

COMAR 10.09.02  
MARYLAND MEDICAL ASSISTANCE PROGRAM

**PHYSICIANS' SERVICES  
PROVIDER FEE MANUAL**

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EFFECTIVE JANUARY 2013

## INTRODUCTION TO THE FEE MANUAL

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### Overview

#### Introduction

This chapter introduces the format of the Maryland Medical Assistance Program (**the “Program” or “MA”**) Physicians' Services Provider Fee Manual and tells the reader how to use manual. General information on policy and billing instructions for providers enrolled in the Physician Services program may be found in this manual. Information in this manual is updated as needed.

A current copy of the [Provider Fee Manual](#) is available on the Program's website:

<http://mmcp.dhmf.maryland.gov/SitePages/Provider%20Information.aspx>

#### Background

This manual describes the Maryland Physicians' Services program (Fee-For-Service) and explains covered services, service limitations, billing practices, and fee schedules.

Please note, the Program's **Managed Care Organizations (MCOs)** have separate manuals and instructions. For more information on Maryland's MCO providers, refer to:

<http://mmcp.dhmf.maryland.gov/healthchoice/SitePages/Home.aspx>

There are additional manuals to assist providers in the Physicians' Services Program linked throughout this document. These manuals are designed to provide helpful information and resources as supplements to this manual.

#### Legal Authority

This manual derives its legal authority from **Code of Maryland Regulations (COMAR) 10.09.02**, subtitled Physician's Services.

The regulations may be viewed in their entirety online at the Maryland Division of State Documents website: [www.dsd.state.md.us](http://www.dsd.state.md.us).

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**Manual Use and Format**

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<b>Purpose</b>	The purpose of this manual is to provide policy and billing instructions for providers who bill on the paper <u>CMS 1500 claim form</u> or the electronic <u>CMS 837P</u> (professional) claim format and are reimbursed under the Physicians' Fee Schedule.
<b>Chapter Numbers</b>	Chapter numbers appear as the first digit in bold before the page number, at the bottom of the page.
<b>Page Numbers</b>	Page numbers follow chapter numbers in consecutive order at the bottom of the page.

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**Characteristics of the Manual**

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<b>Chapter Overview</b>	The first page of each chapter is an overview page that summarizes the main content of that chapter. Each overview page will contain at least an introduction and a topic roster.
<b>Topic Roster</b>	A list of the topics covered in each chapter and the page for each topic.
<b>Update Log</b>	Each chapter will use update logs in a similar format to the topic roster to detail any changes, additions, or deletions between current and previous versions of the manual.
<b>PDF Format</b>	While this manual may be printed out, the PDF version of this manual contains additional features that printed versions do not. These include, but are not limited to: <ul style="list-style-type: none"><li>• Text search (On Windows: <b>CTRL + F</b>. On Mac: <b>CMD + F</b>)</li><li>• Hyperlinks to chapters (See Tables of Contents)</li><li>• User flexibility (Bookmarks and annotations)</li><li>• Hyperlinks to websites</li></ul>

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**Definitions**

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**“Admission”** means the formal acceptance of a patient who is to be provided with medically necessary services.

**“Acquisition cost”** means the purchase price of a drug, supply, or material, less any discount, for the amount administered or supplied, including any portion of tax or shipping.

**“Anesthesia time”** means the time in minutes during which the anesthesia provider is both furnishing continuous anesthesia care to a patient and is physically present.

**“Attending physician”** means a physician, other than a resident or an intern, who is directly responsible for the patient's care.

**“Assistant surgeon”** means a second physician who actively assists the primary surgeon during a surgical procedure.

**“Bilateral surgery”** means surgical procedures that are performed on both sides of the body at the same operative session or on the same day.

**“Consulting-specialist”** means a licensed physician who meets at least one of the following criteria:

- Board certified by a member board of the American Board of Medical Specialties and currently retains that status
- Demonstrates satisfactory completion of a residency program accredited by the Liaison Committee for Graduate Medical Education, or the appropriate Residency Review Committee of the AMA
- Board certified by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Specialists
- If a residency program was completed in a foreign country, can demonstrate qualifications and training are acceptable for

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admission into the examination system of the appropriate American Specialty Board.

**"Contiguous state"** means any of the states which border Maryland and the District of Columbia.

**"Critical care"** means the direct delivery of medical care for a patient whose illness or injury acutely impairs one or more vital organ systems, such that there is a night probability or life threatening deterioration of the patient's condition.

**"Date of service"** means the date of discharge or outpatient service.

**"Emergency services"** means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- (a) Placing the patient's health, or with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy; or
- (b) Serious impairment to bodily functions; or
- (c) Serious dysfunction of any bodily organ or part.

**"Healthcare Common Procedure Coding System(HCPCS)"** means the specified code set for procedures and services, according to HIPAA.

**"Health Services Cost Review Commission (HSCRC)"** means the independent organization within the Department of Health and Mental Hygiene which is responsible for reviewing and approving rates for hospitals pursuant to COMAR, Title10, Subtitle 37.

**"International Classification of Diseases, Ninth Revision, Clinical**

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**"Modification, (ICD-9-CM)"** means the classification system developed by the United States Department of Health and Human Services, Public Health Service National Center for Health Statistics, based on the Ninth Revision of the International Classification of Diseases (ICD-9). It is designed for the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by diseases and operations for data storage and retrieval.

**"Medical Assistance Program"** means a program that provides medical coverage for certain low income people and families,

**"Medicare"** means the medical insurance program administered by the federal government under Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq.

**"Medically necessary"** means a service that is all of the following:

- Diagnostic, preventive, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition;
- Consistent with current accepted standards of good medical practice;
- The most cost efficient service that can be provided without sacrificing effectiveness or access to care;
- Not primarily for the convenience of the consumer, their family or the provider.

**"Modifier"** means a reporting component which indicates when a service or procedure was performed in an altered manner that necessitates a change in fee from the schedule rate, but not a change in procedure code.

**"Neonate"** means infant birth to 28 days of life.

**"Organ"** means a grouping of bodily tissues which perform a specific function.

**"Provider"** means any entity, facility, person, or group who is enrolled in the Program and who renders services to Program participants.

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**"Preauthorization"** means the approval required for payment from the Department or its designee.

**"Program"** means the Maryland Medical Assistance Program.

**"Provider"** describes any entity, facility, person or group who is enrolled in the Medical Assistance Program, renders services to Program recipients, and bills the Program for those services. Under the Program, providers that use all of a subset of procedure codes found in the Physicians' Services Provider Fee Manual include:

- Certified Nurse Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Clinics
- Physicians
- Podiatrists
- Optometrists
- Audiologists
- Speech/Language Pathologists
- Occupational Therapists
- Physical Therapists
- Portable X-ray
- Other Diagnostic Services
- School-based Health Centers

**"Participant"** means a person who is enrolled in the Medical Assistance Program.

**"Reconstructive surgery"** means surgery expected to approximate normal physical appearance and/or improve functionality when quality of life is significantly impaired.

**"Referral"** means a transfer of the patient from one physician to another for diagnosis and treatment of the condition for which the referral was made.

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**“Unbundling”** means using independent codes to bill separately for ancillary procedures which are already included in the CPT’s procedure definition.

**“Trauma physician”** is defined as a physician who provides trauma care in a trauma center to trauma patients on the State Trauma Registry. Emergency room physicians who are not trauma physicians are paid according to the Fee Manual for Medicaid recipients.

## GENERAL INFORMATION

### Overview

#### Introduction

This chapter introduces key concepts associated with understanding the services that are covered by the Maryland Medical Assistance Program (the "Program") and how to bill for those services.

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**Federal Guidelines**

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**Medicare**

The Program is the payer of last resort and follows Medicare guidelines; physician services that are not medically necessary are not covered under the Program. Specifics on coverage are found in the [Coverage](#) section beginning on [page 2-4](#).

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**HIPAA and HCPCS**

The Administrative Simplification provisions of the **Health Insurance Portability and Accountability Act (HIPAA)** of 1996 require that standard electronic health transactions be used by health plans, including private, commercial, Medical Assistance (Medicaid) and Medicare, health care clearinghouses, and health care providers. A major intent of the law is to allow providers to meet the data needs of every insurer electronically with one billing format using health care industry standard sets of data and codes.

In January, 2009, the Federal government mandated the implementation of HIPAA -compliant 5010 transaction standards to support the mandated upgrade to the ICD-10-CM classification system. 5010 compliance allows for improved technical coordination, accommodation for evolving business needs, and consistency in reporting requirements. The 5010 compliance deadline went into effect on July 1, 2012.

Any questions regarding 5010 compliance should be directed to [dhmh.hipaaeditest@maryland.gov](mailto:dhmh.hipaaeditest@maryland.gov).

Any concerns regarding production files should be directed to [dhmh.ediops@maryland.gov](mailto:dhmh.ediops@maryland.gov)

Providers must use the **Healthcare Common Procedure Coding System (HCPCS)** code set for procedures and services. Coding usage is detailed in the [Coding and Billing](#) section on [page 2-9](#).

More information on HIPAA may be obtained from <http://www.hhs.gov/ocr/privacy/hipaa/administrative/index.html>

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**NPI**

Effective July 30, 2007, all health care providers that perform medical services must have a **National Provider Identifier (NPI)**. The NPI is a

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unique, 10-digit, numeric identifier that does not expire or change. NPIs are assigned to improve the efficiency and effectiveness of the electronic transmission of health information. Implementation of the NPI impacts all practice, office, or institutional functions, including billing, reporting, and payment.

The NPI is administered by **the Centers for Medicare and Medicaid Services (CMS)** and is required by HIPAA. Providers must use the legacy MA number as well as the NPI number when billing on paper.

Apply for an NPI by using the web-based NPI application process via the **National Plan and Provider Enumeration System (NPPES)** at [www.nppes.cms.hhs.gov/NPPESWelcome](http://www.nppes.cms.hhs.gov/NPPESWelcome).

A paper application is available at: <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms10114.pdf>

Submit completed, signed paper copies of the NPI Application/Update Form (**CMS-10114**) to the NPI Enumerator at the address below:

NPI Enumerator  
P.O. Box 6059  
Fargo, ND 58108-6059  
1-800-465-3203  
[customerservice@npienumerator.com](mailto:customerservice@npienumerator.com)

Use the NPI as the primary identifier and the MA provider legacy number as the secondary identifier on all paper and electronic claims.

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**NCCI**

**The National Correct Coding Initiative (NCCI)** edits are a series of coding policies developed and maintained annually by CMS to combat improper coding.

Effective October 1, 2010, both Federal law and CMS guidelines require all state Medical Assistance programs to adopt NCCI edits as part of their respective payment methodologies.

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The Program advises providers to check their claims for NCCI compliance prior to submission or appeal. The Program will deny claims when coding conflicts with NCCI edits. For more information regarding NCCI, visit the [NCCI homepage](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html) at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html> .

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## **Coverage**

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### **Covered Services**

The Program covers a wide array of physicians' services, in accordance with [COMAR 10.09.02](#):

- General
  - Medically necessary services rendered in the following places of service:
    - Physician's office
    - Participant's home
    - Hospital
    - Nursing facility
    - Free-standing clinic
    - Elsewhere when the services are performed by a physician, physician group, or other applicable providers
  - Services rendered within the limitations of the CPT guidelines;
  - Services rendered within the limitations of Medicaid, Medicare and NCCI guidelines;
  - Services rendered by providers who are participating providers with the Program;
- Evaluation & Management
  - Evaluation and management codes related to providing check-ups and care for individuals with acute or chronic health care conditions;
- Anesthesia
  - Services rendered by an anesthesiologist other than for cosmetic surgery;
- Surgery
  - Medically necessary surgical procedures;

- Abortions, sterilizations, and hysterectomies under the limitations detailed in the [Services Information](#) section, beginning on page 3-1;
- Medicine codes, including administration codes for the Vaccines for Children Program;
- Drugs & Injectables
  - Drugs dispensed by the physician acquired from a wholesaler or specialty pharmacy;
  - Injectable drugs administered by the physician;
  - Drug and injectable services within the limitations of [COMAR 10.09.03](#);
  - Equipment and supplies dispensed by the physicians within the limitations of COMAR [10.09.12](#);
- Other Services
  - Unlisted services and injectable drugs when accompanied by a medical report, surgery notes, a wholesaler invoice, and/or any other documentation as requested.

