Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

April 23, 2021

Developmental Disabilities Administration (DDA) Invoicing Instructions for Community Pathway's Waiver (CPW) and COVID-19 Non-Fee Payment System (Non-FPS) Services- Effective 3/1/21

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AUDIENCE

DDA Community Pathways Providers

PURPOSE

To update the invoicing and federal billing instructions and procedures for FY21 DDA Community Pathway's Waiver Non-FPS Services including guidance to bill for eligible Non-FPS COVID-19 related costs and additional authorizations for current services and to align the non-FPS rates with the rates in LTSS*Maryland* and application of the January 1, 2021 COLA.

NEW: On January 19, 2021, the Centers for Medicare and Medicaid Services (CMS) approved the Maryland Department of Health (MDH) Developmental Disabilities Administration (DDA) Waiver Amendment #3 2020 with an effective date of January 19, 2021.

Change in Amendment #3 of the DDA Waiver program applications consolidated the three nursing support services (i.e. Nursing Consultation, Nurse Health Case Management, and Nurse Case Management and Delegation) into a single DDA Waiver program service, now called Nursing Support Services effective March 1, 2021.

OVERVIEW

These instructions have been updated to accommodate billing for temporary modifications to DDA's Waiver programs set forth in Appendix K, submitted to and approved by the Centers for Medicare and Medicaid Services, and DDA State Funded services to address the State of Emergency for the COVID-19 pandemic beginning March 13, 2020.

To support the health, safety, and wellbeing of participants and providers, the DDA is implementing temporary service requirements exceptions and operational changes including flexibilities related to financial support, settings, and staffing.

Therefore, there is a need for providers to be able to bill for eligible Community Pathways Non-FPS COVID-19 related costs for services currently billed using this invoicing process and for Shared Living providers to be able to bill for isolation days.

For the COVID-19 services in the Family Supports Waiver and Community Supports Waiver, providers will follow the same invoicing process in PCIS2 for payment. Additionally, any additional or new authorized Behavioral Support Services will be billed using the current invoicing process for those services. To receive payment for services rendered for FY21 dates of service for all other CPW Non-FPS services and COVID-19 services, providers will submit invoices and federal billing claims to the Regional Offices for approval and processing and will continue to enter attendance in PCIS2 for the FPS services.

Comprehensive guidance regarding the Appendix K changes and billing for services can be found in the guidance documents posted on DDA's website here: DDA Appendix K.

COMMUNITY PATHWAYS AND COVID-19 NON-FPS SERVICES

In FY21, 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 of 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.

Below you will find a list of the FY21 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-Nurse Case Management and Delegation (ended 2/28/21)	15 minutes	W5804	
9	Nursing-Nurse Health Case Management (ended 2/28/21)	15 minutes	W5802	
10	Nursing Support Services (New 3/1/21)	15 minutes	W5804	
11	Participant Education, Training and Advocacy	UPL	W5780	Receipt
12	Remote Support Services	UPL	W5820	Receipt
13	Respite Care-Camp	UPL	W5850	
14	Respite Care-Day	Day	W5822	
15	Respite Care-Hour	Hour	W5830	
16	Transition Services	UPL	W5860	Receipt
17	Transportation (not Add-On)	UPL	W5862	
18	Vehicle Modification	UPL	W5871	Receipt
19	Community Living Group Home Trial Experience *(formerly Community Exploration)*	Day	W0215	Receipt
20	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.

For COVID-19 related service, the service flexibilities and financial supports that will be paid using this form are noted below:

1. **Retainer Payment (Supported Living)**

During the COVID-19 epidemic, some participants may choose to stay with their families or may be supported in other systems (e.g. hospitals, nursing facilities, etc.) In these situations, providers may request a COVID-19 Retainer Payment when they are not providing or paying for services, for a particular person. If Supported Living billing for an individual has transitioned to LTSS*Maryland*, retainer payments as of their transition date would need to be billed on the LTSS*Maryland* Billing Claims Summary form that can be found on the DDA's website under the Forms section here: DDA Appendix K.

