2019

Developmental Disabilities Administration

Provider Portal User Manual

Version 3.0

MARYLAND
Department of Health

Table of Contents

Common Terms and Definitions

Billing Entry - Entries made by providers for services rendered

Billing Unit – Defines how a service is authorized and billed. Billing unit can be (1) Daily: each day of service is one-unit (2) Hourly: each hour of service is one-unit (3) Quarter Hourly: each 15 minute increment is one-unit (4) Monthly: each month of service is one-unit (5) Milestone: one time service (6) Upper Pay Limit: Total cost of services provided up to a maximum authorized amount

CCS – Coordination of Community Services

Claim - A claim is created for each service rendered to a person by a provider for a date of service (for daily, hourly, quarter hourly services); month of service (for monthly services); completion of a single milestone (milestone services); or a cost accrual date (upper pay limit services)

CMRO – Central Maryland Regional Office

DDA – Developmental Disabilities Administration

DOB – Date of Birth

DOS – Date of Service

ESRO – Eastern Shore Regional Office

ESP – Emergency Service Plan

EVV – Electronic Visit Verification

Exceptions - Conditions that prevent a claim from being processed for payment

FEIN – Federal Employee Identification Number

ICN – Internal Control Number. Medicaid's Internal Claim Number

IVR – Integrated Voice Response

ISAS – In-home Supports Assurance System

LTSS – Long Term Services and Support

LTSS Program: A Person's program enrollment in LTSS on the date of service

MDH – Maryland Department of Health

MMIS – Medicaid Management Information System

MMIS Program: A person's waiver program enrollment in Medicaid, determined by the Special Program Code that is set up in MMIS on the date of service

PCP – Person Centered Plan

PCP Program: The program type which is associated with the Person-Centered Plan (PCP) active on the Date of Service

PHI – Protected Health Information

Proc Codes - Medicaid waiver service billing code

RA – Remittance Advice

RA Date – The check date or date on which provider received payment for a service

RA Number – Check Number associated with the payment for a service

RO – Regional Office

Service - An individual service delivered to person

Service Status – A workflow status that identifies where an entry is currently in the billing process.

SMRO – Southern Maryland Regional Office

SSN – Social Security Number

SPC – Special Program Code (denotes the program a person is in within Medicaid)

UPL – Upper Pay Limit

WMRO – Western Maryland Regional Office

Part A – Getting Started with Provider Portal

1. Introduction to LTSS Provider Portal

The *LTSSMaryland* Provider Portal is an interface for Long Term Care Providers to access information on persons in service, bill for the services provided, and ensure accurate and timely payment. The two types of program-based services are:

- Services Requiring Electronic Visit Verification (EVV) – where staff are required to call in to the Integrated Voice Response (IVR) system to record service start times (clock-in) and end times (clock-out). A pair of clock-in and clock-out by a staff is matched and is automatically submitted for payment. The Provider Portal allows for providers to enter times manually where a call has been missed, up to an allowed number of times.

- Services not requiring an Electronic Visit Verification or Non EVV Services, billed as Unit based, Milestone and Upper Pay limit services:

o   Unit based services include all services that can be provided in time frequencies of "Monthly", "Hourly", "Daily" or "15 min increments"

o   Milestone services are services that are authorized to be provided once in a year

o   Upper Pay Limit or cost based services are services that are billed based on the cost of the service provided, up to an authorized upper limit

The *LTSSMaryland* Provider Portal also allows the Provider Agency to correct errors in billing, view and resolve billing issues, review and electronically accept service referrals, be notified of important communication from DDA and manage staff access to the portal.

2. Registering your Agency for the First Time

To register your Provider Agency to use the *LTSSMaryland* Provider Portal, contact the technical help desk at ISASHelpDesk@*LTSSMaryland*.org or 1-855-463-5877 to create an administrator account.

You will need to provide the following information:

- Your name
- Your email addresses
- Provider Agency phone number
- Provider Agency name
- Provider Agency FEIN

Communication on username and instructions to set password will be sent to the registered email address.

2.1 Setting up staff access to the LTSSMaryland Provider Portal

To set up additional staff to access the *LTSSMaryland* Provider Portal, the Agency administrator should complete the below steps:

1. Create a new Staff Profile in the *LTSSMaryland* Provider Portal (Refer to Section 5.2) with the appropriate role.
2. Contact help desk at ISASHelpDesk@*LTSSMaryland*.org or 1-855-463-5877 to set up an account and username.
3. Staff should follow instructions sent to the email address entered in the Staff Profile to set up a password to access the *LTSSMaryland* Provider Portal.

NOTE: Webinar trainings are available at www.LTSStraining.org.

2.2 Logging into the LTSSMaryland Provider Portal

Steps to Login:

1. The *LTSSMaryland* Provider Portal website URL is https://*LTSSMaryland*.org.
2. Enter the Username and Password and click the Sign In button.

   Important: Do NOT share your username or password with anyone.
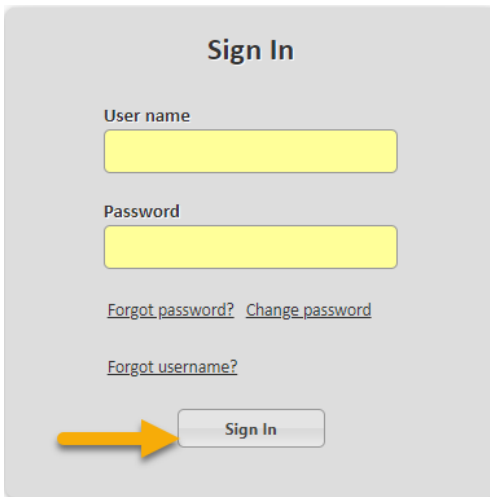
3. Choose the LTSS/ISAS Live (2014 New).

   NOTE: The site can be accessed with the following browsers:

- Google Chrome 19 and later [Recommended]
- Microsoft Internet Explorer 8, 9 or 10
- Firefox 12 and later

2.3 Portal Navigation Guide

Along the top of the *LTSSMaryland* Provider Portal are the following menu options:

Tab	Functions
Home	Portal Landing Page; Displays announcements from DDA and pending tasks for the Provider Agency
Services	Used to bill for services; view entered service details; resolve billing issues; and view MMIS claims and payments
Clients	Allows accessing information on persons in service; review and accept/decline service referrals
Providers	Create accounts for staff requiring access to the *LTSSMaryland* Provider Portal and the IVR system for electronic visit verification
Reports	Access to all reports
Help	Links to training material, FAQs, and Helpdesk and DDA contact information
Feedback	Reporting system issues in the Provider Portal

2.4 Homepage

Upon logging into the *LTSSMaryland* Provider Portal you are presented with the Provider Portal Home page. The Home page has two sections: Announcements and Actions Required.

2.5 Announcements

The 'Announcements' section is used by MDH to publish important communication to Provider Agencies. Review the Announcements section at every login to see if there is any new communication from DDA.

2.6 Actions Required

The Actions Required section lets you see all tasks that require your Provider Agency to take an action. Tasks are staff role-specific and shows

- Plans pending acceptance by the Provider Agency. The count of service plans pending acceptance is updated in real-time; that is, as you take the action to accept or decline a service request, it will disappear from your dashboard
- Plans accepted by the Provider but not yet approved for service
- Plans accepted by the Provider and either approved or denied in the past seven days
- Billing issues requiring resolution due to which claims to be held from submission

ACTIONS REQUIRED (AS OF 9:00AM 09/27/2019)

▼ SERVICE PLANS PENDING ACCEPTANCE

Plans Pending Acceptance	Counts
Due Today	0
Due Tomorrow	1
Due in 5 Days	1

RO Approved/Denied/Pending Plans	Counts
RO Approved Service Plans in the last Seven days	0
RO Denied Service Plans in the last Seven days	0
Provider Accepted Service Plans Pending Approval	2
Provider Accepted Service Plans Pending RO	0

3. Service Referrals & Alerts on Persons in Service

3.1 Accepting Service Referrals

Through the Person-Centered Planning process, the Coordination of Community Services (CCS) provider works with the person to identify Provider Agencies for services outlined in the person's Service Plan. To complete the service referral, the CCS documents the Providers selected by the person in the service plan and refers it to the provider for acceptance. All identified Provider Agencies must accept the service referral prior to final Service Plan approval by the DDA.

Service is Referred for acceptance (or declination from the Provider in the following situations:

- When a new person is referred
- When authorized units or cost of services change in a Revised PCP
- When a new service is added for the person in a revised PCP
- When an Annual PCP is completed.

Providers are required to either accept or decline a service referral within 5 business days.

After 5 business days, Providers will no longer be able to review or decide on the service referral. At this time, the person in service may choose to modify the referral, resend the service referral or identify another Provider.

3.2 Service Referral Notifications

Provider designated program and administrative staff are notified of new service referrals from the CCS through the Actions Required section of the *LTSSMaryland* Provider Portal Home Page. Service referral notifications are categorized by number of days before they expire, as detailed below:

- *Due Today* – service referrals expiring today
- *Due Tomorrow* – service referrals expiring today or tomorrow
- *Due in 5 days* – service referrals expiring anytime within the next five business days (cumulative)

Clicking on each count redirects the provider to a list of service referrals due within the indicated time period. From here services can be reviewed, accepted or declined.

3.3 View Details of Service Plan

Details of a service referral can be viewed by clicking on the "View" button for each person. This opens the Person-Centered Plan Details.

Each section is expandable/collapsible. The sections are detailed below.

3.4 Client Information

Includes basic demographic and high-level information of the person in service.

3.4.1 Plan Details

The Plan Details section shows the basic information of the plan:

- Program type – The program the person is enrolled in
- Meeting Date – The date the meeting was conducted to draft the PCP
- Annual PCP Date- The effective date of the Annual PCP. This gives an insight into when the Annual PCP is due
- Effective/End Date – The start and end dates of this PCP
- Plan Type – The type of the PCP (Initial/Annual/Revised)
- Is Urgent – If Yes then the PCP decisions are taken with Urgent priority
- Monthly Monitoring required – Whether or not monthly monitoring is required is indicated in this field

3.4.2 Plan Contacts

Includes information on CCS contact person for the Service Plan.

3.4.3 Summary

This section includes information on the person including what they like and admire about them, and what they are interested in doing. It also includes information on the best way to communicate with the person.

PERSON CENTERED PLAN - DETAILS ✕

> CLIENT INFORMATION

> PLAN DETAILS

> PLAN CONTACTS

> SUMMARY

What I like and Admire about Myself:
--

What I am Interested in Doing:
--

Important People in My Life:
--

Best Way to Communicate With Me:

Technology I use:
--

> OUTCOMES

> DETAILED OUTCOMES

> SERVICE AUTHORIZATION

> SIGNATURES

> SERVICE PLAN WORKFLOW HISTORY

> PROVIDER ACCEPTANCE WORKFLOW HISTORY

3.4.4 Outcomes

Includes outcomes of the services and the description of these outcomes.

3.4.5 Detailed Outcomes

Includes detailed description of the outcomes and which service/s these are associated with. Also describes how these outcomes of the associated services are important to/for the person in service.
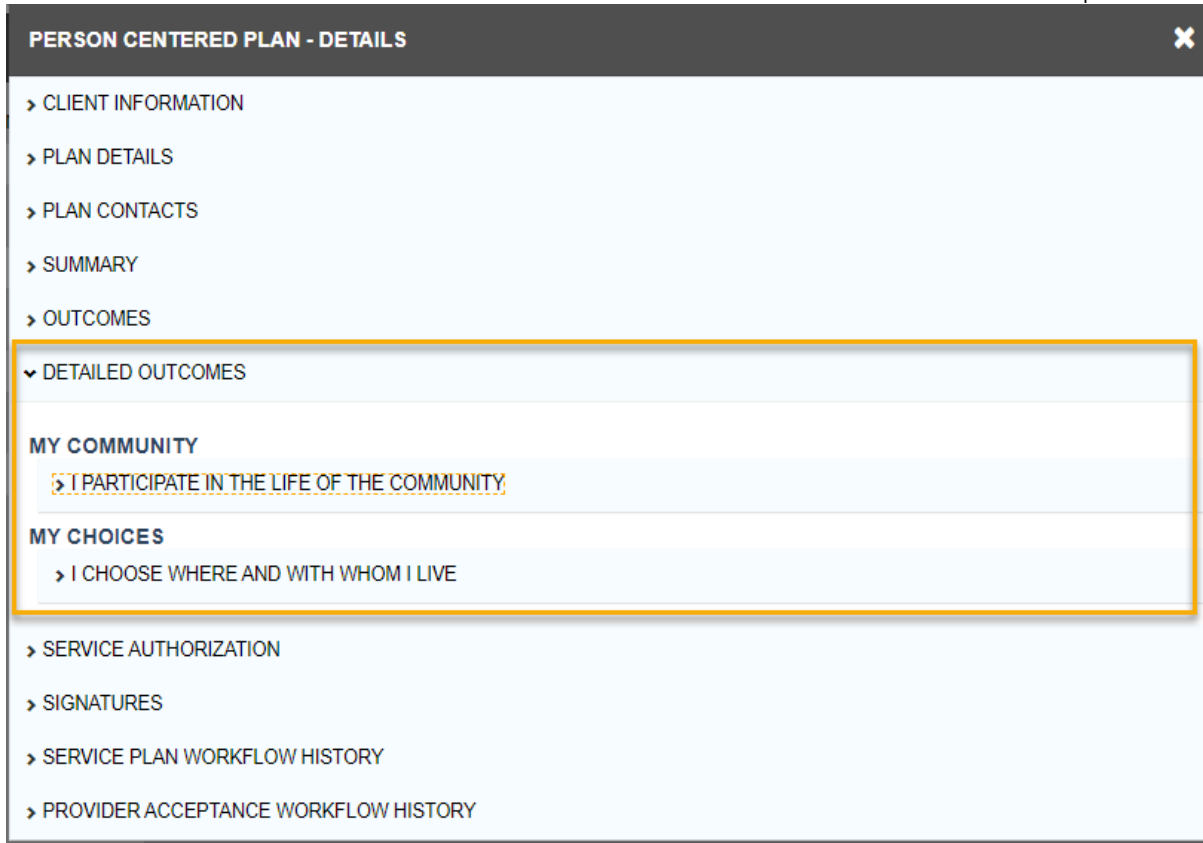
3.4.7 Additional Information

More information about the assigned service can be found by clicking on the service name from the list of services. This opens a service view window (Refer to the screenshots below - Part1 and Part2), where the following information is available.

- Service Plan
- Service Information
- Provider Information
- Service Details

VIEW SERVICE ✕

Service Plan

Program Type: **CP**

I will self-direct services on this plan: **No**

Service Information

Service Category: **All**

Service Title: **Day Habilitation 2:1 Staffing Ratio**

Outcome(s) service is supporting: **My Choices - I choose where and with whom I live**

Frequency: **Weekly**

Scope (level of support, staffing ratio, reason for service): **scope**

VIEW SERVICE ✕

Provider Information

Provider Name: **Day Care Center of Baltimore**

Provider Number: **345678900**

Location: **333 First Street, Test, MD 21000**

Phone Number: **434434433**

Service Details

Annual Service Cost: **$4,500.00**

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
15	15	15	15	15	15	15	15	15	15	15	15

3.4.6 Service Authorization

Services that the person will receive through the Provider Agency, with authorized monthly units and cost across the plan year.

1. Unit Based services - services which have units of hourly, monthly or 15-minute increments.
2. Milestone Based services - are services that are authorized once a year.
3. Upper Pay Limit (Cost-based) services - are services which have an associated cost with it every time the service is provided.

> DETAILED OUTCOMES

▾ SERVICE AUTHORIZATION

Plan Type & Effective Date	Billing Unit	Service and Provider	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Annual Service Cost	Due Date	Actions
Initial - 08/01/2019	Hourly	Day Habilitation 2:1 Staffing Ratio - Day Care Center of Baltimore	15	15	15	15	15	15	15	15	15	15	15	15	$4,500.00	N/A	*N/A*
Initial - 08/01/2019	Hourly	Day Habilitation Small Group (2-5) - Day Care Center of Baltimore	30	30	30	30	30	30	30	30	30	30	30	30	$9,000.00	N/A	*N/A*
Initial - 08/01/2019	Hourly	Day Habilitation 1:1 Staffing Ratio - Day Care Center of Baltimore	20	20	20	20	20	20	20	20	20	20	20	20	$6,000.00	09/30/2019	Accept Decline

Service Provider Plan Year Cost

Annual Waiver Plan Services Total:	$19,500.00
DDA State Only Funded Services Total:	$0.00
Service Provider Plan Year Cost:	$19,500.00

> SIGNATURES

3.4.8 Signatures

Copy of signature page for any accepted services [Refer to Section 0].

3.4.9 Service Plan Workflow History

Shows the history of the service plan from creation to approval. Provider users can see the transition from "In Progress" to "Pending Regional Program Staff Review" to "Clarification Requested" status to "Approved" status.

3.4.10 Provider Acceptance Workflow History

Shows the history of electronic service requests from the CCS to the provider and the provider's responses.

> PLAN CONTACTS

> SUMMARY

> OUTCOMES

> DETAILED OUTCOMES

> SERVICE AUTHORIZATION

> SIGNATURES

> SERVICE PLAN WORKFLOW HISTORY

∨ PROVIDER ACCEPTANCE WORKFLOW HISTORY

Action	Service and Provider	By	Date	From Review Status	To Review Status	Comments
Pending	Day Habilitation 1:1 Staffing Ratio - Day Care Center of Baltimore	DDAHQ, ddaadmin1	09/23/2019 12:22:09	New	Pending Acceptance	
Accept	Day Habilitation 1:1 Staffing Ratio - Day Care Center of Baltimore	Admin Provider	09/13/2019 16:22:31	Pending Acceptance	Accepted by Provider (pending approval)	
Pending	Day Habilitation Small Group (2-5) - Day Care Center of Baltimore	DDAHQ, ddaadmin1	09/13/2019 16:22:17	New	Pending Acceptance	
Pending	Day Habilitation 2:1 Staffing Ratio - Day Care Center of Baltimore	DDAHQ, ddaadmin1	09/13/2019 16:21:01	New	Pending Acceptance	
Pending	Day Habilitation 1:1 Staffing Ratio - Day Care Center of Baltimore	DDAHQ, ddaadmin1	09/13/2019 16:11:26	New	Pending Acceptance	

3.5 Accepting a Pending Service Request

Provider designated Program and Administrative staff can accept service referrals, by the following steps:

1. See Service Notifications (Refer Section 3.2)
2. From the Service Plan results page, review the service plan information

SERVICE PLAN SEARCH RESULTS - 1   Sort By: None ▾

Name: **DOE, JOHN**   Client ID: **3319311EB633110**   Program Type: **CP**   Status: **In Progress**
Effective Date: **08/01/2019**   End Date: **--**   Active: **No**   Decision Date: **--**
Plan Type: **Initial PCP**   (A) View

Service	Provider	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Annual Service Cost	Due Date	Actions
Day Habilitation 1:1 Staffing Ratio (B)	Day Care Center of Baltimore	20	20	20	20	20	20	20	20	20	20	20	20	$6,000.00	09/30/2019	Accept Decline

3. Click on the "View" (A) button to review the Service Plan in detail. The user can also look at the individual service by clicking on the service name, for example Day Habilitation 2:1, by clicking on the name(B).

4. Services can be accepted in two ways:

    a. Click on Accept link on the service line from the Service Plan Search Results page.

    b. Click on the Accept link from the services in the Service Authorization section inside the service plan view.

5. The signature page opens. Review service details in the signature page.

MARYLAND DEPARTMENT OF HEALTH

Provider Signature Page

Plan Information

Name: John Doe
Nickname/Also Known As:
LTSS ID#: 3319311EB633110
Plan Type: Initial PCP
Plan Create Date: 09/13/2019
Annual PCP Date: 07/01/2020
Assigned CCS Coordinator: CCS Coordinator
This plan only contains services for the CP waiver program and is subject to DDA approval. Funding and access to CP services for John Doe is contingent upon John Doe maintaining eligibility for the program.

Attestation

By signing this plan, I certify that on behalf of Day Care Center of Baltimore:
✔ If approved by the DDA, I agree to provide the services requested, as indicated below, and per policy and regulation.
✔ I agree with the contents of the plan, including its documents of John Doe's needs and goals.
✔ I understand that the individual is free to choose from any qualified provider for the services.
✔ If there are restrictions in the plan, then John Doe, or his or her legal guardian or surrogate decision-maker, has consented to them per policy and regulation.
✔ I will follow, and ensure my staff will follow, policies and procedures on identifying and reporting potential abuse, neglect, and exploitation.
✔ I am authorized to make these attestations on behalf of Day Care Center of Baltimore.

Services

Service and Provider	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Annual Service Cost
Day Habilitation 1:1 Staffing Ratio - Day Care Center of Baltimore	20	20	20	20	20	20	20	20	20	20	20	20	$6,000.00
Scope: scope													Frequency: Monthly

6. Read the electronic signature acknowledgement and click checkbox (1) to authorize electronic signature.

7. Click 'Sign' (2) to add your electronic signature.

8. Click 'Accept' (3) to formally accept the service. Once a service is accepted, the action cannot be cancelled. If changes are needed, Providers will need to coordinate with the person and CCS to make the updates.

Attestation

By signing this plan, I certify that on behalf of Day Care Center of Baltimore:

✔ If approved by the DDA, I agree to provide the services requested, as indicated below, and per policy and regulation.
✔ I agree with the contents of the plan, including its documents of John Doe's needs and goals.
✔ I understand that the individual is free to choose from any qualified provider for the services.
✔ If there are restrictions in the plan, then John Doe, or his or her legal guardian or surrogate decision-maker, has consented to them per policy and regulation.
✔ I will follow, and ensure my staff will follow, policies and procedures on identifying and reporting potential abuse, neglect, and exploitation.
✔ I am authorized to make these attestations on behalf of Day Care Center of Baltimore.

Services

Service and Provider	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Annual Service Cost
Day Habilitation 1:1 Staffing Ratio - Day Care Center of Baltimore	20	20	20	20	20	20	20	20	20	20	20	20	$6,000.00
Scope: scope													Frequency: Monthly

① ☑ I am signing this Agreement electronically. I understand that it is unlawful to knowingly submit false information to the MDH. I agree that my electronic signature is the legal equivalent of my manual signature on this Agreement. I consent to be legally bound by this Agreement's terms and conditions. I also agree that no certification authority or other third-party verification is necessary to validate my E-Signature and that the lack of such certification or third-party verification will not in any way affect the enforceability of my E-Signature or any resulting contract between myself and MDH.

Day_Admin User

Day_Admin User - Day Care Center of Baltimore 2019-09-27 02:11:52 PM

② Sign ✎

③ Accept | Cancel

9. After completing the acceptance, the signature page closes, and a copy of the signature page becomes available to view from the 'Signatures' section within the service plan details (See Section 0).

3.6 Declining a Pending Service Request

Provider designated Program and Administrative staff can decline service referrals, by the following steps:

1. See Service Notifications (Refer Section 3.2)
2. Services can be declined in two different ways
3. Click on Decline link on the service line from the Service Plan Search Results page

SERVICE PLAN SEARCH RESULTS - 1

Sort By: None ▼

Name: **DOE, JOHN**	Client ID: **3319311EB633110**	Program Type: **CP**	Status: **In Progress**
Effective Date: **08/01/2019**	End Date: **--**	Active: **No**	Decision Date: **--**
Plan Type: **Initial PCP**			View

Service	Provider	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Annual Service Cost	Due Date	Actions
Day Habilitation 1:1 Staffing Ratio	Day Care Center of Baltimore	20	20	20	20	20	20	20	20	20	20	20	20	$6,000.00	09/30/19	Accept / Decline

4. Click on the Decline link from the services in the Service Authorization section inside the service plan view.

5. A comment is required when declining services. Providers can use the Comments box to communicate necessary changes to the CCS and request an updated service referral to be set back. Providers can also use this opportunity to communicate the reason for denial to the CCS. For example, when Day Program capacity is reached, and additional persons cannot be accepted.

6. After entering a comment click 'Decline'.

7. Once a service request has been declined, PHI of the person is hidden. The Person's name is replaced with initials and the 'View' button becomes unavailable.

3.7 Filtering Service Plan Results

Results can be filtered using the filter criteria described in this section. In addition, users can navigate directly to the service plan search page and search for service plans by choosing one or more available filter criteria.

Navigation: *Home Page - > Clients - > Left Nav Menu - > 'Search Service Plans' icon*.

The search results are described for each of the filter/search criteria specified below.

- Client Last Name, Client First Name – Search for service plans by the person's first or last name

- Service Type – Search for service plans by selecting one or more service types from the dropdown list

- Site Address – If one of the service types selected is 'Supported Living', the 'Site Address' field is enabled and allows the provider to filter to one or more sites

- Provider #/Name – Search for service plans by selecting one or more assigned provider location numbers/names from the dropdown list

- Review Status – Search for service plans by current status (this field allows only one selection)

- ● Pending Acceptance: Service plans with services pending acceptance by the provider
- ● Declined by Provider: Service plans with services that been declined by the provider
- ● Accepted by Provider (pending approval): Service plans with services accepted by the provider, pending CCS submission to the Regional Office
- ● Pending RO: Service Plans (PCPs) awaiting the Regional Office review and approval. These services have been accepted by the provider and submitted by the CCS
- ● RO Approved: Service Plans (PCPs) approved by Regional Office
- ● RO Denied: Service Plans (PCPs) denied by the Regional Office
- • Due Date – This field is enabled when review status 'Pending Acceptance' is selected
  - ● Due Today – Service referrals expiring today
  - ● Due Tomorrow – Service referrals expiring today or tomorrow
  - ● Due in 5 Days – Service referrals expiring within the next five business days

- Decision Date From and To – These date fields are enabled when review status 'RO Approved' or 'RO Denied' is selected and allows the provider to search for approved/denied plans within a specific date range. (Refer to below screenshot for RO Approved)

1. Click 'Search' to narrow the service plan results by the entered parameters.

3.8 Tracking Accepted Service Plans

Status of service plans that have been accepted can be tracked from the Actions Required section of the Home page. The following counts are available and clicking the count redirects the user to the service plans list page, where further filtering is possible.

- RO Approved Service Plans – Count of Service Plans approved by the Regional Office
- RO Denied Service Plans – Count of Service Plans denied by the Regional Office
- Provider Accepted Service Plans Pending Approval – Count of Provider accepted service plans pending CCS submission of the service plan to the Regional Office
- Provider Accepted Service Plans Pending RO – Count of Provider accepted service plans pending decision by the Regional Office

Clicking on each count redirects you to view the service referrals accepted by the provider and is currently with the CCS, RO or Approved.

3.9 Alerts on events for Persons in Service
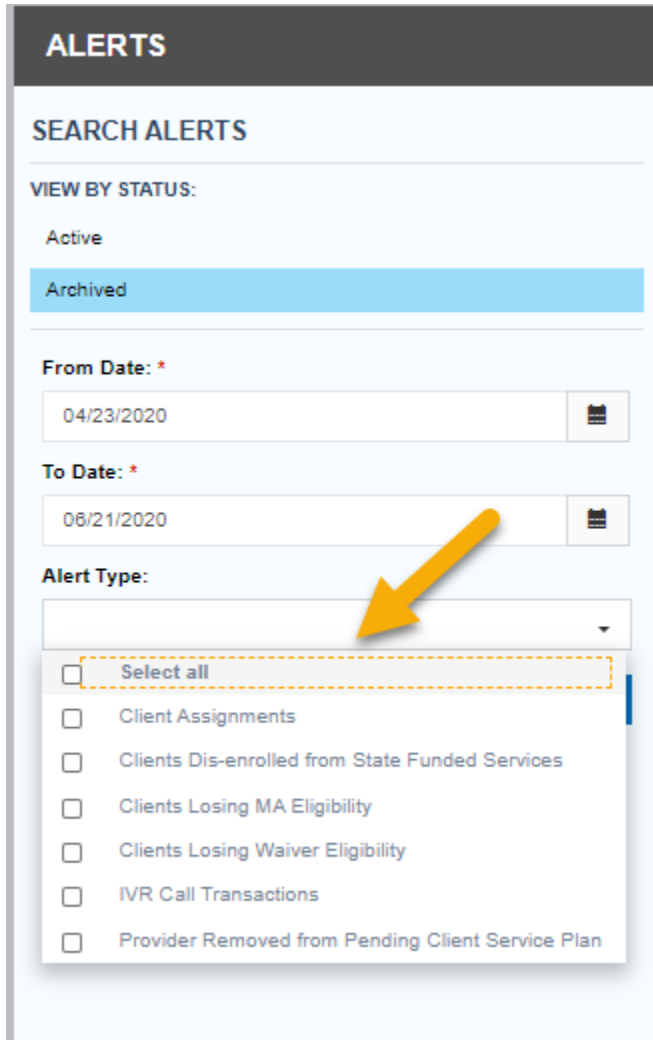
Alerts allow a notification to providers of things that have changed with the person, so they can plan and manage their services, by navigating to the Alerts menu at the top.

Providers may receive notifications on one the below reasons (categorized as Alert Type)

- Client Assignment: when a person no longer requires a service from the Provider, as provider assignment on service plan is removed

- Client Dis-enrolled from State Funded Services: When a person receiving services through the DDA State Funded Program and has lost program eligibility to continue to receive services

- Client Losing MA Eligibility: When a person has lost eligibility for receiving services funded by Medicaid

- Client Losing Waiver Eligibility: When a person has lost eligibility to receive DDA waiver services

- IVR Call Transactions: A Direct Service Professional (DSP) has used the ISAS Call-in System to clock time for a person whose personal supports services are not yet billed through LTSS MD

- Provider Removed from Pending Client Service: When a Provider has accepted to provide service to a person, but the provider has been removed from the Service Plan after Provider's acceptance

Providers can filter their alerts by the Alert Types (reason) or by date the alerts were received

Users see different alerts based on their user role

- All Administrators (Admin Providers) receive all alerts for the Provider Agency.

- Program Directors and Program Staff receive alerts on ending services on service plan and loss of waiver/program eligibility

- Billing staff receive alerts on loss of waiver/program eligibility, and when DSPs use the ISAS Call-in System for clients for who Provider is not billing for EVV services through LTSS MD

Users may archive alerts that they have reviewed to clear it from the default alerts list

4. Client Profile

4.1 Searching for Persons Receiving Services

Administrative, Billing, and Program staff from the Provider Agency can search for and view information including demographics, enrollment information, service plans, and other data about the persons they support in the "Client" tab in the *LTSSMaryland* Provider Portal. Each person has a "Client Profile" that displays information about the person. Provider Agencies are only able to search for and view persons that are actively receiving services or are approved for services in the future. Providers cannot modify the client profile.

Navigate to the Client Search Page: Home Page - > Clients - > Left Nav Menu - > 'Clients' icon.
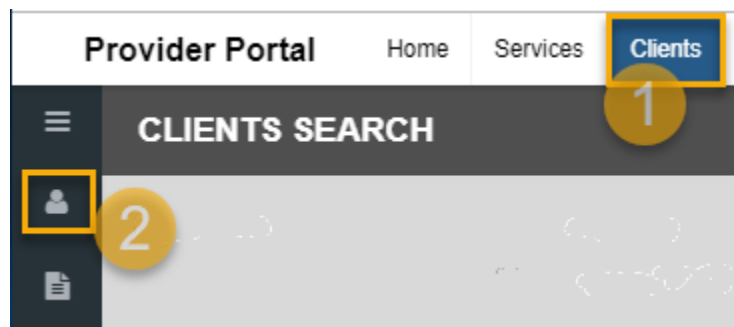
The following search parameters are available to search for client profiles (See below screenshot listing all the search parameters):

- DOB – Person's Date of Birth. This is a calendar selection that also accepts manual entry in the format MM/DD/YYYY
- Phone# – Person's phone number. Auto Formats to (###) ###-####)
- Last Name – Person's last name
- First Name – Person's first name

Client Profiles

- Client ID – Person's unique LTSS identifier
- MA# – Person's Medicaid number
- Client Region – Assigned DDA Regional Office for the person (CMRO, ESRO, SMRO, WMRO)
- Enrolled Program – Person's currently enrolled program
- Client MA Eligible –Yes/No (active Community Medicaid eligible or not)
- Jurisdiction – List of Maryland Counties
- Provider #/Provider Name – Provider Agency locations assigned to the provider staff. All assigned locations are available for selection from a dropdown. Multi-select is allowed
- Waiver Eligibility – Yes/No. Allows filtering on whether the person is currently enrolled in a waiver program or not

Provider Portal   Home   Alerts   Services   **Clients**   Provide

CLIENTS SEARCH   ❮

Date of Birth:

📅

Phone #:

(555) 555-5555

Last Name:

First Name:

Client ID:

MA #:

Client Region:

All selected (5)   ▾

Enrolled Program:

All selected (9)   ▾

Client MA Eligible:

All selected (2)   ▾

Jurisdiction:

All selected (25)   ▾

Provider # /Provider Name:

All selected (200)   ▾

Waiver Eligibility:

All selected (2)   ▾

Reset   **Search**

1024.9 ms

After entering the desired parameters, click 'Search' to filter the results. The below screenshot displays a sample of search results that match the entered criteria.
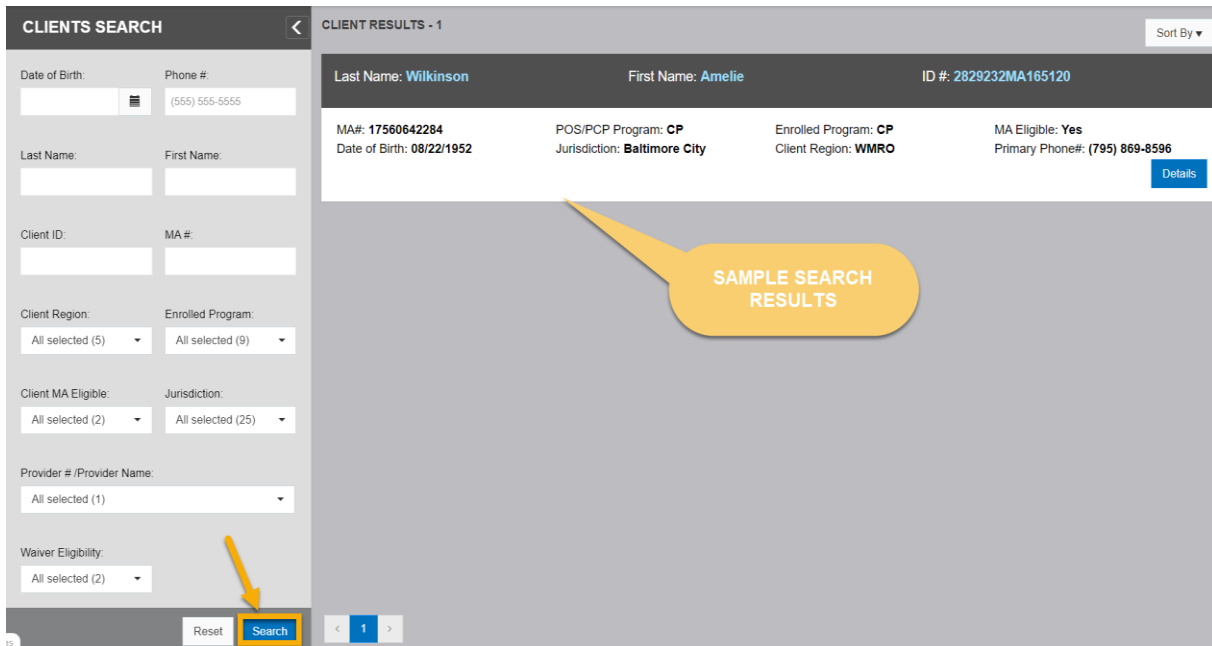
4.1 Viewing a Person's LTSS Profile

After searching for persons, the LTSS profile information of the person can be viewed by clicking 'Details' on the person's record.
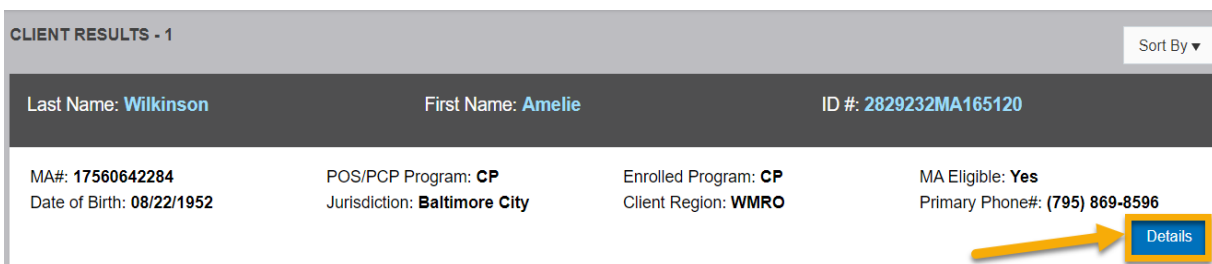
The 'Client Information' window opens with the following sections. Each section is expandable and collapsible.