The Program does not cover the following services through the Physicians' Services Program:

- General
  - Services not considered medically necessary;
  - Services that are investigative, experimental, or part of a clinical trial;
  - Services provided outside of the United States;
  - Services denied by Medicare as not medically necessary without additional justification;
  - Services prohibited by the Maryland Board of Physicians or the Boards governing the other professionals that use these codes;
- Evaluation & Management
  - Preoperative and postoperative evaluation when billed separately from the [Global Surgery Package](#) (see page 3-3);
  - A separate payment for referrals from one physician to another for treatment of specific patient problems;
  - Physicians' services included as part of the cost of an inpatient facility or hospital outpatient department;

- Visits solely to accomplish one or more of the following services:
  - Prescription, drug, or food supplement
  - Collection of specimens for laboratory procedures
  - Recording of an electrocardiogram
  - Ascertainment of the participant's weight
  - Interpretation of laboratory tests or panels
- Broken or missed appointments;
- Anesthesia
  - Preoperative evaluations for anesthesia when billed separately from the administration of anesthesia;
  - Anesthesia for the provision of cosmetic surgery services;
- Surgery
  - Cosmetic surgery – when surgery is performed to maintain normal physical appearance or enhance appearance beyond average level toward an aesthetic ideal;
  - Sterilization reversals and gender changes (sex reassignment);
  - Services rendered to an inpatient before one preoperative inpatient day, unless preauthorized by the Program;
  - Abortions, sterilizations, or hysterectomies performed without the accompanying documentation completed in advance (see [Reproductive Health](#) on page 3-17);
  - Services requiring a preauthorization performed without requiring a preauthorization from the Program;
  - Radial keratotomy, or other surgical procedures intended to reduce or eliminate the need for eyeglasses;
- Medicine
  - Specimen collection, except by venipuncture or capillary or arterial puncture;
  - Autopsies;
  - Audiometric tests for adults for the sole purpose of prescribing hearing aids;
  - Fertility treatment;
  - Services rendered by an employed non-physician extender under a supervising physician's provider number;
- Drugs and Injections
  - Administration of vaccines for adults ages 19 and older;

- Physician-administered drugs obtained from manufacturers that do not participate in the federal Drug Rebate Program;
- Immunizations required for travel outside the U.S.;
- Injections and visits solely for the administration of injections, unless medically necessary and the participant's inability to take appropriate oral medications are documented in the patient's medical record;
- Program prescriptions and injections for central nervous system stimulants and anorectic agents when used for weight control;
- Drugs, vaccines, and supplies dispensed by the physician that the physician acquires at no cost;
- Drugs written on prescription pads that do not prevent copying, modification, or counterfeiting;
- Fertility drugs;
- Other Services
  - Laboratory or X-ray services provided by another facility;
  - Disposable medical supplies usually included with an office visit;
  - Professional services rendered by either mail or telephone;
  - Acupuncture;
  - Completion of forms and reports;
  - Services provided at no charge to the general public;
  - Providing a copy of a participant's medical record when requested by another licensed provider on behalf of the recipient;
  - Telephone calls;
  - Consults via the internet.

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## ***Payment***

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### **Physicians' Services**

The fee schedule for physicians' services lists the **Current Procedural Terminology (CPT)** codes and the maximum fee paid for each procedure. A provider using CPT coding selects the procedure or service that most accurately identifies the service performed. Providers are paid either the lesser of their charge or the maximum allowable fee. Although some providers delegate the task of assigning codes, the accuracy of the claim is solely the provider's responsibility and is

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subject to audit. Please note the Program pays differentially based on site of service. This information is also included in the fee schedule.

The fee schedule is available to view at:

<http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx>

Providers must adequately document any service or procedure in the medical record and maintain records as necessary to fully document the services provided. The provider must then retain the records for six years.

Lack of acceptable documentation may cause the Program to deny payment. If the Program has already paid the provider, the Program may request repayment or impose sanctions.

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### **Payment In Full and Maximum Payment**

All payments made by the Program to providers shall be considered payment in full for services rendered. Providers are prohibited from collecting additional payment from Program participants or participants' families for either covered or denied services; such action constitutes an overpayment and is in violation of both Federal and State regulation.

Providers must bill the Program their usual and customary charge to the general public for similar services, except for:

- injectable drugs,
- the provision of diagnostic or therapeutic pharmaceuticals, and
- supplies

In these cases, providers must bill their acquisition cost.

Payments to providers will be the lowest of either the physician's customary charge, acquisition cost, or the program's fee schedule.

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**Third Party Recoveries**

In general, the Program is always the payer of last resort. If a participant is covered by other federal or third-party insurance (e.g., Medicare or AETNA), the provider must seek payment from that source first.

The only exception to the payer of last resort rule is for the provision of **Early and Periodic Screening, Diagnosis and Treatment services (EPSDT)**/ HealthyKids services, such as well child care and administration of VFC vaccines and prenatal care. Providers may bill the Program for these services first, even if the participant has other insurance.

For more information, please consult the [EPSDT Manual](http://dhmh.maryland.gov/epsdt/SitePages/Home.aspx) at:  
<http://dhmh.maryland.gov/epsdt/SitePages/Home.aspx>

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**Coding and Billing**

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**Common Procedure Coding System**

The Program uses the five-character HCPCS codes for the billing of services on both the CMS-1500 paper form and 837P electronic claim format. These include the numeric CPT codes and the Level II alphanumeric HCPCS codes.

**CPT**

The Fee Manual primarily utilizes current CPT codes. Physicians must have access to the latest revision of CPT in order to properly bill for services rendered.

The **American Medical Association (AMA)** develops the CPT, and publishes revisions annually; the Program updates this fee manual to reflect changes to the CPT.

For more information on AMA products, please call (800) 621-8335 or visit:

<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page>

**Level II HCPCS**

The Physicians' Services Program also utilizes Level II national alphanumeric HCPCS codes for procedures or services that do not appear in the CPT. These include the –J codes for billing injectable

drugs, -A codes for radiopharmaceuticals, -Q codes for contrast materials, and -G codes for digital mammography. For -J codes, the Program requires providers to bill their acquisition costs. The Program does not post a fee schedule for Level-II HCPCS codes.

## Unbundling

Providers must include all necessary services in the CPT's definition of a given procedure. Though independent CPT codes may exist for ancillary services, billing of these codes separately for packaged procedures, called "unbundling", is prohibited.

Up to two modifiers may be reported on each service line on the CMS-1500 claim form. If more than two modifiers must be reported, use the primary modifier in the first position and the second most important modifier in the second position; identify any additional modifier(s) by line number in Block 19 of the CMS-1500 claim form.

Up to four modifiers may be used in the HIPAA-compliant 837P electronic format.

## Program-Accepted Modifiers

The Program recognizes two levels of modifiers: Level I modifiers found in CPT, and Level II modifiers found in HCPCS, which are updated by CMS.

Providers must report modifiers where applicable and that affect processing and/or payment.

### *Example:*

Modifiers -RT (right side) and -LT (left side) are not acceptable substitutes for modifier -50 (bilateral), and will not process correctly.

Providers may use unlisted modifiers to provide additional information about a service, but the Program does not consider unlisted modifiers in claims processing.

All anesthesia procedure codes 00100 - 01999 require modifiers.  
The Program will reject anesthesia codes billed without the appropriate modifier. Please refer to the [Appendix](#) for a complete list of anesthesia

modifiers (see page 4-9).

If a claim contains multiple surgical procedure codes, the provider is only allowed to bill one code without modifier -51; the provider must bill all other codes with modifier -51.

Surgical assistance requires a licensed physician (i.e., a second surgeon). **Physician's Assistants (PA)** are not allowed to assist in surgery and will not be paid.

Trauma services rendered by trauma physicians to trauma patients on the State Trauma Registry in trauma centers are paid at 100% of the Medicare rate.

For more information on trauma services, please consult the [Appendix](#) (see page 4-1).

The Program recognizes modifier -**TC (Technical Component)** only on certain radiology procedure codes; providers may not use modifier -TC for procedures outside of radiology. The Program recognizes modifier -**26 (Professional Component)** for both radiology and medicine services.

### **Informational Modifiers**

Providers may use informational modifiers to report additional data on procedures; however, they may or may not affect payment levels or claims processing.

For anesthesia services, modifiers -G8, -G9, and -QS are informational only and do not affect payment.

For surgical services, use modifier -50 instead of modifiers -RT and -LT for bilateral surgical procedures.

### **Modifiers Not Accepted**

Using modifiers that the Program does not accept will result in unprocessed and/or unpaid claims. Providers must then resubmit claims using appropriate modifiers.

Commonly used but unacceptable modifiers include, but are not limited

to:

- -AD: Medical supervision by physician: more than four procedures (for anesthesia)
- -47: Anesthesia by surgeon
- -55: Pre-operative management only
- -66: Surgical team – Info
- -81: Minimum Assistant Surgeon

For a list of acceptable modifiers, refer to the [Appendix](#) (see page 4-9).

## Payment Rates

The payment rate for each modifier is a percentage of the listed fee. Payment rates for multiple modifiers are multiplied together to determine the payment amount.

*Example:*

Modifiers -50 (bilateral) and -51 (multiple) typically have rates at 150% of the base rate and 50% of the base rate, respectively. If reported together on the same service line, the payment rate is 75% of the base rate ( $1.50 \times .50 = 0.75$ ).

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## Unlisted Medical or Surgical Codes

There are no listed fees for “unlisted procedure codes” in the [Physicians' Fee Schedule](#). These codes must be manually priced and must include legible surgical notes or other medical record documentation to enable a medical reviewer to arrive at a value for the procedure. Refer to the beginning of each section of the CPT book for a complete a list of unlisted services or procedures.

## Billing Unlisted Procedures

When billing for unlisted procedures, include:

- Adequate definition or description of the nature of illness
- Extent and need for the procedure
- Time, effort and equipment necessary to provide the service

Additional items may include:

- Complexity of symptoms
- Final diagnosis
- Pertinent physical findings
- Diagnostic and therapeutic procedures
- Concurrent problems

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The medical reviewer may require additional documentation in order to accurately determine procedure value, including, but not limited to:

- Invoices from wholesalers
- **Explanation of Benefits (EOB)** from Medicare or third party payors
- **Food and Drug Administration (FDA)** documentation
- Manufacturer's explanation for drug use

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### **Billing Time Limitations**

Providers must submit Fee-For-Service claims within 12 months of the rendered service date. If a claim is received by the Program within the 12-month limit but is rejected due to erroneous or missing data, a re-submittal will be accepted within 60 days of rejection OR within 12 months of the date the service was rendered. If the Program rejects a claim because of late receipt, the participant may not be billed for that claim. If a provider submits a claim and receives neither payment nor rejection within 90 days, the claim may be resubmitted.

### **Crossover Claims**

When a provider bills Medicare B for services rendered to a Medicaid participant, and the provider accepts assignment on the claim (Block 27 on the CMS-1500 claim form), the payments are made automatically.

In the uncommon event that a provider is not paid within four weeks of receipt of the Medicare payment, the provider should bill a hardcopy CMS-1500 form to the Program.

Providers should only submit claims to Medicare for services rendered to patients who are dually eligible for both Medicare and Medicaid. The Program must receive Medicare/Medicaid Crossover claims within 120 days of the Medicare payment date. This is the date on Medicare's Explanation of Benefits form. The Program recognizes the billing time limitations of Medicare and will not make payment when Medicare has rejected a claim due to late billing. In general, the Program will only pay up to the maximum of its allowed amount.

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**Policy Requirements**

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**Medical Record Documentation**

The Program may ask for additional documentation (including, but not limited to: medical reports, surgery notes, or invoices). This section details the requirements necessary for proper payment.

