June 5, 2023

**FY24 Developmental Disabilities Administration (DDA)**

**Community Pathway’s Waiver (CPW) Non-Fee Payment System (Non-FPS) Services Invoicing Instructions**

**Effective Date: July 1, 2023**

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**Audience**

DDA Community Pathways Providers

**Purpose**

To update the invoicing and federal billing instructions and procedures for FY24 DDA Community Pathway’s Waiver Non-FPS Services and remove guidance regarding billing for COVID-19 Appendix K flexibilities that ended June 30, 2023.

**Overview**

On April 19, 2023, the Centers for Medicare and Medicaid Services (CMS) approved the Developmental Disabilities Administration (DDA) Waiver Renewal 2023 for the Community Pathways program with an effective date of July 1, 2023.

The Waiver Renewal focuses on clarifying service description information and does not necessarily affect the billing process for non-FPS services in PCIS2. More information regarding the updates in the Waiver Renewal can be found on DDA’s website here: DDA Waiver Renewal 2023 Services Update Summary Chart.

Also, COVID-19 Appendix K flexibilities ended June 30, 2023, so those services have been ended and the guidance regarding the billing for those services has been removed from these instructions.

**Community Pathways Non-FPS Services**

In FY24, all non-FPS services should be set up on the Services screen in PCIS2 as “Community Pathways Non-FPS”. PCIS2 has been updated to include all the non-FPS services included in the Community Pathways Waiver that may be authorized on a Person-Centered Plan (PCP). The Community Pathways Non-FPS Service will allow all non-FPS services authorized in the PCP to be listed along with their budgeted amounts under this Service. Please note that non-FPS services for individuals in the Community Support Waiver (CSW) and Family Support Waiver (FSW) are not included in this invoice and should be billed using the Invoice Tab in PCIS2.

Below you will find a list of the FY24 Non-FPS Services that may be authorized in the Community Pathways Waiver and that would be billed using the Invoice template (Behavioral Support Services will be billed using a different process and invoice template). When selecting services on the Consumer Service Detail tab, column I will prepopulate with the correct procedure code to be used for the federal billing.

|  |  |  |  |
| --- | --- | --- | --- |
| **Non-FPS Services** | **Service****Unit** | **Waiver Procedure Code** | **Documentation need with Invoice** |
| 1 | Assistive Technology and Services  | UPL | W5690 | Receipt |
| 2 | Environmental Assessment | Milestone | W5740 | Receipt |
| 3 | Environmental Modification | UPL | W5750 | Receipt |
| 4 | Family and Peer Mentoring Supports | Hour | W5760 | Receipt |
| 5 | Family Caregiver Training and Empowerment | UPL | W5770 | Receipt |
| 6 | Housing Support Services | Hour | W5630 | Receipt |
| 7 | Live-In Caregiver Supports | Month | W5877 | Receipt |
| 8 | Nursing Support Services  | 15 minutes | W5804 |  |
| 9 | Participant Education, Training and Advocacy | UPL | W5780 | Receipt |
| 10 | Remote Support Services | UPL | W5820 | Receipt |
| 11 | Respite Care-Camp | UPL | W5850 |  |
| 12 | Respite Care-Day  | Day | W5822 |  |
| 13 | Respite Care-Hour | Hour | W5830 |  |
| 14 | Transition Services | UPL | W5860 | Receipt |
| 15 | Transportation (not Add-On) | UPL | W5862 |  |
| 16 | Vehicle Modification | UPL | W5871 | Receipt |
| 17 | Community Living Group Home Trial Experience *(formerly Community Exploration)* | Day | W0215 | Receipt |
| 18 | Supported Living | Day | W5620 |  |

For the services that do not require receipts with the invoice, providers should maintain documentation of service provision. The DDA may conduct random audits of non-FPS services invoices by requesting all detailed documentation such as timesheets, logs, case notes, payroll, and other evidence to substantiate invoice data.

State-Only Funded Services

Participants may be authorized to receive services that are not included in the current Community Pathways Waiver program but are authorized to be paid with State funds. This invoice template may be used to bill for these services as well, but they would not be eligible for federal matching funds. So, 1500 forms would not be required for these services. The State-Only funded services are included in the list below.

|  |
| --- |
| **State-Only Funded Services** |
| 1 | Other (State-Only Funded) |
| 2 | Rent-Individual Support (State-Only Funded) |
| 3 | Skilled Nursing (State-Only Funded) |
| 4 | Camp-Non-Respite (State-Only Funded) |
| 5 | Respite (State-Only Funded) |
| 6 | Transportation (State-Only Funded) |

**Billing Prerequisites & Requirements**

DDA Provider Waiver Status

You must be an authorized DDA provider to provide DDA services, and you must be an authorized service provider on a participant’s Person-Centered Plan (PCP) to bill for a participant. If you are NOT listed as the authorized provider for the service on the PCP, you may not provide or bill for the service. Additional information on billing prerequisites and requirements may be found in Appendix C: Participant Services of the Community Pathways Waiver Renewal 2023 application.

