Maryland Department of Health
Home and Community-Based Services
Maryland Medical Assistance Programs

BILLING INSTRUCTIONS FOR PROVIDERS ENROLLED TO PROVIDE SERVICES IN THE COMMUNITY PERSONAL ASSISTANCE SERVICES PROGRAM (CPAS), COMMUNITY FIRST CHOICE (CFC) PROGRAM and THE HOME AND COMMUNITY BASED OPTIONS WAIVER (HCBOW)

July 1, 2019

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Instructions for Completing eMedicaid/CMS-1500

These billing instructions are for Medical Assistance (also called Medicaid) services covered under the Community First Choice (CFC), the Community Personal Assistance Services Program (CPAS) and the Home and Community-Based Options Waiver Program (HCBOW). The CFC Program is governed by COMAR 10.09.84, CPAS is governed by COMAR 10.09.20 and the HCBOW is governed by COMAR 10.09.54

The Maryland Department of Health (MDH) is the State's lead agency for the Medicaid Program.

This booklet was prepared to provide proper billing instructions for CPAS, CFC and HCBOW services. The next section, "Frequently Asked Billing Questions", contains all of the general information you need to know about billing. The "Instructions for Completing the CMS-1500", section beginning on page 5 gives detailed information about completing the CMS-1500 billing form.

The final section, "Specific Information on Services", gives detailed information about CFC, and HCBOW services. Please be sure to read this information carefully so that your claims will be appropriately submitted and paid.

Before you render and/or bill for CFC or HCBOW service, ask yourself these questions:

1. ***Am I enrolled as a Community Personal Assistance Service (CPAS), Maryland Medical Assistance CFC and/or <u>Home and Community Based Options Waiver</u> provider?***

   If you are interested in enrolling as a provider, contact the CFC/Waiver Provider Enrollment Unit Division at 410-767-1739. Once enrolled, you will receive an approval letter and a Medical Assistance provider number from DHMH. This letter will include: 1) your 9-digit Medical Assistance provider number; and 2) the types of services you can provide.

   If you have any questions regarding your provider number(s), call the Provider Master File Unit at 410-767-5340.

2. ***Is this person a participant in the CPAS, CFC or the HCBOW?***

   Prior to providing and/or billing for any services, you must contact the participant's supports planner:
   - Verify the participant's waiver eligibility.
   - Request a copy of the participant's plan of service.
   - Check the plan of service to make sure that the service you are providing is on the plan of service. (If the service is NOT on the plan of service, you may not be paid for that Service).
   - Check the plan of service to make sure you are authorized to provide services for the

participant. (If you are NOT listed as the authorized provider for the service on the plan of service, you may not provide or bill for the service!)

Each time you provide a service you should:

- Verify the participant's Medical Assistance eligibility by calling the Eligibility Verification System (EVS) at 1-866-710-1447. EVS is an automated system that you can use 24 hours a day, 7 days a week. To use EVS, you will need your provider number and either the participant's medical assistance number or the participant's social security number and the date(s) of service. To retrieve an EVS Brochure call 410-767-6024 to request one or go to:

  https://encrypt.emdhealthchoice.org/emedicaid/eDocs/pe/E0003EvsUserGuide.pdf.

3. Have I been added to the participant's plan of service?

Prior to approval to provide any waiver services, you are required to be on the participant's plan of service. The participant's supports planner will provide a copy of the plan of service to you after it has been approved by the Department.

4. How do I submit claims for reimbursement?

Providers enrolled to provide personal assistance services to individuals enrolled in CPAS, CFC and/or the HCBOW are required to use an automated billing system called the In-home Supports Assurance System (ISAS). ISAS is a phone-based electronic billing system that personal assistance workers use to log their work hours when clocking in and out. The ISAS system generates electronic claims and makes billing more accurate and easier to process.

To learn more information about the ISAS system, providers can request a DVD by calling 1-855-463-5877.