Providers must include the following in a participant's medical record, presented in a complete and legible manner:

- Details of each patient encounter( including the date, the reason for the encounter, appropriate history and physical exam, review of lab, X-ray, and other ancillary services), assessment, and a plan for care (including discharge plan, if appropriate);
- Past and present diagnoses;
- Relevant health risk factors;
- The patient's progress, including response to treatment, change in diagnosis, and patient non-compliance;
- The written plan for care for on-going treatment, including: medication, specifying frequency and dosage; referrals and consultations; patient/family education; and, specific instructions for follow-up;
- Documented support of the intensity of patient evaluation and/or treatment;
- Authentication by date and signature from physician and/or non-physician health care professional;
- Any CPT/HCPCS procedure codes and ICD-9-CM codes supported by the information in the medical record about the patient's condition.

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**Pre-Authorization**

Pre-authorization is required for some physician services and procedures within the fee schedule. Refer to the [Appendix](#) for a summary of this information in the [Pre-authorization Decision Procedure](#) section (p.4-6) or the [EVS user guide](#) at:

<http://mmcp.dhmh.maryland.gov/docs/Maryland%20Medicaid%20Brochure%20V3.pdf>

### Covered Procedures or Services Requiring Pre-Authorization

Providers must obtain pre-authorization before performing the following services:

- Reconstructive surgery;
- Lipectomy and panniculectomy ;
- Transplanting vital organs;
- Surgical procedures for the treatment of morbid obesity;
- Elective services from a noncontiguous state;
- Services rendered for elective admissions for inpatient hospital services before one pre-operative day.

For Medicaid participants in acute general hospitals and in designated hospitals, the Department will perform utilization review in accordance with [COMAR 10.09.06](#)

The Utilization Control Agent (UCA) will perform utilization, preauthorization, concurrent, and retrospective review procedures for services rendered involving elective admissions, inpatient procedures, pre-operative days, administrative days, and medical record review.

For information concerning proper protocol and interaction with the UCA, please consult the Delmarva provider hotline at (888) 571-3629.

### Services Not Covered by Medicare

The Program generally does not cover services that Medicare has determined to be medically unnecessary. However, the Program may authorize these services if the provider can satisfactorily document medical necessity in a particular case.

### Requirements

The Program will preauthorize services when the provider submits adequate documentation demonstrating that the service is medically necessary. For services that require preauthorization, providers must submit the request in writing. A **Preauthorization Request Form for Physician Services (DHMH-4523)**, available at: <http://www.emdhealthchoice.org/providerinfo/pdf/pg75.pdf> must be completed and submitted to:

Acute Care Administration  
Office of Health Services  
Division of Hospital and Professional Services

201 W. Preston Street, 2nd Floor  
Baltimore, Maryland 21201

Providers must also attach supporting documentation which includes, but is not limited to, the following:

- Complete narrative justification of the procedure(s)
- Brief history and physical examination
- Result of pertinent ancillary studies, if applicable
- Pertinent medical evaluations and consultations, if applicable

The Program will send a written decision in response to all written requests for preauthorization.

If the Program approves the request, the provider will receive a preauthorization number. The provider must then enter the number in Block 23 of the CMS-1500 claim form when billing for the service. Authorizations are valid for 60 days from the date of the approval letter. Preauthorization only relates to the medical necessity of providing the service described in the written request. The approval is not a verification of the participant's eligibility for Medical Assistance, nor is it an approval for the provider to perform the service for other participants.

Providers must obtain preauthorization for making arrangements to send a participant out of state for elective services. The standard regulations and procedures for consultation using the UCA apply.

Referrals to both contiguous states and Washington, D.C. generally do not require an out-of-state pre-authorization, though there are some exceptional circumstances (e.g., organ transplantation). For information concerning proper protocol and interaction with the UCA, please consult the Delmarva provider hotline at (888) 571-3629.

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**Dual-Eligibles and  
Coordination with  
Medicare**

Many Medical Assistance participants are also eligible for Medicare benefits. Since Medicare is the primary payer for a dually eligible-participant, the Program will waive otherwise required preauthorization if the service is both approved and covered by Medicare. However, if

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any part of a claim or the entire claim is rejected by Medicare and the claim is referred to the Program for payment, services will be covered by the Program only if the provider obtained preauthorization from the Program for those services before providing the service.

While the Program follows Medicare guidelines, there may be billing differences between the Program and Medicare (codes, modifiers, etc.). Since Medicare is the primary payer for dually-eligible participants, providers should follow Medicare guidelines for completing the CMS-1500 claim form posted at :

[http://www.valueoptions.com/members/forms/files/CMS1500\\_ClaimForm.pdf](http://www.valueoptions.com/members/forms/files/CMS1500_ClaimForm.pdf)

The Program does not pay Medicare Part B coinsurance or copayments for dates of service after August 10, 2010 on claims where Medicare payment exceeds the Medicaid fee schedule. Therefore, if Medicare pays the claim at an amount equal to or greater than the Medicaid fee schedule, Medicaid will pay all or part of the coinsurance to bring the total payment to the provider equal to the Medicaid fee schedule. This methodology will not be applied when:

- The amount submitted to Medicaid is for the deductible;
- The service is not covered by Medicaid;
- The service is categorized by Medicare as a mental health service;
- The service is billed using a HCPCS beginning with a letter from A to W;
- CPT codes are priced by report;
- The service is billed using CPT codes 00100 to 01999; or
- The service is reimbursed by Medicaid at 100% of the Medicare rate

Providers must submit claims for Medicare/Medicaid dual-eligibles directly to the Medicare intermediary.

Place the participant's 11-digit identification number in Block 9A of the CMS-1500 claim form and check "Accept Assignment" in Block 27

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when billing Medicare. This will assure that Medicare will automatically forward the appropriate information to the Program. Check both Medicare and Medicaid in Block 1 of the CMS-1500 claim form; failure to do so will delay payment.

Refer to p. 2-13 in the [Billing Time Limitations](#) section for information regarding dual eligibles and billing time limitations.

### **Additional Guidelines and Resources**

Please refer to the Program's Physicians' Services Regulations in [COMAR 10.09.02](#), current guidelines, the Physician Fee Schedule, and/or [transmittals](#) for additional information on services requiring preauthorization.

For complete CMS 1500-claim form billing instructions, please visit: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf>

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### **Consultation & Referral**

There are important distinctions between a consultation and a referral. See the definitions portion of the [Introduction](#) for details (see page 1-1). Appropriate billing is dependent upon whether the provider is an attending physician or is a consultant specialist.

A consultation requires a written opinion or advice rendered by a consultant-specialist whose opinion or advice is requested by the patient's attending physician for the further evaluation or management of the patient by the attending physician. If the consultant-specialist assumes responsibility for the continuing care of the patient, any subsequent service rendered by him/her is not a consultation, but is an established patient office visit or is subsequent hospital care, depending on the setting. The consultation must be provided in the specialty in which the consultant-specialist is registered with the Program.

The physician to whom a referral for treatment is made, whether he/she is a generalist or a specialist, will be considered to be the treating physician and not the consultant.

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### **NDC Reporting Requirements**

Federal regulations require states to collect **National Drug Code (NDC)** numbers from providers for the purpose of billing manufacturers for drug rebates.

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	<p>In order for physician-administered drugs to be paid by the Program, the manufacturer must participate in the Medicaid Drug Rebate Program. The provider must also report a valid 11-digit NDC number and the quantity administered on the CMS-1500 claim form; this includes physician-administered drugs for immunizations and radiopharmaceuticals.</p>
<b>Codes Requiring NDC Numbers</b>	<p>Providers must report the NDC/quantity when billing for drugs using -A, -J, and-Q codes, including the unlisted -J codes (J3490 and J9999), as well as certain CPT codes.</p> <p>The NDC reporting requirements for physician-administered drugs also extend to claims when the Program is not the primary payer, but is either the secondary or tertiary payer.</p>
<b>NDC Number Billing Instructions</b>	<p>Providers must report the actual NDC number on the package or container from which the medication was administered.</p> <p>It may be necessary to pad NDC numbers with left-adjusted zeroes in order to report eleven digits:</p> <p><i>Example:</i></p> <p>The NDC from the label may appear: 12345-678-90; using the 5-4-2 format, it should be reported: 12345-0678-90.</p> <p>Always report single digits with a preceding zero.</p> <p><i>Example:</i></p> <p>The NDC from the label may appear: 12345-0678-9</p> <p>Providers should enter: 12345-0678-09.</p> <p>Use <u>Block 24 of the CMS-1500 claim form</u> for reporting the NDC number.</p>

The top shaded area of the six service lines is the location for reporting supplemental information including NDCs for drugs. This area allows for the entry of 61 characters from the beginning of 24A to the end of 24G on the CMS-1500 claim form.

When entering supplemental information for NDC, do so in the following order:

- 1) NDC qualifier
- 2) NDC code
- 3) One space
- 4) Unit/basis of measurement qualifier
- 5) Quantity

The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, Use a decimal; do not use commas.

*Example:*

1234.562 99999999.999

The NDC qualifier N4 is used when reporting supplemental NDC information. Begin at Block 24A of the CMS-1500 claim form by entering the qualifier N4, followed by the 11-digit NDC number. Do not enter a space between the qualifier and the NDC number. Do not enter hyphens or spaces within the NDC number.

Skip a space and enter the applicable unit/basis of measurement qualifier, followed immediately by the numeric quantity administered to the participant.

The following qualifiers are used when reporting NDC unit/basis of measurement:

F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit

Providers can report more than one NDC in the shaded lines of Box 24 of the CMS-1500 claim form.

Enter the first NDC qualifier, NDC number, unit qualifier, and quantity at Block 24A . Skip one space after the first item and enter the next NDC qualifier, NDC number, unit qualifier, and quantity.

This may be necessary when multiple vials of the same drug are administered with different dosages and NDCs.

## Denials

The Program will deny claims for drugs if :

- NDC is missing or invalid
- NDC is unable to be rebated
- NDC Unit of Measure is missing or invalid
- NDC Quantity is missing

For reporting the NDC on 837P electronic claims, providers must use the 2410 Loop (Drug Identification):

- LIN03 = NDC code
- CTP04 = Quantity
- CTP05 = Unit of Measure (UOM)

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## ***Additional Information***

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### **Tamper Proof Prescription Pads**

Providers must write prescriptions on tamper-proof pads which prevent copying, modification, and/or counterfeiting. Pharmacies will not fill prescriptions written on pads that do not meet these standards.

### **Program Coverage and Follow-Up or Aftercare Days**

The Program does not pay the surgeon for hospital and office visits during the surgical aftercare period. Providers should report complications, the presence of other diseases, or injuries requiring additional services using the appropriate procedures.

When the follow-up period is listed as zero, the listed value is for the procedure only. In such cases, providers should bill for all post-operative care on a service-by-service basis.

Listed surgical procedures include the operation itself and uncomplicated follow-up care. Fees for surgical procedures include follow-up care for the number of days listed in the [Medicare Fee Schedule](#).

## **SERVICES INFORMATION**

### **Overview**

#### **Introduction**

This chapter provides an overview of services that are reimbursable by the Maryland Medical Assistance Program (the "Program" or "MA"), and instructions for billing them under normal and modifying circumstances.

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## ***Evaluation & Management***

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### **CPT Guidelines & Modifiers**

CPT **Evaluation & Management (E&M)** service guidelines apply for determining an appropriate level of care. Generally, CPT descriptions for E&M services indicate “per day” and only one E&M service may be reported per date of service.

Modifier -21 for prolonged E&M service is informational only and does not affect payment.

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### **Preventive Exams**

The comprehensive nature of the preventative medicine service codes (99381–99397) reflects an age and gender appropriate history/exam and is **not** synonymous with the “comprehensive” examination required in E&M codes 99201–99350.

The Program will pay for Behavioral Change Intervention codes 99406–99409.

Modifier -25 should be added to the office/outpatient code to indicate that a significant, separately identifiable E&M service was provided by the same physician on the same day as the preventative medicine service. The appropriate preventative medicine service is additionally reported.

For detail regarding this [patient medical record documentation](#), please refer to page 2-14.

