

THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# Health Homes

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## Billing Instructions

**Maryland Medical Assistance**

**8/28/2013**

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## I. GENERAL INFORMATION

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### A. Introduction

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

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

These billing instructions are designed to help Health Home providers understand the proper billing procedures for Health Home services within Medicaid. Instructions include information about the required processes in becoming a Health Home provider and the procedures involved in participant enrollment, claims submission, and reimbursement.

### B. Getting Started

Health Home providers will submit claims directly to the Department of Health and Mental Hygiene's (DHMH) Fee-For-Service system. Before billing for Health Home services, providers must take the following steps:

#### 1. Obtain Required Approval or Exemption

Health Homes must have the appropriate certification or approval as a PRP, MTS, or OTP provider from the Office of Health Care Quality (OHCQ), the Mental Hygiene Administration (MHA), or the Alcohol and Drug Abuse Administration (ADAA), as appropriate. Depending on the provider type, this may be substituted with a letter of exemption from the appropriate organization.

#### 2. Apply for a National Provider Identifier

Health Home providers must obtain a National Provider Identifier (NPI), a unique 10-digit identifier that health care providers must use on all transactions as mandated by the Health Information Portability and Accountability Act (HIPAA). Additional NPI information can be found on the Center for Medicare and Medicaid Services (CMS) website at <https://nppes.cms.hhs.gov/NPPES/Welcome.do> or by calling the NPI assistance phone line at 1-800-465-3203.

### **3. Apply for a Medical Assistance Provider Number**

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

### **4. Apply to be a Health Home**

Providers must complete a Health Home provider application and the required attachments before billing for Health Home services. Providers who wish to enroll more than one provider type as a Health Home may submit a single Health Home application, assuming Health Home protocols will be shared between the programs. In cases where Health Home protocols will vary significantly between programs, please submit separate applications to capture these differences. In the case of a single application for multiple provider types or sites, please be sure to indicate this on the application. The provider application and instructions may be found at <http://dhmh.maryland.gov/bhd/SitePages/Health%20Homes.aspx>. Applications may be submitted via email to [dhmh.healthhomes@maryland.gov](mailto:dhmh.healthhomes@maryland.gov).

### **5. Register with eMedicaid**

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

## II. VERIFYING PARTICIPANT ELIGIBILITY

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

In order to be eligible, a recipient's Eligibility Information status must read "*Eligible for date of service*" and the Benefit Description must reflect full Medicaid benefits. Only full Medicaid recipients are eligible to receive Health Home services. For example, the image below is a screenshot of an EVS message for an individual who is ineligible for Health Homes. Although the Eligibility Information reads "*Eligible for date of service*," the Benefit Description specifies that the individual is a Qualified Medicare Beneficiary (QMB), which is not a full Medicaid recipient.

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

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

- "*Recipient is QMB only.*"
- "*Recipient is SLMB only.*"
- "*Recipient has PAC primary adult care coverage.*"
- "*Recipient's benefits are limited to family planning services only.*"
- "*Recipient has other health insurance.*"

For more information about EVS, visit the online user's guide at <https://mmcp.dhmdh.maryland.gov/docs/EVS%20Brochure%20March%202013.pdf>.

### III. HEALTH HOME SERVICES

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

- 1. The Health Home Intake Assessment:** Providers may only bill this service once for each patient. The only exception is if a participant was discharged and is reenrolling at least 6 months later. Intake assessments conducted during the pre-enrollment stage prior to the official implementation of the Health Homes program on October 1, 2013 should be billed with a Date of Service of October 1, 2013.

Service	Procedure Code	Unit of Service	Rate
Health Home Intake Assessment	W1760	Per Assessment	\$98.87

- 2. Health Home Monthly Services:** Providers may bill this service once per calendar month or 12 times per calendar year. Payment for this service is dependent upon the provider meeting the minimum service provision and documenting those services in eMedicaid. Monthly service claims should be billed with a Date of Service of the last day of the month in which the services were provided. For example, all services provided in the month of November would be billed with a Date of Service of November 30<sup>th</sup>.

Service	Procedure Code	Unit of Service	Rate
Health Home Monthly Services	W1761	Per Month	\$98.87

## IV. SUBMITTING CLAIMS

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### A. Filing Statutes

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

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

### B. Electronic Claims

Claims may be submitted electronically through the eClaims system within eMedicaid. This online service will enable providers that bill on the CMS 1500 to submit their claims electronically and receive payment sooner. For instructions on registering as an eClaim user, please reference the eClaims Overview document, which can be found on the eMedicaid homepage at <https://encrypt.emdhealthchoice.org/emedicaid/>.

Authorized users will see a link to "eClaim" on their eMedicaid homepage that leads to the "Claim Home" page. There, a provider can submit a new claim, view recently submitted claims, or search the claim history. For more detailed information and instruction, please reference the eClaims Tutorial document, which can be found on the eMedicaid homepage. Additional questions may be directed to [dhmh.eMedicaidMD@maryland.gov](mailto:dhmh.eMedicaidMD@maryland.gov).

### C. Paper Claims

Providers may also submit paper claims using the CMS 1500 form. A sample form and detailed instructions for filling out the form as a Health Home provider will be available on or before September 30, 2013.

Completed claims may be mailed to the following address:

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

**D. Rejected Claims**

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

1. Data was incorrectly keyed or was unreadable on the claim,
2. The claim is duplicative or has previously been paid, or
3. The claim should be paid by another party.

**E. Remittance Requests**

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

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

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

For questions or concerns regarding incorrect payment, please contact the Adjustment Unit at 410-767-5346.