Providers enrolled to provide other CFC and/or HCBOW services may submit claims electronically via eMedicaid. eMedicaid allows providers secure online access to verify participant eligibility, submit claims for reimbursement, check claim status and view remittance advices. Additional information regarding eMedicaid can be found at *https://encrypt.emdhealthchoice.org/emedicaid/* .

5. What services are billed electronically by way of https://encrypt.emdhealthchoice.org/emedicaid/?

- Assisted Living
- Assistive Technology
- Consumer Training
- Dietitian and Nutritionist Services

- Environmental Accessibility Adaptations
- Environmental Assessments
- Family Training
- Home-Delivered Meals
- Personal Emergency Response System
- Senior Center Plus

Filing Limitations

Claims ***must*** be received within 12 months following the date of service. The subsequent exceptions apply in addition to the initial claim submission.

- 12 months from the date of the IMA-81 (Notice of Retro-eligibility)
- 60 days from the date of Third Party Liability EOB
- 60 days from the date of Maryland Medicaid Remittance Advice

The Program **will not** accept computer-generated reports from the provider's office as proof of timely filing. The **only** documentation that will be accepted is a remittance advice, Medicare/Third-party EOB, IMA-81 (Notice of Retro-eligibility) and/or a returned date stamped claim from the Program.

1. What can I do to avoid payment delays?

To avoid payment delays, you should:

- Make sure all information entered on the eClaim form is correct, including your Provider Number and the Participant's Medical Assistance ID Number.
- If a waiver participant has other insurance besides Medical Assistance, such as Medicare, private insurance, or other health insurance coverage, the participant's other insurance carriers should be contacted to verify if the waiver service is covered. **If the insurer does not cover the waiver service, please indicate "Services not Covered" by inserting Value "K" in Block 11 of the eClaim form.**

Instructions for Completing the eClaims

Providers are required to complete certain blocks on the eClaim Form in order to receive payment. Table 1 shows all blocks that must be completed on the eClaim Form to receive payment for CPAS, CFC and/or Waiver services.

Remember:

- Be sure that the information entered is correct, especially when entering your Provider Number and the recipient's Medical Assistance ID number.
- **Claims must be submitted within 12 months of the date of service.**

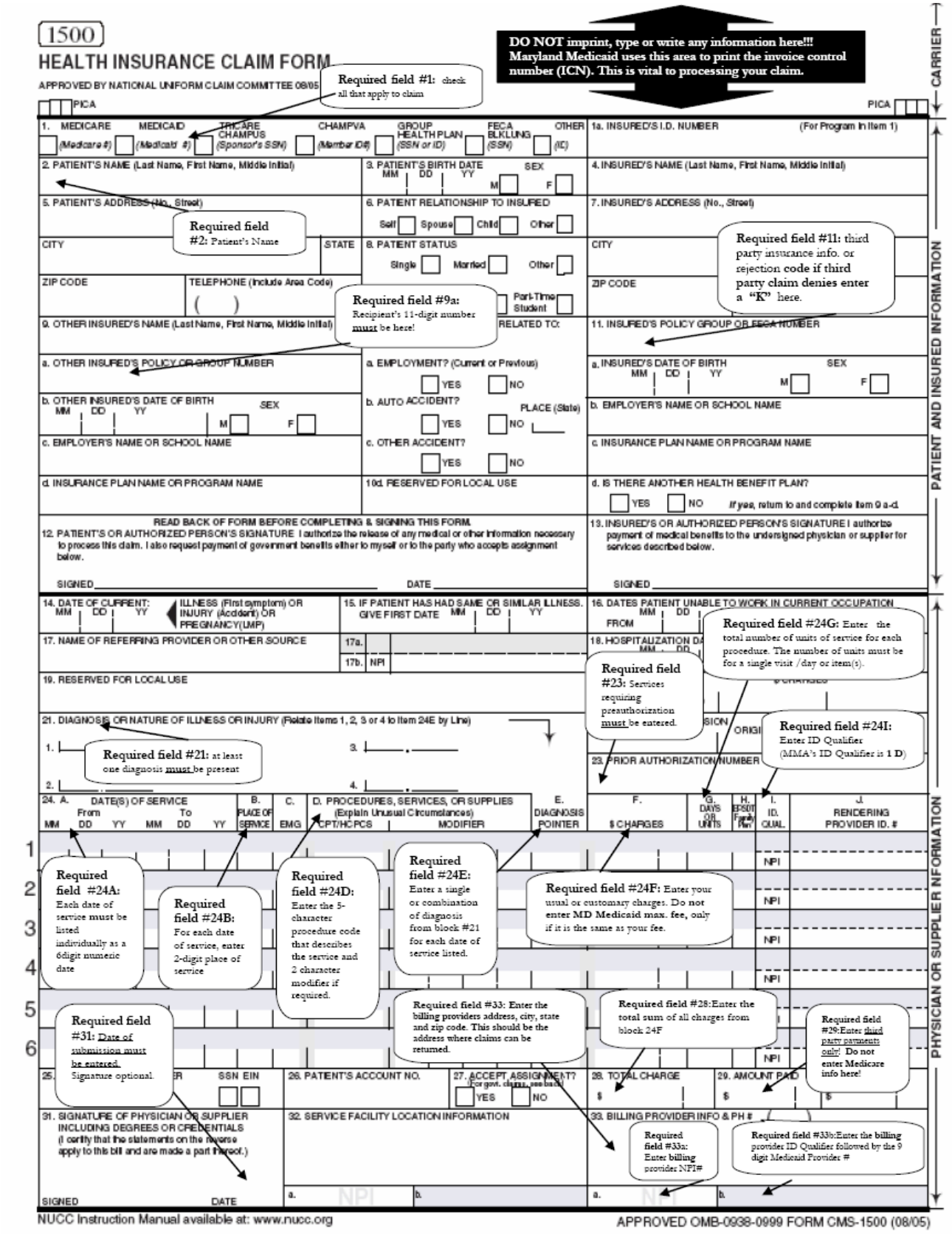
TABLE 1: Blocks to Complete on CMS-1500 for Billing

