Maryland
DEPARTMENT OF HEALTH

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Maryland Medicaid Program
Reproductive Health Services

This series of factsheets replaces the HealthChoice Self-Referral Manual and the OB/GYN/Family Planning Provider Services Manual.

Most Maryland Medicaid beneficiaries are enrolled in managed care organizations (MCOs) through the HealthChoice program. However, it is common for beneficiaries to have fee-for-service (FFS) Medicaid before MCO enrollment and for short periods of time after breaks in Medicaid eligibility. Some services, referred to as "carve outs," are not covered by MCOs but are covered by FFS Medicaid and reimbursed by the state.

For beneficiaries in MCOs, it is important to understand that beneficiaries can self-refer to out-of-network providers for certain services. This overview and the accompanying factsheets are provided to assist providers in understanding self-referral and reproductive health coverage for both the FFS and MCO systems. Reproductive health topics covered include:

> **Factsheet #1. Self-Referral Provisions for HealthChoice Members**
> **Factsheet #2. Family Planning Services**
> **Factsheet #3. Medicaid Family Planning Program**
> **Factsheet #4. Long-Acting Reversible Contraceptives (LARCs)**
> **Factsheet #5. Permanent Sterilizations**
> **Factsheet #6. Abortion Services**
> **Factsheet #7. Obstetrics and Gynecology**

The Medicaid program covers a wide variety of services including but not limited to:

- General
  - Medically necessary services rendered within the limitations of the CPT, Medicaid, Medicare, and NCCI guidelines, provided by providers who are participating with the Program

- Evaluation and Management (E&M)
  - E&M 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

- o Medically necessary surgical procedures
- o Abortions, sterilizations, and hysterectomies under the limitations detailed in the **Reproductive Health Services Factsheets** and the **Professional Services Provider Manual** available on the Program's website: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx
- Drugs and injectables
    - o Drugs dispensed by the provider acquired from a wholesaler or specialty pharmacy
    - o Injectable drugs administered by the provider
    - o Drugs and injectable services within the limitations of COMAR 10.09.03
    - o Medicine codes, including administration codes for the Vaccines for Children Program
- Other Services
    - o Unlisted services and injectable drugs when accompanied by a medical report, surgery notes, a wholesaler invoice, and/or any other documentation as requested

For specific information, go to the **Professional Services Provider Manual** and **Fee Schedule** at https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx

Lab Tests

Providers and clinics should only bill, as a part of the office visit, for labs and cytopathology services that are provided in their facility. If lab and/or cytopathology results are performed by an outside lab, the provider or clinic may not bill Medicaid for the test(s); the lab should bill Medicaid directly.

Fee-for-Service Billing

Providers rendering services under Medicaid's Fee-for-Service program must bill using the CMS-1500 and submit 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, providers can resubmit the claim 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 recipient may not be billed for that claim. Under no circumstances may a Medicaid recipient be billed for a Medicaid covered service. If a provider submits a claim and receives neither payment nor rejection within 90 days, the claim may be resubmitted.

Claims can be submitted in any quantity at any time within the filing statute of limitations, which is 12 months from the date of service. The following guidance is in addition to the initial claim submission:
- 12 months from the date of service of the IMA-81 (Notice of retro eligibility)
- 120 days from the date of the Medicare Explanation of Benefits (EOB)
- 60 days from the date of Third-Party Liability EOB
- 60 days from the date of the Maryland Medicaid Remittance Advice (RA)

The Program **will not** accept computer-generated reports as proof of timely filing. The **only** documentation that will be accepted is a remittance advice, Medicare or third party EOB, IMA-81, and/or a returned date stamped claim from the Program.

Paper claim submissions may take up to 30 days from date of receipt to process. Invoices are processed weekly. Payments are issued weekly and sent to the provider's pay-to address.

Claims should be mailed to the following address:

> Claims Processing
> Maryland Department of Health
> P.O. Box 1935
> Baltimore, MD 21203

Electronic claim submissions are processed faster. Claims submitted electronically must be done in the ANSI ASC X12N 837P format, version 5010A. A signed *Submitter Identification Form and Trading Partner Agreement* must be submitted, as well as testing before transmitting such claims.

For questions and information about testing electronic claims submission, please send inquiries to: mdh.ediops@maryland.gov

eClaims allows for direct billing through the e-Medicaid website. This service enables certain provider types that bill using the CMS-1500 to submit their single claims electronically. Claims that require attachments cannot be submitted through this new feature. Claims will be processed the same week they are keyed and payment will follow the next week.

