

**MARYLAND MEDICAID
CMS 1500 FORM BILLING INSTRUCTIONS FOR
PRIVATE DUTY NURSING AND SHIFT HOME
HEALTH AIDE/CERTIFIED NURSING ASSISTANT
SERVICES**

PROGRAMS INVOLVED:

**EPSDT-PRIVATE DUTY NURSING
MODEL WAIVER
RARE AND EXPENSIVE CASE MANAGEMENT (REM)**

EFFECTIVE JULY 30, 2007

THESE INSTRUCTIONS ARE FOR PAPER CLAIMS ONLY

Rev. 2007

Maryland Medicaid Billing Instructions for
EPSDT-Private Duty Nursing and REM Optional Services

These billing instructions are for billing paper claims only.

These services are billed on the CMS 1500 form which are available from the Government Printing Office, the American Medical Association, major medical oriented printing firms, or visit: (<http://www.cms.hhs.gov/providers/edi/cms1500.pdf>).

For information on electronic billing, please refer to the EPSDT- Private Duty Nursing and REM section of the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: “Professional 837”.

BILLING TIME LIMITATIONS

Invoices must be received within nine (9) months of the date of service on the invoice. If a claim is received within the 9-month limit but rejected, resubmission will be accepted within 60 days of the date of rejection or within 9 months of the date of service, whichever is longer. If a claim is rejected because of late receipt, the patient may not be billed for that claim. If a claim is submitted and neither a payment nor a rejection is received within 90 days, the claim should be resubmitted.

OTHER THIRD PARTY RESOURCES

All other third-party resources should be billed first and payment either received or denied before the Medical Assistance Program may be billed for any portion not covered. However, if necessary to meet the 9-month deadline for receipt of the claim(s), the Medical Assistance Program may be billed first and then reimbursed if the third-party payor makes payment later. Blocks on the CMS 1500 that refer to third party payers must be completed only if there is a third party payer other than Medicare or Medicaid. Medicaid is, by law, the “payer of last resort”. If a recipient is covered by other insurance or third party benefits such as Worker’s Compensation , CHAMPUS or Blue Cross/Blue Shield, the provider must first bill the other insurance company before Medicaid will pay the claim.

It is preferred that invoices be typed. If printed, the entries must be legible and in black or blue ink only. Do not use pencil or a red pen to complete the invoice, otherwise payment may be delayed or the claim rejected. The instructions which follow are keyed to the form locator number and headings on the CMS 1500 form.

Completed invoices are to be mailed to the following address:

Maryland Medical Assistance Program
Division of Claims Processing
P. O. Box 1935
Baltimore, MD 21203

If you have been paid incorrectly for a claim or received payment from a third party after Medical Assistance has made payment, you must submit an Adjustment Request Form (DHMH 4518A) to correct the payment. To submit an Adjustment Request Form, please follow the directions on the back of the form and mail to:

Maryland Medical Assistance Program
Adjustment Section
P.O. Box 13045
Baltimore, MD 21203

**Maryland Medicaid CMS 1500 Form Billing Instructions for Model Waiver,
EPSDT- Private Duty Nursing and REM Optional Services**

Note: These instructions are for paper submission on the CMS 1500 only.

Field	Title	Action
<u>Block 1</u>	Claim Type	Show all types(s) of health insurance applicable to this claim by checking the appropriate box(es). Enter the patient's Medicare number, if applicable.
<u>Block 1a</u>	Insured's ID Number	Optional (Medical Assistance (MA) 11 digit ID number is required in 9a).
<u>Block 2</u>	Patient's Name	Enter the patient's (recipient's) name as it appears on the Medical Assistance card.
<u>Block 3</u>	Patient's Birth Date	Optional
<u>Block 4</u>	Insured's Name	Optional
<u>Block 5</u>	Patient's Address	Optional
<u>Block 6</u>	Patient's Relationship to insured	Optional
<u>Block 7</u>	Insured's Address and Telephone #	Optional
<u>Block 8</u>	Patient Status	No entry required.
<u>Block 9</u>	Other Insured's Name	No entry required.
<u>Block 9a</u>	Other Insured's Policy or Group	Enter the Patient's (recipient's) 11 digit Maryland Medical Assistance (MA) number exactly as it appears on the MA card. The MA number must appear in this block regardless of whether or not a recipient has other insurance. Medical Assistance eligibility should be verified on each date of service by calling EVS. EVS is operational 24 hours a day, 365 days a year at the following number: 1-866-710-1447.
<u>Block 9b</u>	Other Insured's Date of Birth	No entry required.
<u>Block 9c</u>	Employer's Name or School Name	No entry required.
<u>Block 9d</u>	Insurance Plan Name or Program Name	Optional.