- Client Demographic Overview – Includes the persons' demographic information, like date of birth, phone number, and if the person has a guardian
- Address to receive Services – Provides the person's address
- Waiver/Program Enrollment Status – Includes the person's waiver and program enrollment information
- Current Assignments – Includes contact information of all assigned contacts for the person's service plan
- Representatives – Includes contact and relationship information of the person's authorized representatives

4.2 Viewing a Person's Service Plans

From the person's Client Information window, providers can view service plans by clicking on the Service Plans tab on the left. Select 'Detail' on a service plan to view the details.

1. Click 'Details' on a person's record.

CLIENT RESULTS - 1   Sort By ▾

Last Name: **Wilkinson**   First Name: **Amelie**   ID #: **2829232MA165120**

MA#: **17560642284**   POS/PCP Program: **CP**   Enrolled Program: **CP**   MA Eligible: **Yes**
Date of Birth: **08/22/1952**   Jurisdiction: **Baltimore City**   Client Region: **WMRO**   Primary Phone#: **(795) 869-8596**

Details

2. Select Service Plans menu on the left. A List of approved service plans for the person provided by your provider agency is displayed.

3. Click 'Details' to view details of a service plan. The following sections are available in the service plan. (Refer to Section 0 for details on each section).

CLIENT INFORMATION FOR WILKINSON, AMELIE   ✖

CLIENT PROFILE

Client LTSS ID #: **2829232MA165120**   Current MA#: **17560642284**   POS/PCP Program: **CP**   Enrolled In: **CP**   MA Eligible: **Yes**

Waiver: **DRW**

SERVICE PLANS

SERVICE PLANS

Program Type	Date Created	Service Plan Type	Effective Date	End Date	Status	Active	Actions
CP	03/01/2019	Initial PCP	03/01/2019		Approved	Active	Details

---

CLIENT INFORMATION FOR WILKINSON, AMELIE   ✖

CLIENT PROFILE

Client LTSS ID #: **2829232MA165120**   Current MA#: **17560642284**   POS/PCP Program: **CP**   Enrolled In: **CP**   MA Eligible: **Yes**

Waiver: **DRW**

SERVICE PLANS

PERSON CENTERED PLAN - DETAILS   ↩ Back to List   Expand All

> CLIENT INFORMATION

> PLAN DETAILS

> PLAN CONTACTS

> SUMMARY

> OUTCOMES

> DETAILED OUTCOMES

> SERVICE AUTHORIZATION

> SIGNATURES

> SERVICE PLAN WORKFLOW HISTORY

> PROVIDER ACCEPTANCE WORKFLOW HISTORY

412.1 ms

The Service Plan that is being viewed can also be printed by using the "Print" action on the details page. This action opens the Service Plan as a pdf that can then be printed.
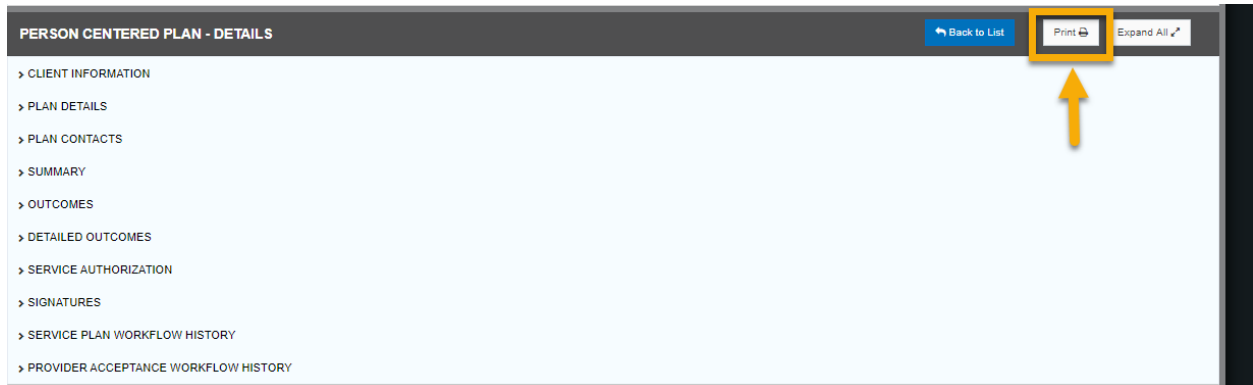
5. Staff Administration

5.1 Staff Roles

The following sections depict roles available to staff in the *LTSSMaryland* Provider Portal.

5.1.1   Admin Provider Role

Admin Providers are responsible for the agency's administrative tasks. This user role can perform all functions for the Provider Agency in the *LTSSMaryland* Provider Portal, including creating new staff profiles, activating and deactivating staff profiles, managing all billing functions, and accepting service referrals. An existing administrator can create and designate other staff as administrators (Process of Creating Staff Profile is defined in detail in Section 5.2).

5.1.2   Billing Provider Role

The Billing Provider role manages billing processes. The Billing Provider is not able to create or edit staff profiles. This role is set up by the Admin Provider (Process of Creating Staff Profile is defined in detail in Section 5.2).

5.1.3   Staff Provider Role

Staff Providers are Direct Support Professionals (DSPs) who provide Personal Supports services to people. For the Provider Agency to bill for Personal Supports services requiring an Electronic Visit Verification (EVV), each DSP must use the Integrated Voice Response (IVR) system and have a staff profile in *LTSSMaryland* Provider Profile, with the Staff Provider role. This role is set up by the Admin Provider (Process of Creating Staff Profile is defined in detail in Section 5.2).

5.1.4   Provider Program Director Role

Provider Program Directors are responsible for making decisions on service referrals. Provider Program Directors can view billing information but cannot enter or modify it. This role is set up by the Admin Provider (Process of Creating Staff Profile is defined in detail in Section 5.2).

5.1.5   Provider Program Staff

Provider Program Staff assist the Provider Program Director with reviewing service plan referrals before the Provider Program Director makes decisions on accepting or declining service referrals. Provider Program Staff can view billing information but not enter or modify it.

5.1.6   Provider Role Based Access

	Access LTSS Provider Portal	Create or Modify Staff Profiles	Bill for Services	Accept Services	Access Person's Information
Admin Provider	Yes	Yes	Yes	Yes	Yes
Billing Provider	Yes	No	Yes	No	Yes
Staff Provider	No	No	No	No	No
Provider Program Director	Yes	No	No	Yes	Yes
Provider Program Staff	Yes	No	No	No	Yes

5.2 Creating a Staff Profile

Provider Agency designated administrative staff, with the Admin Provider role, can create a new staff profile to enable staff to access the Provider Portal or the IVR system. Following steps describe the process of creating a new Staff Profile.

All information entered for every Staff profile must be true and accurate.

1. Go to the 'Providers' tab in the Provider Portal
2. Click the staff icon on the left

   Navigation: Home Page - > Providers - > Left Nav Menu - > 'Staff' icon.

3. Click the "Create New Staff" box on the upper right.

4. A "New Staff Profile" page is displayed.

NEW STAFF PROFILE ✖

①	②	③	④	⑤
Role Selection	Demographics	Employment	Contact	Review & Submit

Agency:
Personal Home Care Agency

Location(s): *
All selected (1) ▾

Role(s): *
▾

Cancel   ← Previous   Next →

5. Agency Field is pre-populated with your provider agency's name.

6. Location(s) is a required field. Select the sites that the new user will be assigned to by clicking to check the box for the relevant sites in the drop-down menu in the Location(s) field. Multiple Sites can be selected. (Note: All Sites in the Provider Agency are selected by Default).

NEW STAFF PROFILE ✖

①	②	③	④	⑤
Role Selection	Demographics	Employment	Contact	Review & Submit

Agency:
Personal Home Care Agency

Location(s): *
All selected (1) ▾

🔍 Search   ⊗

☑ **Select all**

☑ Personal Home Care Provider,765765401
123 Main St   ⓘ

Role(s): *
▾

Cancel   ← Previous   Next →

7. Role(s) is a required field that defines the permissions for the staff whose profile is being create. Staff can have more than one role assigned to them by selecting the checkboxes next to the appropriate Role (Refer Section 5.1 on roles).

8. Once all the required information is entered, click "Next."

9. When creating staff profiles for Admin Provider, Billing Provider, Provider Program Director and Provider Program Staff roles, fill in at least the staff person's First Name and Last Name in the Demographic tab, these are the required fields.

10. When creating staff profiles for DSPs or Staff Provider roles, fill in the staff person's First Name and Last Name, SSN, Date of Birth and Fluent Languages in the Demographic tab. These are the required fields.

NEW STAFF PROFILE   ✖

✓	2	③	④	⑤
Role Selection	Demographics	Employment	Contact	Review & Submit

Prefix: First Name: *   Middle Name: Last Name: *   Suffix:

Gender: SSN: *   Date of Birth: *

▼   📅

Fluent Language(s): *   Other Language:

None selected▾

Cancel   ← Previous   Next →

11. In the Employment tab, the required fields are Business Title (organization's business title for the staff), Employment Type (select one of the options) and Staff Effective Start Date (Staff's original start date. Can be today's date, a past date or a future date).

NEW STAFF PROFILE   ✖

✓	✓	3	④	⑤
Role Selection	Demographics	Employment	Contact	Review & Submit

Business Title: *   Employment Type: *

                                                              ▼

Staff Effective Start Date: *

09/27/2019   📅   Full Time
                                Contractor
                                Part Time
                                N/A

Cancel   ← Previous   Next →

12. In the Contact tab, enter the Contact Type, Phone # and email address.

An email address is also required to create staff profiles. If a Staff provider doesn't have an email address enter the agency's email address.

13. Review all the entered information, make changes if necessary and Submit.

After a new staff profile is created, in order to set up username and password to access the *LTSSMaryland* Provider Profile, please follow steps in Section 2.1.

5.3 Staff Search

All providers can search and view staff belonging to the same Provider Location(s) as them.

Navigation: Home Page - > Providers - > Left Nav Menu - > 'Staff' icon
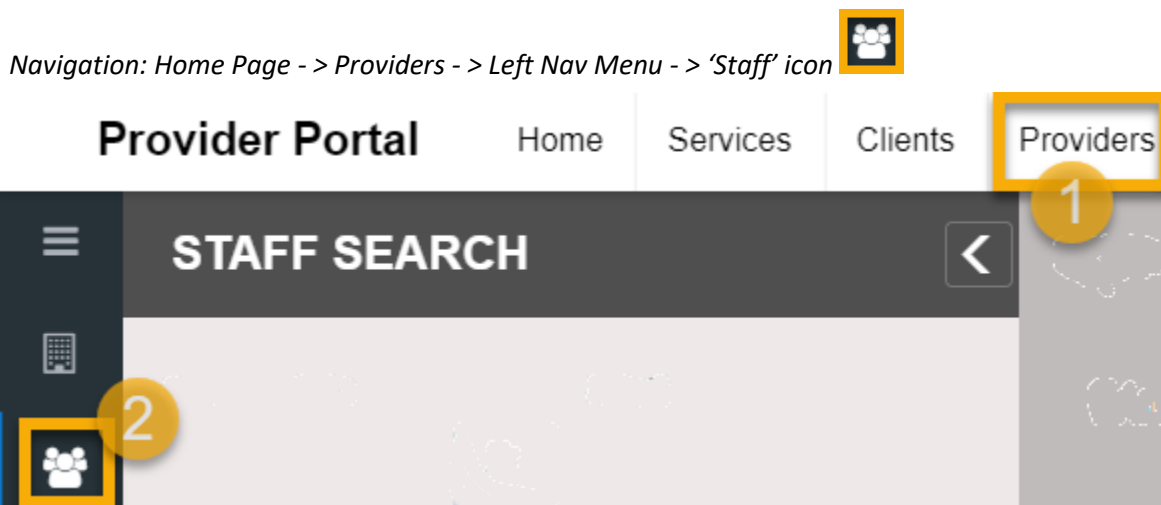
Staff Profiles can be searched with any of the below paraments:

- DOB – Staff Date of Birth (calendar field – accepts manual entry in format MM/DD/YYYY)
- SSN – Social Security Number
- Staff Last Name/ Staff First Name – Search by name
- Status – All/Active/Inactive field (default is All)
- Phone# – Phone number of staff (numeric field formats user entry into (NNN) NNN-NNNN)

- Provider #/Provider Name – Only locations assigned to the user performing the search, are listed in the dropdown. Multi-select is allowed

- Provider Attribute – Provider Attribute is the LTSS identifier for the Provider Type. The *LTSSMaryland* Provider Portal is currently accessed by Personal Assistance Services (PAS) Providers, Community Options (CO) Programs Providers and DDA Providers. Attributes applicable to the locations of the provider are available for selection

- Provider Role – Lists different roles that a provider staff can have

Click 'Search' to filter the results. All matching staff records are displayed on the right *panel. (See below screenshots*).

5.2 View Staff Profile

Staff with Admin Provider, Billing Provider, Provider Program Director and Provider Program Staff roles can search for staff profiles. Staff Profile information can be viewed by selecting 'Details' on the desired profile.

The Staff Details page displays.

5.3 Edit Staff Profile

Provider Agency designated administrative staff, with the Admin Provider role, can edit staff profiles that belong to their provider and have been assigned to a provider location(s) for which the Admin Provider user is authorized.

The steps below explain the process of Editing a Staff Profile in your assigned location:

1. Click 'Edit' to make changes to the staff profile. The following fields are editable (See below screenshot for reference):

    DEMOGRAPHICS

- Prefix
- Last Name
- Middle Name
- First Name
- Suffix
- Gender
- Date of Birth
- SSN
- Fluent Language(s)

    LOCATION

- Location(s)

- Role(s)

LOGIN INFORMATION

- Allow Login (staff providers do not have login access)
- Login Name

EMPLOYMENT

- Business Title
- Employment Type

CONTACT

- Type
- Phone #, Extension
- Phone Notes (more than one can be added)
- Email Address (more than one can be added)

2. Click 'Save' to complete changes

5.4 Deactivate a Staff Profile

When a staff provider is terminated or resigns, Admin Providers are responsible for inactivating the staff profile with accurate vacate dates.

Below steps define the process of Deactivating a Staff Profile:

1. Go to the 'Providers' tab in Provider Portal

2. Click the staff icon to the left

3. Search for Staff profile that you would like to make Inactive

4. Select "Details" button to navigate to the staff details page

5. Select edit in bottom right corner of the Staff Profile page

6. Select "Deactivate Staff" hyperlink in Employment section

7. Enter the required fields, Deactivation Date and Deactivation Reason

Deactivate Staff

Deactivation Date:

🗓

Deactivation Reason:

Cancel   **Submit**

8. Click "Submit" button – Deactivation is submitted

Once staff is deactivated, they will not show in a search of active staff. However, if the deactivated staff is a staff provider, they will still be able to clock in and out.

6. Provider Locations Profile

6.1 Provider Agency Locations Search

Staff with Admin Provider, Billing Provider, Provider Program Director and Provider Program Staff roles may search for and view information on the Provider Locations they belong to.

Navigation: Home Page ⬜ Providers ⬜ Left Nav Menu ⬜ 'Provider Search' icon.
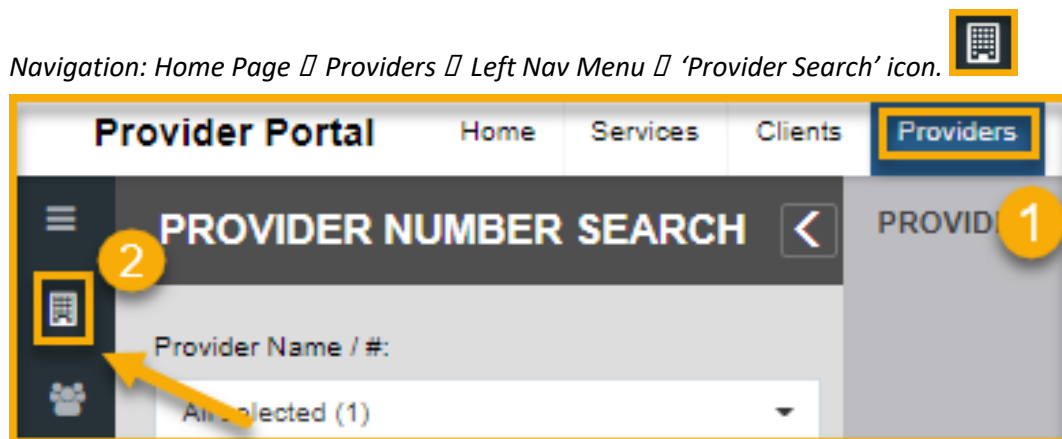
Provider Location Profiles can be searched with any of the below parameters:

- Provider Name/Number – Only locations assigned to the user performing the search, are listed in the dropdown. Multi-select is allowed. Each Provider Number corresponds to either the Parent MA# or a location/site within the Provider Agency

- Status – All/Active/Inactive (Default is All)

- Provider Attribute – Provider Attribute is the LTSS identifier for Provider Type. The *LTSSMaryland* Provider Portal is currently accessed by Personal Assistance Services (PAS) Providers, CO Programs Providers and DDA Providers. By default, all attributes applicable to Provider Numbers within the Provider Agency are selected, and this list can be filtered down to search for one or more attributes if needed

- Category of Service – This field lists the authorized categories of service (COS) that the provider numbers within the Agency are authorized to provider. By default, all COS codes applicable to Provider Numbers within the Provider Agency are selected, and this list can be filtered down to search for one or more COS code if needed

Click 'Search' to filter the results.

All matching Provider Numbers within the Agency are displayed on the right panel search results (See below screenshots). Each result corresponds to either the Parent MA# or one of the locations/sites within the Provider Agency.

PROVIDER RESULTS - TOTAL : 1			Sort By ▾
Agency Name: Daily Care Center	Provider #: 345678900	Status: Active	
Location Name: **Day Care Center of Baltimore --**	Phone #: 434434433		Details
Provider Attribute: **DDA Community Provider**	COS Codes: **Day Hab**	SAMPLE SEARCH RESULTS	

Note: The Status of the Provider Number is listed in the header and can have the value of "Active" or "Inactive" and reflects the on the status of the Medicaid Provider Number in MMIS.

6.2 View Provider Agency Locations

After searching for Provider Locations, information on each Provider Number, as set up in MMIS, can be viewed by selecting 'Details'. Providers with below roles are able to view details on a Provider Number

- Admin Provider
- Billing Provider
- Provider Program Director
- Provider Program Staff

PROVIDER RESULTS - TOTAL : 1			Sort By ▾
Agency Name: Daily Care Center	Provider #: 345678900	Status: Active	
Location Name: **Day Care Center of Baltimore --**	Phone #: 434434433		Details
Provider Attribute: **DDA Community Provider**	COS Codes: **Day Hab**		

The Provider Number details page displays.

6.2 Edit Provider Number Information

Provider Agency designated staff, with the Admin Provider role, can edit contact information on Provider profiles they belong to. All information other than contact information reflect the Provider Number set up in MMIS and cannot be modified. Any additional updates beyond the Phone and Email would have to be made via ePREP.

The steps below explain the process of editing an assigned Provider Number:

1. Click 'Edit' to make changes to the Provider Number contact details. The following fields are editable (See below screenshot for reference):

   - Business Phone

   • Type

   • Phone #

   • Phone Notes

   - Business Email

   • Email

2. Users may add additional contact information by clicking the <+> in the desired section
3. Click 'Save' to complete changes

Part B – Non-EVV Services

This section provides information on how to bill for services that do not require an electronic visit verification. For information on services requiring electronic visit verification, please see Part C.

7. Billing for Non-EVV Services

The Billing Entries' left menu option within the 'Services' Tab allows administrative and billing staff from Provider Agencies to bill for services that do not require an electronic visit verification. The units or costs of services provided on the same date of service, need to be added together and billed at one time in a batch process.

Navigation: Home Page - > Services Tab - > Left Nav Menu - > 'Billing Entries' icon

Providers with the below roles can create billing entries

- Admin Provider
- Billing Provider

Billing Entries capture the details of the provided service including the person receiving service, provider location, date, service type and the units or cost of services. They are then converted to claims billed to Medicaid or made available on the State Payment report for state reimbursement.
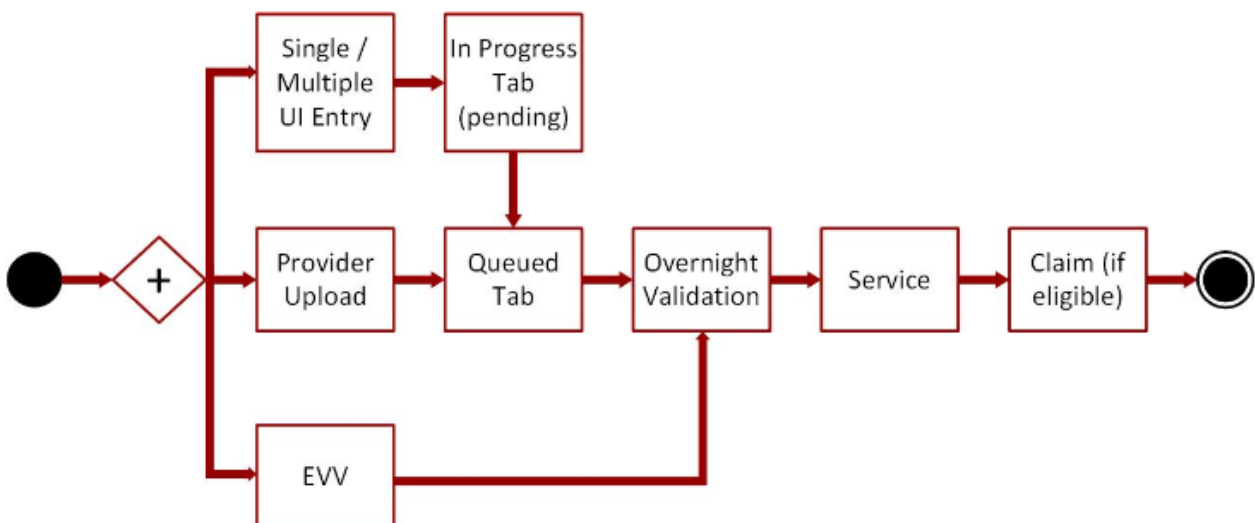
7.1 Creating Multiple Billing Entries

Providers with the below roles can create, save and submit multiple billing entries for each service type.

- Admin Provider
- Billing Provider

The Multiple Entries Form allows Providers to enter billing for one or more persons receiving a service across multiple locations within your agency, for a specified time period.

Navigation: Home Page - > Services Tab - > Left Nav Menu - > 'Billing Entries' icon *- >Multiple Entries*
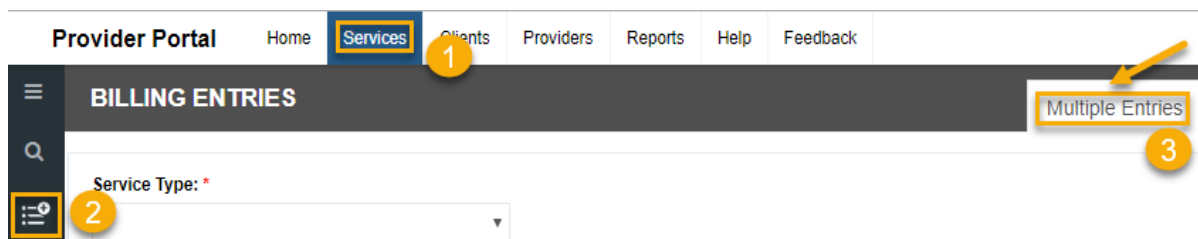
1. Select Service Type
   - Select the service type from the Service type dropdown. Only services that the Provider Agency Location is authorized to provide will populate in this selection. Billing can be entered for only one service at a time
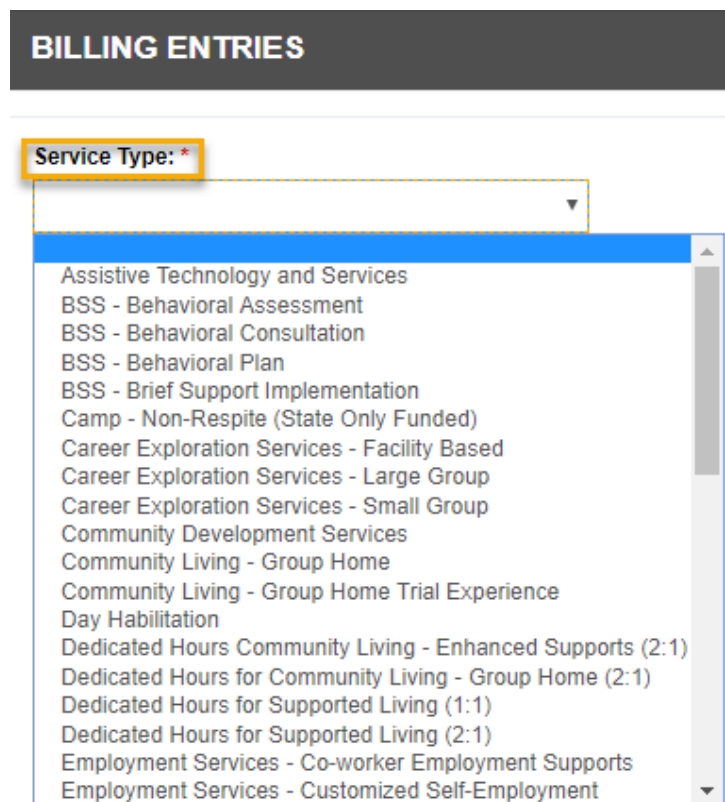
2. Date of Service – This parameter varies based on the Service type selected. Dates entered cannot go back more than 1 year from today's date
    i. For services with a Monthly unit, a From Month and To Month of Service can be entered to bill for multiple months. If you are only billing from one month, you can enter the same month in From and To. You can only bill for months that are in the past

    ii. To bill a range of services with Daily, Hourly, Quarter-Hourly units, or Upper pay limit service, a From Date of Service and To Date of Service can be entered. Example: Respite, Day Habilitation, Personal Supports, Transportation services, etc.

    iii. To bill for services that are typically provided once at a time, a single Date of Service should be entered. Example: Assistive Technology and Services, Transition Services, Behavioral Assessment, etc.

3. Provider Name/Number
    ● Lists the Provider Sites/Number(s) authorized to provide the selected service for the Provider Agency on that Date of Service. The list of available Provider locations displayed in the dropdown is dependent on the date of service selected. For site-based services all site MA numbers are available for selection
        i. This list of available Provider/Site locations is based on the Provider Numbers authorized for providing the selected service on dates entered

4. Select the Day of Week – Within the selected date range, the 'Day of the week' field can be used to pick only the Days in which the service was provided
   ● The default selection of days is based on the service type selected. If the service is defined to also be provided on weekends, then the default selection will show all the default days selected
   ● User is able to make changes to the Days of week selected by unchecking the checkbox

5. Select Participants - Populates a list of all persons receiving the services within the entered date range. This list is populated based on the person having an approved PCP with the provider number authorized to provide the selected service in the entered date range
   ● All persons can be selected by using the "Select All" option or
   ● One or more person(s) can be selected by checking or unchecking the person name in the Available Clients list. Once a person is selected, they are added to the Selected Clients list
   ● Billing Entries will be created only for the persons in Selected Clients list
   ● A count of persons selected will be displayed in the drop-down

6. If user tries to create billing entries for clients that do not meet the input parameters, system throws an error with a message similar to 'The selected clients do not have service authorizations that meet the input criteria.' System does not create billing entries for those clients

7. If there are no participants available for the specified input criteria, then the system displays a message in the Participants dropdown saying "None available for the input criteria"

8. After entering all the above inputs, select Create Billing Entries to create a billing entry for each date of service authorized for the selected clients in the entered date range

    Note:

    1. The maximum limit of entries generated per page is 200 entries
    2. The maximum entries that can be created is 5000 entries

The generated list of billing entries has the properties below:

- Date of Service
- DOW (Day of Week)
- Client ID
- Client MA #
- First Name
- Last Name
- Provider
- Units/Cost of Service/Item
    - Units – for unit-based services based on the Service type selected in input
    - Cost of Service/Item – for cost-based services based on Service type selected in input.

- Actions – Allows deletion of an entry that should not be billed. This can be used when a person did not receive service on a specific date, or other reasons when service was not provided to the client on the date of service or has already been billed

If Service Type selected is a service type which has a Retainer fee option for example "Community Living -Group home", then the output options are the below. The generated list of billing entries has the properties below:

- Date of Service
- DOW (Day of Week)
- Client ID
- Client MA #
- First Name
- Last Name
- Provider
- Units/Cost of Service/Item –
  - o Units – for unit-based services based on the Service type selected in input
  - o Cost of Service/Item – for cost-based services based on Service type selected in input.
- Actions – Allows deletion of an entry that should not be billed. This can be used when a person did not receive service on a specific date, or other reasons when service was not provided to the client on the date of service or has already been billed
- Retainer Fee – If the option was chosen on the DOS, the Admin/Billing provider can select this option

Date Of Service	DOW	Client ID	Client MA#	First Name	Last Name	Provider ^	Units (Day)	Actions
09/10/2019	Tues	2289774EK923120	10101010222	Abraham	MaxVal-State	284068311 - DDA Billing Location 1		Delete
							Retainer Fee: ☐	

For each date of service to a client, you must enter the units (Screenshot below) or cost of service (Screenshot below) provided, depending on the selected service type. User can tab down the list for entry of units or cost, by using the Tab key

BILLING ENTRIES (60)   ☐ Unit/Cost Error (0)   ☐ Provider Error (0)

Date Of Service	DOW	Client ID	Client MA#	First Name	Last Name	Provider	Units (Hour)	Actions
09/01/2019	Sun	2069016ER730121	45656777722	Rebecca	Kbs1	284068311 - DDA Billing Location 1		Delete
09/01/2019	Sun	2289774EK923120	10101010222	Abraham	MaxVal-State	284068311 - DDA Billing Location 1		Delete

In case more than one site is authorized for the same service for a client in a month, as is the case during transitions, the specific provider# for the service date should also be selected.

Once all the entries are complete, they can be saved for further review within the Provider Agency or submitted for billing, as detailed in Section 7.2 and Section 7.3

7.2 Saving Multiple Billing Entries

"Save Entries" action can be used to save entries for further review. This is dependent on your Agency's billing policy or process.

The user is not allowed to make any modification to the below input criteria,
1. Service Type
2. From/To Date of Service
3. Provider/Site#
4. Days of the week

5. Participants

If the user wishes to make a change, he would have to click the Reset button to reenter all the input criteria.

Upon selecting "Save Entries" action, entries are checked for the errors below:

- Entered units exceeds the maximum allowed for a day for the service
- Entered cost exceeds the maximum allowed for the service
- Entries with units or cost not entered
- Entries with a Provider number not selected, where applicable

All billing entries that pass the check are saved for future review and user is notified on the number of entries that were saved.
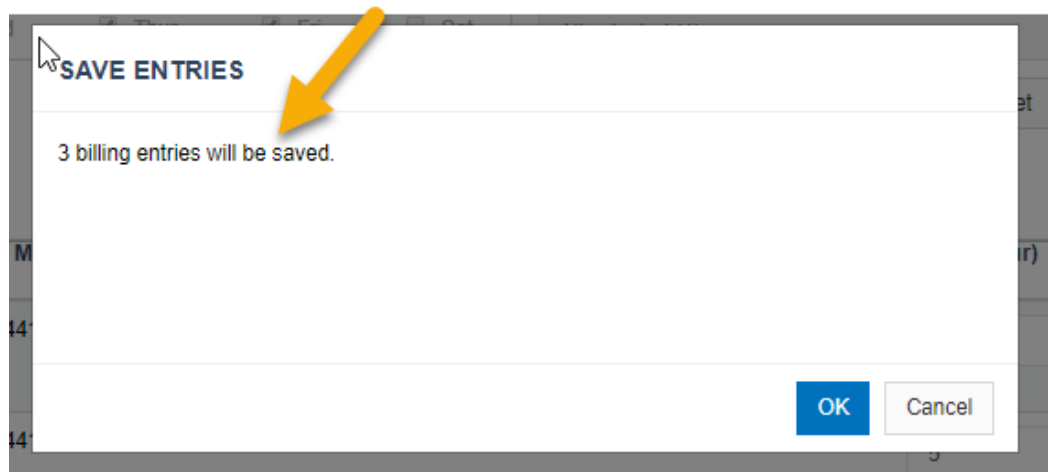
Entries that fail the check are retained on the list and are not saved. A count of errors and filter option is available to narrow down the list to display only records with errors so they can be easily identified and corrected. Once corrected, the entries can be saved by selecting the "Save Entries" action again.

