MARYLAND
Department of Health

Addendum Cover Page for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

PT VC HIV CASE MANAGEMENT

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)**
Monday – Friday from **7am – 7pm.**

All providers are required to use the **e**lectronic **P**rovider **R**evalidation and **E**nrollment **P**ortal, or ePREP (eprep.health.maryland.gov) for enrollment, information updates, provider affiliations and revalidations.

Please fill out the information below and upload the completed addendum to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional documents requested within the addendum.

Provider Information

NPI:

Tax ID:

MA Provider Number (if already enrolled in Maryland Medicaid):

Please visit health.maryland.gov/ePREP for more information about ePREP

Addendum Cover Page for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

PT VC HIV CASE MANAGEMENT

Please upload this form to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional applicable supporting documents requested below.

Section I:

Please upload the following documents to ePREP :

1. Written policies and procedures for the implementation and provision of DES and/or HIV case management services.
2. A copy of current licenses and resumes of all members of multi-disciplinary teams and/or case managers (i.e., physicians, nurses, social workers). Please see COMAR 10.09.32 for specific requirements.
3. A copy of all signed written agreements between your agency and agencies in which referrals for DES or case management services may be given to or accepted from. (If your agency is applying for both services and will not have additional agreements with other agencies, you do not need to submit this form.

Section II:

1. Please check all that apply to the following statement:

   I am applying to participate in Medical Assistance Targeted Case Management for HIV- Infected Individuals as a:

   ❑ Diagnostic Evaluation Services (DES) provider

   ❑ Ongoing Case Management provider

2. Please read the section below and sign on page 4 where applicable

I hereby certify that as a Medical Assistance Targeted Case Management for HIV- Infected Individuals provider, I will meet the provider requirements and render the covered services in accordance with COMAR 10.09.32 and any amendments thereto.

All applicants must submit the following documentation:

a. Written policies and procedures for the implementation and provision of DES and/or HIV case management services.
   Please include the process for the reassessment of participants and case closure.
b. A copy of current licenses and resumes of all members of multi-disciplinary teams and/or case managers (i.e., physicians, nurses, social workers). Please see COMAR 10.09.32 for specific requirements.
c. A copy of all signed written agreements between your agency and agencies in which referrals for DES or case management services may be given to or accepted from. (If your agency is applying for both services and will not have additional agreements with other agencies, you do not need to submit this form.)

All applicants must agree to the following:

a. To be available to participants at least eight hours a day, five days a week, except State holidays.
b. To complete and update the plan of care consistent with the requirements of the regulations.

c. To present qualified Medicaid recipients with the option of receiving HIV DES and HIV ongoing case management from a choice of providers. The provider acknowledges that the participant's ongoing case manager may participate as a member of the multidisciplinary team.
d. Medical Assistance Targeted Case Management services will not be delivered free of charge to non-Medicaid participants. The provider must charge all non- Medicaid recipients for the service according to a fee schedule which may be billed to a participant, either in full or using a sliding fee scale, or directly to a third-party payer.

By signing and submitting this application, the provider agrees to the following, as stated in COMAR 10.09.32:

For DES providers only:

- The provider will bill only upon completion of a multidisciplinary assessment and signature of all multidisciplinary team members on the individualized plan of care.
- The provider will convene a multidisciplinary team for each participant as specified within the regulations. The team will perform a multidisciplinary assessment and revise the plan of care for the participant annually, or more frequently if significant changes occur during the year.
- The assessment will include all of the components in COMAR 10.09.32 using the Department's HIV/AIDS Bio-Psychosocial Assessment Form as a guide.
- The plan of care will include all of the components in COMAR 10.09.32 using the Department's Case Management Plan of Care Form as a guide.
- The provider must have access to specialty physicians experienced and trained in provision of services to HIV-infected individuals, for consultation as necessary concerning a participant's medical assessment and the medical plan of care.

For Ongoing Case Management providers only:

- The provider has established alternatives for managing participants' medical and social crises during off-hours that will be specified in participants' individualized plans of care.
- The provider ensures that case managers are knowledgeable of the eligibility requirements and application procedures for applicable federal, State, and local government assistance programs.
- The provider agrees to maintain a current listing of medical, social, housing, mental health, financial assistance, counseling and other support services available to HIV-infected individuals.
- The provider agrees that case managers will adhere to all provisions in the plan of care and monitor and evaluate the plan appropriately.
- The provider must have a written policy for case closure.

3. Please complete the Agreement of Understanding Between an HIV Diagnostic Evaluation Services Provider and An HIV Ongoing Case Management Provider below. This agreement of understanding ***does not*** need to be completed if diagnostic evaluation services and case management are being rendered by the same provider.

The providers of this agreement of understanding mutually agree that the case manager selected by the client and employed by the HIV Ongoing Case Management provider shall:

- Serve as a member of the client's multidisciplinary team convened by the HIV Diagnostic Evaluation Services provider and participate in the multidisciplinary assessment and development of the client's plan of care;
- Be given access to the client's plan of care for its implementation; and

- Order an assessment of the client and revision to the plan of care by the HIV Diagnostic Evaluation Services provider, as necessary.