DDA Participant Waiver Status

Providers should verify the participant’s Medical Assistance eligibility prior to submitting an invoice and claim for the participant. An individual’s waiver eligibility status can be found in PCIS2 under the “Consumer” module, under the “Waiver” tab. A provider can also 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 the website <https://encrypt.emdhealthchoice.org/emedicaid/eDocs/eMedicaid_web.pdf>. The provider should notify the individual’s Community Coordinator (CCS) to resolve any eligibility issues.

Services Are on the Person-Centered Plan (PCP)

Prior to providing and/or billing for any waiver services, the provider should confirm that the services are on the PCP and that the providing agency is the authorized provider for those services. Services or costs should be billed according to the cost detail in the PCP. For instance,

* PCP that has respite services with annual allowable units of 14 days, should be billed using the current daily unit rate. A provider should not invoice for more than 14 days of respite annually.
* PCP that has respite services with annual allowable units of 112 hours, should be billed using the current hourly unit rate. A provider should not invoice for more than 112 hours of respite annually.

If the service is NOT on the PCP, a provider may not be paid for that service. A provider may not bill for units or costs that exceed the budgeted or allotted units on the PCP. 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.

**Invoicing Instructions**

These procedures do **not** apply to any FPS services and their add-on services currently billed through PCIS2. Those services are paid through the quarterly prepayment and PCIS2 automatically submits claims to Medicaid. These procedures are for services and/or costs identified as Non-FPS Services and listed under the participant’s services under the Community Pathways Non-FPS service on the Services screen and/or Supplemental Services list in PCIS.

**PCIS2 Supported Living Billing Instructions:** The invoice total for this service on a date of service should be the Base Rate plus any add-on rates. Invoicing for the add-on’s separately from the Base rate results in duplicate claims being submitted for the same date of service causing them to be denied.

Frequency and Timing

Effective July 1, 2019, non-FPS services costs will be paid on a reimbursement funding system using the invoice template and procedures outlined in this guidance.

A provider may submit a non-FPS service invoice at any point during the state fiscal year. A provider has two months after the end of a fiscal year, September 1st, to submit invoices for that fiscal year. Charges incurred for the prior fiscal year will not be processed for payment after the two-month deadline of September 1st.

Invoicing Submission Requirements

The invoice must be completed accurately to process payment to the provider. For an invoice to be processed the provider will need to submit all the following to their Regional Office:

1. An electronic copy of the invoice (excel file)
2. A printed copy of the cover page with the provider signature in blue ink
3. Corresponding Medical Assistance claims for all waivered services for waivered individuals or the Remittance Advice of claims that were submitted through eMedicaid
4. Receipts, if applicable

Electronic copies should be emailed to:

* Central Maryland Regional Office (CMRO): mathew.abraham@maryland.gov
* Eastern Shore Regional Office (ESRO): renee.benjamin@maryland.gov and copy eharris@maryland.gov
* Southern Maryland Regional Office (SMRO): terrie.logue@maryland.gov
* Western Maryland Regional Office (WMRO): wmro.supportinv@maryland.gov Invoice Template Instructions

The Non-FPS services invoice is an excel workbook that is composed of three worksheets, identified by a tab and tab title at the bottom of the workbook. The instructions are organized by the tabs in the workbook. Please enter values into corresponding blank cells that can be selected. The spreadsheets include cells that automatically calculate values, which are identified by a gray coloring.

Tab A: Cover Page

The cover page consists of basic provider information necessary for the DDA to identify the provider agency and process payment. All fields must be completed.

Multiple non-FPS services costs may be billed on one invoice.

To complete the Service line, if the non-FPS services are still bundled under an FPS service and listed in the Supplemental services screen in PCIS2, choose the correct FPS service to populate the correct PCA. If the non-FPS service is listed under the Community Pathways Non-FPS service on the Services screen, select Non-FPS Service in the dropdown to populate the correct PCA code created for these services.

Tab B: Consumer Budget

Part B serves to monitor spending relative to the individual’s budget. The DDA will only pay up to the budgeted amount for the individual. In the spreadsheet insert the service by individual. If an individual has more than one non-FPS service cost, then there needs to be a separate row for each service.

Below are explanations for the columns on the spreadsheet.

|  |  |  |  |
| --- | --- | --- | --- |
| **Col** | **Column Title** | **Description** | **Calculation** |
| A | Consumer Last Name | Input last name |  |
| B | Consumer First Name | Input first name |  |
| C | Consumer MA # | Input consumer’s medical assistance # (11 digits) |  |
| D | Waiver Eligible (Yes/No) | Choose “Yes” or “No” from the dropdown list |  |
| E | Non-FPS Service | Choose the Non-FPS Service or State-Only Funded service from the dropdown list |  |
| F | Regional Log # | Inputs SFP # |  |
| G | Actual Budget | Input the actual budget for the supplemental service, one-time-only costs |  |
| H | Year-to-Date Paid Charges | Input the total amount paid for the service or cost for the year |  |
| I | Remaining Budget | Excel automatically calculates | G -H |
| J | Requested Invoice Charges | Excel automatically calculates | The sum of charges for that individual for that service calculated on tab C column H |
| K | Amount to be Paid | Excel automatically calculates | If J > I, then K = IIf J < I, then K = J |
| L | Unfunded Invoice Charges | Excel automatically calculates | If J > I, then L = I - J |
| M | Denied Claims | Excel automatically calculates |  |