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## ***Surgery***

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### **Global Surgery Package**

The Program generally follows CPT surgery guidelines for the following surgical scenarios:

- bilateral and multiple procedures
- separate procedures
- add-on procedures
- modifier -51 -exempt procedures

Payment for surgery includes related services that are furnished either

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by the surgeon who performs the surgery or by members of the same specialty group. This payment method is known as the global surgery package.

The global surgery package includes the following services:

- Pre-operative visits beginning with the day before the surgery for major surgeries (those with at least a 90 day post-operative period) and the day of the surgery for minor surgeries;
- Intra-operative services that are a usual and necessary part of a surgical procedure;
- Treatment for complications following surgery, including additional medical or surgical services required of the surgeon during the post-operative period;
- Follow-up visits within the post-operative period related to recovery from the surgery, including a surgeon's visits to a patient in an intensive care or critical care unit;
- Post-surgical pain management by the surgeon;
- Supplies for certain services furnished in a physician's office;
- Miscellaneous services and items, including: dressing changes; local incision care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

An E&M service is not payable on the same day as a procedure with a global surgery period.

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**Less Than Full  
Global Package**

Physicians furnishing less than the full global surgery package for procedures with ten or 90 day global periods must bill their portion of care correctly.

Use modifier -54, surgical care only, to bill for a surgery when another physician who is not a member of the same group provides all or part of the outpatient post-operative care. The Program generally assumes that the surgeon is responsible for pre-operative, intra-operative, and

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inpatient hospital post-operative care at a minimum. Payment to the surgeon who does not perform the outpatient post-operative care will be 80% of the listed fee for the procedure.

Use modifier -55, postoperative management only, when a physician other than the surgeon provides all or part of the post-operative care after hospital discharge. The surgeon must transfer care to the second physician and both must keep a copy of the written transfer agreement in the patient's medical record. The physician assuming care must bill the surgical code, use the date of surgery as the service date, and report modifier -55.

Modifier -56, preoperative management only, is not payable by the Program.

Report modifier -52, reduced services, if a service or procedure is partially reduced or eliminated at the physician's discretion. A report is required to determine the change in fee for payment.

Report modifier -53, discontinued procedures, if a surgical or diagnostic procedure is terminated after it was started. There is no fixed payment rate for modifier -53; payment from the Program is dependent upon the details of the operative note.

Modifier -22, unusual procedural services, is informational and does not affect payment; the Program uses it for data reporting services but it is not reimbursable.

The reporting of modifiers is subject to post-payment audit.

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### **Multiple Surgical Procedures**

For multiple surgical procedures performed during the same surgical session, report the major or primary surgery on the first service line with no modifier. Report each additional procedure performed during the same surgical session on subsequent service lines with the modifier -51. All services should be reported on one claim. The maximum units of service allowed for a surgery procedure without a modifier -51, exclusive of certain add-on and -51 exempt codes, is one.

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Modifier -51 should be used to report multiple procedures, performed at the same session, by the same provider. The primary procedure or service is reported as listed and the additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s).

Example: Excision of tendon

26180: Excision of tendon, finger, flexor or extensor, each tendon

26180-51: Excision of tendon, finger, flexor or extensor, each tendon (multiple procedures)

Conversely, procedures identified as "Add-on" or "-51-exempt" are paid at 100% of the listed fee for the procedure and are not subject to the multiple surgery reduction. Add-on and -51-exempt procedures should not be reported using modifier -51.

Example: Fasciectomy

26123: Fasciectomy, partial palmar with release of single digit

26125: Each additional digit

There are instances when the primary procedure code specifies that each additional procedure should be reported, but there are no additional codes to report subsequent procedures. In these cases, report the primary procedure on one line without modifier -51 and report the additional procedures on a second line using the same procedure code with modifier -51. Report add-on codes and modifier -51 exempt codes when appropriate. Place multiple units on a single line without modifier -51 when there are no additional codes to report subsequent procedures.

When more than one of the same subsequent procedure is performed, indicate the number of services in Block 24G on the CMS-1500 claim form. If the number of units reported exceeds the Program's maximum for that procedure, the line item will be suspended, indicating that additional medical documentation is required.

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**Bilateral Surgical Procedures**

The descriptions for some procedure codes include the terms “bilateral” or “unilateral or bilateral.” The fee for these codes reflects the work involved if done bilaterally as the description states.

If a bilateral procedure is performed, report the bilateral procedure if available. When there is no code describing bilateral services, report the bilateral service on one claim line, adding modifier -50, bilateral procedure. Payment for a bilateral procedure reported appropriately with modifier -50 is based on the lower of the amount billed or 150% of the listed fee for the procedure.

For bilateral procedures, do not bill the same code on two separate lines using the modifiers -RT (right side) and -LT (left side). Modifiers -RT and -LT are not acceptable substitutes for modifier -50 (bilateral), and will not process correctly.

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**Assistant Surgeons**

The Program covers assistant surgeon services for designated surgical procedures when the services are medically necessary. Physician assistants are not considered to be assistant surgeons.

Use either modifier -80, assistant surgeon, or modifier -82, assistant surgeon (when qualified resident surgeon is not available), to report surgical procedures with an assistant surgeon. Payment for assistant surgeon services will be 20% of the fee for the surgical procedure.

Modifier -81, minimum assistant surgeon, is not payable by the Program.

Payment for services at the assistant surgeon rate will not be made if reported with modifiers -54, surgical care only, and -55, post-operative management only. Modifier -54 will be paid at 80% of the listed fee for the procedure.

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**Anesthesia**

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**Procedure Codes**

Use procedure codes 00100 – 01999 to report the administration of anesthesia. These codes describe anesthesia for procedures categorized by areas or systems of the body. Other codes describe anesthesia for radiological and miscellaneous procedures. Report only one primary anesthesia service for a surgical session using the anesthesia code related to the major surgery. Every anesthesia service must have an appropriate anesthesia modifier reported on the service line, except for procedure 01996.

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**Modifiers**

If an appropriate modifier for anesthesia services is not reported, the service will be denied. A separate payment will not be made for any anesthesia services performed by the physician who also performs the medical or surgical service for which the anesthesia is required. For a list of modifiers accepted by the Program, consult the Appendix.

Modifier -47, anesthesia by surgeon, is not used by the Program.

The Program will not make additional payments for patient risk factors such as patient age, health status (CPT Physical Status Modifiers or Qualifying Circumstance procedure codes), or for **monitored anesthesia care (MAC)**. There is no separate payment for the medical supervision of a **Certified Registered Nurse Anesthetist (CRNA)** by a physician.

Modifier -AD is not used by the Program.

Use of modifier -QS is for informational purposes only and will not change payment.

Occasionally, a procedure that usually requires either no anesthesia or local anesthesia must be done under general anesthesia due to unusual circumstances (e.g., CAT-scans and MRI procedures). Report this by adding modifier -23, unusual anesthesia, to the procedure code of the basic service. The Program requires an anesthesia report to be submitted with the claim when modifier -23 is used. The report must

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document the total anesthesia time in minutes, the qualified individual who performed the anesthesia, and under what circumstances.

There is no separate payment made for any services ordinarily provided as part of the anesthesia service. This includes the pre-anesthetic examination of the patient, pre- or postoperative visits, intubation, and normal monitoring functions. These procedures should not be reported separately when provided in conjunction with the provision of anesthesia.

Unusual forms of monitoring are not included in the payment for anesthesia services. Unusual forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) may be reported separately, in addition to providing the basic anesthesia administration.

Use unlisted procedure code 01999 when surgery is aborted after general or regional anesthesia induction has taken place. Include a copy of the anesthesia report with an indication that the surgery was cancelled.

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**Time and Base Units**

Anesthesia time begins when the anesthesia provider begins to prepare the patient for induction of anesthesia and ends when the patient is placed under post-operative supervision and the anesthesia provider is no longer in personal attendance. In the event of an interruption, only the actual anesthesia time is counted; all anesthesia start and stop times must be documented in the medical record.

Report the total anesthesia time in minutes in Block 24G of the CMS-1500 claim form.

Convert hours to minutes and enter the total anesthesia minutes provided for the procedure. Do not include base units and do not divide the total anesthesia time into 15-minute time units. To bill for anesthesia administered for multiple surgeries, use the anesthesia code with the highest anesthesia base unit value and report the actual time in minutes that extends over all procedures.

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Time units are not recognized for anesthesia procedure code 01996 (daily management of epidural or subarachnoid continuous drug administration). For this particular code, only one unit of service is allowed and providers are not required to report an anesthesia modifier.

Base units have been assigned to each anesthesia procedure code and reflect the difficulty of the anesthesia service, including the usual preoperative and postoperative care and evaluation. Do not include base units when reporting anesthesia time. Base units will be added during claims processing.

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**Preauthorization**

Anesthesia code 00802, anesthesia for panniculectomy, is the sole anesthesia code that requires preauthorization, as it may be considered for cosmetic purposes, and therefore, medically unnecessary.

If a surgical procedure itself requires prior authorization, the Program assumes that the operating physician has obtained the appropriate authorization to perform the service. The anesthesia provider will not be held responsible for providing proof that the procedure was authorized. Federal statute requires that all claims for services, including anesthesia claims related to hysterectomies or sterilization procedures, include proof that informed consent was obtained and meets the Program's consent requirements before payment can be made for the service. Anesthesia claims for induced abortion procedures must include proof that the service was performed for one of the five medical reasons allowed for an abortion.

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**Medical Direction**

The Program will make separate payment to physicians and CRNAs for medically directed anesthesia services. All of the following conditions must be met for medically directed anesthesia services to be paid to the physician. For each patient, the physician must:

- Perform a pre-anesthetic examination and evaluation
- Prescribe the anesthesia plan
- Personally participate in the most demanding procedures in the anesthesia plan including, if applicable, induction and emergence
- Ensure that procedures in the anesthesia plan that are not

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performed by the physician are performed by a qualified individual

- Monitor the course of anesthesia administration at frequent intervals
- Remain physically present and available for immediate diagnosis and treatment of emergencies
- Provide indicated post-anesthesia care

The medical direction service furnished by a physician is not covered if the physician directs anyone other than a qualified physician or CRNA. The physician must document in the patient's medical record that the physician performed the pre-anesthetic exam and evaluation, provided post-anesthesia care, and was present during some portion of both the anesthesia monitoring and the most demanding procedures (including induction and emergence), where indicated. Total anesthesia care time must also be clearly indicated in the medical record.

A physician who is directing the concurrent administration of anesthesia to four or fewer surgical patients should not be involved in furnishing additional services to other patients.

If the physician is addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or providing periodic (as opposed to continuous) monitoring of an obstetrical patient, it does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. A physician may also receive patients entering the operating suite for subsequent surgeries, check on or discharge patients from the recovery room, or handle scheduling matters while directing concurrent anesthesia procedures without affecting coverage for medical direction.

If the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case, or is not available to respond to the immediate needs of the surgical patients, the physician's services are considered supervisory and are not covered as medical direction.

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Routine post-operative pain management is the responsibility of the surgeon and is part of the global fee paid to the surgeon, which includes all care after surgery. Non-routine postoperative pain management, however, may be provided by an anesthesiologist under certain circumstances. For example, placement of a continuous epidural to manage postoperative pain is separately covered under the appropriate CPT code for a continuous epidural when a physician (or CRNA under a physician's supervision) performs the service and the procedure was not used as the mode of anesthesia for the surgery. Daily management of a continuous epidural on subsequent postoperative days is covered under the appropriate procedure code.

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**Payment and Add-on Codes**

All claims reporting the administration of anesthesia must include the following:

- The appropriate anesthesia procedure code (00100 – 01999)
- Anesthesia time (in minutes)
- The appropriate anesthesia modifier to identify who rendered the service

The anesthesia procedure code, modifier, base units, total time in minutes, and procedure fee are utilized for calculating payments for anesthesia services.

Payment for anesthesia services is based on the following formula:  
 [Time Units (minutes) + (Base Units x 15)] x Fee x Modifier = Payment

*Example:* 00500

time = 300 minutes, ABU's = 15, Modifier = QX

$[300 + (15 \times 15)] \times 1.1486 \times 0.50 = 301.51$

The Program does not determine time units on the basis of one time unit for each 15 minutes of anesthesia time. Instead, **anesthesia base units (ABUs)** are converted to time units by multiplying by 15. Payment for anesthesia services will be the sum of the total time in minutes and the base units converted to time units multiplied by the listed fee per unit and by the modifier rate (50% or 100%). Payment will be the lower

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of the provider's charge or the calculated fee amount.