See additional guidance regarding this topic on DDA's website here: DDA Appendix K #1- Retainer Payment Guidance- Revised Feb. 11, 2021.

NEW: A service for COVID-19 Supported Living Retainer Payment was added to this invoice for this purpose.

2. **Day Time Shared Service Hours Authorization (Supported Living)**

Due to State Executive Orders (including the closures of day programs and schools) and Governor Hogan's Stay at Home Executive Order 3-30-20, the DDA is authorizing a set amount of shared day time service hours to support the additional staffing agencies are providing. For Supported Living, the additional hours will be added automatically to one participant at the location and PCIS2 will adjust the rate accordingly. You will invoice the rate calculated using the approved Residential rate in PCIS2 which will include the additional hours for the home using the current service, Supported Living. See additional guidance regarding this topic on DDA's website here: DDA Appendix K #2 - Residential Day Time Shared Hours Authorization.

3. **Increase Rate When Supporting People with COVID-19 Virus (Nursing services, Supported Living, and Shared Living**

Rates may be increased for directly supporting participants that tested positive for the COVID-19 virus, and therefore are isolated to account for increased cost such as excess overtime of direct support professionals to cover staffing needs, additional infection control supplies, and service costs. The DDA may increase rates by up to 50% to account for the added risk and cost. See additional guidance regarding this topic on DDA's website here: DDA Appendix K #7 - Increased Rate for Supporting Person with COVID-19 Virus- Revised July 9, 2020. If Supported Living billing for an individual has transitioned to LTSS*Maryland*, isolation payments as of their transition date would need to be billed on the LTSS*Maryland* Billing Claims Summary form that can be found on the DDA's website under the Forms section here: DDA Appendix K.

NEW: Services added to the invoice to bill for isolation rates include:

a) **COVID-19 Nursing- Nurse Case Management and Delegation Services-Isolation Rate (ended 2/28/21)**
b) **COVID-19 Nursing- Nurse Health Case Management-Isolation Rate (ended 2/28/21)**

c) **COVID-19 Nursing Support Services (New 3/1/21)**
d) **COVID-19 Supported Living- Isolation Rate**
e) **COVID-19 Shared Living- Isolation Rate**

4. **Additional hours of Respite Service available without preauthorization**

Participants can access up to an additional 360 respite service hours, or 15 days, specifically related to the COVID -19 emergency without prior authorization by the DDA. See additional guidance regarding this topic on DDA's website here:
DDA Appendix K #4 - Exceptions to Pre-Authorization and Service Requirements- Revised May 3, 2020.

NEW: Services added to the invoice for additional units of Respite services include:
a) **COVID-19 Respite-Daily**
b) **COVID-19 Respite-Hourly**

Below you will find a list of eligible COVID-19 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.

New services included on this invoice are labeled as COVID-19 and are to be used to bill for services eligible for retainer payment, isolation rates, or to authorize additional units of service for period of the public health emergency.

COVID-19 Services		Service Unit	Waiver Procedure Code	Documentation need with Invoice
1	COVID-19 Nursing- Nurse Case Management and Delegation Services- Isolation Rate (ended 2/28/21	15 minutes	W5804	*
2	COVID-19 Nursing- Nurse Health Case Management-Isolation Rate (ended 2/28/21)	15 minutes	W5802	*
3	COVID-19 Nursing Support Services (New 3/1/21)	15 minutes	W5804	*
4	COVID-19 Respite- Daily	Day	W5822	*
5	COVID-19 Respite- Hourly	Hour	W5830	*
6	COVID-19 Supported Living- Isolation Rate	Day	W5620	*
7	COVID-19 Supported Living Retainer Payment	Day	W1983	*
8	COVID-19 Shared Living-Isolation Rate	Month	W2123	*

*No documentation needs to be sent with this invoice for COVID-19 services; however providers must maintain case notes and documentation of direct service delivery including the date of service, service provided, time of service, and name of person that provided the service. Information such as a positive COVID-19 test determination and case notes for the isolation rate must be submitted to the DDA upon request.