Saved entries are not processed for billing. Provider should submit the entries for the services to be picked up for pre-claim validation processing and subsequent claim submission. Refer to Section 7.8 on reviewing and submitting saved billing entries

7.3 Submitting Multiple Billing Entries

This section describes how completed billing entries on the 'Multiple Billing Entry' form can be submitted directly to be moved to a queue for overnight pre-claim validation processing and billing.

The "Submit Entries" action is available above the list of generated billing entries and allows the user to submit the billing entries to the queued list of billing entries for processing.

The user is not allowed to make any modification to the below input criteria,
1. Service Type
2. From/To Date of Service
3. Provider/Site#
4. Days of the week
5. Participants
If the user wishes to make a change, he would have to click the Reset button to reenter all the input criteria.

Upon selecting this action, entries are checked for the below errors:
● Entered units exceeds the maximum allowed for a day for the service
● Entered cost exceeds the maximum allowed for the service
● Entries with units or cost not entered
● Entries with a Provider# not selected, where applicable

All billing entries that pass the check are included in the queue up for overnight pre-claim validation processing and billing, and user is notified on the number of entries submitted.
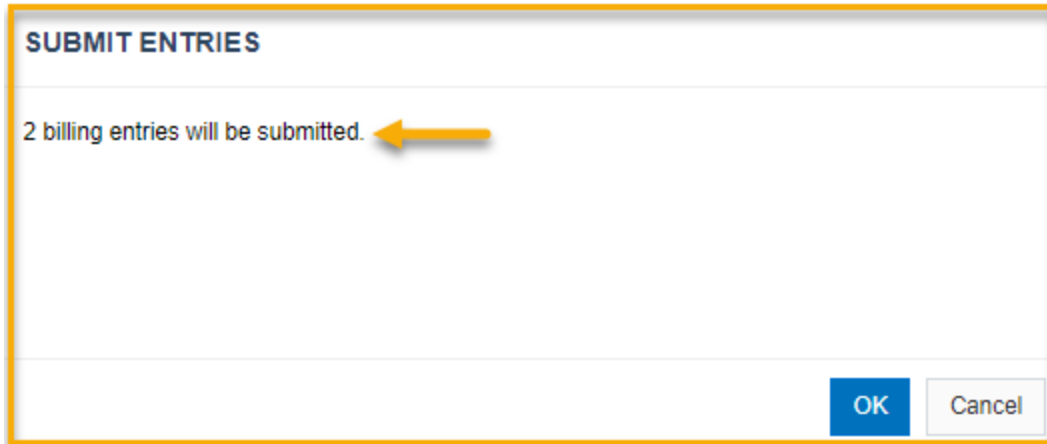
Entries that fail the check are retained on the list and are not submitted. A count of errors and filter option is available to narrow down the list to display on records with errors so they can be easily identified and corrected. Once corrected, the entries can be submitted by selecting the "Submit Entries" action again.
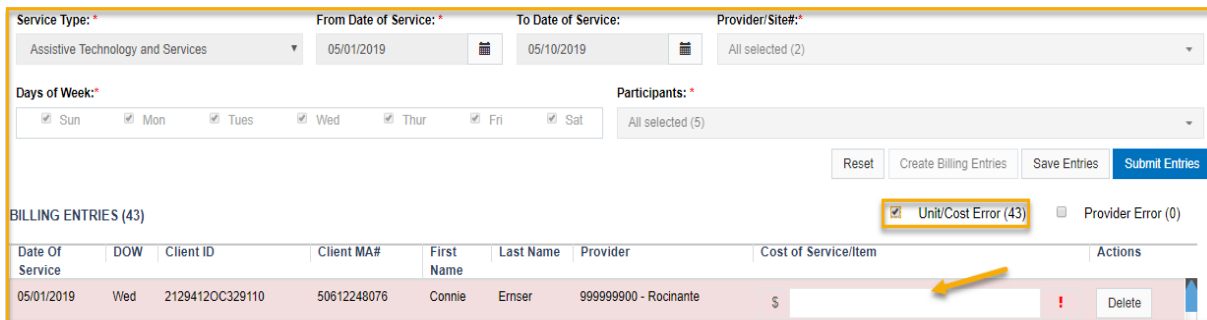
Submitted Billing Entries can be viewed in the Queued Tab of the Billing Entries page (Refer to Section 7.6) until they are picked up in an overnight process to be converted into services which are then processed for billing. Once Billing Entries are converted to Services, they are no longer visible on the Queued Tab, but can be searched and viewed through the Search Services page (Refer to Section 8.1)

7.4 Creating a Single Billing Entry

This section describes how administrative and billing staff submit one billing entry at a time. This feature services these purposes:

- Create and save or submit one billing entry at a time
- To allow the Provider Agency to bill one date of service at a time

This is useful for missed entries or services that are only billed on one date. Example: Milestone services or assistive devices.

Navigation: Home Page - > Services Tab - > Left Nav Menu - > 'Billing Entries' icon *- >Single Billing Entry*
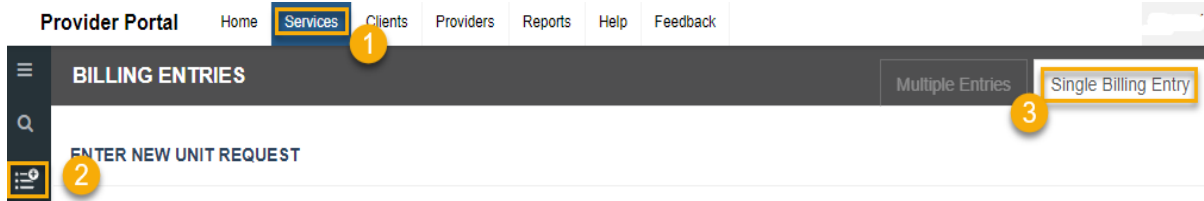
The Single Billing Entry tab requires the following inputs:

1. Select Service Type
   - Based on the Service type selected, the Type of unit is auto populated (1)
   - For Residential services like Group Home and Enhanced Supports – there is an additional user input to identify Retainer Fee services which enables providers get paid for services when client is not available
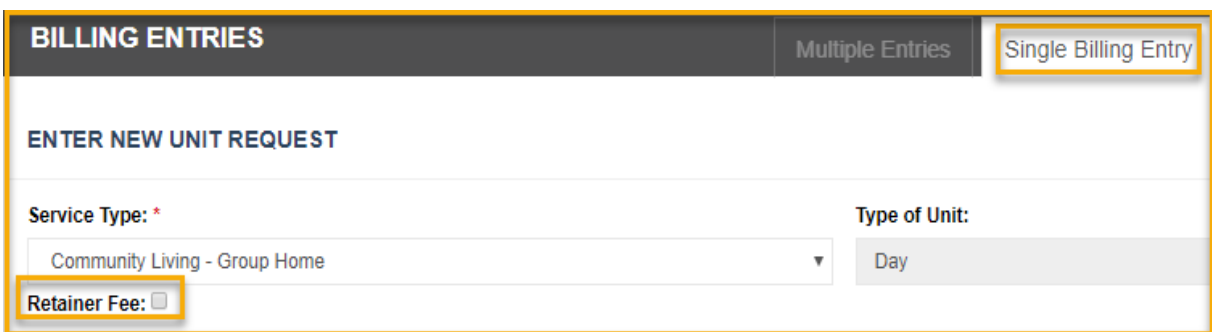
2. Date of Service
   - Based on the Date of Service entered, the Day of the Week is auto populated (2)
3. Provider/ Site #
4. Enter Client ID/ MA #- Client ID/MA# must be entered exactly
   - Based on the Provider selected for the Date of Service and Service type, the user has to enter the Client ID/MA# exactly and the dropdown shows the matching client found (3)
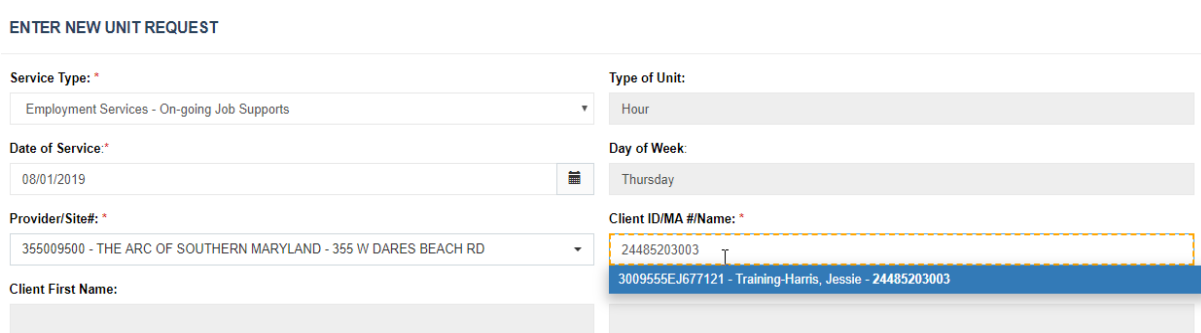
   - If the Client ID is not correctly entered, then the system displays an error message that says "Client Not Found" as shown in the below screenshot
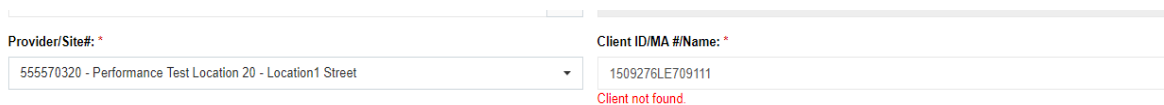
5. Client First Name and Client Last Name will populate based on the Client ID/MA # that was entered

6. Units or Cost (depending on the service type selected)
   - Units can be entered if the selected service type is a Unit based service
   - Cost can be entered if the selected service type is a Cost based service

Note: If provider is not listed on an active PCP for the Date of Service, only the person's initials will be displayed. This will allow a provider to complete past billing for person's the agency is no longer serving.

Once the user has reviewed the entries for accuracy, the Submit or Save action can be selected to save the entry for further review or submit the entry to be queued for overnight billing.

7.5 Save Single Billing Entry

"Save Entries" action can be used to save entries for further review. This is dependent on your Agency's billing policy or process.

Once all information is supplied and you click 'Save', the system displays a success confirmation message that the entry has been saved and can be viewed in the 'In Progress' tab discussed in Section 7.8
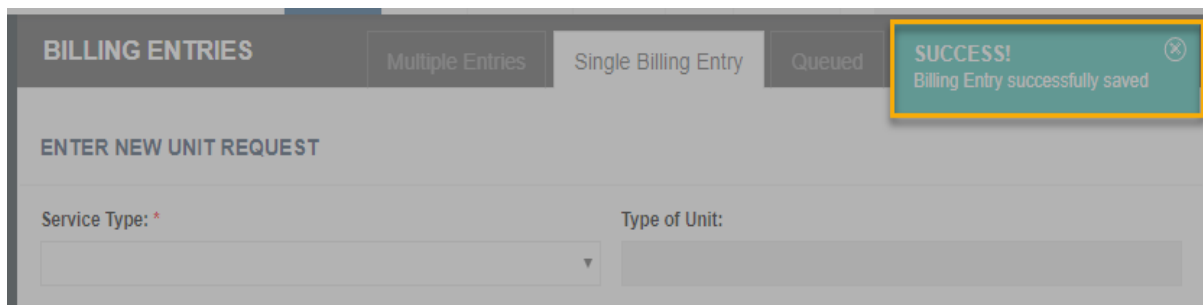
7.6 Submit Single Billing Entry

This section describes how completed billing entries on the 'Single Billing Entry' form can be submitted directly to be moved to a queue for overnight pre-claim validation processing and billing by clicking the 'Submit' button

Once all information is supplied and you click 'Submit', the system displays a success confirmation message that the entry has been submitted and can been viewed in the 'Queued' tab discussed in <mark>Section 7.7</mark>
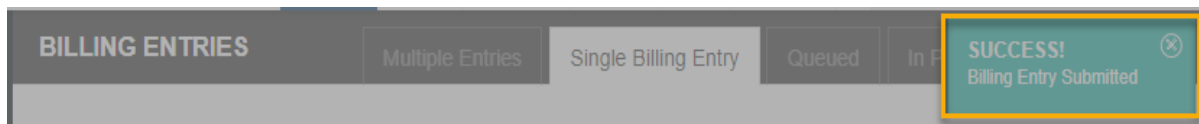
7.7 View Submitted Entries for Billing in the Queued Tab

Administrative and Billing Staff from a Provider Agency (with the below roles)

- Admin Provider
- Billing Provider

can access the 'Queued' Tab in the Billing Entries Page to view billing entries submitted on a day for all locations they are authorized for. Billing entries submitted from both 'Multiple Entries' and 'Single Billing Entry' tabs can be found in this 'Queued' tab. Queued Tab shows only the entries submitted on the current date, as the queued entries are processed for billing every night. The entries that are processed overnight are no longer visible on the Queued Tab, but can be accessed from the Services Search Page (Refer Section 8.1)

Provider Uploaded Entries:

Billing entries entered into the system via the 'Provider Upload' API mechanism are also recorded and displayed in the 'Queued' tab. This will be the third 'Source' type in the field dropdown. These are billing entries that are electronically submitted to the *LTSSMaryland* Provider Portal via the upload API. This information is retrieved from the Provider Agency application without logging into the Provider Portal application. These entries are also pending overnight validation like the entries from the multiple and single-entry tabs.

Navigation: Home Page - > Services - > Left Nav Menu - > 'Billing Entries' icon *- > Queued*
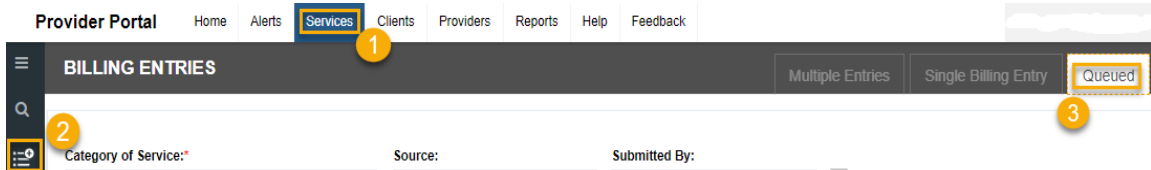
The following filters are available to view billing entries in the Queued Tab. (See screenshot below listing all filter criteria):
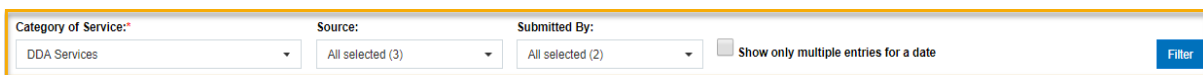
- Category of Service: User can select the type of service – For Providers providing only DDA services, this input will be selected as 'DDA Services' by default)

- Source: User can select the source type – Single Entry, Multiple Entry, Provider Upload. Single and Multiple Entry options are used to filter to entries created through the respective forms and Provider Upload option can be used to filter to entries submitted through the automatic upload process

- Submitted by: The dropdown lists all billing or administrative staff that have submitted billing entries displayed on this page, and can be used to filter to view entries submitted by one or more staff

- Show only Multiples for Date: Billing entries with same parameters – Service Type, Date of Service, Provider Number and Client ID entered on the same date are listed when this filter option is selected. Billing Entries are tagged as 'Active' or 'Duplicate' where Active entries are the latest entries that will be processed for billing and the Duplicate entries are older entries with the same parameters as the 'Active' entry. The duplicate entry will not be processed into a claim and will be sent to the 'Duplicates' tab in the overnight billing process. This has also been explained in a separate section below (Refer to Section 7.11)

Date of Service	Service Type	Provider Name/Number	Units / Cost	Client Name	Submitted Date-Time
5/1/19 Active	Community Living - Group Home	Performance Test Location 0 555570300	1	Smith, John	Oct 28, 2019 4:09:07 PM
5/1/19 Duplicate	Community Living - Group Home	Performance Test Location 0 555570300	1	Smith, John	Oct 28, 2019 4:07:00 PM

Billing entry records on the Queued Tab display the following parameters (see screenshot below) as entered when they were created and submitted from the Multiple and Single Billing Entry Tabs or the Provider Upload referenced above.

The icon lets the user expand the billing entry to view more fields on the record.

- Date of Service: Date the service was rendered
- Service Type: The type of service rendered
- Provider Name/Number: Provider Location name and number where the service was rendered
- Units/Cost: Number of units or cost associated with the service rendered
- Client Name: Name of the client for whom the service was rendered
- Submitted Date-Time: The date and time the billing entry was submitted for the service
- Day: The day of the week the service was rendered
- Type of Unit: The billing unit of the service type
- Client LTSS ID: Client LTSS identifier
- Client MA#: Client Medicaid Number
- Source: Mode of entry of the billing entry – Single entry, Multiple entry or Provider Upload
- Submitted By: The staff submitting the billing entry

Discarding Queued Billing Entries:

If there are any reasons why an entry has to be discarded. Examples:

- Billing entries for days when the client was not rendered services,
- Billing entries with incorrect information
- Duplicate Billing entries

If any of the submitted and queued billing entries are found to be invalid or with errors, providers can

select one or more billing entries and click on the 'Discard' [Discard (2) 🗑] button to delete the entries.

7.8 Reviewing and Submitting Saved Billing Entries in In Progress Tab

Administrative and Billing Staff from a Provider Agency can access the 'In Progress' Tab in the Billing Entries Page to view billing entries saved on a day for all locations they are authorized for. Billing entries saved from both 'Multiple Entries' and 'Single Billing Entry' tabs can be found in this 'In Progress' tab.

Navigation: Home Page - > Services - > Left Nav Menu - > 'Billing Entries' icon *- > In Progress*
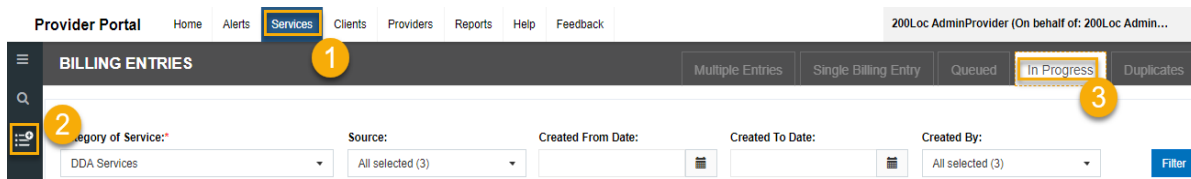
Upon navigation, all saved billing entries are displayed, which can be further filtered by applying one of more of the following filters:

- Category of Service: User can select the type of service – For Providers providing only DDA services, this input will be selected as 'DDA Services' by default
- Source: User can select the source type – Single Entry, Multiple Entry
- Created From Date/ Created To Date: Date range to filter billing entries based on when they were entered and saved
- Created By: The dropdown lists all staff that have saved billing entries, which are available on this page

Note: Provider Uploaded entries will NOT show up in the In-Progress tab as they will directly be moved to the 'Queued' tab as mentioned in Section 7.7.

Billing entry records display the following parameters, as entered and saved from the Single or Multiple Billing Entry Tabs.

		Date of Service	Service Type	Provider Name/Number	Units / Cost	Client Name	Created Date-Time	Follow Up
☐	▲	6/3/19	Day Habilitation	Rocinante 999999900	1	Anderson, Velva	Oct 31, 2019 2:28:55 PM	
		Day	Type of Unit	Client LTSS ID	Client MA#	Source	Created By	Comments
		Monday	Hour	1739740EV116100	56877525526	Single	James Holden	

The icon lets the user expand the billing entry to view more fields on the record.

- Date of Service: Date the service was rendered
- Service Type: The type of service rendered
- Provider Name/Number: Provider Location name and number where the service was rendered
- Units/Cost: Number of units or cost associated with the service rendered
- Client Name: Name of the client for whom the service was rendered
- Created Date-Time: The date and time the billing entry was saved

- Follow up: This flag lets users to tag billing entries that need further review (Refer Section 7.10)
- Day: The day of the week the service was rendered
- Type of Unit: The billing unit of the service type
- Client LTSS ID: Client LTSS identifier
- Client MA#: Client Medicaid Number
- Source: Mode of entry of the billing entry – Single entry or Multiple entry
- Created By: The staff saved the billing entry
- Comments: This option lets users to add comments to billing entries when the 'Follow-up' flag is tagged for further review (Refer Section 7.10)

Discard Billing Entries:

If any of the saved billing entries are found to be invalid or with errors, users can select one or more

billing entries and click on the 'Discard' button Discard (2) 🗑 to delete the entries. Billing entries for days when the client was not rendered services, billing entries with incorrect information are some examples that could be discarded.

Submit Billing Entries:

Staff can submit billing entries from the 'In Progress' tab directly by selecting one or more entries and clicking on the 'Submit' button.

Staff must confirm the submit action by clicking 'Yes' in the following pop-up.

SUBMIT

Are you sure you want to Submit 2 Billing Entries?

Yes   No
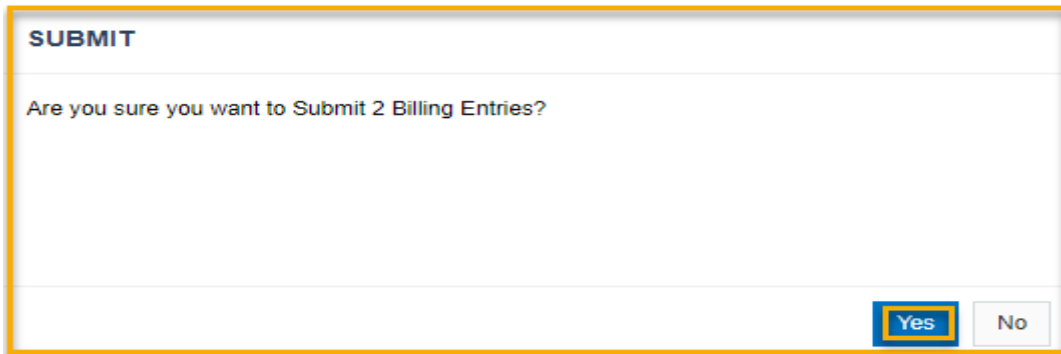
System displays a confirmation message upon successful submission.

Multiple Entries   Single Billing Entry   Queued

SUCCESS! ⊗
Billing Entries have been submitted
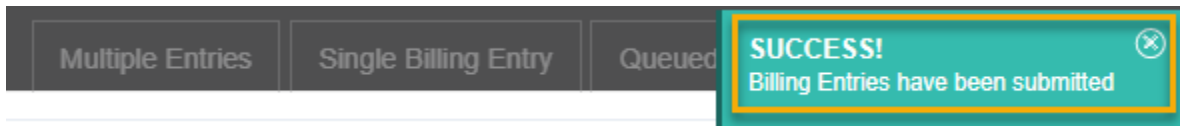
7.9 Edit a Saved Billing Entry before Submitting

Administrative or Billing Staff can make changes to the saved billing entries from the In-Progress Tab by

selecting one billing entry at a time and clicking on the 'Edit' button **Edit** to make changes.

Navigation: Home Page - > Services - > Left Nav Menu - > 'Billing Entries' icon ⊟⊕ *- > In Progress tab ->*

Select one or more Billing Entries -> Edit **Edit**
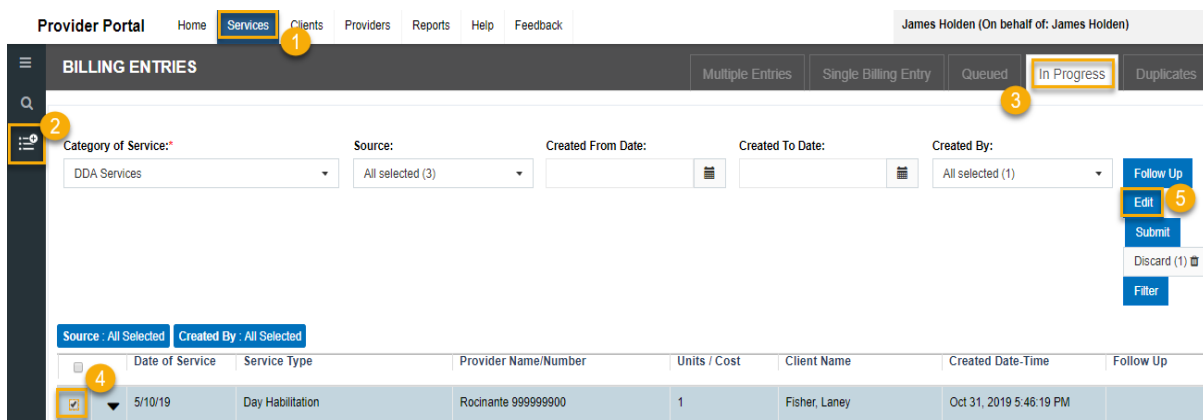
After selecting edit, the billing entry opens with the editable fields below:

1. Date of Service: change the date of service of the billing entry to correct the date
2. Provider/Site#: change the Provider# the billing entry is created for, if the service was rendered at a different site.

3. Units: change the Units/Cost of the billing entry. The field is restricted by the defined limits for the service on the billing entry and will throw an error if user enters a value that is greater than the defined limit.

Once the fields have been updated, user clicks on 'Submit' button to submit the billing entry for further processing. Submitted billing entries are moved from the 'In Progress' tab to the 'Queued Tab'.

7.10 Flagging a Saved Billing Entry for Follow-up

Providers with below roles review saved billing entries from the 'In-Progress' tab, can flag and add follow-up comments to billing entries that can be viewed by other staff including the staff who created the billing entries.

- Admin Provider
- Billing Provider

Users can select one or more billing entries and click on the 'Follow Up' button Follow Up to add comments to the billing entry.

Comments are required to be entered and will be applied to all selected billing entries. User clicks on 'Submit' to save the comments.

The entered comments can be viewed on the billing entry where the 'Follow Up' flag is set to 'Yes' and the comments are listed under the 'Comments' field.

7.11 View Duplicate Billing Entries in the Duplicates Tab.

Providers submit billing entries each day and the billing process converts them to Services as the first step. If billing is entered for the same person, date of service, provider# and service type more than once, they are dropped as a "Duplicate" and are not converted into services. The claims for these services are summed up to the day before entry so they can be billed at one time in a batch process.

Note: Section 8.3 and Section 8.4 discusses how 'Services' can be edited to make corrections or be discarded.

The dropped entries can be viewed from the 'Duplicates' Tab

Navigation: Home Page - > Services - > Left Nav Menu - > 'Billing Entries' icon *- > Duplicates*
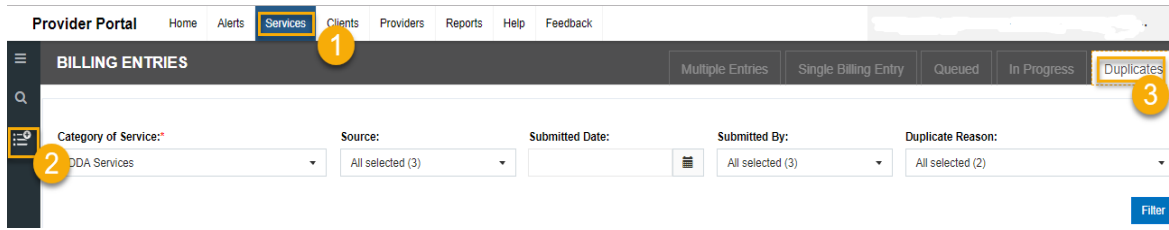
The following filters are available to view billing entries (See screenshot below listing all filter criteria):
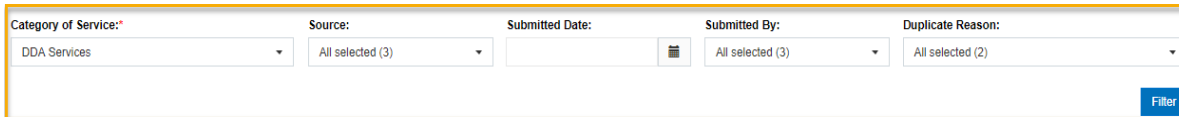
- Category of Service: User can select the type of service – For Providers providing only DDA services, this input will be selected as 'DDA Services' by default
- Source: User can select the source type – Single Entry, Multiple Entry, Provider Upload. Single and Multiple Entry options are used to filter to entries created through the respective forms and Provider Upload option can be used to filter to entries submitted through the automatic upload process
- Submitted Date: Date field to filter duplicate billing entries for a specific date
- Submitted By: The dropdown lists all staff that have submitted billing entries displayed on this page
- Duplicate Reason: This dropdown field lists the two duplicate reasons stated above – 'Replaced with Subsequent Entry' and 'Existing Service'. This allows user to filter the billing entries by each reason.

The two types of duplicate reasons are

1. Replaced with Subsequent Entry: These are duplicates entered on the same day. For instance, if the provider entered more than one billing entry for the same service rendered on the same day, the latest entry will be retained for processing and the older entries will be marked as a duplicate
2. Existing Service: These are duplicate billing entries of previously billed services that were entered and processed by the system. This means that a 'Service' exists that matches the newly entered billing entry. In this case, the newly entered billing entry will be marked as a duplicate

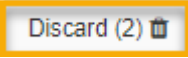Billing entry records display the following parameters (See screenshot below):

The icon lets the user expand the billing entry to view more fields on the record.
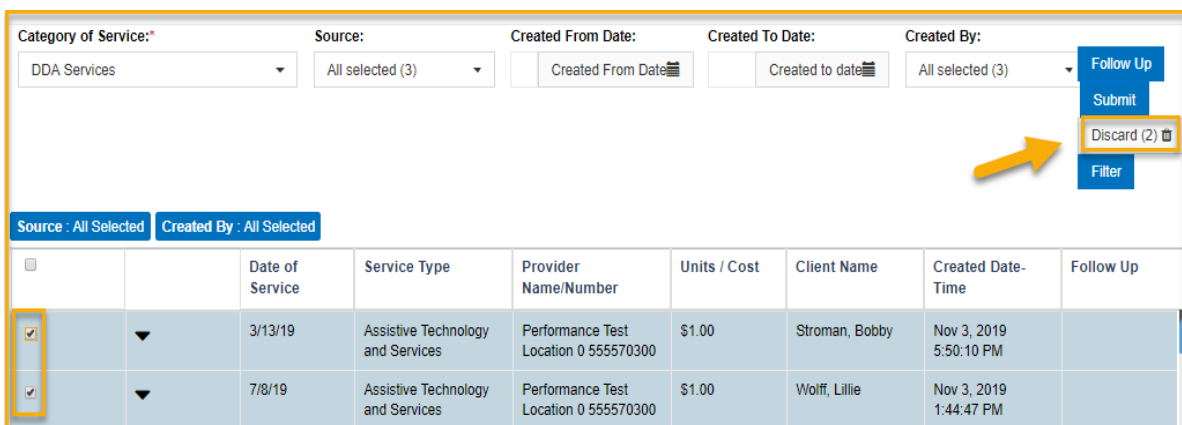
- Date of Service: Date the service was rendered
- Service Type: The type of service rendered
- Provider Name/Number: Provider Location name and number where the service was rendered
- Units/Cost: Number of units or cost associated with the service rendered
- Client Name: Name of the client for whom the service was rendered
- Submitted Date-Time: The date and time the billing entry was submitted for the service
- Duplicate Reason: One of the two duplicate reasons associated with the billing entry
- Day: The day of the week the service was rendered
- Type of Unit: The billing unit of the service type
- Client LTSS ID: Client LTSS identifier
- Client MA#: Client Medicaid Number
- Source: Mode of entry of the billing entry – Single entry, Multiple entry or Provider Upload
- Submitted By: The staff submitting the billing entry

8. Manage Entered Services and Claims for Non-EVV Services

In the *LTSSMaryland* Provider Portal, service refers to an individual service delivered to a person.

For non-EVV services, it's the Service rendered by the Provider to a person, billed as total units or cost for a time period

- Services rendered on a date for Daily, Hourly and Quarter-Hourly
- Service provided on a one-time basis for Milestone
- Individual cost of items for Upper Pay Limit

All users in the Provider Agency having access to the *LTSSMaryland* Provider Portal with the below roles are able to search and view information on billed services for the Agency:
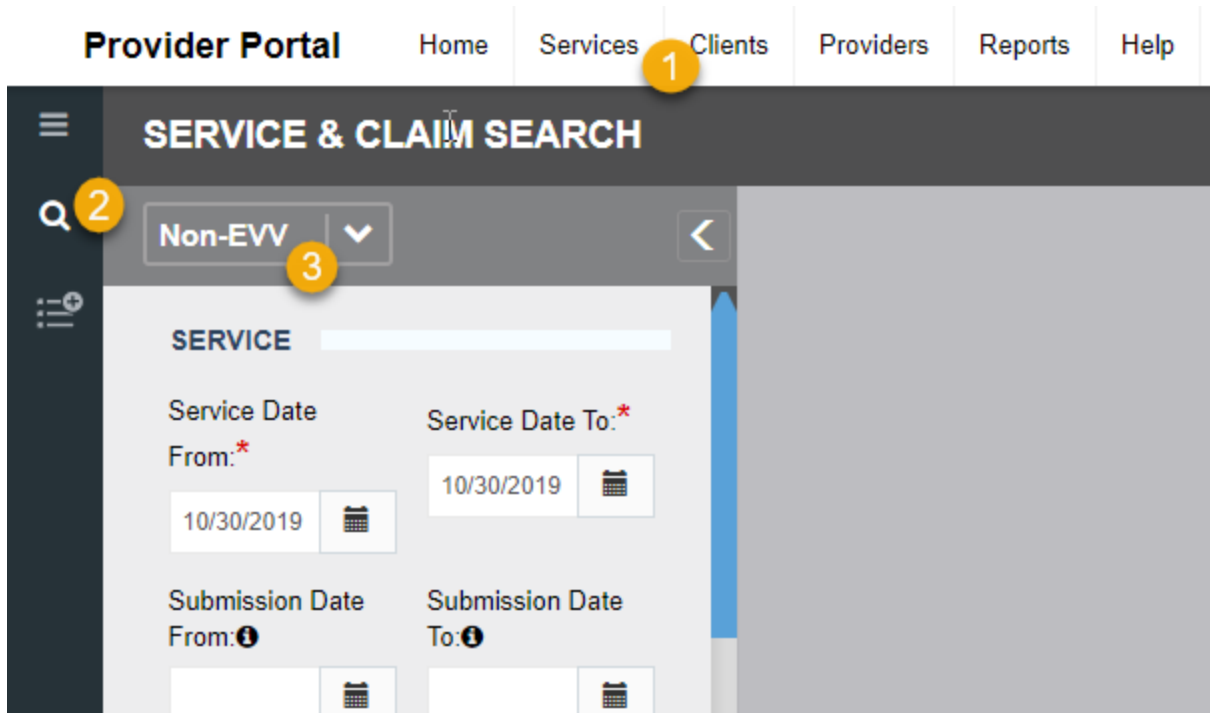
- Admin Provider
- Billing Provider
- Provider Program Director
- Provider Program Staff

8.1 Searching for Entered Services

Providers with below roles can view the entered services and claims information for the Provider Agency. Services and Claims is located in the 'Services' area (1), within the 'Search Services' left menu (2) and selecting 'Non-EVV' above the search panel (3).