If a physician personally provides the entire anesthesia service, payment will be 100% of the calculated amount. Medically directed anesthesia services will be paid at 50% of the calculated amount for both the CRNA and the physician. Non-medically directed CRNA services are paid at 100% of the calculated fee. Physician supervision services are not paid separately.

When billing for anesthesia for multiple surgical procedures, report the anesthesia procedure code with the highest base unit value and indicate the total time for all procedures.

The Program uses the anesthesia relative value units established by Medicare in its payment methodology. The Anesthesia Uniform Relative Value Units Guide can be found on the Novitas Medicare Solutions web site at <https://www.novitas-solutions.com/index.html>.

Current CPT includes add-on codes for two areas: anesthesia involving burn excisions or debridement and obstetrical anesthesia. The add-on codes should be billed in addition to the primary anesthesia code. Report the anesthesia time separately for both the primary and the add-on code, based upon the amount of time appropriately associated with each code. The appropriate anesthesia modifier must also be reported with the add-on codes to identify who rendered the service.

#### Burn Excisions and Debridement

In the burn area, use code 01953 in conjunction with code 01952.

#### Obstetrics

In the obstetrical area, use codes 01968 and 01969 in conjunction with code 01967.

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## **Trauma Services**

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### **Details**

Trauma services may only be rendered in a hospital or trauma center. To bill for trauma services, use modifier –U1.

For full details on billing instructions for trauma claims, please refer to the [Appendix](#) (see page 4-1).

For a list of Trauma Centers in Maryland, please refer to the [Appendix](#) (see page 4-4).

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## **Critical Care Services**

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### **Coding Guidelines**

The Program covers critical care services consistent with CPT definitions and guidelines. Each day that critical care is billed, the medical record must support the level of service provided.

In order to determine that critical care services rather than other E&M services are medically necessary, the following criteria must be met, in addition to the CPT descriptions:

Services require direct personal management by the physician: they are life- and organ-supporting interventions which require frequent, personal assessment and possible manipulation by the physician, where failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant, or life-threatening deterioration of the patient's condition.

Procedure code 99291 is used to report the first 30-74 minutes of critical care provided to a critically ill or injured patient over 24 months of age on a given date. Report critical care of less than 30 minutes total duration on a given date using the appropriate E&M code. Use procedure code 99292 to report additional block(s) of time up to 30 minutes each beyond the first 74 minutes.

Providers must document the actual time spent with the patient while delivering critical care services in the medical record. For any period of time spent providing critical care services, the physician must devote

full attention to the patient and may not provide services to any other patient during the same period of time. When billing for critical care services, report a quantity of "1" for up to the first 74 minutes of critical care provided. If 75 or more minutes of care is provided, report a quantity of "1" for each additional 30 minutes of care under the appropriate code.

Do not bill ventilation management in addition to critical care services by the same physician on the same day; critical care includes ventilation management.

For neonates who are receiving ventilation management services, not critical care, the services should be reported under the ventilation management codes.

Refer to NCCI edits for codes which cannot be billed with 99291 and 99292.

The following services are included in reporting the critical care codes 99291–99292 and should not be billed separately:

- Interpretation of cardiac output measurements (93561, 93562)
- Chest xrays (71010, 71015, 71020)
- Pulse oximetry (94760, 94761, 94762)
- Blood gases and information data stored in computers (e.g., ECGs, and blood pressures)
- Hematologic data (99090)
- Gastric intubation (43752, 91105)
- Temporary transcutaneous pacing (92953)
- Ventilatory management (94656, 94657, 94660, 94662)
- Vascular access procedures (36000, 36410, 36415, 36540, 36600)

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**Neonatal and Pediatric  
Critical Care**

All newborns born to women who are enrolled in Medicaid at the time of birth are also eligible for Medicaid. Coverage will begin at birth and continue at least through the infant's first birthday. If a pregnant woman is enrolled in an MCO at the time of delivery, her newborn is automatically

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enrolled in the same MCO. Providers seeing a pregnant woman should encourage her to choose a provider for her newborn by the eighth month of pregnancy.

Do not use the mother's MA number when billing for services rendered to a neonate. The neonate must have his or her own MA number. Hospitals are responsible for sending information to the Program so that the baby can be assigned a new number.

To ensure or to verify proper enrollment procedure for billing purposes, please consult the [Maryland Medical Assistance OB/GYN Family Planning and Provider Services Billing Manual](http://mmcp.dhmf.maryland.gov/Documents/OB%20MANUAL%20March%202012.pdf) at:  
<http://mmcp.dhmf.maryland.gov/Documents/OB%20MANUAL%20March%202012.pdf>

Critical care services provided to neonates are reported with the neonatal critical care codes 99468 and 99469. These codes represent care starting with the date of admission (99468) and subsequent day(s) (99469), and may be reported only once per day.

If a neonate is no longer considered to be critically ill, use either the Intensive Low Birth Weight Services codes for those with present body weight of less than 2500 grams (99478, 99479) or the Subsequent Hospital Care codes (99231-99233) for those with present body weight over 2500 grams.

Critical care services provided to persons 29 days through 24 months of age are reported with pediatric critical care codes 99471 (care starting with date of admission) and 99472 (subsequent days); these codes may be reported by a single physician only once per day, per patient, in a given setting.

For neonatal and pediatric critical care codes, age determination in days is calculated by subtracting the date of birth from the date of service.

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Refer to NCCI edits for codes which cannot be billed with 99291 and 99292.

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## ***Reproductive Health***

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### ***Obstetrics***

Providers must bill deliveries separately from prenatal care. The Program does not use global procedure codes 59400, 59510, and 59610.

The Program will pay prenatal care providers a separate fee for the **Maryland Prenatal Risk Assessment (MPRA)** process which includes:

- 1) completion of the **MPRA Form (DHMH 4850)** at the first prenatal visit;
- 2) forwarding the form to the local health department; and
- 3) development of a plan of care.

Use code H10001; limited to one unit per pregnancy. The Program does not use code 99420.

In addition to the E&M code, the Program will pay prenatal care providers an additional fee for "Enriched Maternity Services." An "Enriched Maternity Service" includes all of the following:

- 1) individual prenatal health education;
- 2) documentation of topic areas covered (See Appendix for sample content and form);
- 3) health counseling; and
- 4) referral to community support services.

Use code H1003; limited to one unit per prenatal and postpartum visit. The Program does not use codes 99411 and 99412.

The Program will pay for Behavioral Change codes 99406 and 99407. When billing with H1003 the provision of this service must be in addition to the smoking and tobacco use/cessation counseling

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component of the “Enriched Maternity Service.”

The Program will pay for alcohol and/or substance abuse structured screening and brief intervention codes 99408 and 99409. When billing with H1001 the assessment must be in addition that which is required as part of the MPRA. When billing with H1003 the provision of this service must be in addition to the alcohol and substance use/cessation counseling component of the “Enriched Maternity Service.”

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## Gynecology

Use the appropriate Preventive Medicine codes for routine annual gynecologic exams. Use 99383 – 99387 for new patients or 99393 - 99397 for established patients. Use the appropriate E&M codes for problem-oriented visits. Use 99201 - 99205 for a new patient or 99211 - 99215 for an established patient.

The collection of specimens to be processed by an outside lab, such as pap smears, is considered part of the office visit and will not be reimbursed separately. Payments to the laboratory which processes the specimen and determines the results will be paid under the Laboratory Program.

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## Hysterectomies

Regulations require physicians who perform hysterectomies (not secondary providers, such as an assisting surgeons or anesthesiologists) to complete the [Document for Hysterectomy form \(DHMH 2990B\)](#).

The Program will pay for a hysterectomy only under the following conditions :

The physician who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, both orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing AND the individual or her representative, if any, has signed a written acknowledgement of receipt of that information (patients over the age of 55 do not have to sign);

OR

The physician who performs the hysterectomy certifies, in writing, that

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either the individual was already sterile at the time of the hysterectomy and states the cause of the sterility or the hysterectomy was performed under a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible; the physician must include a description of the nature of the emergency.

The completed form, "[Document for Hysterectomy](#)" (DHMH 2990B), must be kept in the patient's medical record.

The Program will not pay for a hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy.

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## Abortion

Abortions are covered by the Program for five medical reasons:

- Risk to life of the mother
- Risk to mother's current or future somatic health
- Risk to mother's current or future mental health
- Fetal genetic defect or serious deformity or abnormality
- Mother was a victim of rape or incest

Either a law enforcement official or public health service provider is required to submit documentation where the rape or incest of the mother was reported. The document must include the following information:

- Name and address of victim
- Name and address of person making report (if different from the victim)
- Date of the rape or incest incident
- Date of the report
- Statement that the report was signed by the person making it
- Name and signature of the person at the law enforcement agency or public health service who took the rape or incest report

The "[Certification of Abortion](#)" (DHMH 521) form must be completed and kept in the patient's medical record for services related to the

termination of a pregnancy (except spontaneous abortion or treatment of ectopic pregnancy) or for medical procedures necessary to voluntarily terminate a pregnancy for victims of rape and incest. These include surgical CPT procedures 59840-59841, 59850-59852, 59855-59857, and 59866 and anesthesia code 01966.

Providers who choose to submit paper claims are not required to submit the DHMH 521 form with the claim. Please refer the Program's [CMS-1500 billing instructions](#) for complete details.

When billing for the medical termination of early intrauterine pregnancy through the administration of mifepristone, also known as RU-486, use the unlisted CPT Medicine code 99199. "Medical Abortion" must be written on the CMS-1500 claim form below the procedure code in Block 24D.

Diagnosis code 635 or 638 must be entered on Line 1 of Block 21 of the CMS 1500 claim form. The date of service on the [DHMH Form 521](#) and the CMS-1500 claim form is the date that the patient signs the required Patient Agreement and takes the 600 mg oral dose of mifepristone. The fee for this procedure includes all medically necessary office or out-patient clinic visits over a two-week period for administration of the drugs and appropriate follow-up, and the actual cost of the drugs. Do not bill for office visits in addition to procedure code 99199.

It is necessary that the medical record reflect the medical necessity for the therapeutic abortion as determined by the certifying physician. The specific condition for which the abortion is being performed must be documented in the record. Completion of the certification form alone is not sufficient to serve as documentation, nor is it sufficient to render a clinical opinion and/or diagnosis without supporting evidence in the medical record. Lack of acceptable documentation in the medical record will cause the Program to deny payment, or in those cases where payment has been made, the Program will require repayment from the provider.

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**Family Planning Services**

The Program recognizes office visit codes and preventive visit codes as family planning services when billed with a contraceptive management (V25) diagnosis code.

Use the appropriate E&M code for new and established patients for family planning visits based on the complexity of services provided during the visit.

Preventive codes may be used instead of E&M if the service meets the CPT definition. When using a preventive code for an individual under age 21, refer to [Healthy Kids/EPSDT Provider Manual](#) for age -specific screening requirements at <http://dhmh.maryland.gov/epsdt/SitePages/Home.aspx>

Abortions and hysterectomies are not considered family planning services.

The Program covers all FDA-approved contraceptive products and devices, generally identified by -A and -J codes. Providers must bill acquisition cost.

If the provider can document that the acquisition cost of the contraceptive product or device is greater than the allowed fee, the acquisition cost will be paid. Attach a copy of the invoice for the contraceptive product to the claim form for verification purposes.

Providers must report the NDC/quantity when billing drugs, products, and devices using -A and -J codes. For information concerning [billing with NDC](#), see page 2-19.