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 Amendment #3 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 located 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.

For COVID-19 related services:

To support the immediate need for services and supports and provide flexibility with service requirements and limits, the DDA is issuing temporary exceptions to services requirements as outlined in the guidance on DDA's website here: DDA Appendix K #4 - Exceptions to Pre-Authorization and Service Requirements -Revised May 3, 2020.

To support the immediate need for new COVID-19 related services and supports, the DDA is issuing a new temporary services authorization request process that can be found on DDA's website here: DDA Appendix K #5 - COVID-19 New Services Authorization Request Process- Revised June 1, 2020.

Providers will complete the Revised Cost Detail Sheet or DDA COVID-19 Request and Notification - Service Authorization form (DDACOVIDForm#1) as applicable.

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 PCIS2 and for COVID-19 related costs identified in the DDA Appendix K guidance documents to be billed using this invoice.

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.

COVID-19 Services Billing Instructions:

- ***COVID-19 Nursing services Isolation Rates- The isolation rate are prepopulated for these services and will calculate the amount based on the number of units entered.***
- ***COVID-19 Respite Services- Invoice these services for up to 15 days or 360 hours during the time period covered by Appendix K.***
- ***COVID-19 Supported Living- Retainer Payment- Invoice the Base Rate only amount authorized in PCIS on relevant dates of service.***

- ***COVID-19 Supported Living- Isolation Rate- To invoice for isolation days, increase the authorized daily rate from PCIS2 by 50% and invoice the full 150% rate on the relevant dates of service for the isolated individual.***
- ***COVID-19 Shared Living- Isolation Rate- Submit additional isolation costs at 150% of the costs to the Regional Office who will authorize the costs and update the contract amount in PCIS2. Include the additional costs on this invoice along with a 1500 form for the amount of the invoice billed on the last day of the month of service that included the isolation costs.***

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 of 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.

***COVID-19 UPDATE*: Shared Living service has been added to the list of Services in order to bill for the Shared Living Isolation Rate once the additional costs are authorized by the Regional Office and included in PCIS.**

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.

***COVID-19 UPDATE*: Budgets for COVID-19 services that don't require preauthorization should be entered into the Consumer Budget with an (G) Actual Budget amount for at least the amount of the costs to be included on the invoice. If the budgeted amount for the service is not high enough to cover the costs included in the Available Budget for Charges, the expenditures will go into the Unfunded Amount on the Cover Page and will not be included in the Total Invoice Charges.**

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, ***COVID-19 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, or ***COVID-19 costs***	
H	Year-to-Date Paid Charges	Input the total amount paid for the service or cost for the year; don't enter an amount here for COVID-19 costs if billing for new costs	
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 = I If J < I, then K = J
L	Unfunded Invoice Charges	Excel automatically calculates	If J > I, then L = I - J

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, or ***COVID-19 service*** from the dropdown list.	
E	Date of Service**	Input date that service was provided or cost was incurred (must be in FY21); Cannot be duplicate for the same service and person; ***COVID-19 services effective March 13, 2020-March 12, 2021***	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 located 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 ***COVID-19 services: No documentation needs to be submitted with the invoice but must be available to DDA upon request. Includes documentation of a positive COVID test for isolation rates.***	

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 good being provided in order 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

†† 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 AND COVID-19 NON-FPS SERVICES MEDICAID CLAIMS SUBMISSION

Providers can submit a claim electronically or through paper format for Community Pathways Waiver non-FPS services. COVID-19 services cost invoices must include paper 1500 forms for Waiver eligible services and should not be submitted electronically.

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