_____ _____

Authorized Signature HIV Diagnostic Evaluation Services Provider

_____ _____

Authorized Signature HIV Ongoing Case Management Provider

4. Please read the follow statement and sign at the bottom:

I do solemnly declare and affirm under the penalties of perjury that the contents of the foregoing document and of the attachments are true, accurate, and complete. I understand that a provider agreement will not be signed until the application and all required attachments have been received and approved by the Office of Health Services.

_____

Name of Applicant Entry

_____ _____

Authorized Signature Date

Section III: Billing Instructions for HIV Case Management

BILLING INSTRUCTIONS

These billing instructions are for Medical Assistance (also called Medicaid) services covered under the Targeted Case Management for HIV-Infected Individuals program (the Program). The program is governed by COMAR 10.09.32.

The Maryland Department of Health (MDH) is the State's lead agency for the Medicaid Program. The Program is administered at MDH. Billing questions may be directed to the Program at 410-767- 1458.

This packet was prepared to provide proper billing instructions for program 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 gives detailed information about completing the CMS-1500 billing form. Please be sure to read this information carefully so that your claims will be appropriately submitted and paid.

APPROVAL NOTICE AND BILLING INSTRUCTIONS

Maryland Medical Assistance Program

Maryland Department of Health

Targeted Case Management for HIV-Infected Individuals

Your application to become a Medical Assistance provider for Targeted Case Management for HIV Infected Individuals has been reviewed and approved by the Medical Assistance Program and the Maryland Department of Health for the following service(s):

Diagnostic Evaluation Services (DES) provider _____
Ongoing Case Management provider _____

Your new provider number is assigned to a specific procedure code that will allow you to bill only for the service(s), which you provide. This provider number should not be interchanged with any other provider number. Reimbursement for HIV services may begin as of the effective date listed on the enrollment letter. Providers will receive the enrollment letter at the mailing address listed on the application after the enrollment process is complete.

These billing instructions are for Medical Assistance (i.e. Medicaid) services covered under COMAR 10.09.32 for providers of Target Case Management for HIV Infected Individuals.

The following conditions must be met for payment of HIV services:

- The provider must be approved as a Medicaid provider and enrolled to provide the type of services billed;
- The Provider must complete the Enrollment form for HIV Ongoing Case Management;
- The recipient must be Medicaid-eligible as of the date of service;
- The services must be rendered in accordance with COMAR 10.09.32, and any other government requirements;
- The services must not exceed any limitations or restrictions specified in COMAR 10.09.32;
- The provider must submit the appropriate billing form in order to be reimbursed by the program.

FREQUENTLY ASKED BILLING QUESTIONS

This section provides insight into frequently asked questions about the Program. After you read this section, look at the following section "Instructions for Completing CMS-1500" for detailed instructions on paper billing.

Before you render and/or bill for any services, ask yourself these questions:

1. ***Is the participant enrolled in Medicaid?***

   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://mmcp.health.maryland.gov/docs/EVS%20Brochure%20March%202013.pdf.

2. ***Determine if the participant is in a Managed Care Organization (MCO)***

   - A participant's MCO status will be clearly indicated through the EVS system and include the MCO with which they are a member, as well as the contact information for that MCO.

   - If a participant is in an MCO, the claim should be sent to the appropriate MCO according to their billing protocols.

   If the participant is not enrolled in an MCO, follow the billing instructions below.

3. ***How do I submit claims for reimbursement for fee-for-service?***

Electronic Billing

Providers may submit claims electronically via eMedicaid. eMedicaid allows providers secure online access to verify participant eligibility, submit claims for reimbursement, and view remittance advices.Additional information regarding eMedicaid can be found at: https://encrypt.emdhealthchoice.org/emedicaid/

The Maryland Department of Health (MDH) does not provide software for electronic billing. Providers may consult with billing software vendors to learn about electronic billing.

Paper Billing

Providers may submit paper claims to MDH for claims processing, but will experience longer processing times. Paper claims are generally paid within 4-6 weeks.

Providers are encouraged to submit claims electronically. Billing electronically has many advantages. Most importantly, your claim is processed quicker with payment within 1-2 weeks of submission.

If you are billing on paper, you must submit all claims for services on the CMS-1500 (08- 05), previously called the HCFA-1500. You may purchase these forms from a stationary or office supply store.

Filing Limitations

Claims ***must*** be received within 12 months following the date of service. The following exceptions apply 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.

4. *What can I do to avoid payment delays?*

To avoid payment delays, you should:

- Make sure all information entered on the claim form is correct, including your Provider Number and the Participant's Medical Assistance ID Number.

- If a 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 service is covered.
  If the insurer does not cover the service, please indicate "Services not Covered" by inserting Value "K" in Block 11 of the CMS-1500.