Block #	Title of Block	Required Entry
1.	Medicare/Medicaid/CHAMPUS/ CHAMPVA/Group Health Plan/FECA Black Lung/Other	Check the box for Medicaid. Also, check the appropriate box(es) for any other type(s) of insurance applicable to this claim.
2.	Patient's Name	Enter participant's last name, first name, and middle initial from the Medicaid Assistance Card (e.g., Doe, John A).
9a.	Other Insured's Policy or Group Number [Participant's Medicaid ID number]	Enter the **participant's 11-digit Medical Assistance ID number** as it appears on the Medical Assistance Card. The Medical Assistance ID number **MUST** appear here, regardless of whether the participant has other health insurance.
Block #	**Title of Block**	**Required Entry**
11.	Insured's Policy Group of FECA Number	Insert Value "**K**" of the Maryland Medicaid Billing Instructions, in Block 11 of the CMS-1500.
21.	Diagnosis or Nature of Illness or Injury (Relate Items A -H to Item 24.E. by Letter)	Enter code ICD – 10 Diagnostic Code: " **Z598**".

24A.	Date(s) of Service From MM DD YY	Enter **each** separate date of service as a 6-digit numeric date (e.g. 07 01 07) for month, day, and year under the "**From**" heading. **Leave blank** the space under the "**To**" heading. Each date of service must be listed on a separate line. Ranges of dates **are not** accepted on this form.
24B.	Place of Service	For each waiver service, enter the appropriate place of service code: **12** for participant's residence or **33** for Assisted Living.
24D.	Procedures, Services, or Supplies CPT/HCPCS	In the block for CPT/HCPCS, enter the 5-digit Medicaid procedure code for the waiver service (e.g., W4000).
24E.	Diagnosis Pointer	In the block for Diagnosis Pointer, enter the corresponding line letter from Block 21 (e.g., A., B., C., D., E., F., G., H.).
24F.	$ Charges	Enter the **total** charge billed for the procedure code (not the cost per unit of service). Do not enter the maximum fee unless that amount is your usual and customary charge. If there is more than one unit of service on a line, the charge entered for this block should be the **total** for all units on this line.
24G.	Days or Units	Enter the number of units of service for each procedure. The number of units must be for a single device, visit, or job.
28.	Total Charge	Enter the sum of the charges shown on all lines for Block 24F.
31.	Signature of Physician or Supplier including Degree or Credentials [Degree]	**Enter the date the CMS-1500 was completed or submitted. A date must be placed in this field in order for the claim to be reimbursed.** Signature by the payee provider's authorized representative is optional. Signature by physician or supplier should include degree or credentials.