Field	Title	Action
<u>Block10a-c</u>	Patient's Condition Related To	Optional.
<u>Block 10d</u>	Reserved for Local Use	Leave blank.
<u>Block 11</u>	Insured's Policy	If the patient has other third party insurance and the claim has been rejected by that insurer, enter the appropriate rejection code listed below. For information regarding recipient's coverage, contact the Third Party Liability Unit at 410-767-1771.
	<u>CODE</u>	<u>REJECTION REASONS</u>
	K	Services Not Covered
	L	Coverage Lapsed
	M	Coverage Not in Effect on Service Date
	N	Individual Not Covered
	Q	Claim Not Filed Timely (Requires documentation, e.g., a copy of rejection from the insurance company.)
	R	No Response from Carrier Within 120 Days of Claim Submission (Requires documentation e.g., a statement indicating a claim submission but no response.)
	S	Other Rejection Reason Not Defined Above (Requires documentation, e.g., a statement on the claim indicating that payment was applied to the deductible.)
<u>Block 11a</u>	Insured's Date of Birth	No entry required.
<u>Block 11b</u>	Employer Name or School Name	No entry required.
<u>Block 11c</u>	Insurance Plan Name or Program Name	No entry required.
<u>Block 11d</u>	Is There Another Health Benefit Plan?	No entry required.
<u>Block 12</u>	Patient or Authorized Person's Signature	No entry required.
<u>Block 13</u>	Insured's or Authorized Person's Signature	No entry required.

Field	Title	Action
<u>Block 14</u>	Date of Current Illness, Injury, Pregnancy	No entry required.
<u>Block 15</u>	If Patient has had same or similar illness, give first date	No entry required.
<u>Block 16</u>	Dates Patient unable to work in current occupation	No entry required.
<u>Block 17</u>	Name or referring	Completion is optional if a valid Medical Assistance individual practitioner identification Number is entered in Block #17a. To complete, enter the full name of the ordering practitioner. Do not submit an invoice unless there is an order on file that verifies the identity of the ordering practitioner.
<u>Block 17a</u>	I.D. Number of Referring Physician (gray shaded area)	Enter the ID Qualifier – 1D (indicates Medicaid Provider number) followed by the 9-digit (legacy) Medicaid provider number of the referring provider.
<u>Block 17b</u>	NPI	Enter the NPI of the referring, ordering or supervising provider listed in block 17.
<u>Block 18</u>	Hospitalization Dates Related to Current Services	No entry required.
<u>Block 19</u>	Reserved for Local Use	No entry required.
<u>Block 20</u>	Outside Lab	Optional.
<u>Block 21</u>	Diagnosis or nature of illness or injury	This is a required field. Enter the 3, 4 or 5 character code from the ICD-9 related to the procedures, services or supplies listed in Block #24d. List the primary diagnosis on Line 1 and secondary diagnosis on Line 2. Additional diagnoses are optional and may be listed on Lines 3 and 4.
<u>Block 22</u>	Medicaid Resubmission Code	No entry required.

