STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

MEMORANDUM

TO: Medical Day Care Providers

FROM: Marc A. Blowe, Chief MAB/JCT
Division of Community Long Term Care

DATE: November 24, 2015

RE: Revised CMS 1500 Billing Instructions for Medical Day Care Providers

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As you are aware, effective October 1, 2015, medical day care providers are required to enter a diagnosis code when billing medical day care claims electronically and when utilizing the CMS 1500 health insurance claim form for paper billing. Attached for your review and usage, are the revised CMS 1500 billing instructions for the medical day care service, offered to Medicaid participants as a 1915(c) waiver benefit.

In a memo issued on November 4, 2015, medical day care providers were instructed to enter the single ICD-10 diagnosis code of **Z598** in Field 21, for claims for service dates on or after October 1, 2015. For claims submitted for service dates prior to October 1, 2015, medical day care providers must enter the single ICD-9 diagnosis code of **V6089** in Field 21. To assist medical day care providers with avoiding billing errors, examples of the above scenarios are included in the billing instructions.

Instructions for electronic billing can be found in the HIPAA implementation guide. Providers submitting electronic claims must report the proper diagnosis code in the HI segment of the 837P transaction set. Please contact your software vendor for further information.

Questions regarding the medical day care service may be directed to the Division of Community Long Term Care, Office of Health Services, at (410) 767-1444.

Attachment

cc: Maryland Association of Adult Day Services
Health Facilities Association of Maryland
AERS
Delmarva Foundation

MARYLAND MEDICAID
CMS-1500
PAPER
BILLING INSTRUCTIONS

A Comprehensive Guide Focusing on Maryland Medicaid Billing Procedures and Other Useful Information

Effective October 1, 2015:
Only ICD-10-CM codes for claims with **dates of service** on or after October 1, 2015 can be reported.

Dept. of Health and Mental Hygiene
Office of Systems, Operations & Pharmacy
Medical Care Programs

CMS-1500 Paper Billing Instructions for Medical Day Care Providers

Block Number	Title	Action
2	Patient's Name	Enter the patient's name (last name, first name, middle initial) as it appears on the Medical Assistance card .
9a	Other Insured's Policy or Group Number	Enter the patient's (recipient's) 11-digit Maryland Medical Assistance number exactly as it appears on the MA card. The MA number **must** appear in this Block regardless of whether or not a recipient has other insurance. Medical Assistance eligibility should be verified on each date of service by calling EVS. EVS is operational 24 hours a day, 365 days a year at the following number: 1-866-710-1447.
11	Insured's Policy Group or FECA Number	Enter "K". This indicates that Medical Day Care is not covered by any other insurance.
21	Diagnosis or Nature of Illness or Injury	Enter the single ICD-10 diagnosis code of "**Z598**" for claims with service dates on or after October 1, 2015. For claims with service dates prior to October 1, 2015, enter the single ICD-9 diagnosis code of "**V6089**." **Do not** enter any additional diagnosis codes. If there is more than one diagnosis code entered, it will result in non-payment of claims.
24A	Date(s) of Service	Enter each separate date of service as a six digit numeric date (e.g. 06/01/04) under the **"From"** heading. Leave the space under the **"To"** heading blank. Each date of service on which a service was rendered must be listed on a separate line. Ranges of dates **ARE NOT** accepted on this form.
24B	Place of Service	Enter "99".
24D	Procedures, Services or Supplies	Enter the five-character procedure code that describes the service provided.
24F	$ Charges	Enter the usual and customary charge. **Do not** enter the Maryland Medicaid maximum fee unless that is your usual and customary charge. If there is more then one unit of service on a line, the charge for that line should be the total of all units.
24G	Days or Units	Enter "1", the number of days must be for a single day of service. Multiple days of billing should be billed on separate lines.
24I	ID. Qualifier	Enter the ID Qualifier **1D and the Medicaid Provider Legacy Number**
24J (gray shaded area)	Rendering Provider #	Enter the 9-digit Medicaid Provider Number of the provider rendering the service. In some instances, the rendering number may be the same as the payee provider number in Block #33. Enter the provider's NPI in the **un-shaded area.**
28	Total Charge	Enter the sum of the charges shown on all lines of Block 24 F.
31	Signature of Provider and Date	The provider's signature and date are required. The claim date **MUST** be entered in this field in order for the claim to be reimbursed.
33	Billing Provider Info & Phone #	Enter the name, complete street address, city, state, and zip code of the provider. This should be the address to which claims may be returned.
33a	NPI	Enter the NPI number of the billing provider in Block #33. Errors or omissions of this number will result in non-payment of claims. Errors or omissions of this number will result in non-payment of claims.
33b	1D Qualifier and Legacy #	Enter the ID Qualifier **1D,** followed by the 9-digit MA provider number of the billing provider in Block #33. Errors or omissions of this number will result in non-payment of claims. Errors or omissions of this number will result in non-payment of claims.