5. ***Where do I send the completed CMS-1500?***

Completed claims should be mailed to the following address:

Maryland Department of Health
Office of Systems, Operations and Pharmacy
Claims Processing Division
P.O. Box 1935 Baltimore, MD 21203

SERVICE INSTRUCTIONS

Instructions for Completing the CMS-1500

Program providers are required to complete certain blocks on the CMS-1500 in order to receive payment. The table on the next page shows all blocks that must be completed on the CMS-1500 form to receive payment for services.

Payment Procedures can be found in COMAR 10.09.32.06.

Basic Rules for the Paper CMS-1500:

- Use one CMS-1500 for each recipient.
- Be sure that the information entered on the form is legible.
- Double-check all information on the claim, especially the Provider and Recipient Numbers.
- Enter information with a typewriter or in black ink.
- Only six dates of service can be billed on one CMS-1500 form. If you need to bill additional dates, you must complete a new CMS-1500 form with all the required information filled-in.
- **Claims must be submitted within 12 months of the date of service**.

Blocks to Complete on CMS-1500 for Billing Targeted Case Management for HIV Services

Block Number	Title	Action
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.
11.	Insured's Policy Group of FECA Number	Insert Value "**K**" of the Maryland Medicaid Billing Instructions, in Block 11 of the CMS-1500.
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: 11 for provider's office, 12 for participant's residence, or 99 for other facility.
24D.	Procedures, Services or Supplies	Enter the procedure codes: Diagnostic Evaluation Services =S0315 Ongoing Case Management = W0316
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 units of service.
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 is required. The claim date **must** be in this field in order for the claim to be reimbursed.
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 MUST 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 MUST be prefixed with a '1D' in order for the claim to be reimbursed** (e.g., 1D012345678).

A. HIV Diagnostic Evaluation Services (COMAR 10.09.32.04)

Procedure Code	Service	Unit of Service	Maximum Rate Per 12-Month Period
S0315	DES	One unit	$200.00

Covered Service

Diagnostic evaluation services may not be billed until after the assessment is completed along with a completed plan of care with all required signatures. The fee is all-inclusive and not dependent on the amount of time required.

Limitations

Diagnostic evaluation services may only be billed once per 12-month period.

A.

B. HIV Ongoing Case Management Services (COMAR 10.09.32.04)

Procedure Code	Service	Unit of Service	Maximum Rate
W0316	HIV Ongoing Case Management	One unit is equal to 15 minutes (see below for instructions)	$17.86

Covered Service

Six units of ongoing case management may be billed prior to completion of the diagnostic evaluation services, for the case manager's role on the multidisciplinary team. A total of 96 units of service for ongoing case management may be billed per year per client after completion of the Diagnostic Evaluation Service.

Limitations

Reimbursement for case management services is for a distinct service event.

- Case management services must be billed in increments of 15-minutes, referred to as a 15-minute unit. Minutes of service and units are to be totaled by day by service.
- A provider may not bill for a service of less than 8 minutes if it is the only service provided that day.
- For multiple units of the same service on the same day, total the actual minutes and round to the nearest 15 minute increment.
- Please see the chart below for additional examples of accurate billing of daily total minutes as 15-minute units of service. The actual minutes billed for any one case manager in a work day may not exceed the work hours of that case manager.

Units	Minutes of Service
1	Greater than or equal to 8 minutes, but less than 23 minutes (8-22 min)
2	Greater than or equal to 23 minutes, but less than 38 minutes (23-37 min)
3	Greater than or equal to 38 minutes, but less than 53 minutes (38-52 min)
4	Greater than or equal to 53 minutes, but less than 68 minutes (53-67 min)
5	Greater than or equal to 68 minutes, but less than 83 minutes (68-82 min)

Providers must maintain records which fully demonstrate the extent, nature and medical necessity of services provided to Medicaid recipients. The records must support the fee charged or payment sought for the services

and items, and demonstrate compliance with all applicable requirements.

Not all activities performed by the provider are considered billable activities.

- Billable case management activities shall be based on the participant's plan of care.
- Examples of billable activities include but are not limited to face-to-face contacts with the applicant/participant, updating of the plan of care, and collateral contact made to persons on behalf of the participant or that relate directly to the management of the participant's services.

Some examples of non-billable services include, but are not limited to:

- Activities that are not allowable under the Federal definition of case management, such as time spent by the provider solely for the purpose of transporting participants.
- Other examples of non-billable activities include:
  - Case Management services of less than seven minutes duration;
  - Telephone contact with the Department or its designated agent for the purpose of requesting or reviewing authorization;
  - Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan or service data or other information;
  - Completion of billing documentation;
  - Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among team members;
  - Time spent in staff training, clinical supervision or case reviews including for the purpose of treatment planning;
  - Travel time;
  - Attempted contacts or leaving messages; and
  - Services provided by individuals who do not meet the definition of and minimum qualifications for a case manager (COMAR 10.09.32.02).

Thank you for participating in the Targeted Case Management for HIV Infected Individuals Program. If you have any questions regarding this program please contact the Behavioral Health Enrollment Unit at (410) 767-9732 or via email at mdh.bhenrollment@maryland.gov.