Field	Title	Action	
<u>Block 23</u>	Prior Authorization Number	This is a required field. Enter the preauthorization number as it appears on the authorization letter.	
<u>Block 24A</u>	Date(s) of Service	This is a required field. Enter the six (6) digit numeric date of service (e.g. 06/01/07) 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. Range of dates are not accepted on this form.	
<u>Block 24B</u>	Place of Service	For each service, enter the appropriate 2 digit place of service code. Refer to the Maryland Medicaid Value Descriptions (listed below). Use the value of 12 for patient’s residence. When services are rendered to the client outside the home use 99 as the value.	
<u>Code</u>	<u>Location</u>	<u>Code</u> <u>Location</u>	
11	Office	50	Federally Qualified Health Ctr.
12	Patient’s Residence	51	Inpatient Psychiatric Facility
21	Inpatient Hospital	52	Psychiatric Facility Partial Hospitalization
22	Outpatient Hospital	53	Community Mental Health Ctr.
23	Emergency Room – Hospital	54	Intermediate Care Fac./Mentally Retarded
24	Ambulatory Surgical Ctr.	55	Residential Substance Abuse Treatment Ctr.
25	Birthing Ctr.	56	Psychiatric Residential Treatment Ctr.
26	Military Treatment Ctr.	61	Comprehensive Inpatient Rehabilitation Ctr.
31	Skilled Nursing Facility	62	Comprehensive Outpatient Rehab. Ctr.
32	Nursing Home	65	End State Renal Disease Treatment Facility
33	Custodial Care	71	State of Local Public Health Clinic
34	Hospice	72	Rural Health Clinic
41	Ambulance – Land	81	Independent Laboratory
42	Ambulance – Air or Water	99	Other Unlisted Facility
<u>Block 24C</u>	Field Description Changed To EMG	Leave blank.	
<u>Block 24D</u>	Procedures, Services or Supplies	This is a required field. Enter the five (5) character HCPCS procedure code. In addition, for those individuals sharing a nurse the “TT” modifier must be indicated.	
<u>Block 24E</u>	Diagnosis Code Indicator	This is a required field. Enter a single or any combination of diagnosis items (1,2,3,4) from Block 21 above for each line item on the invoice.	

Field	Title	Action
<u>Block 24F</u>	Charges	This is a required field. Enter your usual and customary charge. Do not enter the Maryland Medicaid maximum fee unless that amount is your usual and customary charge. If there is more than one unit of service on a line, the charge for that line should be the total for all units.
<u>Block 24G</u>	Days or Units	This is a required field. Enter the 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.
<u>Block 24H</u>	EPSDT/Family Plan	Leave blank.
<u>Block 24I</u>	ID Qualifier	Enter the ID Qualifier – # 1D Medicaid Provider Number. The number 1 and the Letter D must always precede the 9 digit Maryland MA provider number (also referred to as "legacy" number). Example 1D000000000.
<u>Block 24J</u>	Rendering Provider ID.#	Enter the 9-digit MA provider number of the practitioner rendering the service. In some instances, the rendering number may be the same as the payee provider number in Block #33. Enter the rendering provider's NPI in the unshaded area .
<u>Block 25</u>	Federal Tax ID#	Optional.
<u>Block 26</u>	Patient's Account#	Optional. However, it is recommended that providers place their patient account number or some other information in this field to identify the patient should be the patient's MA number be incorrect. If the recipient's MA number is incorrect, this number will be recorded on the Remittance Advice.
<u>Block 27</u>	Accept Assignment	Not required.
<u>Block 28</u>	Total Charges	Enter the sum of the charges shown on all lines in Block 24F of the invoice.

Field	Title	Action
<u>Block 29</u>	Amount Paid	<p>Enter the amount of any collections received from any Third Party payor except Medicare. If the patient has Third-Party insurance and the claim has been rejected, the appropriate rejection code must be entered in Block 11. Collections from patients are not appropriate.</p> <p>Note: Regulations state that providers shall accept payment by the Program as payment in full for covered services rendered and make no additional charge to any recipient for covered services.</p>
<u>Block 30</u>	Balance Due	Optional.
<u>Block 31</u>	Signature of Physician or Supplier	Signature is optional. The date of submission, however, must be entered in order for the claims to be reimbursed.
	Date Billed	This is a required field. The date of submission must be entered here in order for the claim to be reimbursed.
<u>Block 32</u>	Service Facility Location Information	Not required.
<u>Block 32a</u>	NPI	Not required.
<u>Block 32b</u>	Medicaid (legacy) Provider number	Not required.
<u>Block 33</u>	Billing Provider Info ZIP Code and Phone #	This is a required field. Enter the name, complete street address, city, state and zip code of the provider. This should be the address to which claims may be returned.
<u>Block 33a</u>	NPI	Enter the NPI number of the billing provider in block #33. Errors or omissions of this number will result in non-payment of claims.
<u>Block 33b</u>	Medicaid (legacy) provider number	Enter the ID (Medicaid Provider Number qualifier) followed by the 9-digit Maryland Medicaid number of the provider in block #33. Errors or omissions of this number will result in non-payment of claims.

NOTE: It is the provider's responsibility to promptly report all changes of name, pay to address, correspondence address, practice locations, tax identification number, or certification to Provider Master file at 410-767-5340.