- Admin Provider
- Billing Provider
- Provider Program Director
- Provider Program Staff

Navigation: Home Page - > Services - > Left Nav Menu - > 'Search Services' icon [Q] *- > Non-EVV*

Services can be looked up by entering either the Service, Provider, Person or Claim & Remittance information. Most searches require a Date of Service (DOS) range entered through the Service Date From and To fields, with a combination of other optional inputs as detailed below.

8.1.1 Search by Service Information

Users can search for services using any of the below parameters in combination with the Service Date From and Service Date To fields to get the services with information that matches the search criteria.

● The search is limited to 1-year range. The From and To date cannot be more than one year apart
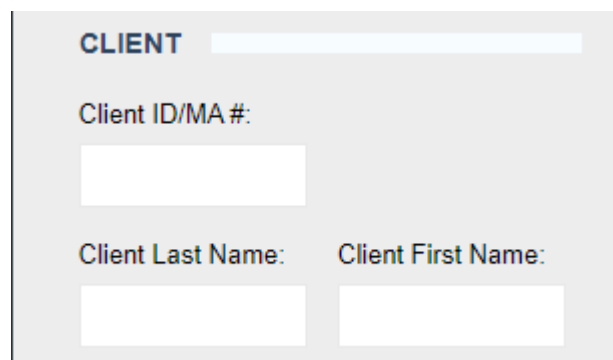
a. Service Date From and Service Date to – Service date is the date the service is provided on. This parameter can be used to return services provided within a DOS range. The Service From and To Dates are defaulted to the date before the current date but can be modified to expand the range.

b. Submission Date From and Submission Date to – Submission date is the date the billing entry was submitted by the provider. This parameter can be used to return services entered between the date ranges.

c. Service Type – Service type is the type of service provided. This parameter allows user to filter down to look for specific service types. By default, all services types for which the Provider has entered services for billing in the Provider Portal are selected. Refer to Appendix A for a list of all DDA services

    d. Service Status – Service status is the status that the service in. Allows to filter down services in a specific workflow status in the system. Refer to Appendix B for the workflow status meanings and transitions.

    e. Exception Type –Exception type is the exception that is currently associated with the activity. All entered services are subject to validation to ensure they are within the defined and authorized services and limits according to the person's PCP. If one or more validation checks fail, corresponding exceptions are assigned, and a claim is not created. This filter allows users to look for specific failures or exceptions so they can be resolved.

       Refer to Section 9 for more information on Exceptions

8.1.2 Search by Client Information

Providers with the below roles can search for services for clients that belong to their agency location, using any of the below parameters in combination with the Service Date From and Service Date To fields, to get the services with information that matches the search criteria.

- Admin Provider
- Billing Provider
- Provider Program Staff
- Provider Program Director

    a. Client ID/MA# - Allows searching for services using Person's LTSS Client ID/MA#
    b. Client Last Name - Allows searching for services using Person's Last Name
    c. Client First Name - Allows searching for services using Person's First Name

8.1.3 Search by Provider Information

Users can search for services using any of the below parameters in combination with the Service Date From and Service Date To fields to get the services with information that matches the search criteria.

    a. Provider#/Name – Allows searching for services with the Provider #/Name for the provider who provided the service
    b. Agency FEIN/Name – Allows searching for services with the provider's agency FEIN or the name of the Provider Agency.

c. Staff Name – Allows searching for services with the DSP's name, where a DSP name has been entered along with the service. This input is available now for Environment Assessments completed for persons in CO programs and is not applicable to DDA Non-EVV services, at this time

d. Staff SSN/ID -- Allows searching for services with the DSP's *LTSSMaryland* Staff Profile Identifier or SSN, where a DSP name has been entered along with the service. This input is available now for Environment Assessments completed for persons in CO programs and is not applicable to DDA Non-EVV services, at this time

8.1.4 Search by Claim and Remittance Information

The Advanced Search feature under 'Services and Claims' Search allows providers to search for entered services based on claim and remittance information, such as Claim ICN and RA Number from MMIS, and Claim Status, Number and Type in Provider Portal.

a. Claim Status – This parameter is used to get services based on their status. Claims can have one of the following statuses. Multiple statuses can be selected.
   i. Submitted to MMIS – services have passed the overnight checks and a claim has been submitted to MMIS
   ii. Paid – The claim submitted to MMIS has been paid
   iii. Rejected – When MMIS returns remittance with no payment for the submitted claim, the claim status will be Rejected
   iv. None (No Status) – There is no Claim created for the service yet. This may be due to the services being held up due to exceptions that need to be resolved prior to claim creation

b. Claim Type - This parameter is used to get services based on the type of claim created for it. Claims can have one of the below types. Multiple claims can be selected
   i. Original – The Original or Initial claim submitted for the service, after the service is first entered and successfully clears the service validation

      ii.   Adjustment- Claims created for modifications made to services after an original claim has been submitted to MMIS and either Paid or Rejected

     iii.   Void- Claims that are reduced to 0 units

     iv.   No claim- There is no Claim created for the service yet. This may be due to the services being held up due to exceptions that need to be resolved prior to claim creation

c.   RA No. (RA Number) – Allows search by the Remittance Advice Number received with a payment made by Medicaid to the Provider. Remittance Advice Number identifies all services paid with the associated check or payment (EFT).
Note: Service Date From and To fields that are required for other searches become optional when RA Number search is used (A) and the Submission Date parameters (B) are disabled for selection.

d.   ICN – Allows search by the Internal Control Number (ICN) received from MMIS. ICN is a 13-digit number assigned to each claim in Medicaid. As ICN identifies a single claim, entering an input parameter in the ICN field disables the other search fields within the search panel. *Note*: There is no ICN for state payment services

e.   Claim# – Allows search by the Claim Number assigned in Provider Portal for services billed to MMIS. The Claim# field is available when viewing services with a claim and can be used for internal communication within the Provider Agency or in communication with DDA

8.2 Search Results

After entering the search parameters described in the above section, the Search action in the search panel should be selected to view the Search results

The Service search results will be defaulted to a listing of services grouped by the Client Name, in ascending alphabetical order. Selecting a Client Information card returns all services for the Client within the search parameters entered.

Users may Filter, Group, or Sort search results.

8.2.1 Filter Search Results by Last Name

- ● Filter By Last Name according to first letter of the Client's last name

8.2.2 Change Search Results Grouping

The default Client grouping of Service Search results can be modified to view the results in one of the following available grouped views

- Group by Provider to view results based on Provider#
- Group by Service Type to view results based on type of Service
- Group by Client return to Client grouping from one of the other views
- No Grouping to view results in descending order based on Service Date
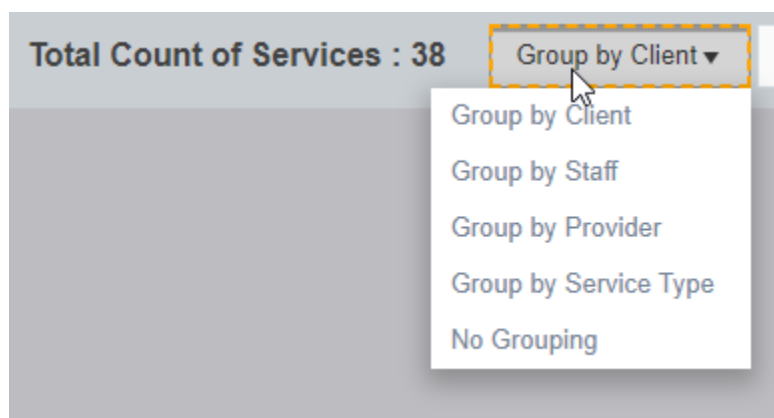
8.2.3 Sort Search Results
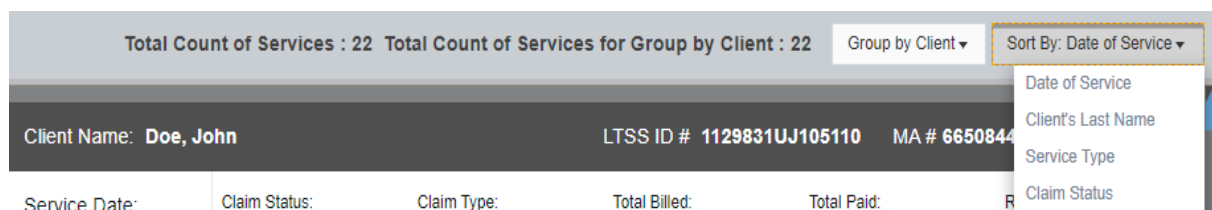
Search results can be sorted by the following parameters

- Date of Service to view results in descending order based on Service Date.
- Client's Last Name to view results in ascending alphabetical order based on last name of client.
- Service Type to view results in ascending alphabetical order based on Type of Service.
- Claim Status to view results in ascending order based on status of the service's claim.

8.3 Viewing Details of a Non-EVV Service

Upon Searching for services, and clicking on the tile for the Client, all the services for the client which match the search criteria, shows up on the screen. These are the primary service details, selecting the detail action on a displayed service opens a pop-up window with more information on the service. The

service date details page has the following sections (A) Service Date Header (B) Claim Details and (C) Service Details

Exceptions – Shall display all the exceptions associated with the service

The Service Details popup is organized into 3 sections.
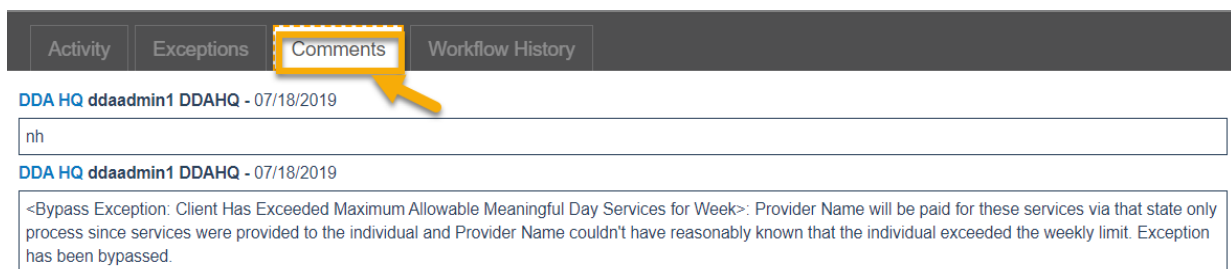
A. Service Header – This section includes the Date of Service, Service Type, Recent Claim Information, Client Information and Provider Information and Claim information along with the Client's information and Provider Information. Information includes -

1. Client Name - Displays the full name of the person receiving service
2. Program Type – The DDA program that the person was enrolled in on the date of service [Refer Appendix G for details on what constitutes an enrolled program]
3. LTSS ID – Unique client ID in LTSS for the person
4. MA# - Medicaid Number of the person, if one is available
5. Service Date -The date on which Service has been provided
6. Service Type - The type of service rendered Units/Cost of Service –
7. Total Paid: The Total Paid amount for the service rendered
8. Provider # - The DDA Medicaid number of the provider
9. Provider Name – The name associated with the provider number for the service
10. Provider Address – The address of the provider that provided the service
11. Provider FEIN – The FEIN of the agency

B. Claim Details – If the Service has a claim created, the Claim Details tile displays information on the claim such as Billed and Paid Amounts and Units, ICN, Remittance Number, and Remittance Date. These fields will be populated only for claims paid by Medicaid and will not be populated for DDA State Funded services (Refer to section 16.6 for DDA State Funded Report). Information includes -

1. Claim Type – denotes whether the claim is original, adjustment or void claim; N/A when claim does not exist or if the service is state funded

2. Claim Status – denotes if the claim is submitted to MMIS awaiting payment, or if it is Paid or Rejected; N/A when claim does not exist or if the service is state funded
3. Total Billed – Total claim amount billed to MMIS for the rendered service; Blank when claim does not exist or if the service is state funded
4. Total Paid – Total payment received for the rendered service; Blank when there is no associated payment from Medicaid, or if the service is state funded
5. Total Units – Total Units for the service
6. Net Billed – Difference between the amount previously billed to Medicaid and the adjusted amount after a claim update; i.e., additional amount requested in an adjustment or amount to be deducted in a negative adjustment; Blank when claim does not exist
7. Net Paid - Difference between the amount previously paid by Medicaid and the adjusted amount paid after a claim update; Blank when claim does not exist
8. Net Units – Difference in units between the previously paid claim and the updated claim
9. Claim Creation Date – The date claim was created and submitted to MMIS
10. ICN – Internal Control Number of each claim in MMIS
11. RA NO- Remittance (Check) Number of the payment received from Medicaid
12. RA Date – Date the payment was received from Medicaid

C. Service Details -- The Service Details comprises of three tabs - Service, Comments and Workflow History tab

   a. Activity tab shows the units/cost of service and the current service status, along with any exceptions identified on the service. A service is created for each entered service, which is subsequently converted into a claim

   b. Comments Tab displays the comments entered by the users accessing the service (Refer to Screenshot4)

   c. Workflow History tab shows the workflow transitions on the service from creation to current status

Activity	Exceptions	Comments	Workflow History

DDA HQ ddaadmin1 DDAHQ - 07/18/2019

nh

DDA HQ ddaadmin1 DDAHQ - 07/18/2019

<Bypass Exception: Client Has Exceeded Maximum Allowable Meaningful Day Services for Week>: Provider Name will be paid for these services via that state only process since services were provided to the individual and Provider Name couldn't have reasonably known that the individual exceeded the weekly limit. Exception has been bypassed.
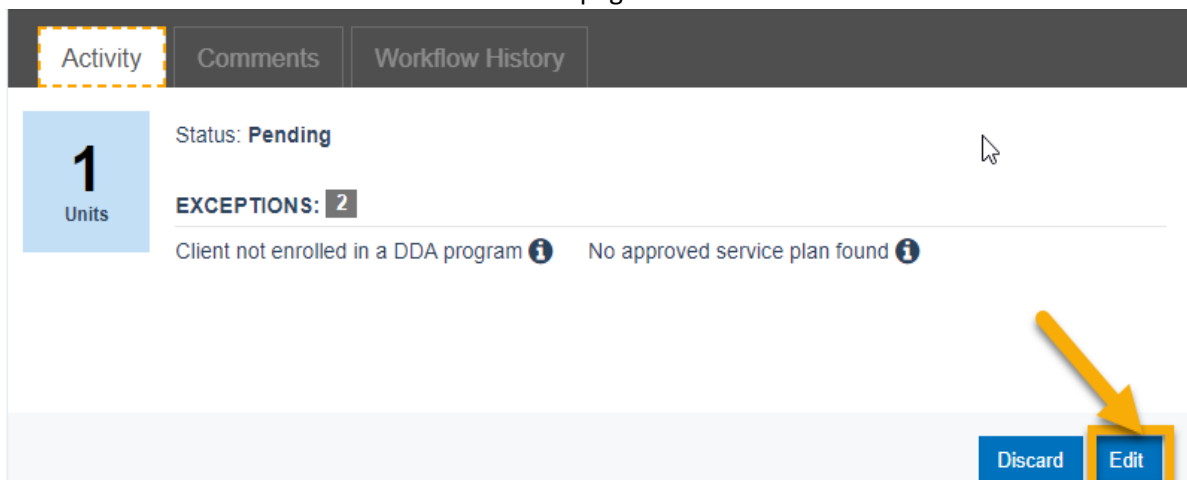
8.4 Editing a Service

This section describes how services can be modified after they are entered. A billing entry that is created for the services rendered by Providers is first converted to a Service in the overnight billing process, before performing service validation and creation of claims to submit to MMIS. When a service is created, it is in a 'Recorded' status and when the service fails validation checks, it is put in a 'Pending' status (Refer to Appendix B for service status workflows). A service in a 'Recorded' or 'Pending' status can be modified through the "Edit" action in the Service Details page. Providers with the below listed roles can edit a service:

- Admin Provider
- Billing Provider

Navigation: Home Page - > Services - > Left Nav Menu - > 'Search Services' icon *- > Non-EVV ⬚ Click on Client Name tile ⬚ Click on Details ⬚ Edit*

1.   Select Edit on Service Date Details page

2.   User can:

> i. Modify the Units or Cost
> ii. Enter a valid Edit reason by selecting from the dropdown options
> iii. Click Save

8.5 Discarding a Service

Providers with the below listed roles can view discarded services or discard a service which is in "Recorded" status or "Pending" status (Refer Appendix B for service statuses). Selecting "Discard" button allows providers to discard a service, with the reason or comment entered.

- Admin Provider
- Billing Provider

Navigation: Home Page - > Services - > Left Nav Menu - > 'Search Services' icon *- > Non-EVV EVV ⏵ Click on Client Name tile ⏵ Click on Details ⏵ Discard*

1. Select "Discard" from Service Date Details page

2. A confirmation pop-up window is presented to confirm the discard. Enter a reason from the available options and select discard or click cancel to cancel the action

3. Once discarded, no further changes are allowed on the service and it becomes grayed out with a "Discarded" watermark applied across the details
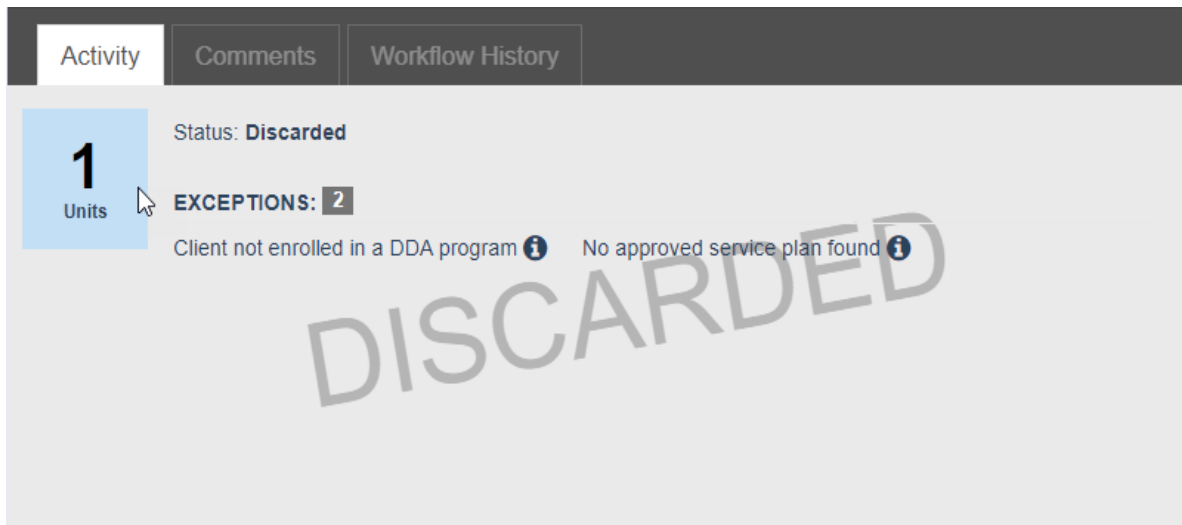
9. Exceptions

Exceptions are circumstances that prevent a service from being billed. A pre-claim check is performed on the entered services to ensure the validity of the services being billed to MMIS. When a service fails a check, an exception is identified on the service. The service will be in a "Pending" status when an exception is identified and will stay in this status until the issue is resolved. There are many reasons for this to occur. Some issues need to be resolved by the Provider, while others require coordination with the CCS and or DDA.

Providers with the below listed roles can view and resolve applicable exceptions.

- Admin Provider
- Billing Provider

Below sections describe every exception type and how it can be resolved.

9.1 Exception Notifications

The pending counts section in the Home Page Actions Required section shows the counts of services that are pending for each exception type.

Exceptions may also be viewed by searching via the Services tab and entering search parameters for the exception.

9.1.1 Pending Exceptions for Provider Resolution

This section lists the exceptions that Provider is responsible for fixing or those that need coordination with the CCS.

Depending on the services the Provider Agency renders, there can be one or both of below sections:

- EVV Services- Exceptions on EVV services to be resolved by the Provider internally or by contacting the CCS, summarized as a total count per exception type
- Non EVV Services – Exceptions on Non-EVV services to be resolved by the Provider internally or by contacting the CCS, summarized as a total count per exception type

Only exceptions for dates of service up to 1 year in the past are displayed in this section, as claims are accepted by MMIS for only up to a year from the date of service.

The counts in the table are hyperlinks, which redirect to the Services Search Results page which lists the services included in the count.

9.1.2 Pending Exceptions for MDH Resolution

This section lists the exceptions that will be resolved by DDA.

Depending on the services the Provider Agency renders, there can be one or both of below sections:

- EVV Services- Exceptions on EVV services to be resolved by DDA, summarized as a total count per exception type
- Non EVV Services – Exceptions on Non-EVV services to be resolved by DDA, summarized as a total count per exception type

Only exceptions for dates of service up to 1 year in the past are displayed in this section, as claims are accepted by MMIS for only up to a year from the date of service.

The counts in the table are hyperlinks, which redirect to the Services Search Results page which lists the services comprised in the count.

9.2 Exception types in Non-EVV Services

Providers users with the below listed roles have the ability to resolve exceptions on Services:

- Admin Provider
- Billing Provider

Provider users are responsible for resolving these types of issues:

- *Multiple supported living sites authorized for the same provider on the service plan* – This occurs when there is more than one supported living site authorized for the person in a month, and the Provider must identify the correct supported living site address in which the service was provided.

- *Provider must confirm Staffing Ratio* – This occurs when there is more than one staffing ratio authorized for a Community Development or Day Habilitation service for the person in a month, and the Provider must identify the correct staffing ratio for the service

- *Provider has exceeded the maximum authorization for the month* – This occurs when provider has billed for more than the authorized units of service for the month. If units are incorrectly entered, Provider may correct the units and resubmit. If additional units of service were provided for a valid reason, Provider must contact CCS to amend the PCP

- *Provider has exceeded the maximum authorization* -- This occurs when provider has billed for more than the authorized milestones or cost of service for the plan year. If services are incorrectly entered, Provider may correct the units/cost and resubmit. If additional units of service or cost of service/item were provided for a valid reason, Provider must contact CCS to amend the PCP

- *Provider # does not have the approved and active Category of Service*: This occurs when the Agency Provider does not have the approved category of service to provide services to a Person
- *Provider is not approved to provide services to a minor:* This occurs when the Agency Provider does not have the approved category of service to provide services to a Person who is a Minor

Agency Providers must contact the Person's Assigned CCS Coordinator about these issues:

- *Client not enrolled in a DDA program:* This occurs when the Person receiving services is not enrolled in a DDA Program on the Date of Service
- *No approved service plan found:* This occurs when the Person receiving services does not have an approved and active Person-Centered Plan on the Date of Service
- *Provider not authorized for the service*: This occurs when the Agency provider is not on the Person's Person-Centered Plan on the Date of Service
- *Client Ineligible for Program:* This occurs when the Person receiving services does not have an active DDA waiver program in Medicaid on the date of service
- *Client LTSS Program does not align with MMIS waiver program:* This occurs when the Person's enrolled program in LTSS does not match with the waiver approved in MMIS on the Date of Service
- *Client ineligible for Medicaid*: This occurs when the Person receiving services is not Medicaid Eligible on the Date of Service
- *Client ineligible for Medicaid but has active waiver program in MMIS:* This occurs when the person is ineligible for Medicaid, but has an active waiver program in MMIS on the Date of Service
- *Client LTSS program does not match the service plan:* This occurs when the Person's LTSS Program does not match is the program on their Person-Centered Plan on the Date of Service

Agency Providers must contact DDA about these issues, in situations where the meaningful day service limits are exceeded by 2 Provider Agencies:

- *Client has exceeded maximum allowable Meaningful Day services for the day* – This occurs when Client has exceeded the maximum allowable Meaningful Day services for the day
- *Client has exceeded maximum allowable Meaningful Day services for the week* – This occurs when Client has exceeded the maximum allowable Meaningful Day services for the week
- *Client has exceeded maximum allowable Dedicated hours for the day* –This occurs when the Client has exceeded the maximum number of units of dedicated hours for the day

9.3 How to Resolve Exceptions

Administrative and Billing provider agency users can resolve an exception by Editing the service (Refer to Section 8.4)

Navigation: Home Page - > Services - > Left Nav Menu - > 'Search Services' icon 🔍 *- > Non-EVV ▯ Click on Client Name tile ▯ Click on Details ▯ Edit*

A. Providers can resolve the exception "Provider must confirm Staffing ratio" by editing the service and selecting the right staffing ratio
   6.   Click on Edit
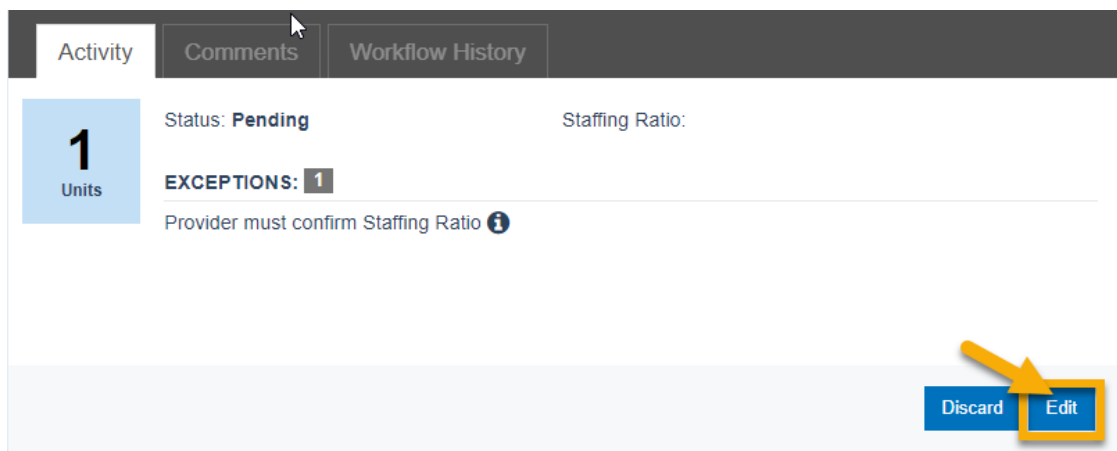
   7.   Modify the below:
         a. Select the right Staffing Ratio from the dropdown
         b. Select the right Edit Reason
         c. Click on Save

3. Once saved, the staffing ratio exception is resolved, and the entry will be included in the overnight validation process.

B. Providers can resolve the exception "Multiple supported living sites authorized for the same provider on the service plan" by editing the service and selecting the right supported living site:

1. Click on Edit

2. Modify the below:
   a. Select the right Supported living site from the dropdown
   b. Select the right Edit Reason
   c. Click on Save

3. Once saved, the multiple supported living sites exception is resolved, and the entry will be included in the overnight validation process.

C. Providers can resolve all the remaining exceptions by manually making an edit and modifying the units on the service if incorrectly exceeded (Refer to Section 8.4)

- The Provider can reach out to CCS coordinator to make changes to the service plan
- The Provider can reach out to DDA for issues.

10. Adjusting Paid or Rejected Claims for Non-EVV Services

10.1 When to Submit an Adjustment

Adjustments are made when a claim has already been submitted to Medicaid and paid or rejected Modifications to services are not possible when a claim is currently being processed at Medicaid (in a status of "Submitted to MMIS"), and provider should wait for the remittance to be received and processed in Provider Portal to adjust. Claims are typically processed on Saturday's and Medicaid returns the remittance information to Provider Portal on the following Tuesday.

10.2 Adjusting Non-EVV Services

Administrative and Billing users from a Provider Agency can Adjust a service for which claim has been generated and paid/rejected to modify the units or cost of the service and submit a new adjusted claim to Medicaid.