33.	Provider's Billing Name, Address, Zip Code, and Phone Number	Enter the name, street, city, and zip code to which the claim may be returned.
33a.	Provider's Medicaid Provider Number [National Provider Identifier]	**Your 9-digit provider number to which payment is made <u>MUST</u> be prefixed with a '5' in order for the claim to be reimbursed** (e.g., 5012345678)**.**
33b.	Provider's Medicaid Provider Number	**Your 9-digit provider number to which payment is made <u>MUST</u> be prefixed with a '1D' in order for the claim to be reimbursed** (e.g., 1D012345678).

Instructions for Completing eMedicaid/CMS-1500



A. Accessibility Adaptations (COMAR 10.09.84)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per 36 Month Period***
W5513	Environmental Accessibility Adaptations	1 unit	$15,000 combined with Assistive Technology

Covered Service

- Definition. "Unit of service" means one or more physical adaptations to a participant's home or place of residence which is completed as one job by a qualified provider and which constitute a single accessibility adaptation.
- Claims submitted using the eMedicaid Website.

Limitations

- The total reimbursement by the Program for accessibility adaptations and assistive technology combined is limited to the amount specified per participant during a 36 month period.
- Reimbursement for a piece of equipment must be approved in the participant's POS and be based on at least two cost estimates from prospective providers.
- Not available to residents living in Assisted Living Facilities

B . Assisted Living Services (COMAR 10.09.54.13)

Procedure Code	**Services**	**Unit of Service**	***Rate per Unit**
W0226	Assistive Living Level II – no medical day care	Daily	$64.01 per day
W0228	Assistive Living Level II – with medical day care	Daily	$48.03 per day
W0227	Assistive Living Level III – no medical day care	Daily	$80.78 per day
W0229	Assistive Living Level III – with medical day care	Daily	$60.56 per day

Covered Service

- Definition. A "unit of service" for assisted living services is defined as one day
- Specific services to be provided are identified in COMAR 10.09.54.13. (1-11).
- Daily rates are based on the participant's level of care and attendance at Adult Medical Care as authorized in .the Plan of Service.
- The service and provider must be identified in the participant's approved Plan of

Service. A copy of the participant's plan of Service must be kept on file

- Assisted living charges paid by the Medicaid Waiver do **not** include room and board. The waiver participant is expected to pay the provider's charge for room and board, which may not exceed $420 per month for a waiver participant. In addition, Waiver rules require that a participant with income over a certain level must make monthly payments toward the cost of their assisted living services. The monthly amount that must be paid to the ALF provider by the participant is called the "contribution to care" (CTC). The amount Medicaid pays the ALF provider is reduced by the amount of the participant's monthly CTC. The monthly CTC amount paid to the provider by the participant is in addition to the amount (up to $420 a month) a participant must pay for room and board. See Waiver Transmittal #21 for additional information on CTC.

Limitations

- The provider may not bill for any days during the month that the participant was not eligible for the waiver or was not considered to be residing in the facility because the participant:
  - moved out of the provider's facility;
  - Had not yet moved into the provider's facility;
  - was an inpatient for one or more nights at a hospital, nursing facility, or other medical institution; or
  - was absent from the provider's facility for more than seven (7) nights during a calendar month at the participant's choice for personal reasons, (i.e., family visit or vacation).
- Claims may only be submitted after the end of the month of service.
- Claims submitted using the eMedicaid Website.