For more information about contraceptive devices and product codes used by the Program, please refer to the [OB/GYN-Family Planning Manual](#) at: <http://mmcp.dhmh.maryland.gov/Documents/OB%20MANUAL%20March%202012.pdf>

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**Sterilizations**

The Program will pay for sterilization procedures, including tubal

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ligation or tubal occlusion, only if ALL of the following conditions are met:

- The individual is at least 21 years of age at the time of consent
- The individual is not mentally incompetent
- The individual is not institutionalized
- The individual has voluntarily given informed consent as described in Part I of the consent document, [Sterilization Consent Form \(HHS 687, HHS, 687-1\)](#)
- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.
- An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

A [Sterilization Consent Form \(HHS 687, HHS, 687-1\)](#) must be completed and kept in the patient's record for all sterilization procedures. If the procedure was performed on the same date of service as another procedure, a modifier -51 is required in [Block 24D of the CMS 1500 claim form](#) for the second or subsequent procedure.

The individual is not eligible for the sterilization procedure until the 32<sup>nd</sup> day after giving consent (signature date on the consent form). The sterilization form consists of four parts:

**PART I: Consent to Sterilization** – The provider must complete this section for all sterilizations and obtain the dated signature of the individual being sterilized.

**PART II: Interpreter's Statement** - This section must be completed only when an interpreter is provided to assist the individual to be sterilized to understand the consent statement.

**PART III: Statement of Person Obtaining Consent** - This section must be completed for all sterilizations and must be signed and dated by the person who counseled the individual to be sterilized.

**PART IV: Physician's Statement** - This section must be completed for all sterilizations by the physician. One of the final paragraphs, the one which is not used, must be crossed out. This section is worded so that the physician is required to sign this form either on or after the date of sterilization. This section may not be signed or dated by the physician prior to the date of sterilization.

**Tubal Ligation and Occlusion**

Use the appropriate CPT code for sterilization procedures and retain the Sterilization Consent Form in the patient's record.

When performing a surgical hysteroscopy in an office setting to induce occlusion (Essure procedure), bill using procedure code 58565. This code includes payment for both the procedure and the device. When the procedure is performed in a hospital outpatient setting, use procedure code 99070 and attach the invoice for payment of the device.

For the three-month follow-up hysterosalpingogram to confirm placement of the implants for bilateral occlusion of the fallopian tubes, use procedure code 58340.

For the occlusion of fallopian tubes by other devices (bands, clips, rings, etc.), use procedure code 58615 and attached the invoice for payment of the device.

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***Healthy Kids / EPSDT***

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**Preventative Medicine Services**

The Maryland Healthy Kids/Early and Periodic Screening, Diagnosis and Treatment (**EPSDT**) Program is a comprehensive pediatric program. This program uses Preventive Medicine (full screening) CPT codes for billing well-child care.

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- **New Patient/Full Screening:** 99381 – 99385 -  
A full screening includes a health and developmental history, unclothed physical exam, appropriate laboratory tests, immunizations and health education/anticipatory guidance.  
NOTE: A newborn infant history and examination completed in a hospital should be billed using CPT newborn care code 99460.
  - **Established Patient/Full Screening:** 99391 – 99395 -  
A full periodic screening is completed on an established patient at subsequent intervals according to the age intervals displayed on the [Maryland Healthy Kids Preventive Care Schedule](#).

Preventive Medicine CPT codes are also used to report a full EPSDT screening provided in a hospital outpatient department setting (when the physician's services are not included in the cost-based hospital rate) and for patients who are in the care and custody of a State agency pursuant to a court order or a voluntary placement agreement (foster care).

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**Substance Abuse Screening**

The Maryland Healthy Kids program requires that any provider seeing Medicaid children must perform a yearly assessment of substance use beginning at 12 years of age, and recommends assessment at earlier ages when the provider suspects problems.

The following are procedure codes for substance abuse assessment and brief intervention under EPSDT:

99406–99409

**Vaccine Administration /  
Vaccines for Children  
Program**

Eligible providers should bill for administering childhood vaccines received at no cost from the federal **Vaccines for Children Program (VFC)** by using the appropriate CPT code for the vaccine/toxoid or immune globulin in conjunction with the modifier **-SE** (state and/or Federally-funded programs/services). Providers will not be paid for vaccine administration unless the modifier **-SE** is appended to the appropriate CPT vaccine code. VFC immunization administration codes are as follows:

VACCINE	CPT-MOD
Hepatitis B Immune Globulin (HBIG)	90371-SE
Hepatitis A, pediatric/adolescent (2 dose)	90633-SE
Hemophilus influenza b, HbOC conjugate (Hib)	90645-SE
Hemophilus influenza b, PRP-OMP conjugate (Hib)	90647-SE
Hemophilus influenza b, PRP-T conjugate (Hib)	90648-SE
Human Papilloma, quadrivalent (3 dose) (HPV)	90649-SE
Influenza virus, split virus, preservative free, 6-35 months	90655-SE
Influenza virus, split, preservative free, > 2 yrs	90656-SE
Influenza virus, split virus, 6-35 months	90657-SE
Influenza virus, split virus, 3-18 years	90658-SE
Influenza virus, live, intranasal	90660-SE
Pneumococcal conjugate, 7 valent, < 5 years	90669-SE
Pneumococcal conjugate, 13 valent	90670-SE
Rotavirus, pentavalent, live,oral, (3 dose)	90680-SE
Rotavirus, monovalent, live, 6-32 weeks	90681-SE
Diphtheria, tetanus toxoids, acellular pertussis and polio virus, inactivated, 5 <sup>th</sup> dose, 4-6 years (DTaP-IPV)	90696-SE
Diphtheria, tetanus toxoids, acellular pertussis, haemophilus influenza type b, poliovirus, 2-59 months (DTaP-Hib-IPV)	90698-SE
Diphtheria, tetanus toxoids and acellular pertussis, < 7 years (DTaP)	90700-SE
Diphtheria and tetanus toxoids, < 7 years(DT)	90702-SE
Measles, mumps and rubella virus, live (MMR)	90707-SE
Measles, mumps, rubella and varicella (MMRV)	90710-SE
Poliovirus, inactivated (IPV)	90713-SE
Tetanus and diphtheria toxoids, 7-18 years (Td)	90714-SE
Tetanus diphtheria toxoids and acellular Pertussis (Tdap) 7-18 years	90715-SE

Varicella virus live	90716-SE
Tetanus toxoid and diphtheria (Td) 7-18 years	90718-SE
Diphtheria, tetanus toxoids, acellular pertussis and Hemophilus influenza b (DTaP-Hib)	90721-SE
Diphtheria, tetanus toxoids, acellular pertussis and Hepatitis B and poliovirus (DTaP-HepB-IPV)	90723-SE
Pneumococcal polysaccharide, 23-valent, 2-18 yrs	90732-SE
Meningococcal conjugate, tetravalent	90734-SE
Hepatitis B, adolescent (2 dose )	90743-SE
Hepatitis B, pediatric/adolescent (3 dose)	90744-SE
Hepatitis B and Hemophilus influenza b (HepB-Hib)	90748-SE

**Sick Visits**

Preventive medicine CPT codes can be used when a child is seen for an illness if the child is both due for a well child exam and if all of the requirements for a Healthy Kids exam can be completed. If the child has already received a preventive well child exam or is too sick to complete a full Healthy Kids exam, use the E&M codes (99201 - 99215) for sick or acute illness related office visits.

Payment is based on the fee schedule or contracted/negotiated rate for the preventive medicine and the allowed sick visit.

The comprehensive nature of the preventative medicine service codes (99381-99397) reflects an age and gender appropriate history/exam and is **not** synonymous with the “comprehensive” examination required in E&M codes 99201-99350.

If the service was an EPSDT well child check-up, the preventive medicine code must be reported. Under certain situations, however, a preventive exam and another E&M service may be payable on the same day. In this case, providers should select the most appropriate single E&M service based on all services provided. If an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventative medicine E&M service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the

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appropriate office/outpatient code should also be reported; conversely, an insignificant or trivial abnormality should not be reported.

Modifier -25 should be added to the office/outpatient code to indicate that a significant, separately identifiable E&M service was provided by the same physician on the same day as the preventative medicine service. The appropriate preventative medicine service is additionally reported.

For detail regarding this patient [medical record documentation](#), please refer to page 2-14.

For information regarding EPSDT, please consult the [EPSDT manual](#) online at: <http://dhmh.maryland.gov/epsdt/SitePages/Home.aspx>

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### **Objective Tests and Other Ancillary Services**

The following are other procedure codes for objective tests approved by the Maryland Healthy Kids Program to be used in conjunction with the screening procedure codes:

- **Developmental Test** - 96110, 96111
- **Hearing/Screening Test** - 92551
- **Vision Screen** – 99173

Immunizations, on-site laboratory services and family planning services are additional procedures which can be used in conjunction with a Healthy Kids exam.

For additional information call the Maryland Healthy Kids Program at (410) 767-1683 or (877) 463-3464, x1683.

The [Healthy Kids Manual](#) may also be accessed online at: <http://dhmh.maryland.gov/epsdt/healthykids/SitePages/Home.aspx>

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### ***Allergy Immunotherapy***

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#### **Procedure Code 95117**

This code refers to professional services for two or more injections of allergen immunotherapy. The Program will pay for a maximum of two

**Procedure Codes 95120 through 95134**

units of service for this procedure, regardless of the number of injections given at one visit.

These codes refer to the injection of the allergen in the prescribing physician's office and include the office visit. Do not bill for an office visit in addition to these codes. The Program will pay for only one unit of service for these procedures regardless of the number of injections given at one visit.

When allergy injections are administered in an office other than the prescribing physician's office, use the appropriate office visit code only if there is a separate identifiable medical service, otherwise, use code 95117. The length of observation time spent by the patient in the office or facility does not increase the level of service.

Do not bill for procedure codes 95120 - 95134 in addition to an office visit code.

**Procedure Code 95144**

This code refers to the preparation and provision of antigens for the patient and includes an office visit. The Program will pay for only one unit of service for this procedure regardless of the number of injections given at the visit.

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**Ophthalmology**
**General**

A general evaluation of the complete visual system includes:

- History
- General medical observation
- External and ophthalmoscopic examinations
- Gross visual fields
- Basic sensorimotor examination

It often includes, as indicated:

- biomicroscopy,
  - examination with cycloplegia
- OR
- mydriasis and tonometry.

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Evaluations always include initiation of diagnostic and treatment programs.

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## ***Renal Dialysis***

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### **General**

Physicians' services associated with renal dialysis must include all of the following medically appropriate standards:

- Visits by the physician to the patient during dialysis at the free-standing dialysis facility, review of laboratory test results, nurses' notes, and any other medical documentation, as a basis for:
  - Adjustment of the patient's medication or diet, or the dialysis procedure
  - Prescription of medical supplies
  - Evaluation of the patient's psychosocial status and the appropriateness of the treatment modality
- Medical direction of staff in delivering services to the patient during a dialysis session;
- Pre-dialysis and post-dialysis examinations, or examinations that could have been furnished on a pre-dialysis or post-dialysis basis;
- Insertion of catheters for patients who are on peritoneal dialysis and do not have indwelling catheters
- Documentation in the medical record written and signed by the physician, documenting that the services were personally provided by the physician.

### **Procedure Codes 90951 through 90962**

These codes refer to age-specific services related to the patient's **end-stage renal disease (ESRD)** in an outpatient setting. ESRD-related physician services include establishment of a dialyzing cycle, outpatient evaluation and management of dialysis visits, and patient management during the dialysis provided during a full month. Report these codes once per month, but do not use if the physician reports hospitalization codes during the same month.

**Procedure Codes 90963 through 90966**

These codes refer to age-specific services related to ESRD performed in the patient's home. Report these codes once per month. Codes 90967 – 90970 are used to report ESRD services less than a full month per day.

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**Lab and Pharmacy Services**

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**Radiopharmaceuticals**

Payment for radiopharmaceuticals is usually considered separately from the procedure. Use HCPCS codes A9500 – A9604. If a HCPCS code has not been established for the radiopharmaceutical used, use code A4641 for a diagnostic agent and code A9699 for a therapeutic agent. A patient specific invoice is required for payment of those two codes, as well as for 8 A-codes which do not have a listed fee: A9512, A9531-A9532, A9542-A9545, and A9550.