Follow the below steps to make adjustments

1. *Navigation: Home Page - > Services - > Left Nav Menu - > 'Search Services' icon* *- > Non-EVV*
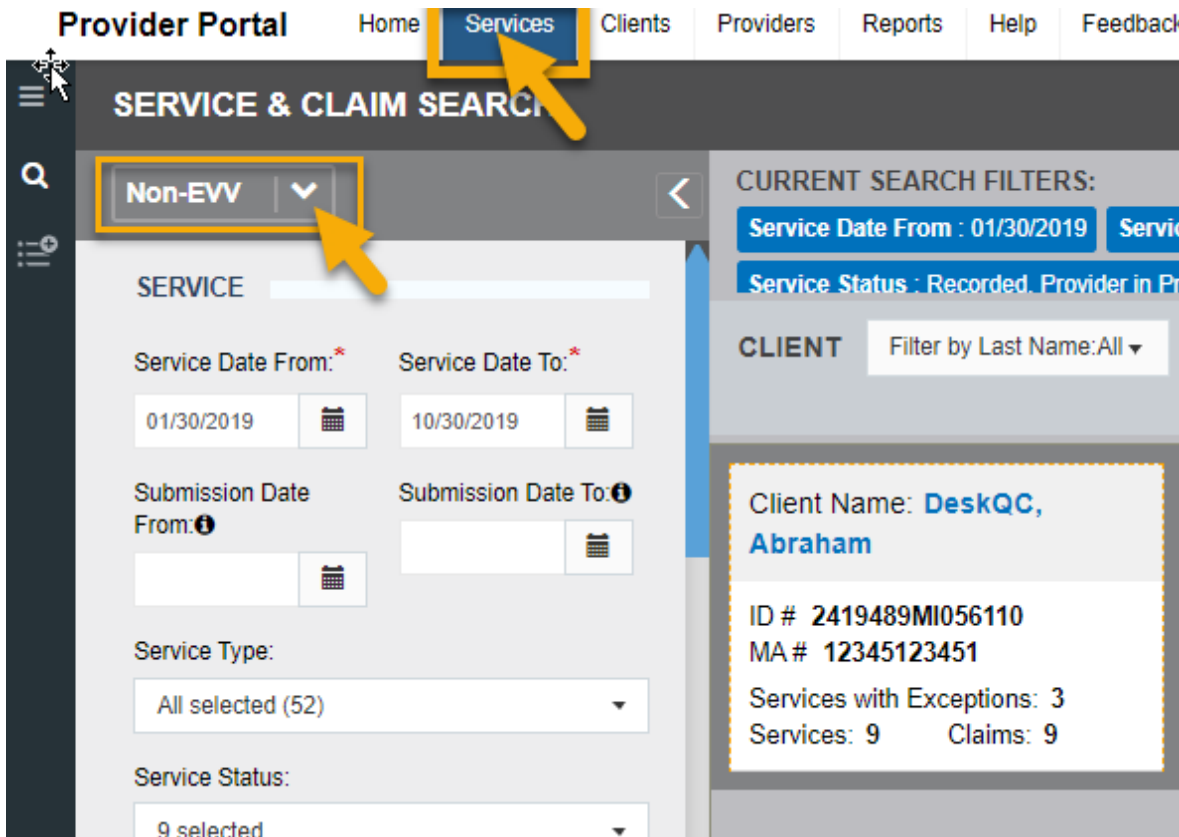
2. Click the Details button on the desired Service search results panel from the search results
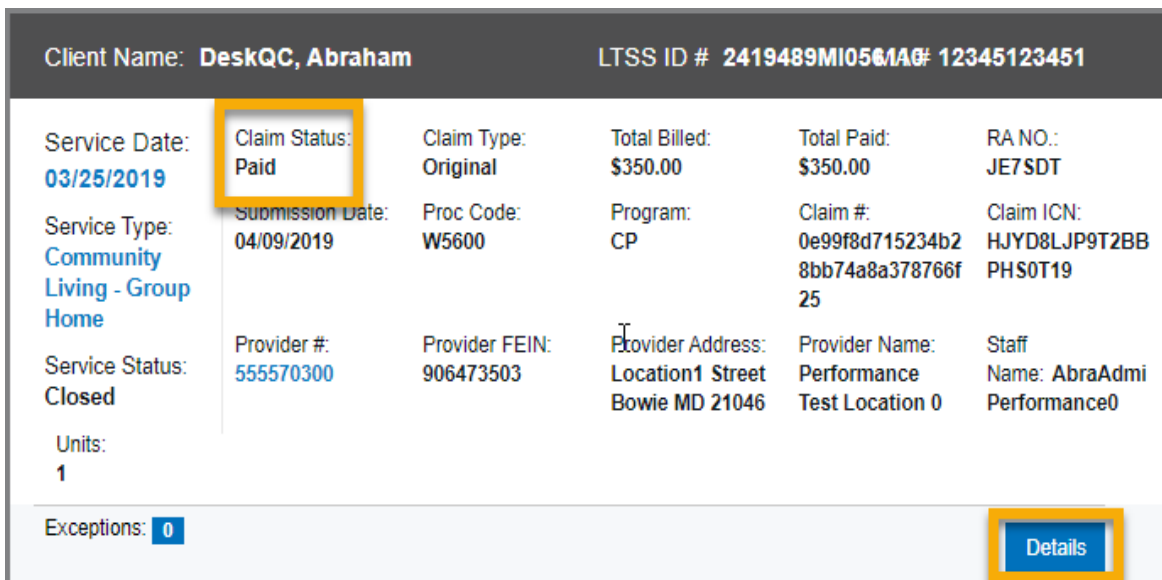
3. Click on Adjust Activity button. System will create a claim row that allows user to edit / void
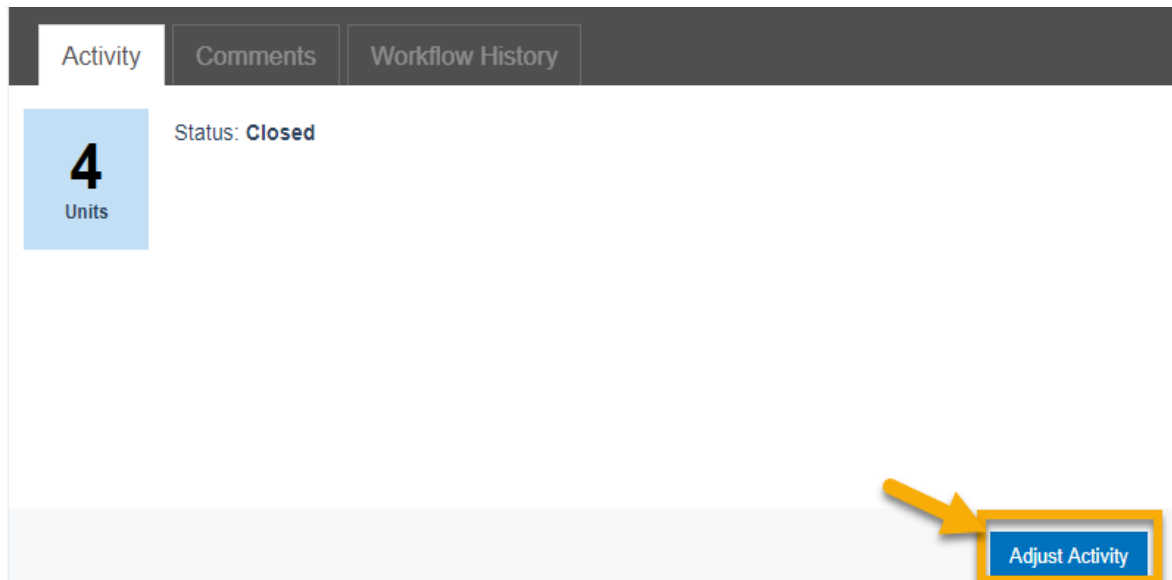
4. Click the Edit button on the new row. System displays relevant fields in Edit mode
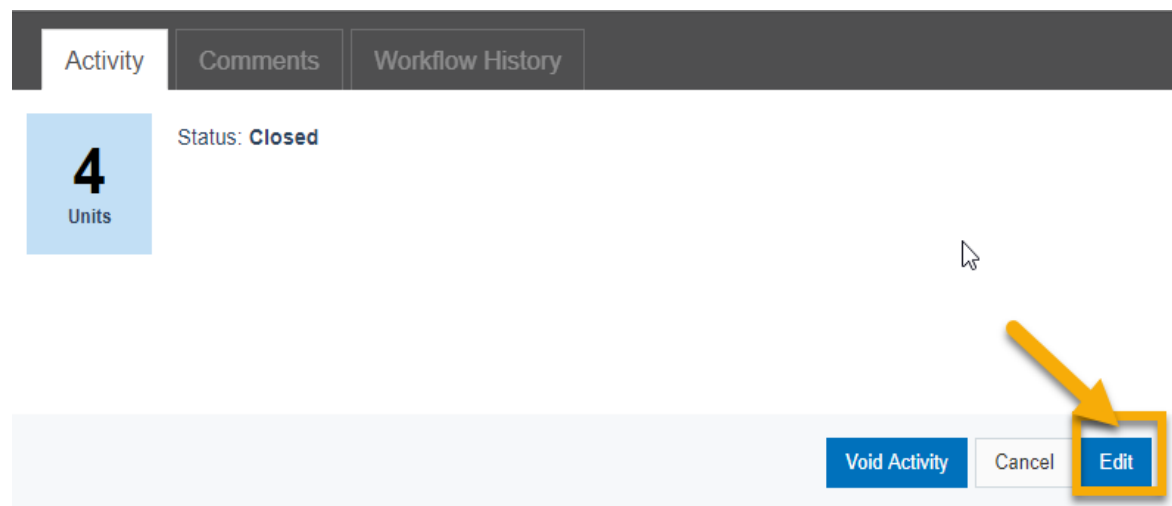
5. Click Cancel to cancel the adjustment
6. Update the following fields as needed:
    a. Units
    b. Edit Reason
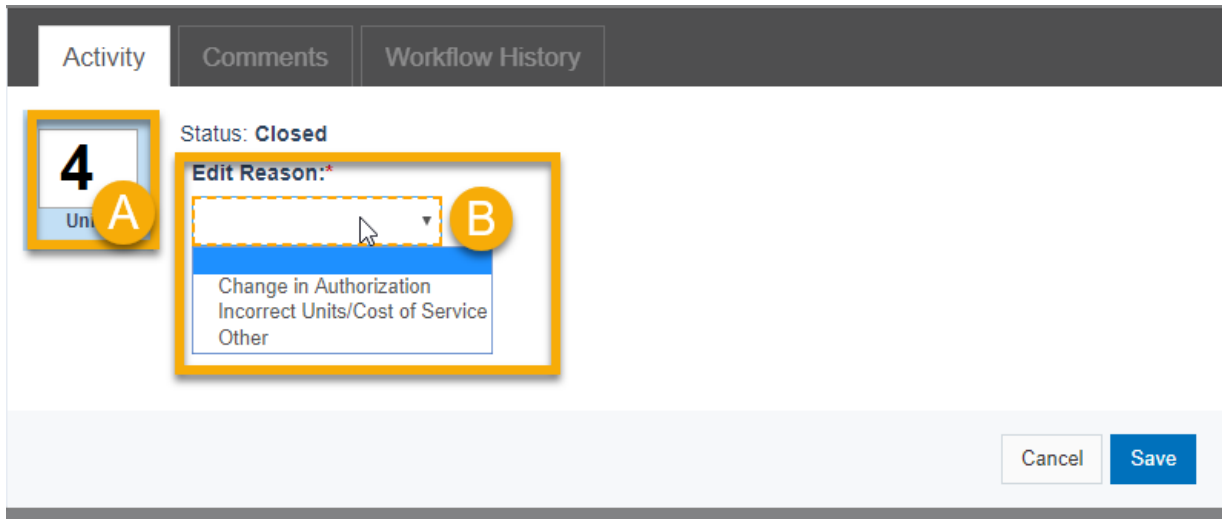
7. Upon selecting Save, the screen will display the Original Claim(A) on a lower panel, and the adjusted/voided(B) submission on the top panel
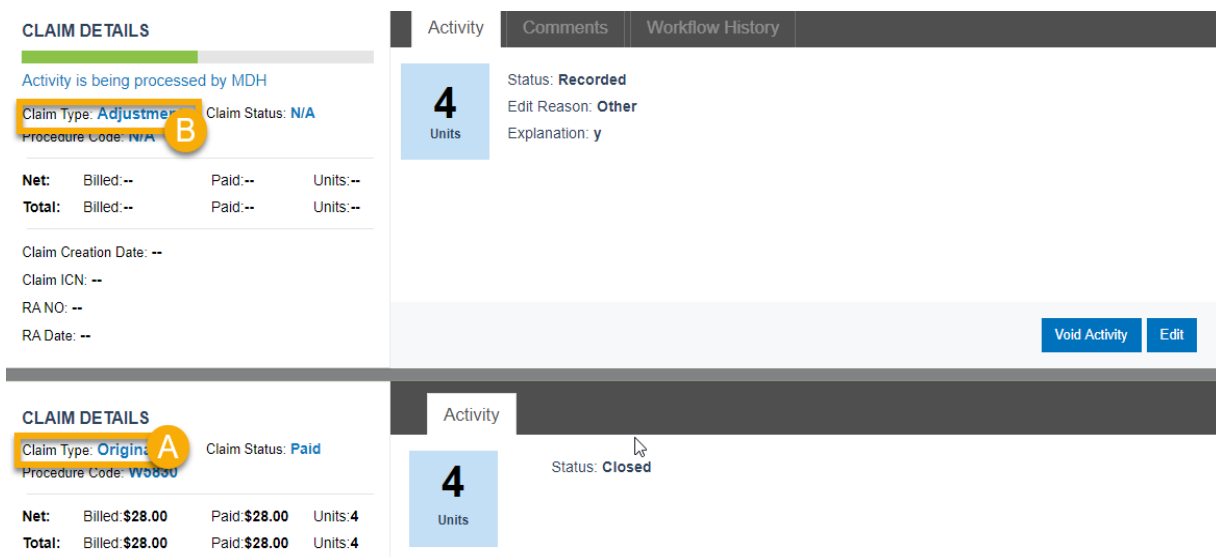
8. In the case of a subsequent adjustment made on an adjusted claim, the latest adjustment record is displayed in the top most row followed by the ones modified earlier

10.3 Voiding a Non EVV Service
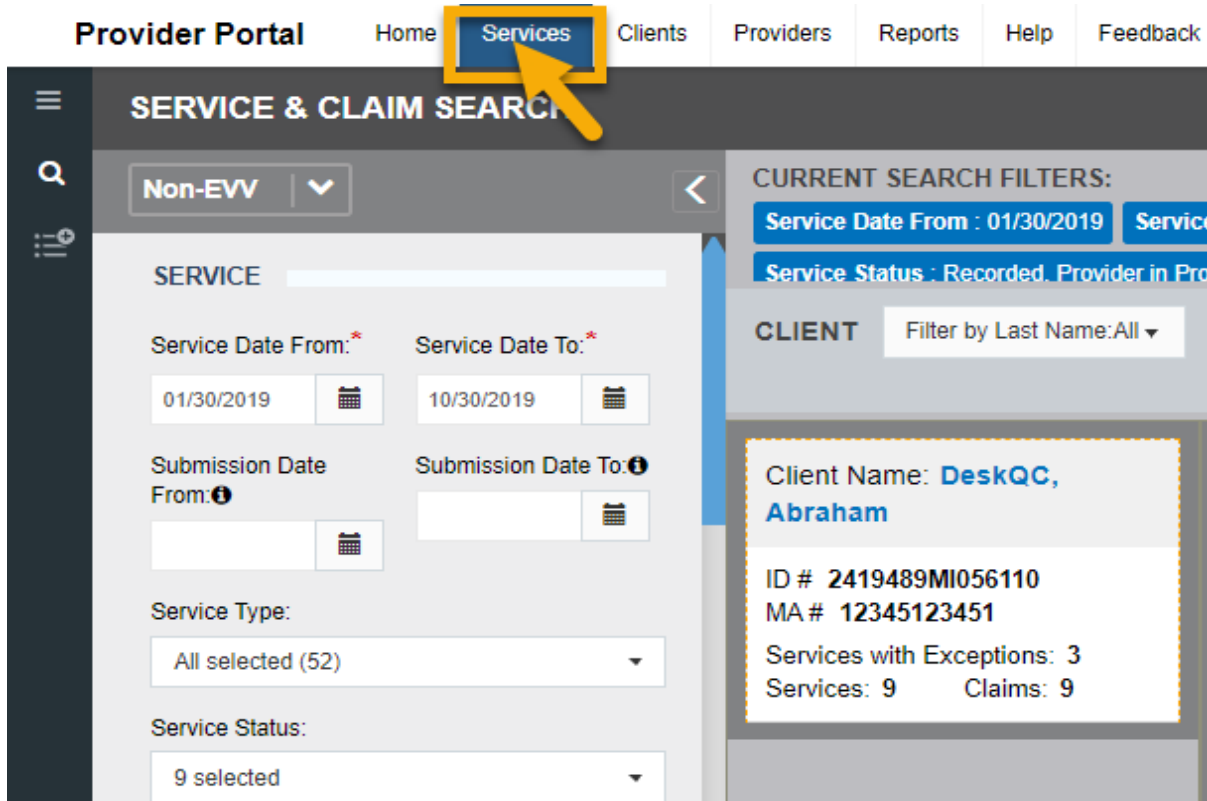
A claim that has been paid by Medicaid can be voided to reduce it down to 0 units and cancel the payment made previously. Providers with the below roles can void a service within a claim processed by Medicaid.

- Admin Provider
- Billing Provider
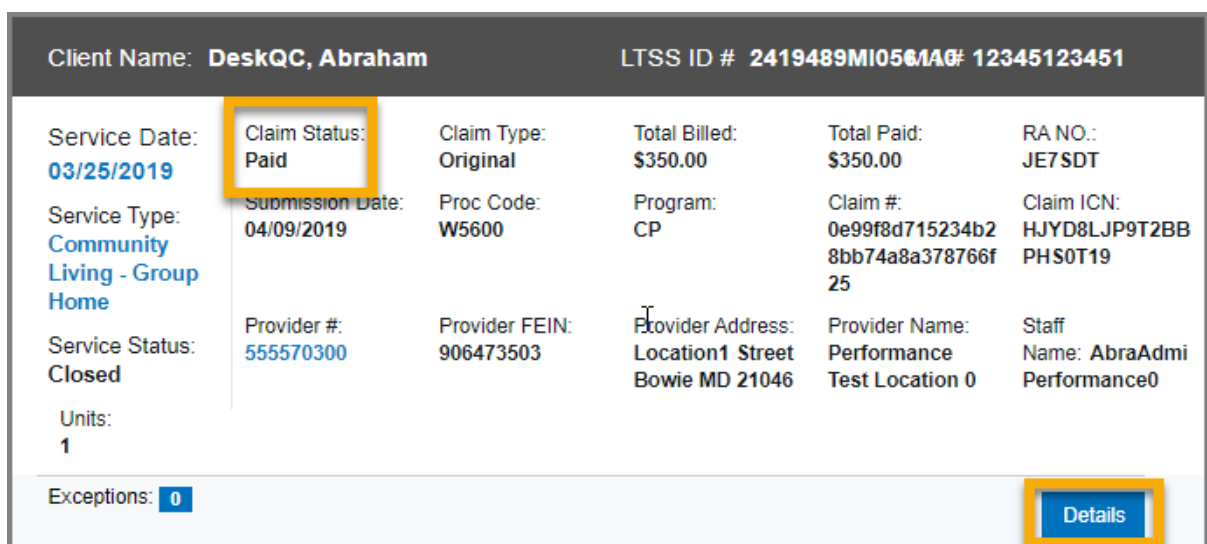
To void a claim:

Navigation: Home Page - > Services - > Left Nav Menu - > 'Search Services' icon *- > Non-EVV*

Search for the claim by entering the relevant search criteria

1. Click the Details button on the desired Service search results panel from the search results

2. Click the "Adjust Activity" button on the Service Date Details view
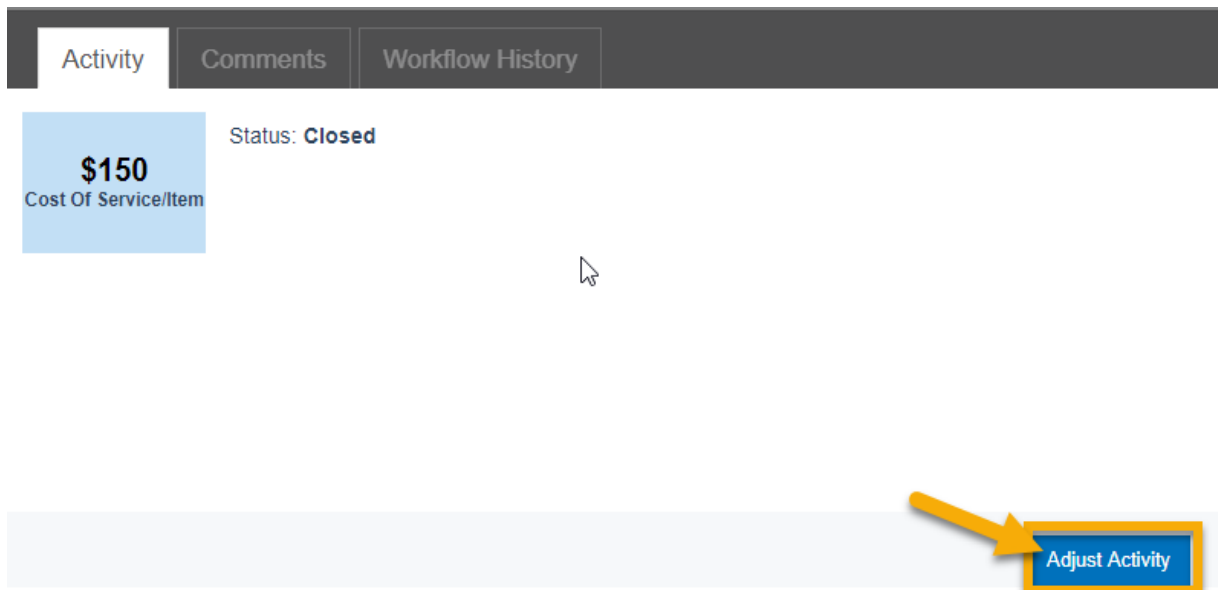
3. Click Void Activity on the new row that has been created
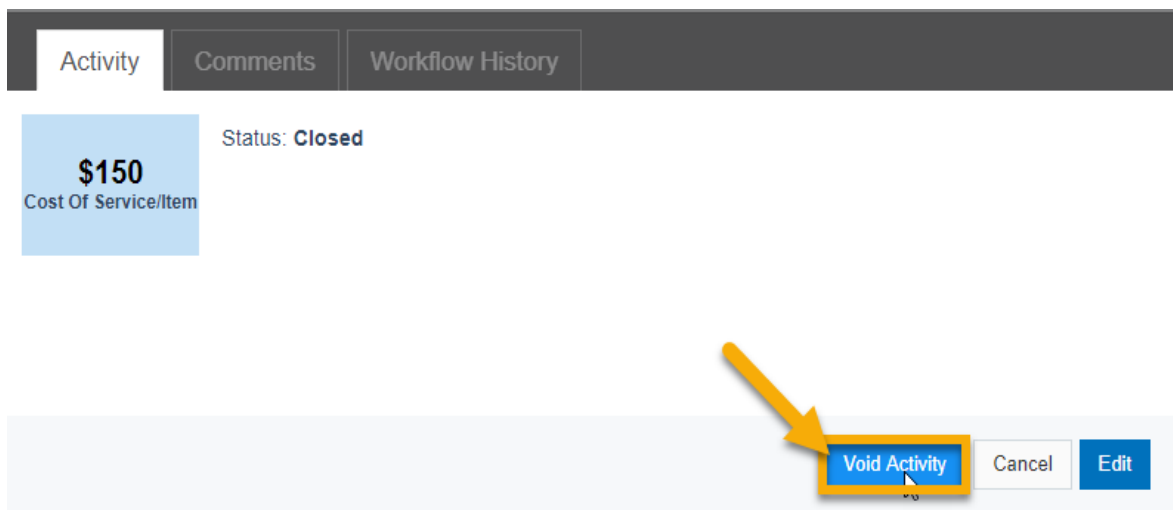
4. Upon selecting Void Activity, the user will be prompted with a confirmation popup and is required to enter Comments and then select Void

VOID SERVICE
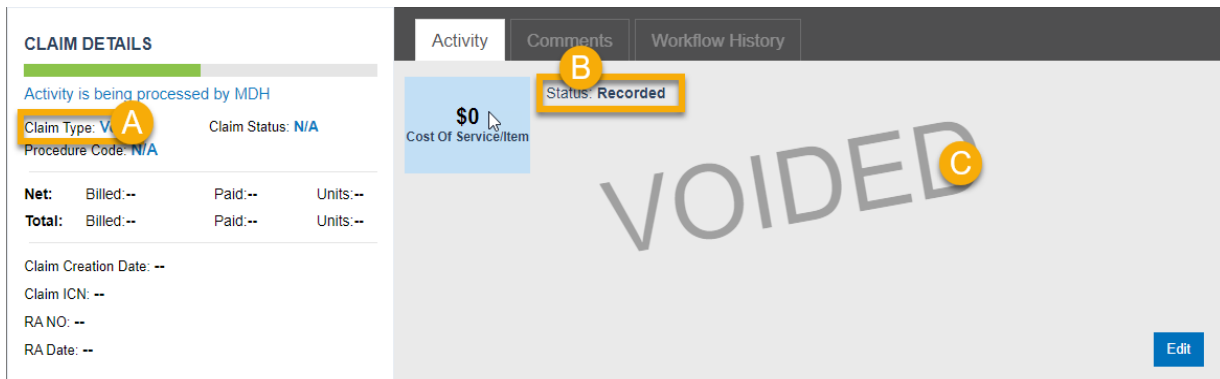
This action will void the activity. Do you wish to proceed?

Comment: *

> test

[Void] [Cancel]

5. Upon voiding, the Claim type for the new row becomes Void (A), the service status will become *Recorded(B)*, and a watermark (C) will display on the service indicating that it has been Voided

CLAIM DETAILS

Activity is being processed by MDH

Claim Type: V**A** Claim Status: N/A
Procedure Code: N/A

| Net: | Billed:-- | Paid:-- | Units:-- |
| Total: | Billed:-- | Paid:-- | Units:-- |

Claim Creation Date: --
Claim ICN: --
RA NO: --
RA Date: --

Activity Comments Workflow History

B
Status: **Recorded**

$0
Cost Of Service/Item

VOIDED **C**

[Edit]

Once voided, a 0-unit claim is sent to Medicaid in overnight billing, and the Voided claim will be deducted from the Provider's next scheduled payment.

Part C – EVV Services

11. Entering EVV Services through the IVR System

All Direct Service Professionals (DSPs) for Personal Supports and Personal Supports Enhanced service must clock in and out of an IVR system at the start and end of each service to record the services and receive payment. The DSP will clock in and clock out using one of the following:

1. The Participant's registered phone in LTSS
2. An alternate phone along with the One-Time Password (OTP) device

DSPs must have a staff profile created in Provider Portal with a "Staff Provider" role and an SSN to be able to user the IVR system so the Provider Agency can get paid for the service. DSPs may NOT use their personal phones to clock in and out through IVR system unless accompanied with an OTP device and approved by the Person's CCS Coordinator.

11.1 Calling the IVR System

To clock in and out through the IVR system the staff provider or DSP should call (833) 917-2100. DSPs will need the following information when they clock in or out through IVR system. It is the Provider Agency's responsibility to ensure all DSPs have the following information prior to providing services to recipients and are fully trained on how to use the IVR system.

- IVR phone number to call
- Participant's Medicaid (MA) number (if needed)
- Agency Provider number
- Staff Provider (DSPs) Social security number
- OTP device ID (if assigned)

DSPs must listen to the IVR prompts and enter the correct information all the way until the END prompt, which will say "Goodbye".

11.2 The DDA Call-in System

Below is an outline of the verbal prompts in the IVR system. It is the Agency Administrator's responsibility to ensure that the Staff Provider is familiar with the Telephonic system prior to providing services. This is a useful tool to assist with training Staff.

Greeting: "Welcome to the ISAS Clock in and Clock out System."

Prompt 1: "For Personal Supports, press 1. For Personal Supports Enhanced, press 2"

 If you pressed 1 : "You selected Personal Supports. If this is the correct service, press 1. If not, press 2"

 If you pressed 2 : "You selected Personal Supports Enhanced. If this is the correct service, press 1. If not, press 2"

Prompt 1A: Sometimes Required (Required if Staff Provider is not calling from Participant phone and using an OTP Device to authorize) "Enter the Participant's 11-digit MA# or 9-digit OTP serial number and press #."

Prompt 1B: Sometimes Required (Required if Staff Provider is not calling from participant phone and using an OTP device to authorize) "Enter the 6-digit OTP passcode."

Prompt 1C: "The phone number you are calling from is not listed on the Client's Plan and no OTP has been issued. If you hang up and call from the correct phone number, your call will be processed successfully. If you continue clocking in or out now, your time will be recorded but DDA will review the call and payment could be affected. To continue with this transaction, Press 1." (You will only hear this message if you do not call from the Participant's phone and no OTP device is assigned)

Prompt 2: "Enter your nine- digit provider number."

Prompt 3: "Enter your nine-digit Social Security Number"

Prompt 4: "To clock in, press '1'. To clock out, press '2'."

> If you pressed 1: "To confirm your clock in time of…<Date/Timestamp> Press 1. To go back, press 2 "(Pressing 1 moves you to the next prompt, pressing 2 takes you back to the beginning of prompt 4)
> If you pressed 2: "To confirm your clock out time of…<Date/Timestamp> Press 1. To go back, press 2 "(Pressing 1 moves you to the next prompt, pressing 2 takes you back to the beginning of prompt 4)

Ending: "Thank you for calling the ISAS Maryland Clock In and Clock out System. Goodbye"

Note: DSPs MUST wait to hear the ENDING prompt before hanging up. If they do not wait, the shift times will not be recorded in DDA IVR.

Visual representation of the ISAS Call Flow
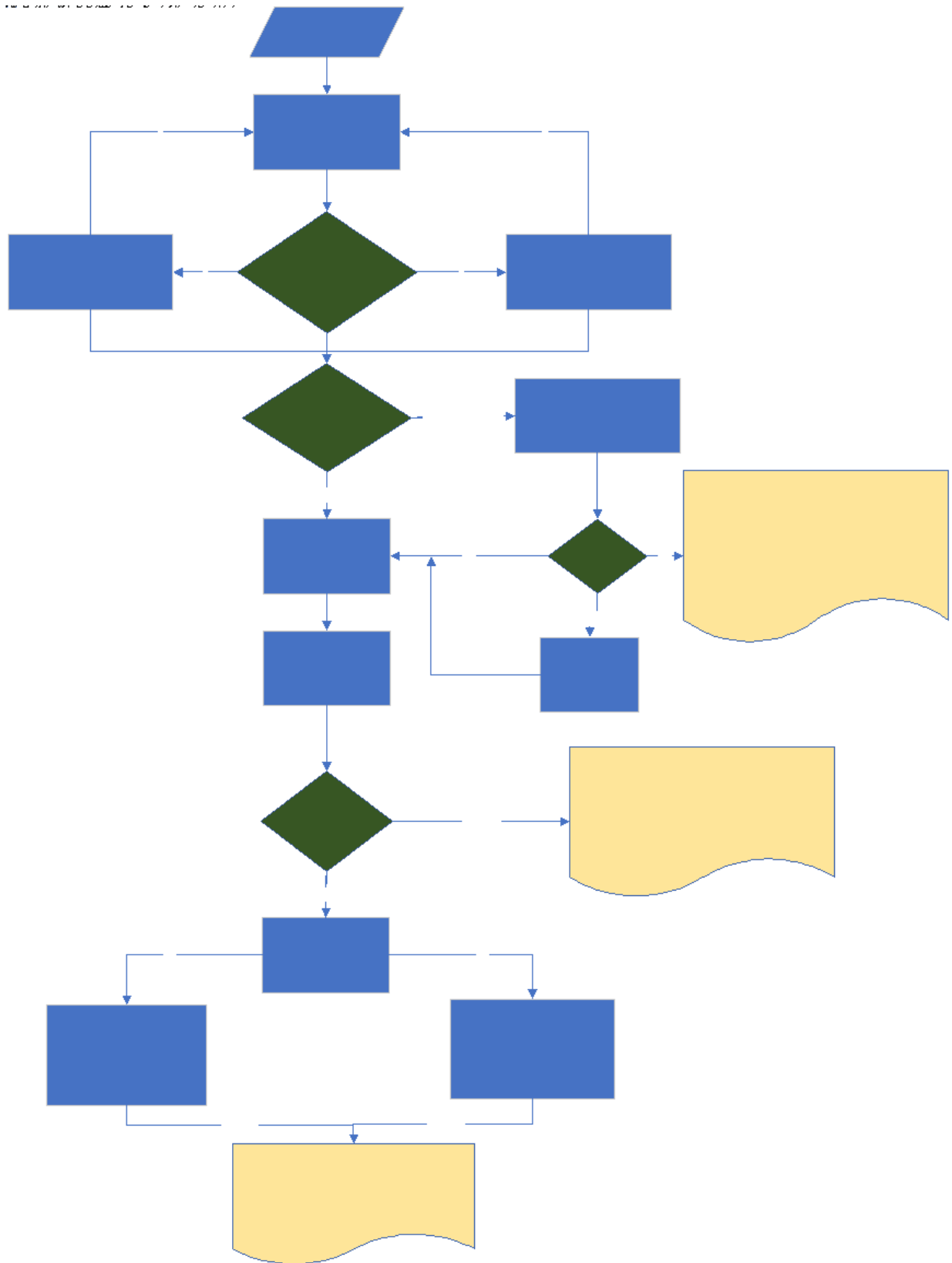
11.3 One Time Passcode (OTP) Device

A One Time Passcode Device (OTP) is a time-synchronized device issued to a Person by the Person's CCS coordinator. The OTP device has been designed to assist DSPs in recording clock in/out times in the ISAS system. Not all participants will have an OTP device in their homes. However, if they do, the Staff Providers are required to use it with every clock in and clock out. OTP devices are solely distributed by the CCS directly to Participants.

Note: OTP devices must ALWAYS remain with the participant to whom it has been assigned. It is considered fraudulent behavior for a DSP to take the OTP device out of the participant's possession.

OTP devices will only be issued under the following conditions:

1. Person does not have a reliable phone that the Staff Provider can use
2. More than one Person lives in the same household & shares a phone
3. The Person often receives Personal Supports service in the community

If an OTP device is assigned, the DSP will hear the following phrase when they clock in and clock out: "Enter the 6-digit OTP passcode". When they hear this phrase, they should look at the number on the device:

Enter the 6 digits. In the picture, below, the DSP would enter 728 197

Note: The number on the front of the device changes every 60 seconds. Staff Providers can tell if the number will change soon by looking at the bars to the left of the number. Each bar tells the Staff Providers that 10 seconds have passed. Staff Providers may wish to write down the OTP code before calling the DDA IVR system so the code will not change.

Note: OTP Devices must always stay with the participant. We recommend keeping the device attached to the refrigerator. CCS will educate the participant to ensure they are aware that the OTP device MUST always be kept in an easily accessible location. If the participant misplaces the OTP device or the device is broken or malfunctioning, the DSP or Agency Administrator must contact the participant's CCS Coordinator

12. View Entered Services and Claims for EVV Services

12.1 Service vs. Claim in EVV

Service:

A clock-in and one clock-out pair makes a Service.

Example: Jane clocked in at 7am and clocked out at 8am. Her hour-long shift is called a "service"

Claim:

One or more services that share the following information are bundled together during the nightly process to make a claim:

- Date of Service
- Provider Number
- Client LTSS ID/ Client MA Number
- Service Type (Personal Supports or Personal Supports Enhanced)
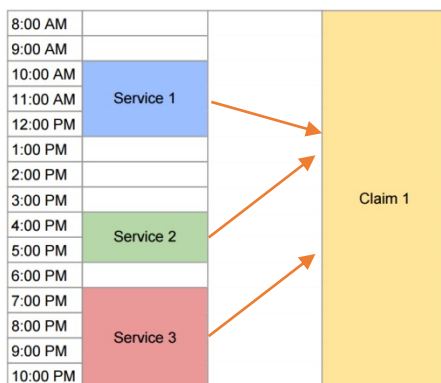
12.2 Service and Claim Search

Providers with below roles can view the entered services and claims information for the Provider Agency.

- Admin Provider
- Billing Provider
- Provider Program Director
- Provider Program Staff

Services and Claims is located in the 'Services' area (1) and selecting 'EVV' above the search panel (2).

Navigation: Home Page - > Services - > Left Nav Menu - > 'Search Services' icon *- > EVV*

Services can be looked up by entering either the Service, Provider, Person or Claim & Remittance information. Most searches require a Date of Service (DOS) range entered through the Service Date From and To fields, with a combination of other optional inputs as detailed below.

12.2.1 Search by Service Information

Users can search for services using any of the below parameters in combination with the Service Date From and Service Date To fields to get the services with information that matches the search criteria (See above screenshot).