C. Assistive Technology (COMAR 10.09.84)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per 36 Month Period***
W5514	Assistive Technology	1 Unit	$15,000 combined with Environmental Adaptations

Covered Service

- Definition. "Unit of service" means a device or appliance that is purchased as one item, included in the price is:
  - Any required training in the use of the device; and
  - An assessment for the use of the device, if the assessment is:
    - Performed directly by the provider; and
    - Routinely included as part of the provider's cost for the item.
- Assistive technology includes non-experimental technology or adaptive equipment, excluding service animals, which enable a participant to live in the community and to

participate in community activities.
- Claims submitted using the eMedicaid Website.

Limitations
- The total reimbursement by the Program for environmental accessibility adaptations and assistive technology are limited during a 36 month period to $15,000.
- Reimbursement for a piece of equipment must be approved in the participant's POS.

D. Behavior Consultation Services

Procedure Code	***Services***	***Unit of Service***	****Rate per Unit***
W1724	Behavior Consultation	1 hour	$70.01 per hour

Covered Service
- Definition . A "unit of service" is one hour (no partial hour increments are accepted).
- Providers must be approved to provide Behavior Consultation Services under the Home and Community Based Options Waiver
- The service and provider must be identified in the participant's approved Plan of Service.
- Services may be provided to waiver participants residing either at home or in an assisted living facility**.**
- The provider must:
  - respond within 24 hours after receiving a referral
  - evaluate the waiver participant's acute behavior change, assess the situation, determine the contributing factors, and recommend interventions and treatments;
  - Verbally review the report with the Supports Planner (SP) and either the family or assisted living provider to discuss the report's findings and recommendations and a course of action, including any related needed medical interventions.
  - Submit a written report to the Supports Planner and to either the family or assisted living provider, which assesses the situation and makes recommendations
  - Claims are to be submitted for services rendered by a qualified individual during a home visit and not for time spent on related activities before or after the visit . See COMAR 10.09.54.20 for additional information on reimbursement for this service.
- Claims submitted using the eMedicaid Website.

E. Consumer Training (COMAR 10.09.84)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Unit***
W5518	Consumer Training	15 min	$11.35

Covered Service
- Definition. "Unit of service" means 15 minutes of service rendered one-on-one by a qualified provider to a participant, not including the time spent by the provider:

- Planning, preparing, or setting up the training; or
- Following up after the training.
- Claims submitted using the eMedicaid Website.

Limitations

- Reimbursement shall be limited to 8 hours per date of service.

F. Dietitian and Nutritionist Services (COMAR 10.09.54)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Hour***
W0212	Dietitian and Nutritionist Services	1 hour	$70.01 per hour

Covered Service

- Definition. “Unit of service” means one hour of covered services provided during or in conjunction with a home visit with a waiver participant.
- This service and provider must be listed in the participant’s approved Plan of Service
- Services must be:
  - Delivered one-on-one, and may not be rendered on a group basis or in a classroom setting.
  - Provided to in-home participants only
- Other third party insurances should be billed prior to billing the Medicaid Waiver.
- Claims submitted using the eMedicaid Website.

F. Environmental Assessments (COMAR 10.09.84)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Unit***
W5512	Environmental Assessment	1	$445.55 per assessment

Covered Service

- Definition. "Unit of service" means the completion of:
  - An on-site environmental assessment of a home or residence where the participant lives or will live as a participant; and
  - On a form approved by the Program.
- Claims for Environmental Assessments performed on or before 1/30/2019 must be submitted using the eMedicaid Website
- Claims for Environmental Assessments performed on or after 1/31/2019 must be submitted through the LTSS Provider Portal as Non- EVV Claims.

Limitations

- May not be provided before the effective date of the participant’s eligibility for services.
- The service must be listed in the participant’s Plan of Service

G. Family Training (COMAR 10.09.54)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Hour***
W0208	Family Training (agency provider)	1 hour	$70.01 per hour

Covered Service

- Definition. "Unit of service" means an hour of service rendered by a qualified provider to one or more family members at the same time in the participant's home or the provider's office, regardless of the number of family members trained at one time, not including the time spent by the provider:
  - Planning, preparing, or setting up the training; or
  - Following up after the training.
- Claims submitted using the eMedicaid Website.
- "Family member" means an individual who:
  - Lives with or provides assistance to the participant; and
  - Is not paid to provide the care.