To become an eClaim user, the administrator from the provider's office must register usersby going to the eMedicaid website: https://encrypt.emdhealthchoice.org/emedicaid

For questions regarding this new feature, how to register, or to determine if your provider type can submit eClaims, please email your questions to: mdh.emedicaidmd@maryland.gov

Go to **CMS-1500 Billing Instructions** at: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx for additional information regarding billing.

Payment in Full and Maximum Payment
The fee schedule for professional services lists the *Current Procedural Terminology (CPT)* codes and the maximum fee paid for each procedure. A provider using CPT coding selects the procedureor service that most accurately identifies the service performed. Providers are paid either the lesser of their usual and customary charge or the maximum allowable fee. 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 recipients or recipients' families for either covered or denied services; such action constitutes an overpayment and is in violation of both Federal and State regulations. Refer to the **Professional Services Provider Manual and Fee Schedule** at:
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Under no circumstances may a Medicaid provider bill a Medicaid beneficiary or MCO member for a Medicaid covered service. See *Provider Transmittal #81* on the Program's website:
https://health.maryland.gov/mmcp/Documents/PT%2039-15%20FINAL.pdf

Other Third-Party Insurance

In general, the Program is always the payer of last resort. If a recipient is covered by other federal or third-party insurance (i.e., Medicare or commercial insurance), the provider must seek payment from that source first before billing FFS Medicaid. For more information, see the **Professional Services Provider Manual** at: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Medicare Crossover Claims

Some Medicaid beneficiaries also have Medicare. *If a beneficiary has Medicare, they will not be enrolled in an MCO*. 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. When a provider bills Medicare B for services rendered to a Medicaid recipient, and the provider accepts assignment on the claim, 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 submit 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. For additional information regarding Medicare Crossover claims, go to **CMS-1500 Billing Instructions** at https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Hospital Admissions

Preauthorization by Telligen, the Program's Utilization Control Agent (UCA), is required for all elective hospital admissions for recipients covered under Medicaid's fee-for-service program. It is the hospital's responsibility to obtain pre-authorization by using Qualitrac to submit level of care requests. For more information regarding Qualitrac, go to https://telligenmd.qualitrac.com/ or call at 888-276-7075.

For questions regarding Medicaid's reproductive health services, contact the Division of Community Liaison and Care Coordination at 410-767-3605.

Websites and Resources

CMS-1500 Billing Instructions
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Code of Maryland Regulations (COMAR)
http://www.dsd.state.md.us/COMAR/subtitle_chapters/10_Chapters.aspx

EPSDT/Maryland Healthy Kids Program
https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx

EVS User Guide
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Formulary Information
www.epocrates.com

HealthChoice MCO Program
https://mmcp.health.maryland.gov/healthchoice/Pages/Home.aspx

HealthChoice Provider Brochure
https://health.maryland.gov/mmcp/healthchoice/Documents/HealthChoice_Provider_Brochure_August%202023.pdf

ICD 10
https://mmcp.health.maryland.gov/Pages/ICD-10-Conversion.aspx
For general questions about ICD-10, send an email to dhmh.icd10@maryland.gov.

Medicaid Provider Information
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Professional Services Provider Manual and Fee Schedule
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Program Transmittals

https://mmcp.health.maryland.gov/MCOupdates/Pages/Home.aspx

SBIRT (Screening, Brief Intervention, and Referral to Treatment)
http://www.marylandsbirt.org/

Reproductive Health Services
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Frequently Requested Phone Numbers

Maryland Medicaid:
- Beneficiary Services/Pharmacy Access: 410-767-5800
- Eligibility Services: 855-642-8572
- HealthChoice Member Helpline: 1-800-284-4510
- HealthChoice Provider Helpline: 1-800-766-8692
- Helpline for Pregnant Members: 1-800-456-8900
- Maryland Pharmacy Program: 1-800-492-5231, option 3
- Mental Health and Substance Use: 1-800-888-1965
- Office of Health Care Quality: 410-402-8000
- Provider Enrollment/Services (covered services, coding, etc.): 410-767-5340
- Provider Relations (billing, claims, other issues):
  410-767-5503 Baltimore Area
  800-445-1159 Outside Baltimore Area

HealthChoice Managed Care Organization (MCOs) Contacts for Providers:
- Aetna Better Health: 866-827-2710
- CareFirst CHPMD: 410-779-9369
- Jai Medical Systems: 888-524-1999
- Kaiser Permanente: 301-816-2424
- Maryland Physicians Care: 800-953-8854
- MedStar Family Choice: 800-905-1722
- Priority Partners: 410-424-4500
- UnitedHealthcare: 800-487-7391
- Wellpoint Maryland: 833-707-0868