- The search is limited to 1-year range. The From and To date cannot be more than one year apart

a. Service Date From and Service Date to – Service date is the date the service is provided on. This parameter can be used to return services provided within a DOS range. The Service From and To Dates are defaulted to the date before the current date but can be modified to expand the range.

b. Submission Date From and Submission Date to – Submission date is the date the Service was submitted by the provider. This parameter can be used to return services entered between the date ranges.

c. Service Type – Service type is the type of service provided. This parameter allows user to filter down to look for specific service types. By default, all services types for which the Provider has entered services for billing in the Provider Portal are selected. Refer to Appendix A for a list of all DDA services

d. Service Status – Service status is the status that the service in. allows to filter down services in a specific workflow status in the system. Refer to Appendix C for the workflow status meanings and transitions.

e. Exception Type –Exception type is the exception that is currently associated with the activity. All entered services are subject to validation to ensure they are within the defined and authorized services and limits according to the person's PCP. If one or more validation checks fail, corresponding exceptions are assigned, and a claim is not created. This filter allows users to look for specific failures or exceptions so they can be resolved.
Refer to Section 14 for more information on Exceptions

12.2.2 Search by Client Information

Services can be searched for by using any of the below parameters in combination with the Service Date From and Service Date To fields, to get the services with information that matches the search criteria.

a. Client ID/MA# - Allows searching for services using Person's LTSS Client ID/MA#
b. Client Last Name - Allows searching for services using Person's Last Name
c. Client First Name - Allows searching for services using Person's First Name

12.2.3 Search by Provider Information

Services can be searched for by using any of the below parameters in combination with the Service Date From and Service Date To fields to get the services with information that matches the search criteria.

a. Provider#/Name – Allows searching for services with the Provider #/Name for the provider who provided the service

b. Staff First and Last Name – Allows searching for services with the DSP's name

12.2.4 Search by Claim and Remittance Information

The Advanced Search feature under 'Services and Claims' Search allows providers to search for entered services based on claim and remittance information, such as Claim ICN and RA Number from MMIS, and Claim Status, Number and Type in Provider Portal.

a. Claim Status – This parameter is used to get services based on their status. Claims can have one of the following statuses. Multiple statuses can be selected.

    i. Submitted to MMIS – Services have passed the overnight checks and a claim has been submitted to MMIS

    ii. Paid – The claim submitted to MMIS has been paid

    iii. Rejected – When MMIS returns remittance with no payment for the submitted claim, the claim status will be Rejected

    iv. None (No Status) – There is no Claim created for the service yet. This may be due to the services being held up due to exceptions that need to be resolved prior to claim creation

b. Claim Type - This parameter is used to get services based on the type of claim created for it. Claims can have one of the below types. Multiple claims can be selected

    i. Original – The Original or Initial claim submitted for the service, after the service is first entered and successfully clears the service validation

    ii. Adjustment- Claims created for modifications made to services after an original claim has been submitted to MMIS and either Paid or Rejected

    iii. Void- Claims that are reduced to 0 units

    iv. No claim- There is no Claim created for the service yet. This may be due to the services being held up due to exceptions that need to be resolved prior to claim creation

c. RA No. (RA Number) – Allows search by the Remittance Advice Number received with a payment made by Medicaid to the Provider. Remittance Advice Number identifies all services paid with the associated check or payment (EFT)
Note: Service Date From and To fields that are required for other searches become optional when RA Number search is used (A) and the Submission Date parameters (B) are disabled for selection

d. ICN – Allows search by the Internal Control Number (ICN) received from MMIS. ICN is a 13-digit number assigned to each claim in Medicaid. As ICN identifies a single claim, entering an input parameter in the ICN field disables the other search fields within the search panel. *Note*: There is no ICN for state payment services

e. Claim# – Allows search by the Claim Number assigned in Provider Portal for services billed to MMIS. The Claim# field is available when viewing services with a claim and can be used for internal communication within the Provider Agency or in communication with DDA

After entering the search parameters described in the above section, the Search action in the search panel should be selected to view the Search results

12.3 Search Results

After entering the search parameters described in the above section, the Search action in the search panel should be selected to view the Search results

The Service search results will be defaulted to a listing of services grouped by the Client Name, in ascending alphabetical order. Selecting a Client Information card returns all services for the Client within the search parameters entered.
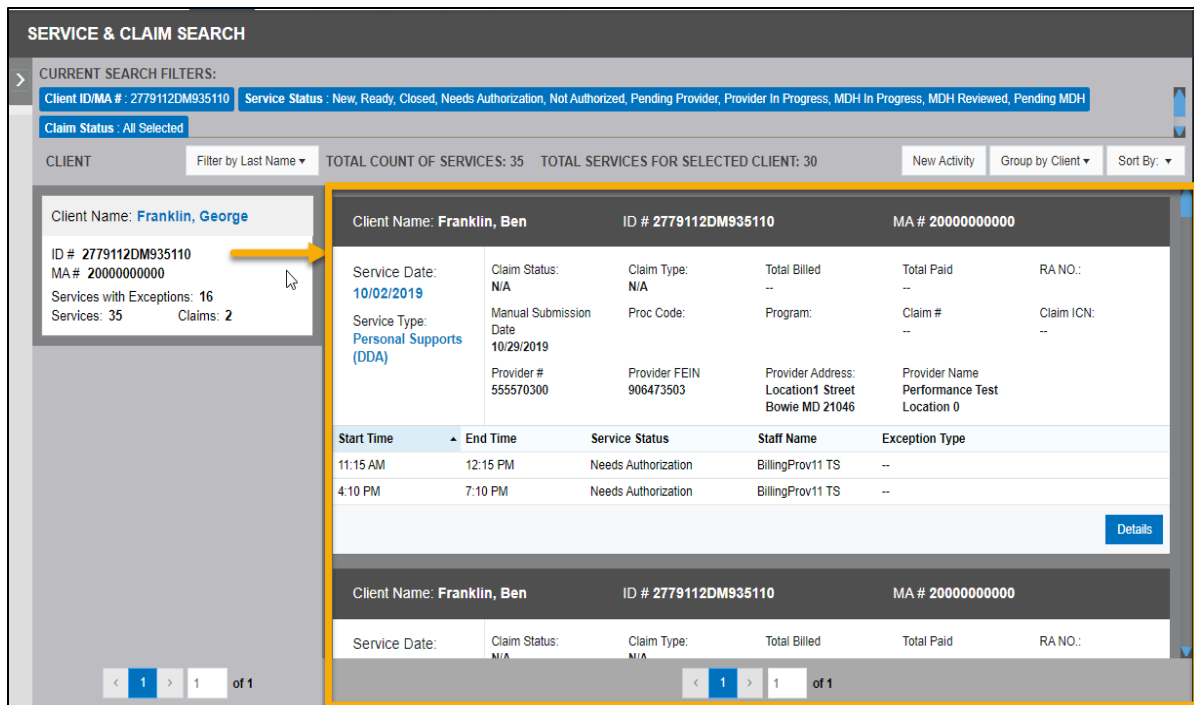
Users may Filter, Group, or Sort search results.

12.3.1 Change Search Results Grouping

The default Client grouping of Service Search results can be modified to view the results in one of the following available grouped views

- Group by Provider to view results based on Provider#
- Group by Staff to view results based on Staff (DSP)
- Group by Service Type to view results based on type of Service
- No Grouping to view results in descending order based on Service Date
- Group by Client return to Client grouping from one of the other views

12.3.2 Filter Search Results by Last Name

- Filter By Last Name according to first letter of the Client's last name

12.3.3 Sort Search Results

Search results can be sorted by the following parameters

- Date of Service to view results in descending order based on Service Date
- Client's Last Name to view results in ascending alphabetical order based on last name of client
- Service Type to view results in ascending alphabetical order based on Type of Service
- Claim Status to view results in ascending order based on status of the service's claim

12.4 Service Date Detail View

The service date details page will display all information regarding services rendered to a client on a service date and the service's associated claims. Agency administrators and billing staff can enter Service Modifications on the service date details page.
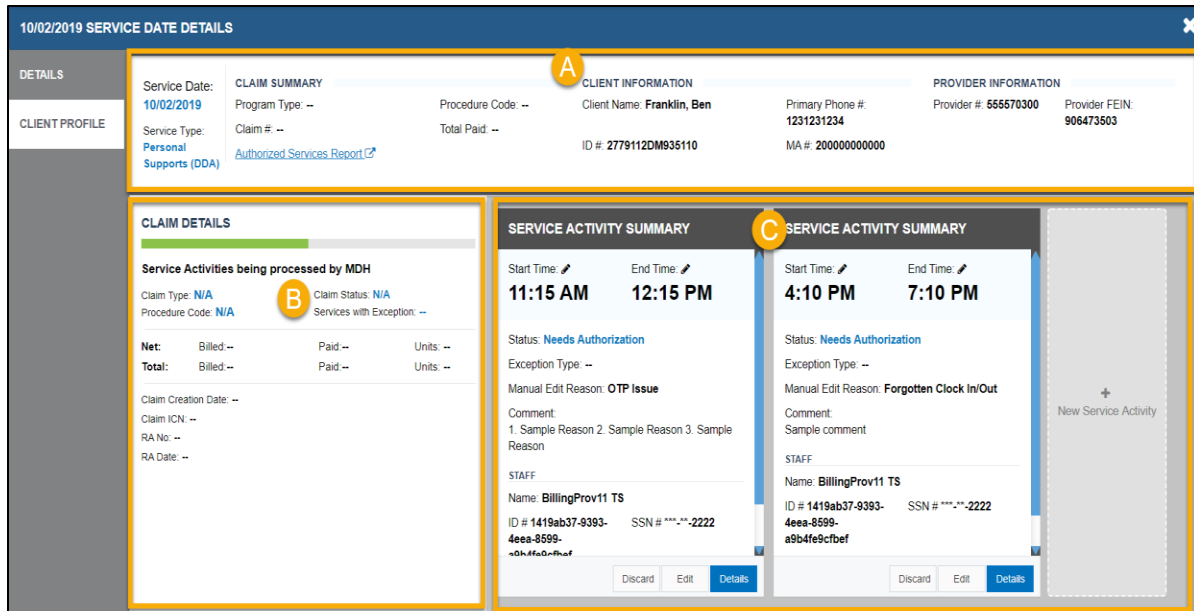
The Service Date Details page is comprised of 3 sections

a. Service Header – This section includes the Date of Service, Service Type, Recent Claim Information, Client Information and Provider Information and Claim information along with the Client's information and Provider Information.

b. Claim Details – If the Services have a claim created, the Claim Details tile displays information on the claim such as Billed and Paid Amounts and Units, ICN, Remittance Number, and Remittance Date

c. Service Details – Each individual shift of service provided by the Agency's staff are displayed as 'Service Activity Summary' cards

12.5 Saved Searches

12.5.1 Saving Commonly Used Searches Parameters

Providers are able to save up to 5 combinations of commonly used Service search filters, using the "Save Search" button on the Search Results page.
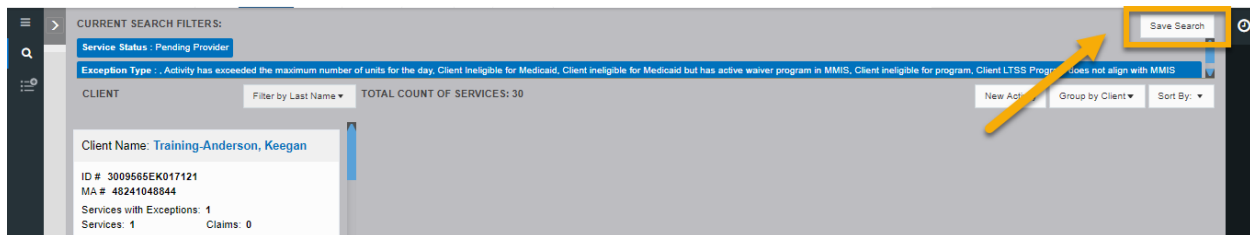
On the pop-up that displays, take the below steps:

1. Enter a Title for the search combination

2. Select a Service Date Range from the Available options

3. Save the Search

SAVE SEARCH FILTERS FOR EVV   ✖

1

Title:*

Pending Services for last month

Service Date Range:*

| Select Date Range |
| Entered Date Range |
| Last Month |
| Current Month |
| Last 30 Days |
| Last 14 Days |
| Last 7 Days |
| Last 2 Days |

2

...aximum number of units for the day, Client Ineligible for Medicaid, Client ineligible for Medicaid but ...gible for program, Client LTSS Program does not align with MMIS waiver program, Client LTSS program does not match the service plan, Client not enrolled in a DDA program, Client Overlap, Client Overlap - Different Program, Missing Clock-in, Missing Clock-out, No approved service plan found, Provider # does not have the approved and active Category of Service, Provider # has been suspended, Provider # has been terminated, Provider has exceeded the maximum authorization for the month, Provider is not approved to provide services to a minor, Provider not authorized for the service, Staff Overlap - Different Provider, Staff Overlap - Different Provider, Different Program, Staff Overlap - Same Provider, Staff Overlap - Same Provider, Different Program

3

Cancel   **Save**

12.5.2 Performing a New Search from Saved Search Parameters

Saved Search Filters can be used   anytime to complete a new search by selecting the Saved Search Filters on the bottom of the Search Panel and selecting the search to perform from the list of saved parameters.

On the pop-up that displays,

1. Expand the Title of the Search to view Saved Search combinations

2. Select Search to perform a new search and get updated results for the saved search filters
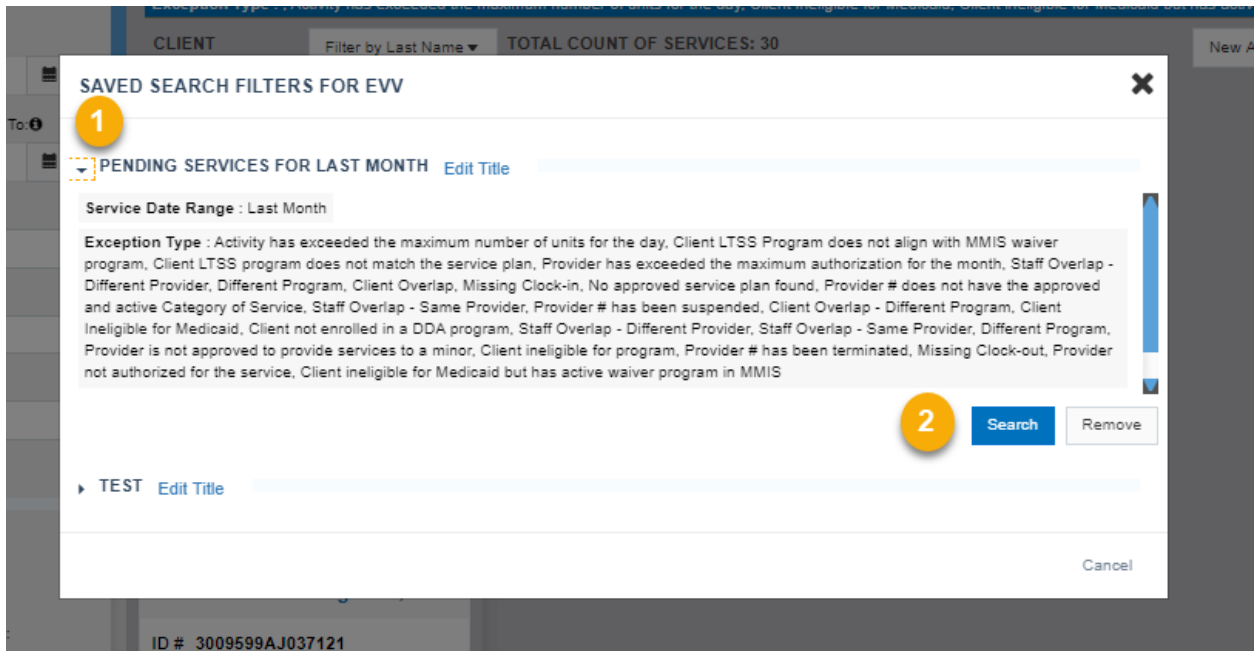
Alternatively, users can remove a saved search from this popup using the "Remove" action or edit the title of a Saved Search using the "Edit Title" action. Search combinations that are not required anymore, or those that was incorrectly added can be removed, and a new Search combination can be saved in its place (up to a maximum of 5 searches).

13. Service Modification (SM)

A Service Modification occurs any time a service entered through IVR system needs to be modified/ changed. A modification can be submitted as a new service, as an edit to an existing service, or as an edit to a service with an associated claim. All SM's must reflect the EXACT date, time and reason for the modification. All modifications submitted that do not reflect accurate information can be considered fraudulent billing.

The following users can complete service modifications -

- Admin Provider
- Billing Provider

13.1 Different Types of Service Modifications (SM)

Missing Time Request (MTR) – If a staff provider is unable to Clock in AND/OR out for a service an administrative or billing staff can submit an MTR through the Provider Portal.

Adjustment: If the service has an associated closed claim for that date but the agency finds an error, Provider can submit an adjustment.

13.2 Service Modification (SM) Policies

DDA policy allows each DSP to have up to 6 unexcused SMs for the month; both MTRs and adjustments. After 6 SMs MDH will review each clock-in and clock-out request for the rest of the month. Each clock-in and clock-out missed is considered as 1 request. Missing Clock-In = 1 Request
- Missing Clock-Out = 1 Request
- Missing Clock-In AND Missing Clock-Out (entire service) = 2 Requests

13.3 Missing Time Request (MTR) Monthly Deadline

Missing Time Requests are due two (2) business days after the end of the month in which the service was performed, unless DDA sends out guidance stating otherwise. All notifications can be found on the home page of Provider Portal.

13.4 Missing Time Request (MTR) Submission Process

DDA will only review MTRs that are submitted with specific information about the details of the MTR. Submissions without this information will not be reviewed. Before submitting MTRs, the Agency Administrator or Billing staff should make sure to communicate with the DSP and when appropriate, the Person's CCS Coordinator. Once the Administrative/Billing staff has the correct and exact reasoning for the missed time, they can add the MTR.

There are two key scenarios related to MTR process:

1. Provider has to add an entire Service (i.e. both clock in and clock out) to the system (Full MTR)

2. DSP has missed either the clock in or clock out for a Service i.e. a partial Service exists in the system (Partial MTR)

13.4.1 Full Missing Time Requests (MTR)

In the Services tab, there are two ways for adding a full Service that wasn't added through the DDA call in system.
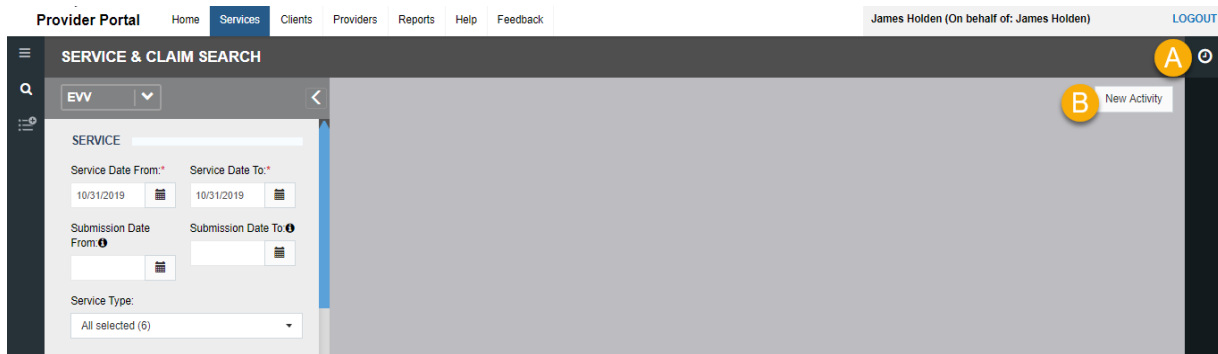
a. Click on the clock icon located in the upper corner on the right panel

Navigation: Home Page ⮞ Services ⮞ Clock icon

    i. Note: User can easily access the icon at any moment they are in the Services tab. For instance, user is viewing the details of a Service and wants to add a missing time for another date / client. The user can quickly select this icon and enter details for the new missing time. Once done, they can revert to the original task at hand without changing screens / pages

b. In the Service & Claim Search page, Click on "New Activity" button on the upper right-hand corner

Navigation: Home Page ⯈ Services ⯈ New Activity (button)
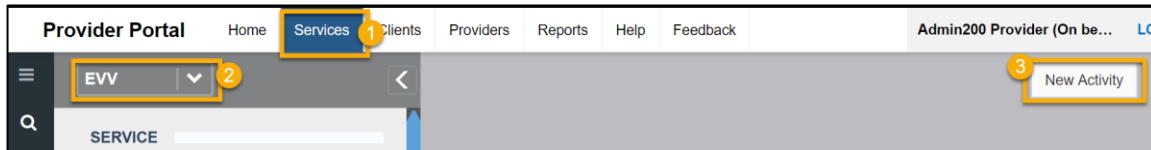
1. Enter the required information to ensure there is not an existing service for the specific time/date or a closed claim, and click on 'Check for Existing Services'
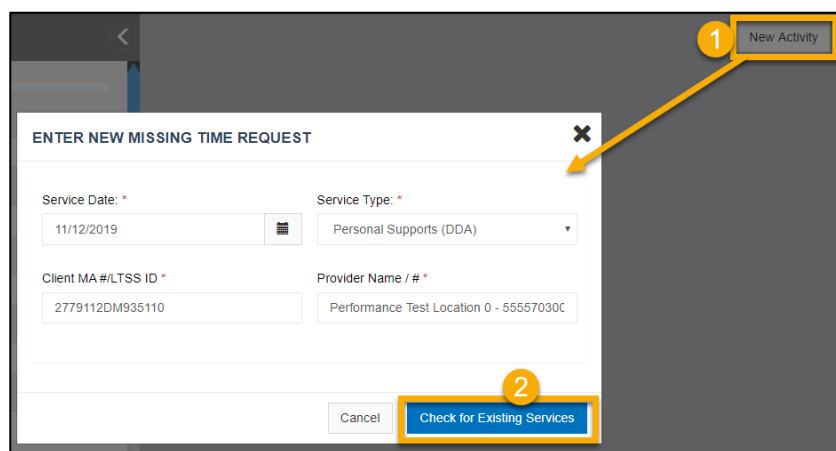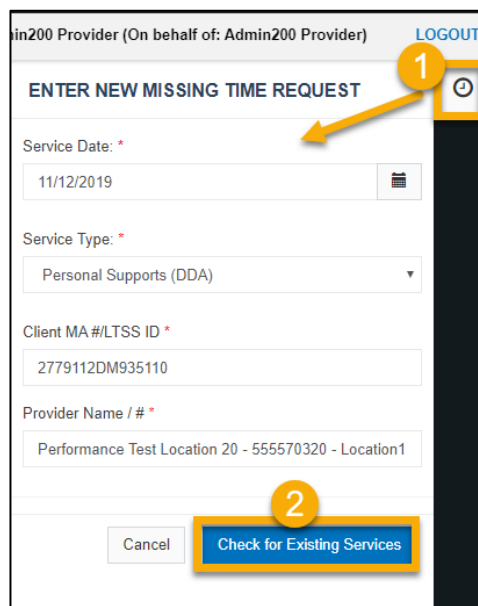
a. If a service exists for the client on this date, you will receive the following message. Click on the Hyperlink to view details of the existing services to add or modify times

ENTER NEW MISSING TIME REQUEST ✖

Service Date: *

10/01/2019 📅

Service Type: *

Personal Supports (DDA) ▼

Client MA #/LTSS ID *

2779112DM935110

Provider Name / # *

Performance Test Location 0 - 555570300

> **Service exists for the entered combination. Please review or edit your clock in and out times from the Claim Detail Page ⤢**

Reset Cancel **Check for Existing Services**

b. If there are no pre-existing services for the client on this date, you will be prompted to complete the service information

3989988HC032120   Performance Test Location 99 - 555570309

> No existing services found for this date. Please enter the additional service information below.

SERVICE INFORMATION

Start Time: *   🕐

End Time: *   🕐   ☐ Next day Clock-out

Manual Entry Reason: *   ▼

IVR Call#:

Comment: *   Your comment here..

Provider: **Performance Test Location 99**
                 Personal Supports - 2O
                 Location1 Street
                 Columbia MD 21046

Client Name: **Andrew Jackson**

Staff Name: *

Staff ID#:

Staff SSN:

Staff Phone:

Reset Cancel **Submit**

Once the information is accurately entered and submitted, a notification will appear in the upper right-hand corner:

YOU HAVE SUBMITTED A SERVICE ACTIVITY!
The new Service Activity has been submitted successfully.
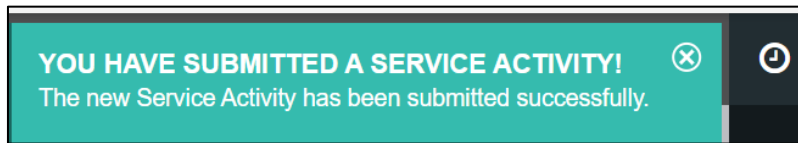
Note: DDA will be required to review MTRs added by Providers who have exceeded the 4 points limits for that DSP within that month of service.

13.4.2 Partial Missing Time Requests (MTR)

1. Review the "Resolve by Provider" header under Actions Required section. This area will notify the agency of all missing times that need to be resolved

2. Select either Missing clock in or Missing clock out by clicking on the blue number count

   a. Missed-clock-in: Staff Provider (DSP) used IVR system to clock-out, but the clock-in was missed due to technical error or staff forgetting the clock-in
   b. Missed-clock-out: Staff Provider (DSP) used IVR system to clock-in, but the clock-out was missed due to technical error or staff forgetting the clock-in

▾ RESOLVE BY PROVIDER

   ▾ EVV SERVICES

Exception Type	Pending	In-Progress	Total
Provider not authorized for the service	30	0	30
Staff Overlap - Same Provider	28	0	28
Client LTSS Program does not align with MMIS waiver program	59	0	59
Provider has exceeded the maximum authorization for the month	73	0	73
Missing Clock-out	119	0	119

3. All open missing clock ins (or outs) will appear in the Search results. Click on a tile with a client name to view all Services for the client with a missing clock in (or out)

Client Name: **Franklin, Ben**

ID # **1649299LC730120**
MA # --

Services with Exceptions: **9**
Services: **9**   Claims: **0**

4. Click on "Details" to open the service date details

5. Click "Edit" on the Service for which missing time has to be entered

6. Enter the missing clock in (or out) information:
   a. If the clock out time is after midnight, you will need to select the "Next Day Clock-out" box
   Note: DDA will only review MTRs that are submitted with detailed comments (See Section 13.5 for guidelines on modification reason)

7. Enter the "Service Call #" This is the phone number that the staff attempted to call in from. If the staff did not call into the ISAS system, then a phone number does not need to be entered

8. Write in the comment box all additional required information
   a. Review the Service Modification Category guide (Refer to Section 13.5) and determine the best main category. Then write it into the comment box

9. Once the information is accurately entered, click the Save button

10. Then, click "Submit Services" button

11. This confirmation will pop up in the upper right-hand corner:

YOU HAVE SUBMITTED ALL SERVICE ACTIVITY! ⊗
Please wait 5 to 10 business days for MDH's review.

13.5 Service Modification Reason

When submitting MTRs, the Agency Administrator and Billing Staff must submit a valid MTR Reason. Submissions without the manual entry reason information will not be reviewed.

a. Review the Service Modification Category guide in <u>section 13.6</u> and determine the best main category. Then select that category from the "Manual Entry Reason" drop down menu

b. Enter the "Service Call #" This is the phone number that the staff attempted to call in from. If the staff did not call into the ISAS system, then a phone number does not need to be entered

c. Review the SM Category Guide and determine the best sub-category for your MTR. Then write it into the comment box.
Note: The sub-category must be selected from the list where the main category that was selected

d. Write in the comment box all additional required information
Note: In some cases, it is required that you work with the Participant's CCS Coordinator.
For Example: If the OTP token is missing or broken and needs to be replaced

Manual Entry Reason: *	OTP Issue ▼
IVR Call#:	
Comment: *	1. OTP Broken 2. SPA Adam Smith notified on 10/1/2019 3.

13.6 Service Modification (SM) Category Guide

STEP 1 Main Category Select a Manual Edit Reason from the drop-down menu in Provider Portal	STEP 2 Subcategory Choose 1 Description that best fits the request and write-in	STEP 3 Additional Information Write in additional required information	Example This is how the MTR should be written
Forgotten Clock-in/out	● Additional Information not required (NA)	● Additional Information not required	Forgotten clock in/out 1. NA 2. NA
Staff busy with Participant	● Non-emergency	● Additional Information not required	Staff Busy with Participant 1. Non-emergency 2. NA
Participant Phone Problems	● Broken ● Out of Minutes	● Date SPA was notified	Participant Phone Problems

	● No reception	● Name of CCS Coordinator contacted ● Other important information	1. Broken 2. CCS Coordinator John Doe was notified on 11/13/2017
ISAS Call Incomplete	● Entered wrong information ● Hung-up before the call was recorded	● Additional Information not required	ISAS Call Incomplete 1. Entered wrong information 2. NA
OTP Issue	● Waiting on a new OTP ● OTP is broken ● OTP is missing/lost ● OTP is not displaying correct numbers	● Date CCS Coordinator was notified ● Name of CCS Coordinator contacted ● Other important information	OTP Issue 1. OTP is Broken 2. CCS Coordinator John Doe notified on 11/13/2017
Correcting Staff Clock in/out Error	● Selected wrong service ● Clocked in/out twice ● System confirmed the wrong time ● Accidentally clocked out at the wrong time ● Provider should not have billed for services – returning funds	● Additional information not required (NA) unless you are returning funds, please describe the situation	Correcting Staff Clock in/out error 1. Selected wrong service 2. NA
Emergency Situation	● Could not clock in/out – Went with Participant to emergency room ● Provided additional hours exceeding the units approved by DDA	● Date CCS Coordinator was notified/hours were approved ● Name of CCS Coordinator contacted ● Other important info, if available	Emergency Situation 1. The Person had to go to the Emergency room 2. CCS Coordinator John Doe was notified on 11/13/2017
ISAS call-in System Outage *Note: The ISAS team will announce outages*	● Additional Information not required (NA)	● Additional Information not required (NA)	ISAS Call-in System Outage 1. NA
New or Substitute Staff	● Staff did not understand how to use the ISAS call in system ● Staff did not have the necessary information to clock in/out	● Additional Information not required (NA)	New or Substitute Staff 1. Staff did not understand how to use the IVR call-in system 2. NA

Other	● A unique situation that is not covered in other categories Note: All MTRs submitted under this category require more research and could experience a delay	● Briefly explain the situation	Other 1. Describe the situation

Note: For remote services, when authorized please use the "Other" category, and include the language "[COVID-19 Remote]"
- Example:
  - Manual Edit Reason: Other
  - Comment:
    - 1. [COVID-19 Remote]
    - 2. Staff prepared a meal in advance and delivered it to the client's home
- Remote services must be entered the day after service was provided, the system will not allow manual services to be entered for the current date.

For additional details, please see the ISAS Service Modification Guide posted on the DDA website.

13.7 Editing a Service

This section describes how services can be modified after they were entered through the IVR system or Provider Portal. Users with the below roles can edit services

- Admin Provider
- Billing Provider

Only services in the following workflow statuses can be edited by Providers (Refer Appendix C for a definition of workflow statuses)

- New
- Provider In Progress
- Pending Provider
- Needs Authorization
- Closed

Note that services in a 'Closed' status have an associated claim to Medicaid and can only be edited once the claim has been returned as Paid or Rejected (see section 15.2). A service in the "Closed" status cannot be edited if it has a claim that is still in adjudication by MMIS, identified through the "Submitted to MMIS" claim status displayed on the left-most card for "Claim Details."

Navigation: Home Page ⬜ Services ⬜ Search EVV Services ⬜ Select a Service on Search results ⬜ Details

1.   Select Edit on the Service to be modified from the Service Date Details page
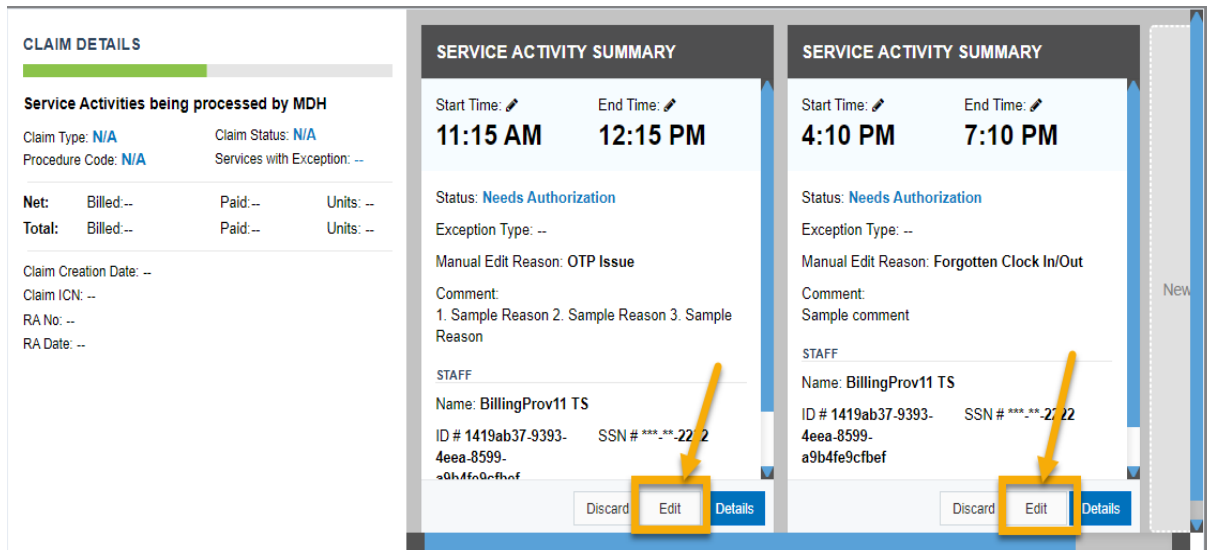
2. Modify the necessary information

   a. Modify the Start time by clicking on the clock icon
   b. Modify the End time by clicking on the clock icon
   c. Enter a valid Manual Edit reason by selecting from the dropdown options
   d. Enter required comments
   e. Click on Save
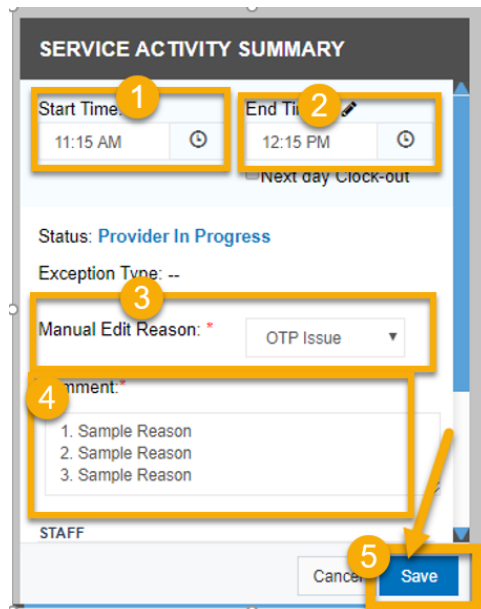
3. Located on the bottom right hand of the summary page is a "Submit Services" button, this button MUST be selected in order to submit the service for DDA for review and approval
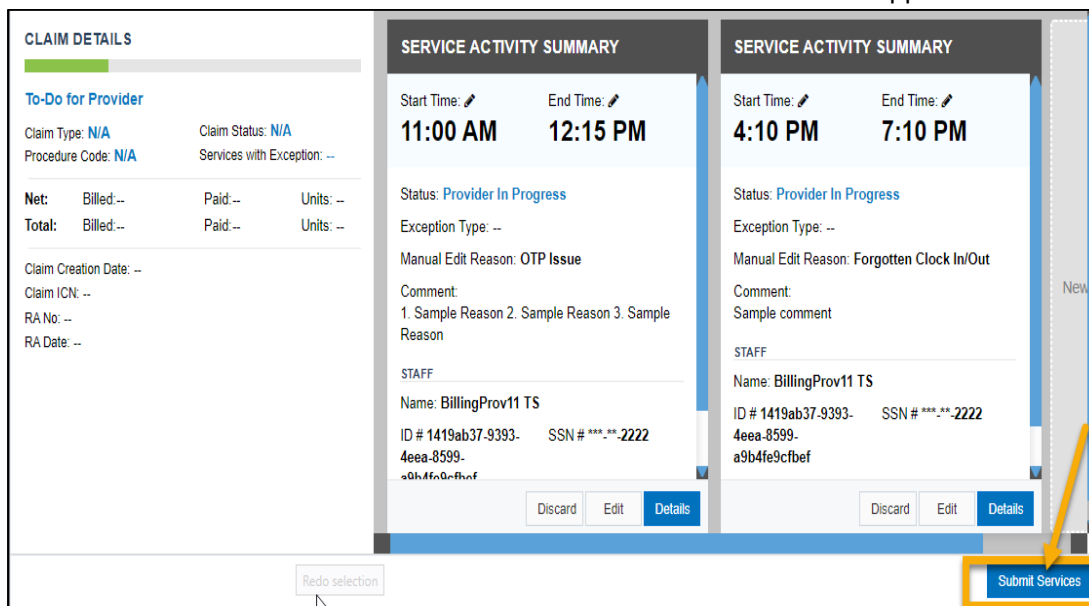
4. The service is assigned a workflow status of "Needs Authorization" and is ready to be processed by DDA
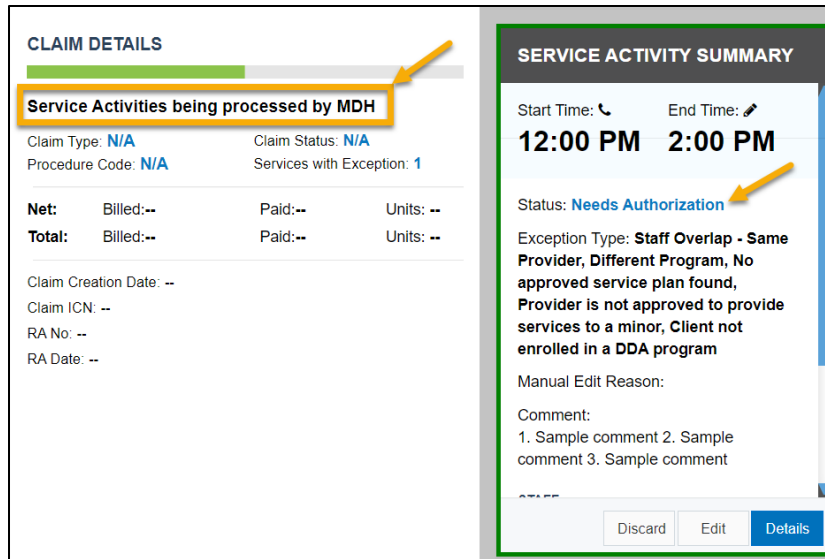
13.8 Discarding a Service

Providers with below roles can discard a service to prevent it from being billed.

