on the Adjustment Request Form.

For UB92 and Nursing Home Claims, the whole document is considered a claim.

7 A. Invoice Control - Enter the Invoice Control Number in question as it appears on the remittance advice.

B. Date of Service - Enter the six (6) digit date of service (MMDDYY) in chronological order (first to last) Enter all six characters consecutively without dashes, slashes or spaces, example: 020698= February 6, 1998.

C. Check One - Underpaid - If the claim in question results in the provider being underpaid (less than what the Program allows;

Overpaid - If the claim in question results in overpayment by either incorrect billing by the Provider, other insurance has paid for the claim, or the Provider received payment for the duplicate claim, etc. and reimbursement is due the State.

D Adjust Reason Code - Mark the reason for the underpayment or overpayment. A listing for the most prevalent reasons are found on the front lower left corner of the DHMH 4518.

E. Enter the total \$ amount due either the Provider (if underpaid) or State (if overpaid).

F. If the original code, units, modifier, or \$ amount charged was incorrect, enter the correct information.

G. Recipient Name - Enter the name of the Recipient (last name first) who actually received the service.

H. Recipient I.D.# - Enter the eleven (11) digit Recipient I.D. #

I. Prior Authorization - Complete only if prior authorization was required for the services billed. Enter the prior authorization number assigned for the service.

J. Check Amount - If more than one check is enclosed, enter the total amount applicable to the specific Recipient

K Check Number - if more than one check is enclosed, enter the check number applicable to the specific Recipient

Adjustment Reason Codes

This is the list of the most prevalent reasons for which an adjustment can be made. If uncertain as to the reason for the payment error, leave Section D blank.

NOTE: Before assigning an Adjustment Reason for a claim, review the remittance advice to ensure the procedure code, modifier, units of service and dollar amount charge is reported accurately.

Additional documentation required for the following Reason Codes:

"07" Explanation of Benefits from Third Party

"79" Explanation of Benefits from Third Party

"87" Copy 206N/C

"BN" Adjustment Transaction Summary

REMARKS

Complete this section to further explain "other" reasons for an adjustment, such as: Refund if appropriate, requests for the additional payments, or further clarification of the error to be corrected may also be included in this section.

Name of Provider Representative, Telephone Number, Date

Print the name of the Provider Representative responsible for completing the form. Enter telephone number and the date the form was completed.

Billing Time Limitation for Adjustment Requests

The same billing time limitation applies to Adjustment Requests as in initial submission of claims.

REMITTANCE ADVICE MUST BE ATTACHED