Tab C: Consumer Service Detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Col** | **Column Title** | **Description** | **CMS 1500 Form Fields** |
| A | Consumer MA # | Excel automatically populates from Consumer Budget tab column (C)  | Field 9a on 1500 form |
| B | Consumer Last Name | Input last name | Field 2 on 1500 form; Last Name first, First Name last |
| C | Consumer First Name | Input first name |
| D | Non-FPS Service\* | Choose the Non-FPS Service, State-Only Funded service from the dropdown list.  |  |
| E | Date of Service\*\* | Input date that service was provided, or cost was incurred (must be in FY22); Cannot be duplicate for the same service and person | Field 24A on 1500 form |
| F | Unit Charge | Excel automatically populates the rate for rate-based services; No rates will populate for UPL or Milestone services |  |
| G | Costs or Units† | Must be populated; Input the total number of units (whole numbers only) that were provided for the date of service or the cost of the Milestone or UPL service. * A unit is a determinate quantity (i.e., hour, day, and month). The description of the unit should be in an individual’s PCP.
* Milestone and Upper Pay Limit (UPL) services units would be 1
 | Cost- Field 24F; Supported Living daily rate from PCIS2. Units- Field 24G on 1500 form; see Service Units on page 3 |
| I | Total Charge $ †† | Excel automatically calculates; columns F\*G | Field 28 on 1500 form is Total of Charges in fields 24F  |
| J | Waiver Procedure Code | Excel automatically populates | Field 24D on 1500 form |
| K | Receipt Needed | Excel automatically populates. If column K is “Yes,” then a receipt and/or other documentation is needed to substantiate the cost or service |  |
| L | Claim Needed  | Excel automatically populates. If the column L is “Yes,” then the provider must submit a claim for the service or good |  |

\*DDA is unable to obtain Federal Medical Assistance Participation if a service is listed as “State-Only Funded.” The purpose of Column D is to gain a description of the services or goods being provided to help ensure that all allowable federal claims are submitted for reimbursement.

\*\* The Date of Service may not be duplicated for the same service for the same person. A yellow highlighted row on the invoice is a duplicate claim. Please revise the information to resolve the duplicate claim error by correcting the date or adding all units together for the date.

† If Units are entered in column G, they must be whole numbers. If a unit is entered as a decimal number, it will be highlighted orange, which is a unit error. To resolve the unit error, please enter a whole number based on the Service Unit for the service noted in the form.

†† For Supported Living, the Total Charge should be the Base Rate plus any add-on amounts added together and invoiced on the same date of service. Please do not invoice add-on charges separately.

**CPW Non-FPS Services Medicaid Claims Submission**

Providers can submit a claim electronically or through paper format for Community Pathways Waiver non-FPS services.

CMS 1500 Form Billing

Providers must use the CMS-1500 billing form version 02/12. A sample form has been posted to the DDA website, under the Provider tab (<http://dda.dhmh.maryland.gov/Pages/Developments/2015/sample%20cms%201500%20form%20icd10.pdf>) that shows all of the required fields that must be filled out. Make sure all information entered on the claim form is legible and accurate, including your Provider Number and the Participant’s Medical Assistance ID Number. For more instructions on federal billing, please visit the DDA website at <https://dda.health.maryland.gov/Pages/Federal%20Billing.aspx>.

CMS 1500 Form Billing Instructions

* Name (2)- Last name first, first name last (Smith, John); must match spelling in MMIS.
* Participant Medicaid # (9a)- always 11 digits; if 0 is the first digit, it must be listed.
* Provider # (24J top; 33b)- always 9 digits
* NPI# (24J bottom; 33a)- 9-digit provider number with a 5 in front ex. 5xxxxxxxxx
* Date (24A) - List each date of service in the 24A From column only. No date ranges should be used. A date of service for the same service can only be billed one time. All units or costs of a service provided on the same day must be added together and billed on the date of service once. MMIS considers dates of service for the same service billed more than once as a duplicate claim even if the units or costs are different. If changes need to be made to previously submitted claims total units or costs, an adjustment of that claim must be requested.
* Units (24G) - For hourly and quarter hour services, the number of units of service provided (hours; 15 mins) must be listed. For example, for an hourly service, if 8 hours of service is provided, 8 units would be listed. For quarter hour services, if 4 hours of service was provided, 16 units must be listed. A unit of 1 is used for days, milestone services, or service costs added together and billed on the same day, Upper Pay Limit services.
* Charges (24F)- Unit cost x # Units
* Total (28)- Total of charges
* Signature/Date (31)- Sign, print, or type name; signature date must be after dates of service being billed.