- Admin Provider
- Billing Provider

Only services in the following workflow statuses can be edited by Providers (Refer Appendix C for a definition of workflow statuses)

- New
- Provider In Progress
- Pending Provider
- Needs Authorization

Note that discard is an option only until a claim is processed for the service. Once billed to Medicaid, providers can no longer discard the service, but they may void a service (see section 15.3) to have the payment for the service deducted through an adjustment

Navigation: Home Page ▢ Services ▢ Search EVV Services ▢ Select a Service on Search results ▢ Details ▢ Service summary

Discard an EVV service:
1.   Navigate to the Service Date Detail page
2.   Select "Discard" button located on the bottom of the Service Activity Summary tile

3. Enter comment explaining why the service is being discarded

4. Select "Discard" button
5. The service is now Discarded

To view a discarded service

1. Within "Service and Claims Search" in the "Services" area, select the date range of the discarded Service and then select the value "Discarded" in the drop down of "Service Status"
2. Select "Search"
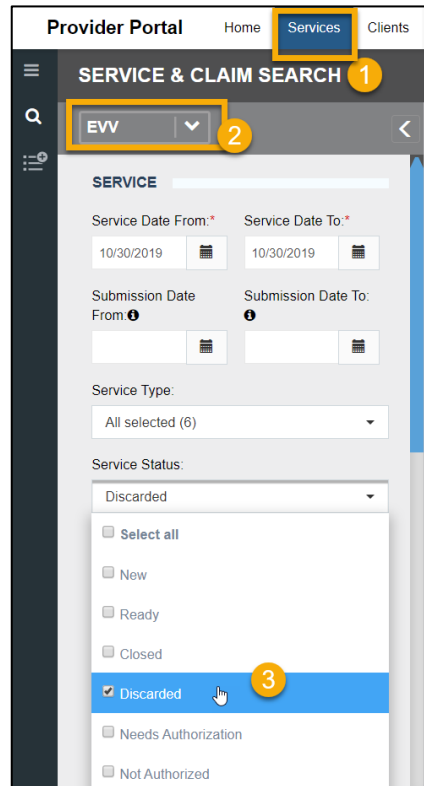
3. Select "Details" for the Service from the Search results.

4. The service details page will display all services including the "discarded" services
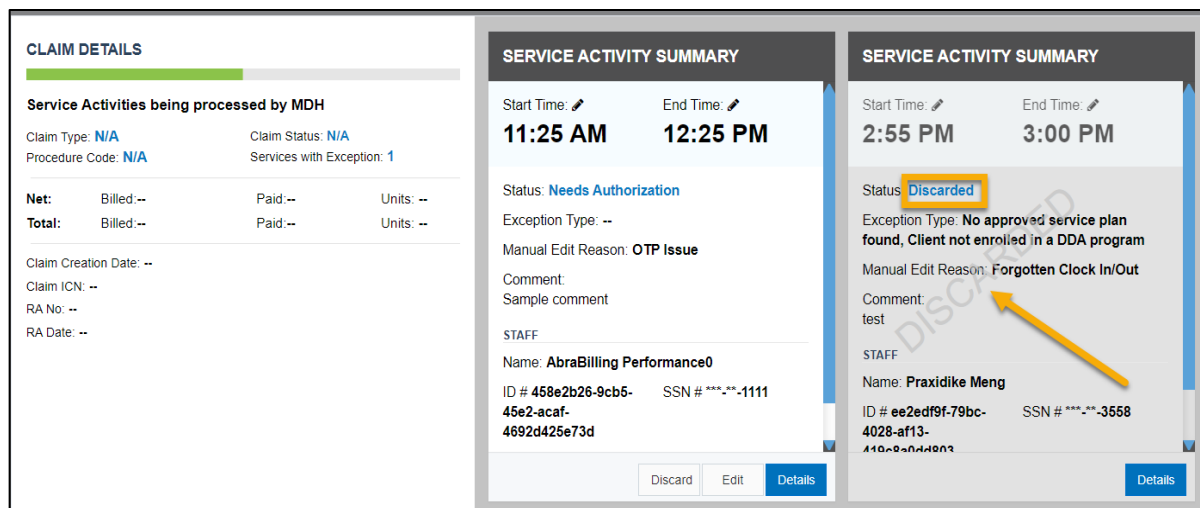
14. Exceptions in EVV Services
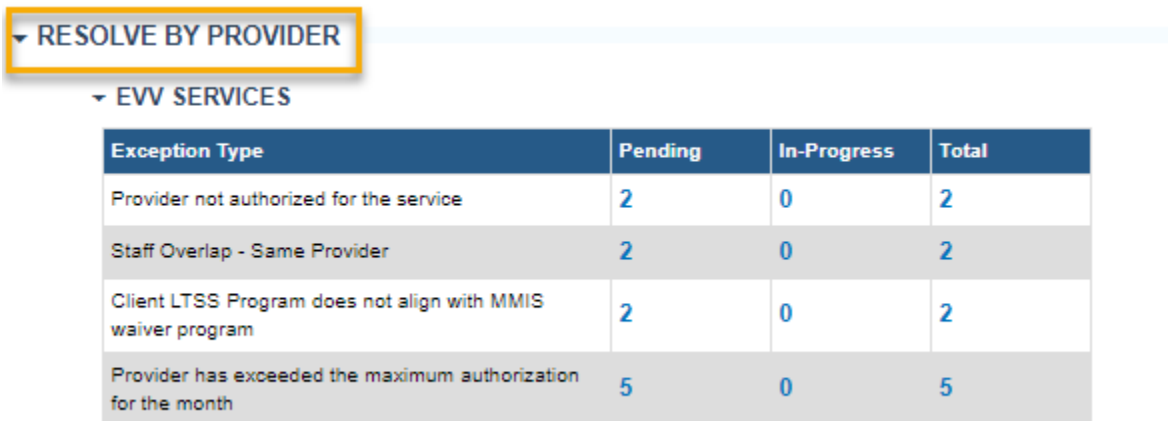
14.1 How to View Exceptions

The pending counts section in the Home Page Actions Required section on the Home shows the counts of services that are pending for each exception type.

Exceptions may also be viewed by searching via the Services tab and entering search parameters for the exception.

14.1.1 Pending Exceptions for Provider Resolution

This section lists the exceptions that Provider is Responsible for fixing or those that need coordination with the CCS. Exception counts are categorized into count of services that are either "Pending" or "In Progress", along with a Total count. Pending column summarized the number of Services with the exception that are yet to be acted upon by the Provider, and the In-Progress column summarized number of services with the exceptions   that are currently being worked on by the provider.

Exception Type	Pending	In-Progress	Total
Provider not authorized for the service	2	0	2
Staff Overlap - Same Provider	2	0	2
Client LTSS Program does not align with MMIS waiver program	2	0	2
Provider has exceeded the maximum authorization for the month	5	0	5

Depending on the services the Provider Agency renders, there can be one or both of below sections:

- EVV Services- Exceptions on EVV services to be resolved by the Provider internally or by contacting the CCS, summarized as a total count per exception type
- Non EVV Services – Exceptions on Non-EVV services to be resolved by the Provider internally or by contacting the CCS, summarized as a total count per exception type

Only exceptions for dates of service up to 1 year in the past are displayed in this section, as claims are accepted by MMIS for only up to a year from the date of service.

The counts in the table are hyperlinks, which redirect to the Services Search Results page which lists the services comprised in the count.

14.1.2 Pending Exceptions for MDH Resolution

This section lists the exceptions that will be resolved by DDA

Depending on the services the Provider Agency renders, there can be one or both of below sections

- EVV Services- Exceptions on EVV services to be resolved by DDA, summarized as a total count per exception type
- Non EVV Services – Exceptions on Non-EVV services to be resolved by DDA, summarized as a total count per exception type

Only exceptions for dates of service up to 1 year in the past are displayed in this section, as claims are accepted by MMIS for only up to a year from the date of service.

The counts in the table are hyperlinks, which redirect to the Services Search Results page which lists the services comprised in the count.

Exceptions may also be viewed by searching via the Services tab and entering search parameters for the exception

14.2 EVV Exception Types

Agency Providers are responsible for preventing and resolving these types of issues:

- *Missing Clock In*: A Staff Provider fails to use the IVR telephonic system to record the start of a service
- *Missing Clock Out*: A Staff Provider fails to use the IVR telephonic system to record the end of a service
- *Staff Overlap - Same Provider*: This occurs when the Staff Provider is clocked in for more than one Person at the same time
- *Staff Overlap - Same Provider, Different Program*: This occurs when the Staff Provider is clocked in for more than one Person each of different programs at the same time
- *Activity has exceeded the maximum number of units for the day:* This occurs when the number of hours/units on the Service exceeds the maximum daily cap for the specific service type
- *Client Overlap*: This occurs when two or more Staff Providers were clocked in for the same service for the same Person at the same time through the same agency
- *Client Overlap – Different Program*: This occurs when two or more Staff Providers were clocked in for different service for the same Person at the same time through same agencies
- *Provider has exceeded the maximum authorization for the month:* This occurs when provider has billed for more than the authorized units of service for the month. If units are incorrectly entered, Provider may correct the units and resubmit. If additional units of service were provided for a valid reason, Provider must contact CCS to amend the PCP

- *Provider # does not have the approved and active Category of Service*: This occurs when the Agency Provider does not have the approved category of service to provide services to a Person
- *Provider is not approved to provide services to a minor:* This occurs when the Agency Provider does not have the approved category of service to provide services to a Person who is a Minor

Agency Providers should contact the Person's CCS Coordinator about these issues:

- *Client not enrolled in a DDA program:* This occurs when the Person receiving services is not enrolled in a DDA Program
- *No approved service plan found:* This occurs when the Person receiving services does not have an approved and active Person-Centered Plan on the Date of Service
- *Provider not authorized for the service*: This occurs when the Agency provider is not on the Person's Person-Centered Plan
- *Client Ineligible for Program:* This occurs when the Person receiving services does not have an active DDA waiver program in Medicaid on the date of service
- *Client LTSS Program does not align with MMIS waiver program:* This occurs when the Person's enrolled program in LTSS does not match with the waiver approved in MMIS
- *Client ineligible for Medicaid*: This occurs when the Person receiving services is not Medicaid Eligible
- *Client ineligible for Medicaid but has active waiver program in MMIS:* This occurs when the person is ineligible for Medicaid, but has an active waiver program in MMIS but has a waiver program approved by MMIS
- *Client LTSS program does not match the service plan:* This occurs when the Person's LTSS Program does not match with what is on their Person-Centered Plan

Agency Providers should contact DDA about these issues:

- *Staff Overlap - Different Provider, Different Program*: This occurs when the same Staff Provider was providing different program services to two different Person's at the same time through two different agencies
- *Staff Overlap - Different Provider*: This occurs when the same Staff Provider was providing same program services to two different Person's at the same time through two different agencies
- *Client Overlap*: This occurs when two or more Staff Providers were clocked in for the same service for the same Person at the same time through different agencies
- *Client Overlap – Different Program:* This occurs when two or more Staff Providers were clocked in for different service for the same Person at the same time through different agencies

14.3 Overlap Service found for the same provider

Agencies are responsible for resolving Overlap services found for the same provider. This occurs when a staff provider is clocked in for 2 different Persons from the same agency at once. If the agency does not resolve the Overlap Exception, the agency will not be paid for the overlapping services. The agency must edit the services so that they no longer overlap and submit the revisions to DDA for review and payment.

Example:

Staff Overlap – Same Provider

Staff Provider: Jane Doe Agency: Personal Home Care
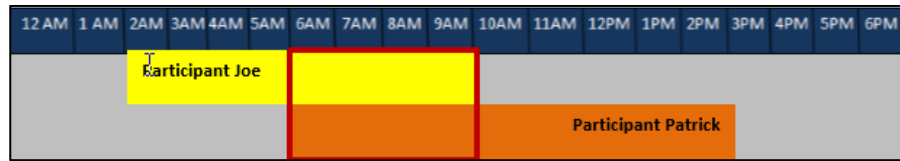
Staff provider Jane Doe is clocked in for two Persons at once from 6:00 AM – 10:00 AM. This is considered double billing and is against state policy. The agency must resolve the overlap in order to receive reimbursement for the service.

14.4 What can Cause an Overlap

There are many circumstances that can cause an overlap. Here are some examples:

- Malfunctioning OTP device
- Staff provider entered the OTP code incorrectly
- A staff provider is to provide another service but instead accidentally clocked in for both parties as personal support services
- The second staff provider clocked in before the first staff provider clocked out
- A staff provider forgot to clock out for their first participant and began providing care for the second participant
- Staff accidentally clocked in and out twice
- Fraudulent behavior/intentional double billing

14.5 Resolving Overlaps

Overlaps can be resolved by updating the start and/or end time of Services that overlap or by discarding a conflicting Service / Shift.

1. Services that have overlap exception can be viewed by selecting the count for the relevant exception in the "Actions" section of the home page
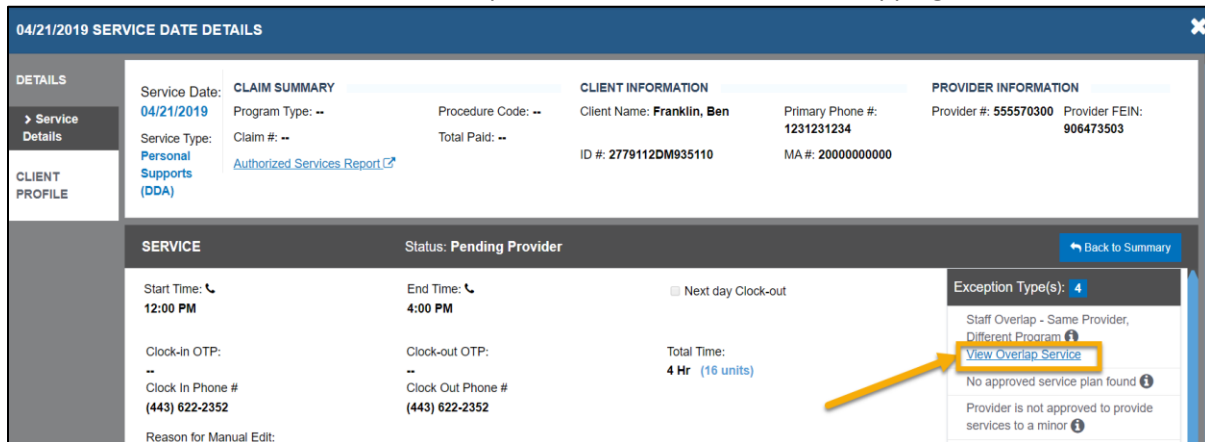
2. System takes user to the Services and Claims search page and displays the list of Services with Overlap exception
3. Click details from the search result to see all Service Services / shifts that are a part of the claim group
4. Once the overlapping service is located, click the details button to open details of the service. Then click the blue "View Overlap Service" link to view the overlapping information

a. This will open the connected overlapping service in a new tab, so that the two services can be reviewed side by side
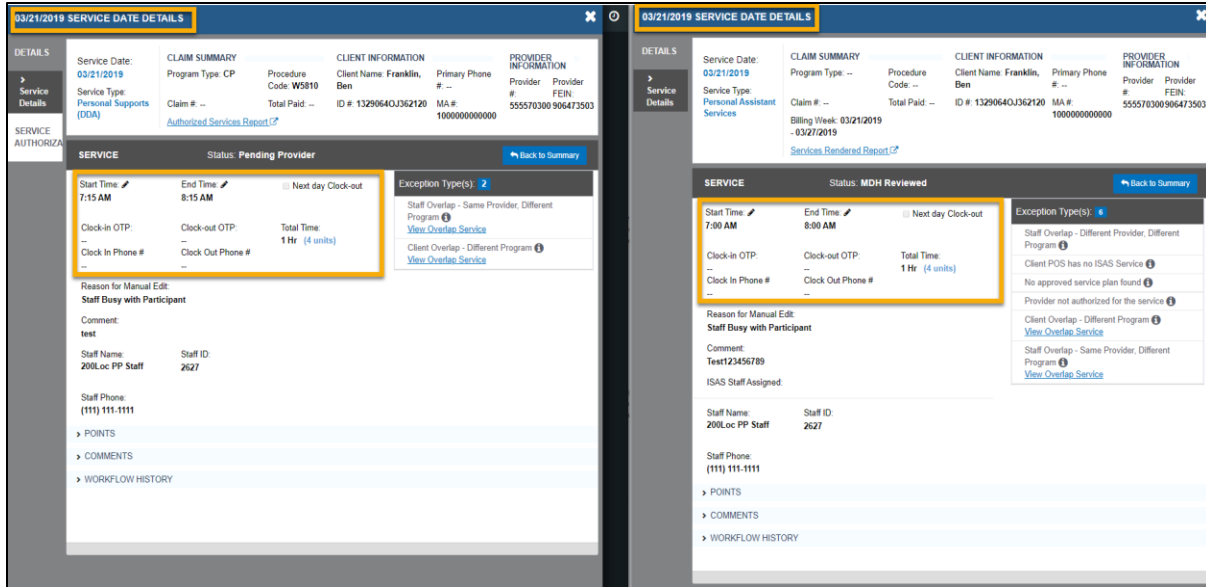
5. To edit or discard a Service that has Overlap exception, click "Back to Summary" button on the Service which you want to edit / discard
   a. This will display the Service Date details page
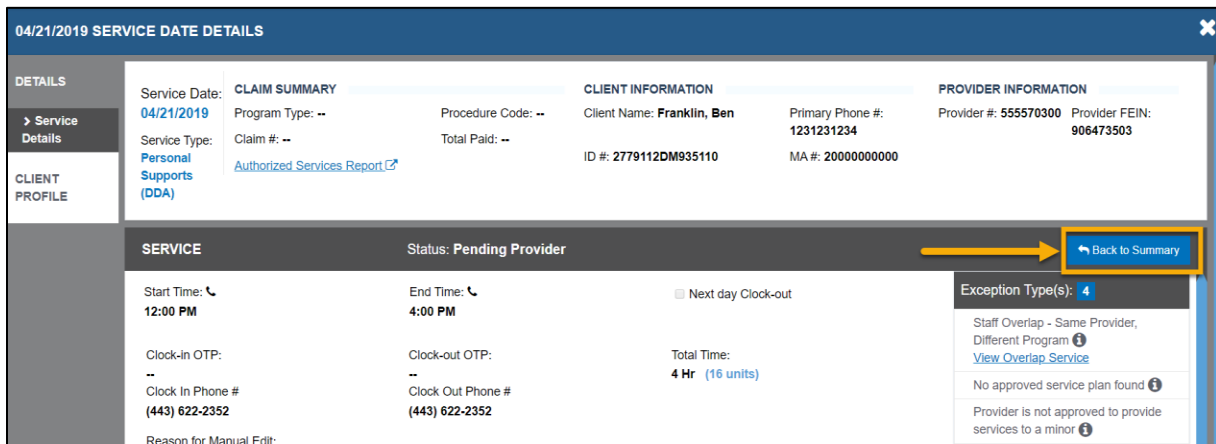
6. Select Edit or Discard button on the Service, based on the action you want to perform. [Refer Section 13.7 & Section 13.8]

Option 1: On selecting "Edit" button, the service will be available for editing. [Refer to Section 13.7]

     a. A reason for the manual edit will need to be submitted. The reasoning option will follow the Service Modification (SM) policy

     b. Once the service has been edited to the accurate time and the correct reason has been entered, click the "Save" button in the lower right-hand corner

     c. Located on the bottom right hand of the summary page is a "submit" button, this button MUST be selected in order to submit the service for DDA review

Option 2 – Discard: [Refer to Section 13.8]

15. Adjusting Paid or Rejected EVV Services

Once a Service has been processed MMIS (i.e. Paid or Rejected), users may still have the need to make changes to the Service. Such changes are referred to as "Adjustments". Examples of adjustments include:

- Modifying the duration of an existing Service, adding a new Service to the claim, and/or voiding a Service
- Voiding one / more Services in a claim will negate the payment received for its duration in the claim
- Voiding all Services in a claim will negate the payment received for the entire claim.

Following Providers roles can adjust EVV Services:
- Admin Provider
- Billing Provider

Adjustment Deadline

Adjustments can be submitted up to 365 days after the Date of Service of the claim. However, when submitting an adjustment, please keep in mind that the DDA team will review and approve the changes. Therefore, please submit the adjustments 14 business days prior to the deadline to ensure your request is resolved before the deadline.

15.1 When to submit an MTR or Adjustment

The Adjustment and Missing Time Request policies are solely based on whether there is a CLAIM or NO CLAIM for the specific date.

- If a claim exists for the specific date – Submit an adjustment
- If a claim does NOT exist for the specific date – Submit an MTR

Note:

1. DDA may assign points to the staff who provided the Service while approving the MTRs / Adjustments. Each Service can be given 1 or 2 points
2. If a staff accumulates the maximum points allowed in a given month, DDA will review any additional MTR / adjustment submitted for that month

Does a claim exist on this date?	Action	Policy	Due date	Max. Cumulative Points Allowed per month	Comment
CLAIM	Add New Service	Adjustment	365 Days	6 Total Points	SM Category Guide
CLAIM	Edit Existing Service (Increase or Decrease)	Adjustment	365 Days	6 Total Points	SM Category Guide
CLAIM	Void	Adjustment	365 Days		SM Category Guide
NO CLAIM	Add New Service	MTR	2 Days after the end of month in which the service was performed	6 Total Points	SM Category Guide
NO CLAIM	Edit Existing Service (Increase or Decrease)	MTR	2 Days after the end of month in which the service was performed	6 Total Points	SM Category Guide

15.2 Adjusting EVV Services

Navigation: Home Page ▯ Services ▯ Search EVV Services with Paid or Rejected Claims ▯ Select a Service on Search results ▯ Details

1. Navigate to the Services tab and search for the claim by entering the relevant search criteria.
2. Click the Details button on the desired Service search results panel from the search results

3. Click on Adjust Services button

4. System will create a new claim details row that appears above the ones already there in the system. Users can make Adjustments in this row
   a. The old claim will move to the row below

5. There are two options to Adjust, based on user's needs. User can perform one or both options, as necessary
   a. To modify the times of an existing Service, select "Edit" button in the Service

b. To enter a new full service, select "New Service Activity"
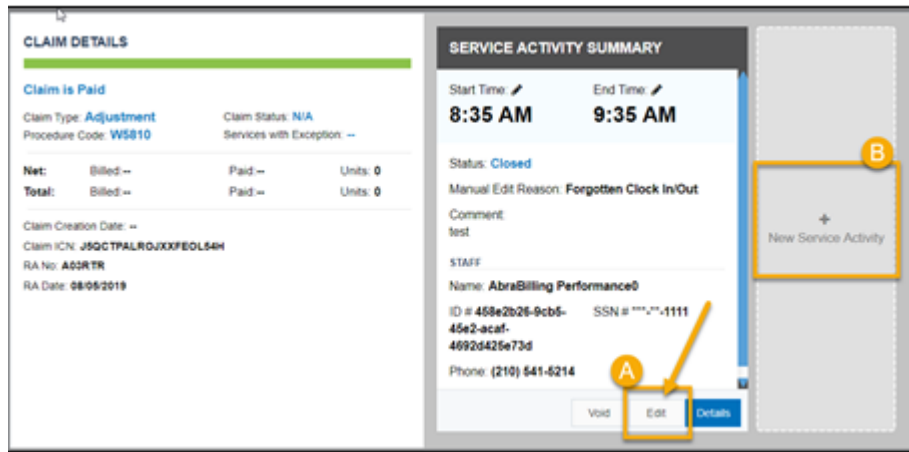
Adjustment by Editing a Service:
1. Once Edit is selected, user can update any of the following values in the Service:
   a. Start Time
   b. End Time
   c. Specify whether the End time is in the following calendar day
2. User has to enter comments before "saving" the changes
   a. Choose comments for Manually Editing the Service
   b. Enter Comments explaining the reason for the change
      i. Note: Follow the format specified in the Service Modification guide while entering comments (refer to Section 13.6).
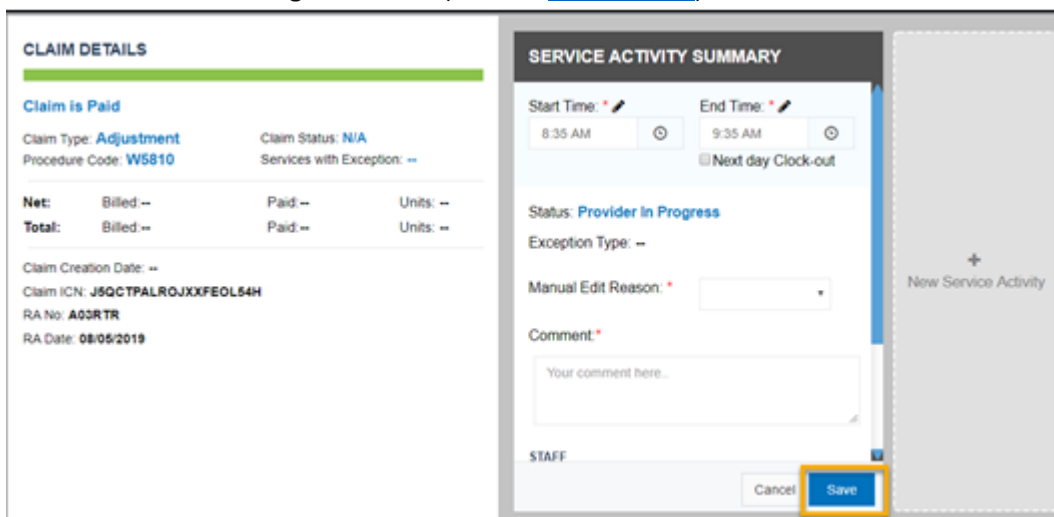
3. User MUST click the "submit Service" button after you are done with the changes. DDA cannot review the services until you have submitted the service. Save is NOT the same as SUBMIT

Adjustment by Adding a New Service / Shift:

1. Once user clicks on "New Service Activity", a new "Service Activity Summary" tile will be created

2. Enter data in all the required fields, including Manual Edit Reason and Comment in the format specified in the specified in the Service Modification guide while entering comments (Refer to Section 13.6 in this user manual)
3. Click Save to save (1) the new Service to the system

4. User MUST click the "Submit Service" (2) button after you are done with the changes. DDA cannot review the services until you have submitted the service. Save is NOT the same as SUBMIT

CLAIM DETAILS

Service Activities being processed by MDH

Claim Type: **Adjustment**   Claim Status: **N/A**
Procedure Code: **W5810**   Services with Exception: **--**

Net: Billed:**--**   Paid:**--**   Units: **--**
Total: Billed:**--**   Paid:**--**   Units: **--**

Claim Creation Date: --
Claim ICN: --
RA No: --
RA Date: --

SERVICE ACTIVITY SUMMARY

Start Time: ✏   End Time: ✏
8:35 AM   **10:35 AM**

Status: **Needs Authorization**

Exception Type: **--**

Manual Edit Reason: **Other**

Comment:
Sample Comments - Increased clock
out time by an hour.

STAFF

Name: **AbraBilling Performance0**

ID # **458e2b26-**   SSN # ***-**-**1111**
9cb5-45e2-acaf-
4692d425e73d

[Void] [Edit] [**Details**]

SERVICE ACTIVITY SUMMARY

Start Time: ✏   End Time: ✏
4:45 PM   **5:45 PM**

Status: **Needs Authorization**

Exception Type: **--**

Manual Edit Reason: **OTP Issue**

Comment:
1. Sample Comment 2. Sample
Comment 3. Sample Comment

STAFF

Name: **AbraBilling Performance0**

ID # **458e2b26-**   SSN # ***-**-**1111**
9cb5-45e2-acaf-
4692d425e73d

[Discard] [Edit] [**Details**]

+
New Service Activity

15.3 Voiding a Service

1. Locate the claim through the "Service and Claim Search" menu located within the Services tab
2. Once the claim is identified, click Adjust Services button located on the bottom of the tile. In the new row that appears, click Void on the service. [Refer Section 15.2]

CLAIM DETAILS

Claim is Paid

Claim Type: **Adjustment**   Claim Status: **N/A**
Procedure Code: **W5810**   Services with Exception: **--**

Net: Billed:**--**   Paid:**--**   Units: **0**
Total: Billed:**--**   Paid:**--**   Units: **0**

Claim Creation Date: --
Claim ICN: **7GH8C2CUZZKHRFLERT6Y**
RA No: **A03RTR**
RA Date: **08/05/2019**

SERVICE ACTIVITY SUMMARY

Start Time: ✏   End Time: ✏
5:00 AM   **7:00 AM**

Status: **Closed**

Manual Edit Reason: **Forgotten Clock In/Out**

Comment:
test

STAFF

Name: **Admin Provider Hinds**

ID # **9174c358-560e-**   SSN # ***-**-
4071-8ff6-
34dd5e3cf275

Phone: **(222) 222-2222**

[Void] [Edit] [**Details**]

SERVICE ACTIVITY SUMMARY

Start Time: ✏   End Time: ✏
8:00 AM   **8:30 AM**

Status: **Closed**

Manual Edit Reason: **Forgotten Clock In/Out**

Comment:
test

STAFF

Name: **Admin Provider Hinds**

ID # **9174c358-560e-**   SSN # ***-**-
4071-8ff6-
34dd5e3cf275

Phone: **(222) 222-2222**

[Void] [Edit] [**Details**]

3. Enter comments in the pop up that appears and click "Void" button
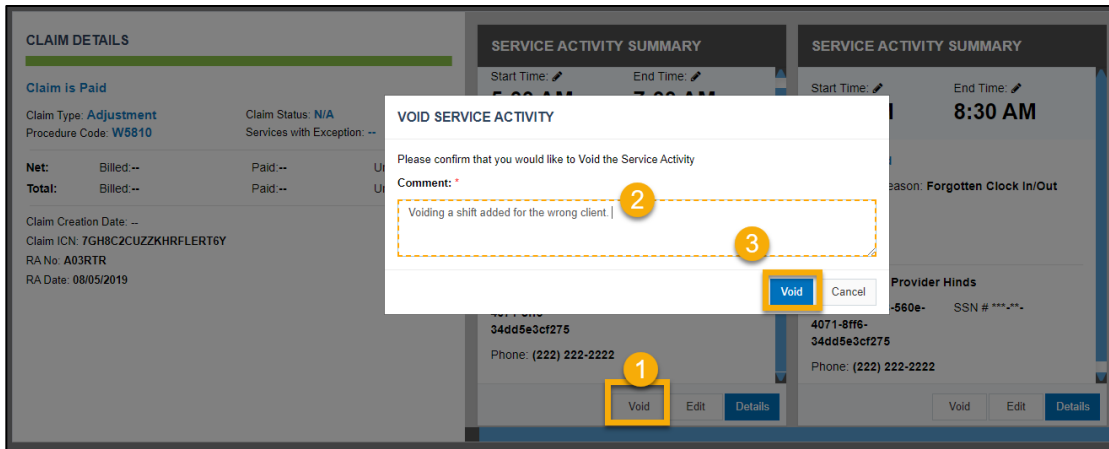
4. System displays a confirmation message
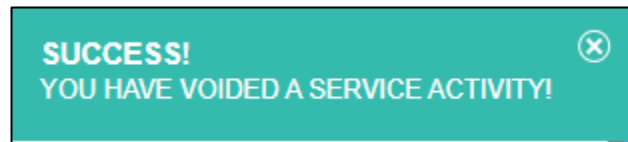
5. Remember to Submit the Service after it has been Voided
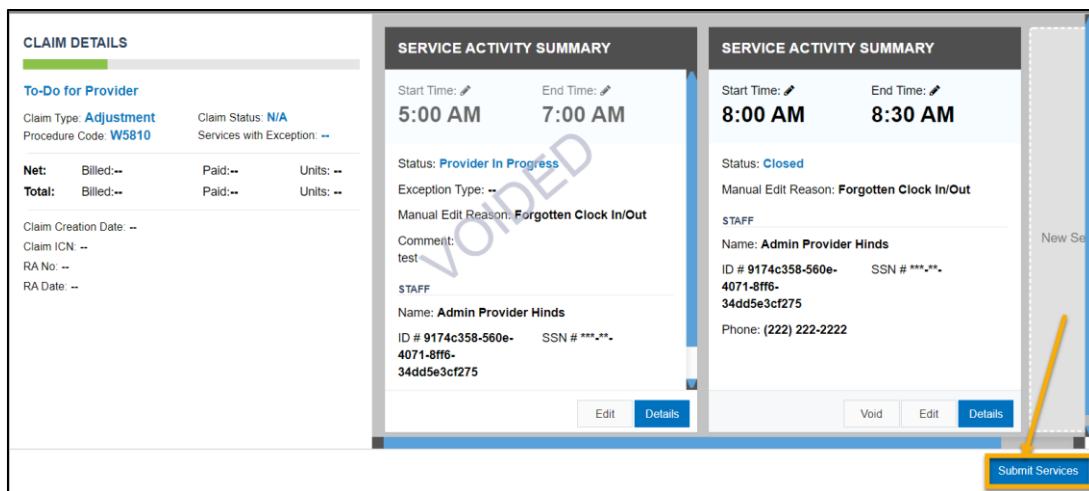
6. Once submitted, status of the Service(s) will change. System will pick the Services for claim creation and the usual process will be followed.

   i. When creating an adjustment claim, system determines if the modifications made on Service(s) result in a change in units from the previous claim. For example, Provider modifies service duration of 2 hours 30 mins to 2 hours 45 mins. Once the change is approved and validated that it is within the authorized units for the month, an adjustment claim is submitted to MMIS to bill for the difference in amount for the additional 15 minutes of time (1 unit) on the service.

   ii. When user voids one or more Services in a claim that has multiple Services, it usually results in a net reduction in units in the adjustment claim. So, the system

will submit an adjustment claim to MMIS for negating the units previously paid. For example, if there were 3 one-hour services/shifts entered for a date and paid, and Provider voids one of the services as it was wrongly inputted, an adjustment claim is submitted to MMIS to reduce billing for the amount corresponding to one-hour or 4 units (since EVV services are billed in increments of 15 minutes)

    iii.   The next section describes how all services to a person on a service date can be voided.