The invoice must supply all the following information:

- Recipient name
- Name of radiopharmaceutical
- Dosage being administered
- Cost of radiopharmaceutical
- Date radiopharmaceutical was administered

Use HCPCS codes Q9951, and Q9965–Q9967 for **Low Osmolar Contrast Media (LOCM)**.

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**Injectable Drugs and Biologicals**

The Program covers injectable drugs and biologicals which are FDA approved and medically necessary.

If a drug is given on the same day as another service, the administration is generally considered part of the other service and cannot be reported separately. If the only service rendered is the injection, the administration cannot be billed separately. Only the J-code for the drug can be reported.

The Program pays providers the acquisition cost for injectable drugs. Providers must bill their actual cost for drugs and biologicals.

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The Program's maximum payment established for each J-code represents the estimated actual cost of the drug to the provider. If the Program's fee is less than the provider's actual cost, the Program will pay the provider the difference between their actual cost and the amount paid by the Program upon appeal. The fees for J-codes are not listed in this manual.

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**Reporting Acquisition Costs using J-Code**

Physicians must bill their acquisition cost for injectable drugs.

Charge the acquisition cost in Block 24F of the CMS-1500 claim form.

The CMS-1500 claim form must include the J-code in Block 24D and the number of units administered in Block 24G.

The dosage indicated in the J-code description multiplied by the number of units reported should equal the total amount of the drug administered.

**Reporting Acquisition Costs using Unclassified J-Codes**

When a drug is administered that does not have a specific J-code or the "strength" is different from the J-codes listed, use the appropriate unclassified J-code in Block 24D of the CMS-1500 claim form.

The maximum number of units that can be administered for an unlisted injectable drug is "1."

Use J9999 for unclassified antineoplastic drugs and J3490 for all other unclassified drugs.

Claims that contain unlisted codes cannot be processed for payment without an attached copy of a recent invoice which clearly shows the per-unit cost of the drug. Unclassified procedure codes require manual review and payment may be delayed.

Payment processing can be facilitated by writing on the attached invoice the calculation used to determine the acquisition cost of the unlisted drug. The NDC in the shaded area of Block 24 A on the CMS-1500

claim form must agree with the name of the drug listed on the invoice. The actual cost documentation is only required for unlisted injectable drugs. The drug will not be paid for if its actual cost cannot be determined from the information reported on the claim or from the invoice.

## Other Requirements

The Program does not pay separately from the E&M visit code for immunization administration (CPT codes 90465 – 90474 are not used/payable by the Program), except for immunizations covered under the [Vaccines for Children Program](#) (see page 3-24).

The Program will not pay providers for drugs unless their manufacturers participate in the Medicaid Drug Rebate Program and the NDC and quantity administered are reported on the CMS-1500 claim form. See [NDC Reporting Requirements](#) on page 2-19.

The quantity reported should reflect the dose given according to the HCPCS description for the code. Use the code with the exact dosage or round the quantity up to best describe the amount given. When administering a dose from a multiple dose vial, only the amount given to the patient should be billed to the Program. If a drug is only available in a single use size and any drug not used must be discarded, the Program will pay for the amount supplied in the vial.

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## Pathology & Laboratory

Providers may only bill the Program for laboratory procedures which they perform or are performed under their direct supervision.

Physicians' service providers cannot be paid for clinical laboratory services without both a **Clinical Laboratory Improvement Amendments (CLIA)** certification and approval by the Maryland Laboratory Administration, if located in Maryland. Laboratory procedures that the physician refers to an outside laboratory or practitioner for performance must be billed by that laboratory or practitioner. The physician may not bill for any laboratory procedure that is referred to a laboratory or another physician.

Interpretation of laboratory results, or the taking of specimens other

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than blood, is considered part of the office visit and may not be billed as a separate procedure. Specimen collections for Pap smears and PKU (Phenylketonuria) for infants are not billable by a physician. Specimen collection by venipuncture, capillary, or arterial puncture are billable.

**For More Information**

Specific information concerning pathology and laboratory services can be found in the [Medical Laboratories Provider Manual and Fee Schedule](#) under [COMAR 10.09.09](#).

Call (410) 767-1462 or (877) 463-3464, x1462 for additional information.

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**Supplies & Materials**

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**General**

Procedure code 99070 refers to supplies and materials. Providers will be paid their acquisition cost for these services.

Invoice documentation is only required for supplies with an acquisition cost of ten dollars or more. Report the name of the supply and the amount supplied in Block 24D of the CMS-1500 claim form. A copy of a current invoice that clearly shows the per-unit cost of the supply must be attached to the claim. The calculation used to determine the acquisition cost should be written on the invoice. No payment will be made if the actual cost cannot be determined from the documentation provided.

Only those supplies provided by the physician over and above those usually included with the office visit or other services rendered may be listed separately under procedure code 99070.

## APPENDICES

### Overview

#### Introduction

This chapter provides information that supplements other chapters in the manual.

#### In This Chapter

This chapter contains:

TOPIC	PAGE
TRAUMA BILLING INSTRUCTIONS	<a href="#">4-1</a>
Trauma Center Information	<a href="#">4-4</a>
PRE-AUTHORIZATION PROCEDURE	<a href="#">4-6</a>
FREQUENTLY ASKED QUESTIONS	<a href="#">4-7</a>
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TELEPHONE DIRECTORY	<a href="#">4-10</a>
LINKS DIRECTORY	<a href="#">4-11</a>
ACRONYMS	<a href="#">4-13</a>

### Trauma Billing Instructions

#### General

The following billing instructions for the CMS-1500 must be followed by trauma physicians in order to be reimbursed by Medicaid for trauma services at the higher Medicare rate:

- a) Report modifier -U1 in one of the modifier positions for the trauma service in Block 24D (modifier field). This modifier is being used to reimburse trauma providers for trauma services at the Medicare rate instead of the Medicaid rate.
- b) List a primary, secondary or additional diagnosis code in Block 21 (diagnosis or nature of illness or injury field) from 800.00 – 959.9, or use a supplementary classification of external causes and injury and poisoning code from E800 – E999 as a subsequent supplementary classification code in Block 21.
- c) List a primary, secondary or additional diagnosis code in Block 24E (diagnosis code field) for each line item on the invoice must be from 800.00 – 959.9, or a supplementary classification of external causes and injury and poisoning code from E800 – E999 must appear as a subsequent supplementary

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classification code in Block 24E for each line item on the invoice when the -U1 modifier is reported.

- d) Report the last two-digits of the trauma center identification number and the six-digit trauma registry (patient identification) in Block 23 (prior authorization number field) as an eight-position number (see table below). The trauma registry number is available from the trauma center where care was provided. If the trauma registry number is less than six digits, place zeros in front of the trauma registry number until you have a six-digit number. For example, if there is only a four-digit trauma registry patient number, fill in the first two positions with zeros.
- e) Report only the place of service codes -21 (inpatient) and -23 (emergency room) in Block 24B (place of service field) for trauma services.
- f) Enter the ID Qualifier 1D followed by the nine-digit Medical Assistance Program provider number of the hospital where the trauma center is located in Block 32B (service facility location information) on the CMS-1500.

The increased fees are only applied to the trauma services rendered during the initial admission or trauma center visit and the resulting acute care stay, not for subsequent follow-up services. ALL REPORTING OF THE U1 MODIFIER WILL BE SUBJECT TO POSTPAYMENT AUDIT.

NOTE: The current revision to the Physicians' Services Provider Fee Manual can be obtained from the Department of Health and Mental Hygiene's web site at [www.dhmh.state.md.us/mma/providerinfo/](http://www.dhmh.state.md.us/mma/providerinfo/).

NOTE: The Program implemented the CMS-1500 (08-05) on July 30, 2007. Billing instructions can be found at [www.dhmh.state.md.us/mma/mmahome/](http://www.dhmh.state.md.us/mma/mmahome/) (click on NPI and Maryland Medical Assistance Program Providers).

NOTE: CMS-1500 (08/05) claim form changes include blocks:

**17A/B** Name of Referring Provider or Other Source

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<b>24C</b>	EMG (not required)
<b>24I</b>	ID Qualifier
<b>24D</b>	Rendering Provider ID #
<b>32A/B</b>	Service Facility Location Information
<b>33</b>	Billing Provider Info & PH #

NOTE: The nine-digit Medical Assistance Program Provider Number will continue to be required on all paper claims. When entering a provider's nine-digit provider number, it must be preceded by the ID Qualifier 1D.

**Trauma Center Information**

Billing instructions by Facility Type are below.

<b>Facility Name</b>	<b>Trauma Center ID (Last 2-Digits of the MIEMSS Facility ID#) + Trauma Registry #</b>
<u>State Primary Adult Resource Center</u>	
R. Adams Cowley, Shock Trauma Center, Baltimore	34 + 6-Digit Trauma Registry Patient Number
<u>Level I Trauma Center</u>	
Johns Hopkins Medical System, Adult Trauma Center, Baltimore	04 + 6-Digit Trauma Registry Patient Number
<u>Level II Trauma Centers</u>	
Johns Hopkins Bayview Medical Center, Adult Trauma Center, Baltimore	01 + 6-Digit Trauma Registry Patient Number
Prince George's Hospital Center, Adult Trauma Center, Cheverly	32 + 6-Digit Trauma Registry Patient Number
Sinai Hospital of Baltimore, Adult Trauma Center	10 + 6-Digit Trauma Registry Patient Number
Suburban Hospital, Adult Trauma Center, Bethesda	49 + 6-Digit Trauma Registry Patient Number
<u>Level III Trauma Centers</u>	
Western Maryland Health System, Cumberland Memorial Trauma Center	20 + 6-Digit Trauma Registry Patient Number
Peninsula Regional Medical Center, Adult Trauma Center, Salisbury	08 + 6-Digit Trauma Registry Patient Number
Washington County Hospital, Adult Trauma Center, Hagerstown	89 + 6-Digit Trauma Registry Patient Number
<u>Pediatric Trauma Centers</u>	
Johns Hopkins Medical System, Pediatric Trauma Center, Baltimore	05 + 6-Digit Trauma Registry Patient Number
Children's National Medical Center, Pediatric Trauma Center, Washington, D.C.	17 + 6-Digit Trauma Registry Patient Number

**Trauma Center Information (continued)**

Billing instructions by Facility Type are below.

<b>Facility Name</b>	<b>Trauma Center ID (Last 2-Digits of the MIEMSS Facility ID#) + Trauma Registry #</b>
<u>State Primary Adult Resource Center</u>	
R. Adams Cowley, Shock Trauma Center, Baltimore	34 + 6-Digit Trauma Registry Patient Number
<u>Level I Trauma Center</u>	
Johns Hopkins Medical System, Adult Trauma Center, Baltimore	04 + 6-Digit Trauma Registry Patient Number
<u>Level II Trauma Centers</u>	
Johns Hopkins Bayview Medical Center, Adult Trauma Center, Baltimore	01 + 6-Digit Trauma Registry Patient Number
Prince George's Hospital Center, Adult Trauma Center, Cheverly	32 + 6-Digit Trauma Registry Patient Number
Sinai Hospital of Baltimore, Adult Trauma Center	10 + 6-Digit Trauma Registry Patient Number
Suburban Hospital, Adult Trauma Center, Bethesda	49 + 6-Digit Trauma Registry Patient Number
<u>Level III Trauma Centers</u>	
Western Maryland Health System, Cumberland Memorial Trauma Center	20 + 6-Digit Trauma Registry Patient Number
Peninsula Regional Medical Center, Adult Trauma Center, Salisbury	08 + 6-Digit Trauma Registry Patient Number
Washington County Hospital, Adult Trauma Center, Hagerstown	89 + 6-Digit Trauma Registry Patient Number
<u>Pediatric Trauma Centers</u>	
Johns Hopkins Medical System, Pediatric Trauma Center, Baltimore	05 + 6-Digit Trauma Registry Patient Number
Children's National Medical Center, Pediatric Trauma Center, Washington, D.C.	17 + 6-Digit Trauma Registry Patient Number

Trauma Center Identification (continued)	Facility Name	Trauma Center ID (Last 2-Digits of the MIEMSS Facility ID#) + Trauma Registry #
<u>Trauma Specialty Referral Centers</u>		
Johns Hopkins Medical System, Burn Center, Baltimore		91 + 6-Digit Trauma Registry Patient Number
Johns Hopkins Medical System, Pediatric Burn Center, Baltimore		93 + 6-Digit Trauma Registry Patient Number
Johns Hopkins Medical System, Eye Trauma Center, Baltimore		95 + 6-Digit Trauma Registry Patient Number
Union Memorial Hospital, Curtis National Hand Center, Baltimore		94 + 6-Digit Trauma Registry Patient Number

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***Pre-Authorization Decision Procedure***

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**Procedure**

Step 1: Call the Medicaid EVS hotline and follow the instructions to verify the patient's eligibility.