Limitations

- Reimbursement shall be limited to 8 hours per service per date of service.
- Service must be listed in an approved POS.

H. Home-Delivered Meals (COMAR 10.09.84)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Unit***
W5516	Home-Delivered Meals	1 meal	$6.36 per meal

Covered Service

- Definition. "Unit of service" means one meal delivered to the participant's home, including the cost of the food, food preparation, and delivery.
- Claims submitted using the eMedicaid Website.

Limitations

- Medicaid will pay a maximum of two units of service per day for a participant.
- Services may only be provided to waiver participants residing at home and the service must be listed in the participant's Plan of Service

I. Medical Day Care (COMAR 10.09.54 and 10.09.07.06)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Unit***
S5102	Medical Day Care	1 day	$82.24 per day

Covered Service

- The Program covers medical day care services provided in accordance with COMAR 10.09.07.

- Provider must be listed on the Plan of Service.

K. Personal Assistance Services (COMAR 10.09.84) (COMAR 10.09.20)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Unit***
W5519	Personal Assistance Service (agency provider)	15 minutes	$4.5075 per unit
W5521	Personal Assistance Service (agency provider)-Shared Attendant	15 minutes	$3.005 per unit per client
W5532	Personal Assistance-Daily Rate	1	$232.66
W5533	Personal Assistance Services (Shared Daily)	1	$155.11 per day
W5527	CPAS Personal Assistance Service	15 minutes	$4.5075 per unit
W5528	CPAS Personal Assistance Service-Shared Attendant	15 minutes	$3.005 per unit per client

Covered Service

- Definition: W5519 & W5521 and W5527 & W5528 - Unit of service" means 15 minutes of service that is preapproved in the plan of service and rendered to a participant by a qualified provider in the participant's home or in a community setting in the company of the participant. W5532 & W5533 – Unit of service is one day of service preapproved in the plan of service and rendered to a participant by a qualified provider when the participant's home or in a community setting in the company of the Participant

Limitations

- The Program may only reimburse for personal assistance services provided

according to an approved Plan of Service

- The maximum number of units that will be paid per day is 48 unit for W5519 & W5527.
- To be reimbursed at the daily rate the POS must indicate that day of the week as eligible for the daily rate.
- Services must be rendered in the company of the participant.

Note: Claims for this service MAY NOT be filed by way of the eMedicaid Website. Service times and dates are documented in and paid through the In Home Supports Assurance System (ISAS).

L. Personal Emergency Response Systems (COMAR 10.09.84)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Unit***
W5510	Personal Emergency Response Systems	1 unit	$500.00*
W5511	Personal Emergency Response Systems (monitoring)	1 month	$45.00 monthly

*Charge may not be more than the Provider's 'usual and customary charge'

Covered Service

- Definition. "Unit of service" means any of the following coverages related to a device, system, or piece of equipment covered under this regulation:
- Purchase and installation;
- Maintenance or repair; or
- Monthly cost of a covered system or rented device or equipment.
- Claims submitted using the eMedicaid Website.

Limitations

- Reimbursement by the Program for personal emergency response systems may only be allowed for participants who:
  - live alone or are alone for significant parts of the day;
  - have no regular caregiver for extended parts of the day; and
  - would otherwise require extensive routine supervision to ensure the participant's health and safety.

M. Senior Center Plus (COMAR 10.09.54.07)

Procedure Code	***Services***	***Unit of Service***	***Rate per Unit***
W1723	Senior Center Plus	1 day	$50.93 per day

Covered Service

- Definition. A "Unit of service" is a day of attendance for at least 4 hours, and includes at least one meal (and a snack if the day program exceeds 6 hours).

- This service, the provider and the units of service must be listed in the participant's approved Plan of Service.
- Senior Center Plus services may be provided to waiver participants residing either at home or in an assisted living facility.

Limitation

- Medicaid will not pay for both Senior Center Plus and Medicaid Day Care for a participant on the same date.