NOTE: **There are only 16 fields that must be completed by medical day care providers on the CMS 1500. Block numbers that are not described above should be left blank.**

1500 EXAMPLE: Claims prior to October 1, 2015

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Jackson, Joseph E.	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY / SEX M F			
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE		8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)	( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: K
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 123456789 00		a. EMPLOYMENT? (Current or Previous) YES / NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F		b. AUTO ACCIDENT? YES / NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES / NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / NO	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V6089 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
		23. PRIOR AUTHORIZATION NUMBER	

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09 16 15	99		S5102		74 50	1		ID	009876543
									NPI	1768371111
2	09 17 15	99		S5102		74 50	1		ID	009876543
									NPI	1768371111
3	09 18 15	99		S5102		74 50	1		ID	009876543
									NPI	1768371111
4	09 19 15	99		S5102		74 50	1		ID	009876543
									NPI	1768371111
5	09 20 15	99		S5102		74 50	1		ID	009876543
									NPI	1768371111
6	09 24 15	99		S5102		74 50	1		ID	009876543
									NPI	1768371111

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	28. TOTAL CHARGE $ 447 00	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Jane Smith 11/25/15 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # Adult Day Care USA 4705 Charles Lane Anywhere, USA 17000 1768371111 MD 009876543		

PHYSICIAN OR SUPPLIER INFORMATION — PATIENT AND INSURED INFORMATION — CARRIER

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

1500 EXAMPLE: Claims on or after October 1, 2015

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jackson, Joseph E.	3. PATIENT'S BIRTH DATE MM DD YY; SEX M / F
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other
CITY / STATE	8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student
ZIP CODE / TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 123456789 00	a. EMPLOYMENT? (Current or Previous) YES / NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M / F	b. AUTO ACCIDENT? YES / NO; PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
	11. INSURED'S POLICY GROUP OR FECA NUMBER: K
	a. INSURED'S DATE OF BIRTH MM DD YY; SEX M / F
	b. EMPLOYER'S NAME OR SCHOOL NAME
	c. INSURANCE PLAN NAME OR PROGRAM NAME
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: MM DD YY; ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
18. RESERVED FOR LOCAL USE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY; FROM / TO
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY; FROM / TO
	20 OUTSIDE LAB? YES / NO; $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. Z598	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
2. / 3. / 4.	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
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										NPI	1768371111
3	10 18 15	99		S5102			74 50	1		ID	009876543
										NPI	1768371111
4	10 19 15	99		S5102			74 50	1		ID	009876543
										NPI	1768371111
5	10 20 15	99		S5102			74 50	1		ID	009876543
										NPI	1768371111
6	10 21 15	99		S5102			74 50	1		ID	009876543
										NPI	1768371111

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	28. TOTAL CHARGE $ 447 00	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Jane Smith 11/25/15 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. / b.		33. BILLING PROVIDER INFO & PH # Adult Day Care USA 4785 Charles Lane Anywhere, USA 17000 1768371111 ID 009876543		

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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