Step 2: Determine whether the recipient is having an in-patient service or out-patient service.

- If in-patient, please call Delmarva for pre-authorization
- If out-patient, please proceed to the next step.

Step 3: Determine whether the recipient has coverage through both Medicaid AND Medicare.

- If Yes, please refer to the section on [Dual-Eligibles](#) and Medicare crossover claims, then proceed to Step 5.
- If No, proceed to the next step.

Step 4: Determine whether the recipient has coverage through the Medicaid HealthChoice program.

- If Yes, call the recipient's HealthChoice MCO to obtain any pre-authorization.
- If No, proceed to the next step.

Step 5: Look up the most recent Physicians' Fee Schedule and find the CPT procedure codes the recipient is planning to receive. In the "Note" column next to your code, determine whether it is blank or if it has a letter indicator.

- If blank, then the procedure does not require preauthorization through Maryland Medicaid.
- If an indicator is present (either a P, A, H, or S), proceed to the next step.

Step 6: Determine the letter of the indicator – P, A, H, or S?

- If P, then a Pre-authorization is required. Please fill out the Medicaid Preauthorization Form per the guidelines and call Provider Relations.
- If A, then a Certification for Abortion is required. Please fill out the Certification for Abortion form per the guidelines and keep them in the patient's record. No additional pre-authorization is required.
- If H, then a Certification for Hysterectomy is required. Please fill out the Certification for Hysterectomy form per the guidelines and keep them in the patient's record. No additional pre-authorization is required.
- If S, then a Certification for Sterilization is required. Please fill out the Sterilization Consent form per the guidelines and keep in the patient's record. No additional pre-authorization is required.

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### ***Frequently Asked Questions***

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#### **FAQ**

Q: Is the fee schedule listed in this manual?

A: The fee schedule is posted in a separate document online. It is, however, incorporated by reference in this fee manual. The fee schedule may be found online at:

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<http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx>

Q: Can the fee schedule be used for Ambulatory Surgery Centers?

A: ASCs rates cannot be found on the Physicians' Fee Schedule. The codes that ASCs may reimburse are based off of the 2007 Medicare ASC fee schedule; the rates are 2% less than what Medicare reimbursed in 2007.

Q: How is a patient pre-authorization determined?

A: If the services are rendered in an inpatient setting, pre-authorization must be determined through Delmarva at (866) 571-3629. If the services are rendered in an outpatient setting and the patient only has Fee-For-Service coverage through Maryland Medicaid, you may use the Physicians' Fee Schedule to determine pre-authorization based on the CPT code. If the Note field has a letter "P" next to a specific code, that code requires pre-authorization. If it a code does not have a letter "P" in the Note field, that code does not require preauthorization. For other letters that may appear in that field, see the following question.

Q: What does A, H, and S stand for in the Fee Schedule?

A: A, H, and S stand for Abortion, Hysterectomy, and Sterilization, respectively. Those procedures do not require preauthorization, but require the provider and the recipient to complete their respective forms to keep on the patient's file.

Q: Where can I find a fee schedule for HCPCS Level II codes, especially J-codes?

A: The Physician's Fee Schedule does not display the reimbursement amounts for HCPCS Level II codes. Providers billing J codes must bill their acquisition costs.

Q: What codes can specialist physicians bill?

A: We do not have a separate fee schedules for different physician specialty types. They should bill according to their scope of practice and expect payment to be the lower of their charge or the rate in the current physician fee manual.

Q: Why are the facility rates lower than the non-facility rates?

A: Both facility and non-facility rates are based on the Medicare rate. For certain codes, the facility rate is lower than the non-facility rate because providers in a non-facility setting also have to take into account administrative overhead.

Q: What is the Program's anesthesia conversion factor?

A: The Program does not reimburse anesthesia in the same way as Medicare. Reimbursement is calculated per one-minute increments instead of per 15-minute increments. Please see [Anesthesia](#) in the Services Information section for further details.

Q: How does the Program cover for new injectable drugs?

A: The Program reimburses all injectable drugs if they are FDA approved, not for use in a clinical trial, and not used for cosmetic surgery or off-label. All injectable drugs are reimbursed based on acquisition cost and may be subject to program review or preauthorization.

**Program-Accepted Modifiers**

Modifier	Description	% of Fee
<b>Anesthesia</b>		
-AA	Anesthesia performed personally by anesthesiologist	100%
-QK	Medical direction of 2-4 concurrent anesthesia procedures	50%
-QX	CRNA service with medical direction by a physician	50%
-QY	Medical direction of 1 CRNA by an anesthesiologist	50%
-QZ	CRNA service without medical direction by a physician	50%
-23	Unusual Anesthesia	Med. Report Required
<b>Evaluation &amp; Management</b>		
-25	Separately Identifiable E&M	Med. Report Required
<b>Surgery</b>		
-50	Bilateral Procedures	150%
-51	Multiple Procedures	50%
-52	Reduced Services	Med. Report

		Required
-53	Discontinued Procedure	Med. Report Required
-54	Surgical Care Only	80%
-55	Postoperative Management Only	20%
<b>Surgical Assistance</b>		
-80	Assistant Surgeon	20%
-82	Assistant surgeon (when qualified resident not available)	20%
<b>Trauma Services</b>		
-U1	Trauma Services	Medicare Conv. Factor
<b>Component Billing</b>		
-26	Professional Component	Same as Medicare
-TC	Technical Component	Difference of -26 Modifier
<b>Vaccine for Children Program</b>		
-SE	VFC Administration	\$23.28

**Telephone Directory**

**Physicians' Services Program**

To obtain a toll-free number for any of the (410) 767- exchanges below, call (877) 463-3464 and ask the appropriate 4-digit extension.

Policy/Coverage Issues	(410) 767-1462
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**Other Programs**

Claims (CMS-1500) & Claims Adjustments	(410) 767-5346
Delmarva Provider Services	(888) 571-3629
Electronic Media Submittal	(410) 767-5863
Eligibility Verification System (EVS)	(866) 710-1447
EPSDT/Health Kids Screening/Certification	(410) 767-1683
Institutional Services	(410) 767-5457
Laboratory Services/Policy/Coverage	(410) 767-5706
LTC Problem Resolution	(410) 767-8699
Medical Assistance Program Training Liaison Unit	(410) 767-6024
Missing Payment Voucher or Lost/Stolen Check	(410) 767-5503
OB/GYN/Family Planning Policy/Coverage	(410) 767-6750
Provider Master File (Enrollment)	(410) 767-5340
Provider Relations	(410) 767-5503
Recoveries	(410) 767-1783
Third Party Liability/Other insurance	(410) 767-1771

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## Links Directory

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### Forms

- **CMS-10114:** [NPI Application/Update Form](#)
- **CMS-1500:** [Health Insurance Claim Form](#)
- **CMS-837P:** [Electronic Health Insurance Claim Form Guidance](#)
- **DHMH-521:** [Certification of Abortion](#)
- **DHMH-2990:** [Document For Hysterectomy](#)
- **DHMH-4523:** [Preauthorization Request Form for Physician Services](#)
- **DHMH 4850:** [MPRA Form](#)
- **HHS-687:** [Sterilization Consent Form \(English\)](#)
- **HHS-687-1:** [Sterilization Consent Form \(Spanish\)](#)

### Websites and Other Resources

- **5010 Compliance:** [dhmh.hipaaeditest@maryland.gov](mailto:dhmh.hipaaeditest@maryland.gov)
- **AMA/CPT:** <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page>
- **CMS-1500 Billing Instructions (complete):** <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf>
- **HIPAA:** <http://www.hhs.gov/ocr/privacy/hipaa/administrative/index.html>
- **NCCI:** <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>
- **NPPES:** [www.nppes.cms.hhs.gov/NPPESWelcome](http://www.nppes.cms.hhs.gov/NPPESWelcome)
- **Production Files Information:** [dhmh.ediops@maryland.gov](mailto:dhmh.ediops@maryland.gov)
- **Physician Fee Schedule:** <http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx>
- **General HealthChoice MCO Program:** <http://mmcp.dhmh.maryland.gov/healthchoice/SitePages/Home.aspx>
- **AMERIGROUP Community Care:** <http://www.amerigroupcorp.com/>
- **Diamond Plan:** <http://chcdelaware.coventryhealthcare.com/>
- **Jai Medical Systems:** <http://www.jaimedicalsystems.com/>
- **Maryland Physicians Care:** [www.marylandphysicianscare.com/](http://www.marylandphysicianscare.com/)
- **MedStar Family Choice:** <http://www.medstarfamilychoice.net>
- **Priority Partners:** <http://www.ppmco.org/>

- **UnitedHealthcare:** <http://www.uhccommunityplan.com>
- **COMAR:**  
[http://www.dsd.state.md.us/comar/subtitle\\_chapters/10\\_Chapters.aspx](http://www.dsd.state.md.us/comar/subtitle_chapters/10_Chapters.aspx)
- **EPSDT Manual:**  
<http://dhmh.maryland.gov/epsdt/SitePages/Home.aspx>
- **EVS User Guide:**  
<http://mmcp.dhmh.maryland.gov/docs/Maryland%20Medicaid%20Brochure%20V3.pdf>
- **Maryland Healthy Kids Manual:**  
<http://dhmh.maryland.gov/epsdt/healthykids/SitePages/Home.aspx>
- **Maryland Healthy Kids Preventative Care Schedule:**  
[http://dhmh.maryland.gov/epsdt/healthykids/SiteAssets/SitePages/table\\_contents/Maryland%20EPSDT%20Healthy%20Kids%20Preventive%20Health%20Schedule%20Oct%2012%20\(1\).pdf](http://dhmh.maryland.gov/epsdt/healthykids/SiteAssets/SitePages/table_contents/Maryland%20EPSDT%20Healthy%20Kids%20Preventive%20Health%20Schedule%20Oct%2012%20(1).pdf)
- **Medical Laboratories Provider Manual and Fee Schedule:**  
<http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx>
- **OB/GYN/Family Planning Manual:**  
<http://mmcp.dhmh.maryland.gov/Documents/OB%20MANUAL%20March%202012.pdf>
- **Transmittals:**  
<http://mmcp.dhmh.maryland.gov/MCOupdates/SitePages/Home.aspx>
- **Self Referred Services:**  
<http://mmcp.dhmh.maryland.gov/docs/SELFREFERRALMAN.Current.update.08.10.pdf>
- **Nursing Services:**  
<http://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Nursing%20Home%20Services.aspx>
- Medical Assistance Program State Plan Disposable Medical Supplies and Durable Medical Equipment
- **Novitas Medicare Solutions:** <https://www.novitas-solutions.com/index.html>

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**List of Acronyms**


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ABUs	Anesthesia Base Units
AMA	American Medical Association
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services'
COMAR	Code of Maryland Regulation
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
E&M	Evaluation & Management
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
ESRD	End-Stage Renal Disease
FFS	Fee For Service
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HSCRC	Health Services Cost Review Commission
ICD	International Classification of Disease
LOCM	Low Osmolar Contrast Media
MAC	Monitored Anesthesia Care
MCOs	Managed Care Organizations
MHCC	Maryland Health Care Commission
MIEMSS	Maryland Institute for Emergency Medical Services System
NCCI	National Correct Coding Initiative
NDC	National Drug Code
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OB-GYN	Obstetrics and Gynecology
UCA	Utilization Control Agent
VFC	Vaccines for Children Program