15.4 Voiding all Services in a Claim

If claim was wrongly submitted when service was not rendered to a person on a date, Provider can void the entire payment for that person for a date of service by following the below sequence of steps.

1. Locate the claim through the "Service and Claim Search" feature available in the Services tab
2. In the "Service Date Details" page, click "Void All Services" button in the latest claim row.
   a. Users with the Admin Provider and Billing Provider roles can void services

3. Enter Comments in the pop up that the system displays
4. Click "Void All" button.
   i.   When creating an adjustment claim, system determines if the modifications made on Service(s) result in a change in units from the previous claim
   ii.   When you "Void all Services" in a claim, it results in the units becoming zero in the adjustment claim. So, the system will submit an adjustment claim to MMIS for zero units, so that the payment received earlier could be negated

CLAIM DETAILS

Claim is Paid

Claim Type: **Adjustment**   Claim Status
Procedure Code: **W5810**   Services with

Net:	Billed:**$0.00**	Paid:**$0.00**
Total:	Billed:**$8.00**	Paid:**$8.00**

Claim Creation Date: **08/05/2019**
Claim ICN: **J7JPYW28Z0MTDGON7EHY**
RA No: **A03RTR**
RA Date: **08/05/2019**

SERVICE ACTIVITY SUMMARY

VOID ALL SERVICES

This action will void all closed service activities in the claim. Do you wish to proceed?

Comment: *

②

Voiding Service added for incorrect date.

③ **Void All**   Cancel

Claim Details

ID # **9174c358-560e-
4071-8ff6-
34dd5e3cf275**

SSN # ***-**-

Phone: **(222) 222-2222**

Details

①

Adjust Services   **Void All Services**

Part D – State Invoice Process and Reports

16. State Invoice Process

16.1 What is the State Invoice Process

Sometimes, services are not eligible for payment by Medicaid, but may be paid by the State. A service is eligible for State payment in the following four (4) situations. Note: Not all non-waiver services are eligible for DDA State-Funded Payment. (Refer to the Appendix H for the invoice process for state only payments via LTSS Maryland)

1. Person has a DDA State Funded program enrollment, either through a Court Order Form or through loss of CP waiver eligibility
2. The Service is of a type that is only state funded
3. Person is receiving services through an emergency situation plan (ESP) due to urgent needs, while awaiting waiver enrollment
4. Services provided to a person by more than one Provider has exceeded the waiver limit, but DDA has determined that the additional services were required by the person

The Provider Portal automatically determines if a service is eligible for payment by the state based on the above four conditions, provided the service cleared the authorization and eligibility checks in the overnight processing.

A service that has cleared all other exception checks and has been determined to be eligible for payment from the State is put in the "State Payment Eligible" status.

At the end of every month, all services added or modified in that month for the Provider Agency and have been found to be eligible for state payment, are bundled together to create the Monthly State Invoice for the Provider. This can be viewed and printed for submission to the state by running the State Payment Report once the month has passed.

After a service addition or modification has been included in the State Payment Report, the service status is then updated to "State Payment Reported".

Follow the below steps for the State Invoice Process:

1. Go to the Reports Menu in the *LTSSMaryland* Provider Portal and select to view the DDA State Payment Report
2. Run the report for the previous month (See 16.4 State Payment Report for more details on running this report)
3. Review all information including total amounts and individual service details.
4. Export report to excel. This creates an invoice (first sheet on the excel) that can be printed.
5. Print the invoice and sign at the bottom
6. Submit the invoice to DDA

Submission Address:

Once completed, the signed invoice and supporting documentation should be emailed electronically to: Accounts_payable.dda@maryland.gov

DDA will process and remit payment via EFT if the provider is setup to receive EFT payments. If not, the provider will receive a paper check via mail.

16.2 Searching and Viewing Services that are flagged for State Payment

Services in the "State Payment Eligible" and "State Payment Reported" statuses can be searched for and viewed in the same way as services in any other status (see 8.1 Searching for Entered Services for Non-EVV Services and Section 12.2 Service and Claim Search for EVV Services).

The Service Status search filter allows Providers to look-up all services either determined to be State Payment Eligible and awaiting to be included in the next State Invoice, or to look-up services that have been reported in a previous State Payment Invoice.

Upon Searching for services, and clicking on the "Details" action, the Service Date Details page shows up-to-date information on when the service was reported on the State Payment Report, in the "Last State Payment Reported Month" field. Claim Type, Claim Status and Proc code are Not Applicable to State Paid Services since there is no Medicaid claim associated with a State Payment.

Note: The service and claim statuses are not updated once the State has paid the Provider for the service, as unlike the Medicaid claim remittance information, the state remittance information does not come back to the *LTSSMaryland* Provider Portal

16.3 Modifying State Payment Services

Services in a State Payment Eligible and State Payment Reported status may be modified by the following Provider users

- Admin Provider

- Billing Provider

An EVV service in "State Payment Eligible" or "State Payment Reported" status that is modified and submitted by the Provider goes to a "Needs Authorization" status and needs to be approved again by MDH and clear all the overnight checks again before the modified service can be determined as State Payment Eligible again. For steps on modifying EVV services, see 13.7 Editing a Service.

A Non-EVV service in "State Payment Eligible" or "State Payment Reported" status that is modified and submitted by the Provider goes to a Recorded status and clear all the overnight checks again before the modified service can be determined as State Payment Eligible again. For steps on modifying Non-EVV services, see 8.4 Editing a Service.

Modifications to a service that was previously included in a Monthly State Invoice goes through as adjustments as the payment needs to be increased or deducted from the original amount.

Once a Service is reported in a State Invoice and has the "State Payment Reported" status, it may not be discarded anymore, if it was entered incorrectly. The service needs to be voided by using the void action on the service date detail page, to be able to deduct the payment from the next month's invoice.

16.4 State Payment Report

The DDA State Payment Report is a Monthly report that allows Provider users to report on services that are eligible for State Payment and print an invoice of the total amounts to submit to DDA for reimbursement from the State. All services entered or modified in a month requiring payment or payment adjustments are consolidated in the monthly report, available after the end of the month. Example: The State payment report for services entered or modified in May 2019 will become available on June 1 2019.

This report would include services for all locations/sites associated with the Provider Agency.

The below Provider roles can view and export the State Payment Report
- Admin Provider
- Billing Provider

Input Parameters:

- Reporting Year - Specify report year
- Reporting Month - list of months in selected year, single select only
- Agency - Select Agency name and FEIN from dropdown, single select only

Once input parameters are entered, scroll to the right end of the page and click 'View Report'
 to generate the report.

Output File:

There are three sections in this report

- Original – Services that were newly entered in the reporting month. Services in the original report may have a date of service in the reporting month or date of service in past months, since services for a date can be entered up for to a year
- Adjustment – Services previously invoiced to the state but were modified in the reporting month. Shown as 2 records in the detail output, one line for reducing payment for the old amount and one line for payment for the new amount determined by the modified service units.
- Recoveries – For those services that were previously included in a State Payment Invoice, but the person retroactively gained waiver eligibility in the reporting month so has been/will be paid by Medicaid. The amount invoiced to the state will be deducted on the month that person's waiver eligibility was updated

Date Created: 11/8/2019 3:32:26 PM

Note: Please Export as Excel to print the Invoice.

DDA State Payment Report

Invoice Number:	DDASF1905-0002
Invoice Date:	11/08/2019
Fiscal Year:	2019
Reporting Period:	May 2019
Provider Agency Name:	DDA Community Provider1
FEIN:	253828083
Address:	Test Street 1, Baltimore, MD 20103
Phone:	4444444444
Service:	DDA State Funded

Category	FY 2019	FY 2018	FY 2017
Original	$1745.02	N/A	N/A
Adjustments	$297.00	N/A	N/A
Recoveries	N/A	N/A	N/A
Total Invoice Amount	$2042.02	N/A	N/A

Bill to Address:

MDH/DDA

201 W. Preston St. 4th Floor

Baltimore, MD 21201

Output Parameters for Original Services:

Provider Name
Provider Number
Group ID
Activity Date
Last Modified Date
Client ID
Service Name
Units
Amount
Reasons for State Only

Original Activities

Total Records: 10

Provider Name	Provider Number	Group ID	Activity Date	Last Modified Date	Client Name	Client ID	Service Name	Units	Amount	Reasons for State Only
DDA Community Provider1	750395899	41	05/08/2019	05/31/2019	WeeklyMax, Abraham	2319190AR495100	Career Exploration Services - Facility Based	8	$240.00	Enrolled in State Funded program

Output Parameters for Adjustment Services:

Provider Name
Provider Number
Group ID
Activity Date

Last Modified Date
Client ID
Service Name
Units
Last Reported Month
Amount
Reasons for State Only

Date Created: 11/8/2019 3:35:03 PM

Note: Please Export as Excel to print the Invoice.

DDA State Payment Report

Adjustment Activities

Total Records: 6

Provider Name	Provider Number	Group ID	Activity Date	Last Modified Date	Client Name	Client ID	Service Name	Units	Last Reported Month	Amount	Reasons for State Only
DDA Community Provider1	750395899	38	03/07/2019	06/20/2019	WeeklyMax, Abraham	2319190AR495100	Career Exploration Services - Facility Based	-8	05/31/2019	($240.00)	Enrolled in State Funded program

Output Parameters for Recoveries Services:

Provider Name
Provider Number
Group ID
Activity Date
Last Modified Date
Client ID
Service Name
Units
Recovery Amount
Last Reported Month
RA NO
Claim ICN
Claim Creation Date
Original Claim ID
Original Claim Amount

Medicaid Eligible Activities — previously reported for State Payment

Total Records: 1

Provider Name	Provider Number	Group ID	Activity Date	Last Modified Date	Client Name	Client ID	Service Name	Units	Recovery Amount	Last Reported Month	RA NO	Claim ICN	Claim Creation Date	Original Claim ID	Original Claim Amount
DDA Community Provider1	787654344	35	01/17/2019	07/11/2019	Boyer, Kellie	3290365EK681211	Community Development Services 1:1 Staffing Ratio	2	$14.00	07/31/2019	BPQJG1	RN7V267O59VRO733X900	07/23/2019	claim/116ca513-ddca-46d8-8286-3ab560db5b0d	$14.00

17. Reports

Provider Portal has a repository of reports that are integral for Administrative, Billing and Program staff to be informed about the Services, Clients, Claims and Remittances related to their clients and services. These reports reside in a separate tab on Provider Portal.

Navigation: Home Page - > Reports
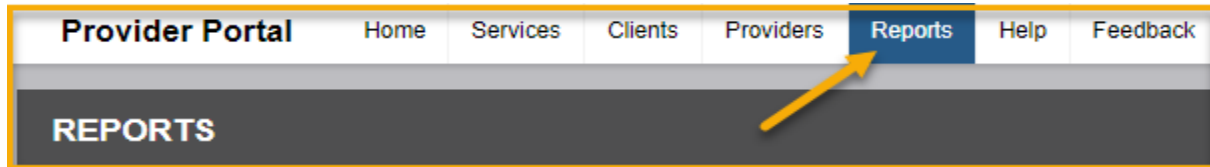
List of Reports:

Category	Name	Actions
Claims	Provider Portal Claims Report	View
Claims	Remittance Advice Report	View
DDA - Provider Portal	Authorized Clients Report	View
DDA - Provider Portal	DDA Authorized Services Report	View
DDA - Provider Portal	DDA Services Rendered Report	View
DDA - Provider Portal	DDA State Payment Report	View
EVV - Provider Portal	EVV Services Overlap Report	View
EVV - Provider Portal	EVV Services Rendered Report	View

Each of these reports are viewable by specific users and are discussed in detail below.

17.1 Provider Portal Claims Report

The Provider Portal Claims Report enables Provider users to view all claims that have been submitted to MMIS, Paid or Rejected and follow-up if required. This report will NOT include DDA State Funded services.

This report can be viewed and exported by the below Provider roles

- Admin Provider
- Billing Provider

Input Parameters:

Submission Date From and To - *Enter specific dates of service submission*	
Service Date From and To - *Enter specific Service Dates*	
Agency Name/FEIN - *Enter name of Agency or FEIN#*	
Provider Locations - *Drop-down list of all assigned locations, allows multi-select*	
Program Type - *Drop-down of Program types, allows multi-select*	
Service - *Dropdown list of all assigned Service Types, allows multi select*	
Claim Status - *Dropdown list of all claim statuses, multi select allowed*	
Client ID/MA# - *Enter Client Identifier*	
Client Name - *Enter Client Name*	

Once input parameters are entered, scroll to the right end of the page and click 'View Report'

 to generate the report.

Output File:

Provider Portal Claims Report

Search Criteria
Submission Date From : 01/24/2019
Submission Date To : 11/24/2019
Service Date From :
Service Date To :
Program Type : CP, CS, FS
Service : ⊞ 140 Service(s) were selected in the input, click + to see all
Agency Name/FEIN : DDA Community Provider1
Location : Test Street 1 -
Client ID/MA# :
Client SSN# : Not Available for Input
Client Name :
Client Region : Not available for input
Claim Status : Submitted to MMIS, Paid, Rejected, Not Submitted to MMIS
Report Date: 11/25/2019
Total Records: 6

Service Date	Client ID	Client MA#	Client Name	Provider #	Provider Name	Service	Program	Claim Submission Date	Claim ICN
08/21/2019	3249907EL470121	12748163208	Feil,Lexie		APPALACHIAN PARENT ASSOC, INC (test)	W2142 Personal Supports - Enhanced	CP	11/04/2019	
10/03/2019	1369497RT008110	12883357047	Paucek,Trey		APPALACHIAN PARENT ASSOC, INC (test)	W2142 Personal Supports - Enhanced	CP	11/04/2019	I9SQ7SWMAZ9PYAT7Y1R1

Output File continued:

Claim Type	Claim Status	Net Paid Amount	Net Billed Amount	Net Units	Total Paid Amount	Total Billed Amount	Total Units	Claim Denial Reason
Original	Submitted to MMIS	$0.00	$13.10	2		$13.10	2	
Original	Paid	$6.55	$6.55	1	$6.55	$6.55	1	

Output Parameters:

Service Date	Claim Type
Client ID	Claim Status
Client MA#	Net Paid Amount
Client Name	Net Billed Amount
Provider #	Net Units
Provider Name	Total Paid Amount
Service	Total Billed Amount
Program	Total Units
Claim Submission Date	Claim Denial Reason
Claim ICN	

17.2 Remittance Advice Report

The Remittance Advice Report allows Provider users to view the total Paid or Rejected amounts for Claims that have been submitted for services performed so that the Providers can reconcile their billing

with the payments received. The report lists Claims associated with the Remittances based on the filters for RA (check) number, RA (check) dates and Service/Claim dates.

This report can be viewed and exported by the below Provider roles

- Admin Provider
- Billing Provider

Input Parameters:

Filter By	\<Select a Value\> ▼		RA No		View Report
RA Year	▼		RA Date	▼	
Service Date From (mm/dd/yyyy)		☐ NULL	Service Date To (mm/dd/yyyy)		☐ NULL
Agency Name/FEIN	DDA Community Provider1		Provider Locations	APPALACHIAN PARENT ASSOC, IN ▼	
Service Category	DDA Services ▼		Service	Assistive Technology and Services ▼	
Claim Status	Paid, Rejected ▼		Client ID/MA#		
Client Name			Client SSN	Not available for input	
Report Output	\<Select a Value\> ▼				

Filter By - *Choose if the Report needs to be filtered by RA No, RA Year/Date or Service Dates*
RA No - *Enter specific Remittance advice Number (Check Number) for a Claim*
RA Year/Date - *Enter specific Remittance advice Dates for a Claim*
Service Date From and To - *Enter specific Service Dates*
Agency Name/FEIN - *Enter name of Agency or FEIN#*
Provider Locations - *Drop-down list of all assigned locations, allows multi-select*
Service Category - *Choose between DDA and ISAS services, allows multi select*
Service - *Dropdown list of all assigned Service Types, allows multi select*
Claim Status - *Dropdown list of all claim statuses, multi select allowed*
Client ID/MA# - *Enter Client Identifier*
Client Name - *Enter Client Name*
Report Output - *Choose between 'Summary Report' and 'Detail Report' output versions – single select*

Once input parameters are entered, scroll to the right end of the page and click 'View Report' [View Report] to generate the report.

Output File: When Summary Report is selected in the Report Output option

Remittance Advice Summary Report

Search Criteria:

Filter By:	Service Dates
RA No:	N/A
RA Year:	N/A
RA Date:	N/A
Service Date From:	1/24/2019
Service Date To:	10/31/2019
Agency Name/FEIN:	PERF TEST AGENCY
Provider Locations:	⊞ 200 Locations were selected in the input, click + to see all
Service Category:	DDA Services; ISAS
Service:	⊞ 100 Services were selected in the input, click + to see all
Claim Status:	Paid; Rejected
Client ID/MA#:	
Client Name:	
Client SSN#:	Not available for input
Report Output:	Summary Report

Total Records: 73

RA No	RA Date	Provider #	Provider FEIN	Provider Name	Paid Amount	Rejected Amount
1NBGEZ	04/17/2019	555570300	906473503	Performance Test Location 0	$16.00	$0.00

Output Parameters:

RA No	Provider Name
RA Date	Paid Amount
Provider #	Rejected Amount
Provider FEIN	

Output File: When Detail Report is selected in the Report Output option

Remittance Advice Detail Report

Search Criteria:

Filter By:	Service Dates
RA No:	N/A
RA Year:	N/A
RA Date:	N/A
Service Date From:	6/5/2019
Service Date To:	11/12/2019
Agency Name/FEIN:	
Provider Locations:	All Locations
Service Category:	Coordination of Community Services; DDA Services
Service:	⊞ 96 Services were selected in the input, click + to see all
Claim Status:	Paid; Rejected
Client ID/MA#:	
Client Name:	
Client SSN#:	
Report Output:	Detail Report

Total Records: 20

Service Date	Client Id	Client MA#	Client Name	Agency Name	Provider #	Provider Name	Provider Address
06/24/2019	3899996LA292120	12345678905	Hickle, Alejandra	PERF TEST AGENCY	555570300	Performance Test Location 0	Location1 Street Bowie Maryland 21046
06/12/2019	1039449AS752121	23025698547	Kulas, Sanford	PERF TEST AGENCY	555570300	Performance Test Location 0	Location1 Street Bowie Maryland 21046

Output continued.

Service	Program	RA NO	RA Date	Claim Submission Date	Claim ICN	Claim Type	Claim Status	Net Paid Amount	Net Billed Amount	Net Units
Personal Supports - W5810	CP	NQUZ2V	07/01/2019	06/25/2019	43FRJJM9GLJZ3WA5UFVM	Original	Paid	$4.00	$4.00	1
Personal Supports - W5810	CP	CXYRLP	06/25/2019	06/13/2019	0GUYYI0ZM2R5NF3RB8TQ	Original	Paid	$32.00	$32.00	8

Total Paid Amount	Total Billed Amount	Total Units	Claim Denial Reason
$4.00	$4.00	1	
$32.00	$32.00	8	

Output Parameters:

Service Date	Claim Submission Date
Client ID	Claim ICN
Client MA#	Claim Type
Client Name	Claim Status
Agency Name	Net Paid Amount
Provider #	Net Billed Amount
Provider Name	Net Units
Provider Address	Total Paid Amount
Service	Total Billed Amount
Program	Total Units
RA NO	Claim Denial Reason
RA Date	

17.3 Authorized Clients Report

The Authorized Clients Report allows Provider users the ability to view all the clients they are currently providing services or authorized to provide services in the future for all the locations of their Agency. Providers will also be able to run Reports that are specific to one Provider location, so that they may have accurate metrics and oversight of the implementation of the number of clients being served at one single location.

This report can be viewed and exported by the below Provider roles

- Admin Provider
- Billing Provider
- Provider Program Director
- Provider Program Staff

Input Parameters:

Agency Name/FEIN – *Enter name of Agency or FEIN#*
Provider Locations – *Dropdown list of all assigned locations, allows multi select*
COS Code – *Dropdown list of all assigned COS codes, allows multi select*
Service - *Dropdown list of all assigned Service Types, allows multi select*
Report Type – *Dropdown list of summary report and detail report, allows single select*
Include Full demographics – *Toggle 'Yes' or 'No' to view Client demographics information*

Once input parameters are entered, scroll to the right end of the page and click 'View Report'

 to generate the report.

Output File: When Authorized Client Summary Report is selected in the Report Type

Output File continued:

Future Authorization End Date	Financial Re-determination Date	CCS Agency	CCS Coordinator	CCS Coordinator Telephone	CCS Coordinator Email
	01/01/9999	CCS Provider 5	TestCcsStaffAllRoles, Chad		chad.auld@feisystems.com

Output Parameters:

Client ID	Authorization Status
Client Name	Future Authorization Start Date
Service Plan Type	Future Authorization End Date
Enrolled Program	Financial Re-determination Date
PCP Program	CCS Agency
Special Program Code (SPC)	CCS Coordinator

SPC Start Date	CCS Coordinator Telephone
SPC End Date	CCS Coordinator Email

Output File: When Authorized Client Detail Report is selected in the Report Type

Output File continued:

Output Parameters:

Client ID	SPC Start Date
Client Name	SPC End Date
Provider Name	Service
Provider Number	Authorized for the Current Month
Service Plan Type	Start Date on the Current/Future Plan
Enrolled Program	End Date on the Current/Future Plan
PCP Program	

17.4 DDA Authorized Services Report

The DDA Authorized Services Report enables provider users to identify Current and past active service authorizations for DDA Clients for DDA EVV and Non-EVV services to view the authorized Units and the Billed or Entered Units by the Providers so that they can identify the performance of the Staff.

Users will have the ability to view a summary report of Authorized units, Billed and Entered units during a specific Authorized period to compare the number of units Billed or Entered against the Authorized units on the Service Authorization. Users can also view a detail Services report to compare units Billed against the Authorized units on the Service Authorization.

This report can be viewed and exported by the below Provider roles

- Admin Provider
- Billing Provider
- Provider Program Director
- Provider Program Staff

Input Parameters:

Service Plan Authorization Period – *Choose between Monthly or Annual report*
Service Plan Year – *Specify plan year*
Service Plan Month – *Dropdown of months in selected year, multi select allowed*
Service Plan Program Type – *Dropdown of program types, allows multi-select*
Agency Name/FEIN – *Enter name of Agency or FEIN#*
Provider Locations – *Dropdown list of all assigned locations, allows multi select*
Service Plan Service – *Dropdown list of all assigned Service Types, allows multi select*
Client ID/MA# - *Enter Client Identifier*
Client Name – *Enter Client Name*

Once input parameters are entered, scroll to the right end of the page and click 'View Report' to generate the report.

Output File:

DDA Monthly Authorized Services Summary Report

Search Criteria:
Service Plan Authorization Period:	Monthly
Service Plan Year:	2019
Service Plan Month:	January, February, March, April, May, June, July, August, September, October, November
Service Plan Program Type:	CP, CS, DDA State Funded, FS
Agency Name/FEIN:	DDA Community Provider1
Provider Locations:	444 Test Way - 787654344; 999 Test Way - 750395899; Test Street 1 - 777702399
Service:	⊞ 51 Services were selected in the input, click + to see all
Client Name:	
Client ID / MA #:	
Client SSN #:	Not available for input
Client Region:	Not available for input
Total Records:	1346

Client ID	Client Name	Client MA #	Agency Name	Provider Location Name	Provider Location Number	Service Plan Program	Service Plan Period	Service Plan Service	Unit Type
1039654ED595111	O'Hara, Dewayne	06554458236	DDA Community Provider1	DDA Billing Location 9	750395899	CP	05/16/2019 - 05/31/2019	BSS - Brief Support Implementation	15 minute increment

Output File continued:

Authorized Units	Billed		Entered		
	Services Units	Balance (Authorized - Services Entered)	Services Units/Cost	Balance (Authorized - Services Entered)	Count of Services with Exceptions
32	16	16	18	14	1

Output Parameters:

Client ID	Service Plan Service
Client Name	Unit Type
Client MA#	Authorized Units
Agency Name	Billed - Services Units
Provider Location Name	Billed - Balance (Authorized - Services Entered
Provider Location Number	Entered - Services Units/Cost
Service Plan Program	Entered - Balance (Authorized - Services Entered
Service Plan Period	Entered - Count of Services with Exceptions

On selecting the count in the Billed Service Units or Entered Service units/cost or Count of services with Exception, the user is redirected to the Detail report

Output File: DDA Authorized Services Detail Report

DDA Authorized Services Detail Report

Total Records: 3

Client ID	Client Name	Provider Location Number	Service Date	Service Type	Service Status Status	Unit Type	Service Activty Units/Cost	Billed Units	Billed Amount	Claim Type	Claim Status
1039654ED595111	Dewayne, O'Hara	750395899	05/03/2019	BSS - Brief Support Implementation	Pending	15 minute increment	3 Unit(s)				
			05/15/2019	BSS - Brief Support Implementation	Pending	15 minute increment	3 Unit(s)				
			05/28/2019	BSS - Brief Support Implementation	Pending	15 minute increment	2 Unit(s)				

Output File continued:

| Claim Level | | | | | State Payment | Exception |
Claim Status ⇅	Total Paid ⇅	Claim ICN ⇅	RA Date	RA No ⇅	Month ⇅	Type ⇅
						Provider has exceeded the maximum authorization for the month
						Provider has exceeded the maximum authorization for the month
						Provider has exceeded the maximum authorization for the month

Output Parameters:

Client ID	Billed Amount
Client Name	Claim Type
Provider Location Number	Claim Status
Service Date	Total Paid
Service Type	Claim ICN
Service Status	RA Date
Unit type	RA No
Service Activity Units/Cost	State Payment Month
Claim Level – Billed Units	Exception Type

17.5 DDA Services Rendered Report

The DDA Services Rendered Report allows a Provider user to run Reports specific to the DDA services, to view accurate metrics and oversight of the implementation of the services provided by DDA Provider locations. This report would include all services rendered by Provider agency locations that are Waiver services (CPW, CSW, and FSW) as well as DDA State Funded Services

This report can be viewed and exported by the below Provider roles

- Admin Provider
- Billing Provider

Input Parameters:

Service Date From (mm/dd/yyyy)*	1/31/2019 12:00:00 AM	Service Date To (mm/dd/yyyy)*	10/31/2019 12:00:00 AM
Agency Name/FEIN	PERF TEST AGENCY	Provider Locations*	Location1 Street - 555570300, Locati ⌄
Service Program Type*	Unknown, CP, CS, FS, DDA State Fun ⌄	Service*	Assistive Technology and Services, BS ⌄
Exception Type*	No Pending reason, Activity has excee ⌄	Client ID/MA#	
Client SSN#	Not available for input	Client Name	
Service Activity Status*	Closed, MDH In Progress, MDH Revie ⌄	Client Region*	Not available for input ⌄

Service Date From and To – *Enter specific dates to view services rendered*

Agency Name/FEIN - *Enter name of Agency or FEIN#*
Provider Locations - *Drop-down list of all assigned locations, allows multi-select*
Service Program Type - *Drop-down of Program types, allows multi-select*
Service - *Dropdown list of all assigned Service Types, allows multi-select*
Exception Type - *Dropdown list of all exception types, allows multi-select*
Client ID/MA# - *Enter Client Identifier*
Client Name - *Enter Client Name*
Service Activity Status - *Dropdown list of all service statuses, allows multi-select*

Once input parameters are entered, scroll to the right end of the page and click 'View Report'
View Report to generate the report.

Output File:

DDA Services Rendered Report

Search Criteria:

Service Date From:	01/31/2019
Service Date To:	10/31/2019
Agency Name/FEIN:	PERF TEST AGENCY
Provider Locations:	⊞ 200 Locations were selected in the input, click + to see all
Service Program Type:	Unknown; CP; CS; FS; DDA State Funded
Service:	⊞ 58 Services were selected in the input, click + to see all
Exception Type:	⊞ 29 Exception Types were selected in the input, click + to see all
Client ID/MA#:	
Client SSN#:	Not available for input
Client Name:	
Service Activity Status:	Closed; MDH In Progress; MDH Reviewed; Needs Authorization; New; Not Authorized; Pending; Pending MDH; Pending Provider; Provider In Progress; Ready; Recorded
Client Region:	Not available for input
Total Records:	697

Service Date	Agency Name	Provider Name	Provider Number	Client Name	Client ID	Client MA #	Program	Service	Service Status	Unit Type
01/31/2019	PERF TEST AGENCY	Performance Test Location 0	Location1 Street - 555570300	A, H	3699933PA983110			Rent - Individual Support (State Only Funded)	Pending	Month

Output File continued:

Units/Cost/Service Duration	Exception Type	Reason for Manual Entry	Service Activity Comments
1 Units	Client not enrolled in a DDA program; No approved service plan found		

Output Parameters:

Service Date	Service
Agency Name	Service Status
Provider Name	Unit Type
Provider Number	Units/Cost/Service Duration
Client Name	Exception Type
Client ID	Reason for Manual Entry
Client MA #	Service Activity Comments
Program	

17.6 EVV Services Overlap Report

The EVV Services Overlap Report helps Provider to view Overlapping services (DDA EVV & ISAS) and correct the services so that they can be processed further for Claim submission. Based on the overlap being within or between agencies, it will be resolved by Provider or MDH, respectively.

Providers have the ability to resolve overlapping Services with overlap either for the same staff or for the same client within their agency

This report can be viewed and exported by the below Provider roles

- Admin Provider
- Billing Provider

Input Parameters:

Service Date From (mm/dd/yyyy)*	11/13/2019 12:00:00 AM	Service Date To (mm/dd/yyyy)*	11/13/2019 12:00:00 AM
Agency Name/FEIN	DDA Community Provider1	Provider Locations*	APPALACHIAN PARENT ASSOC, INC
Staff Name		Staff SSN #	Not available for input
Client Name		Client ID/MA#	
Client SSN#	Not available for input	Client Region*	Not available for input
Service*	Personal Assistant Services, Shared	Service Status*	New, Ready, Closed, Needs Authoriz
Service Overlap by*	<Select a Value>		

View Report

Service Date From and To – *Enter specific dates to view services rendered*

Agency Name/FEIN - *Enter name of Agency or FEIN#*
Provider Locations - *Drop-down list of all assigned locations, allows multi-select*
Staff Name: *Enter the Staff Name (DSP Name)*
Client Name - *Enter Client Name*
Client ID/MA# - *Enter Client Identifier*
Service - *Dropdown list of all assigned Service Types, allows multi-select*
Service Activity Status - *Dropdown list of all service statuses, allows multi-select*
Service Overlap by – *Select if the results to be displayed are due to overlap of Staff or Client*

Once input parameters are entered, scroll to the right end of the page and click 'View Report'

View Report   to generate the report.

Output File: Overlap by Staff – Same agency

Output File continued:

Exception Type	Start Time	End Time	Actions
	5/25/2019 1:35 PM	5/25/2019 2:35 PM	
Staff Overlap - Same Provider;	5/25/2019 2:35 PM	5/25/2019 3:35 PM	Resolve

Output Parameters:

Staff Name	Service
Service Date	Service Status
Provider Name	Exception Type
Provider Number	Start Time

Client Name	End Time
Client ID	Actions
Client MA #	Program

Output File: Overlap by Client

EVV Services Overlap Report - Client

Search Criteria:	
Service Date From:	03/01/2019
Service Date To:	03/02/2019
Agency Name/ FEIN:	DDA Community Provider1
Provider Locations:	APPALACHIAN PARENT ASSOC, INC (test) - 777702399
Staff Name:	
Staff SSN#:	Not available for input
Client Name:	
Client ID / MA#:	
Client SSN#:	Not available for input
Client Region:	Not available for input
Service:	Personal Assistant Services, Shared Attendant, Personal Supports (DDA), Daily Personal Assistant Services, Daily Shared Attendant
Service Status:	New, Ready, Closed, Needs Authorization, Pending Provider, Provider In Progress, MDH In Progress, MDH Reviewed, Pending MDH
Overlap By:	Client
Total Records:	2

Client Name	Client ID	Client MA#	Service Date	Provider Name	Number	Staff Name	Program	Service
Lowe, Evan	3050857VE791211	12356488877	03/01/2019	APPALACHIAN PARENT ASSOC, INC (test)	777702399	Providerloc9, Admin	FS	Personal Supports (DDA)
			03/01/2019	APPALACHIAN PARENT ASSOC, INC (test)	777702399	Client, Reactivate-Current	FS	Personal Supports (DDA)

Output File continued:

Service Overlap				
Service Status	**Exception Type**	**Start Time**	**End Time**	**Actions**
Ready		3/1/2019 9:30 AM	3/1/2019 10:30 AM	
Pending Provider	Client Overlap;	3/1/2019 9:30 AM	3/1/2019 11:30 AM	Resolve

Output Parameters:

Staff Name	Service
Service Date	Service Status
Provider Name	Exception Type
Provider Number	Start Time
Client Name	End Time
Client ID	Actions
Client MA #	Program

Note that selecting "Resolve" action in the output does not actually resolve the overlap. Provider is navigated to the service details page, from where they can view further service details and correct duration to fix the overlap.

17.7 EVV Services Rendered Report

The EVV Services Rendered Report allows Provider users to have the ability to view all DDA EVV or ISAS services rendered by their Staff at all their assigned locations to the Person along with the Date, Time, duration, service activity status, service type, service activity comments and Exceptions. This could include state funded EVV services as well.

This report can be viewed and exported by the below Provider roles

- Admin Provider
- Billing Provider
- Provider Program Director
- Provider Program Staff

Input Parameters:

Service Date From and To – *Enter specific dates to view services rendered*
Service Program Type - Dropdown list of all Programs, allows multi select
Service - *Dropdown list of all assigned Service Types, allows multi-select*
Agency Name/FEIN - *Enter name of Agency or FEIN#*
Provider Locations - *Drop-down list of all assigned locations, allows multi-select*
Staff Name: *Enter the Staff Name (DSP Name)*
Client Name - *Enter Client Name*
Client ID/MA# - *Enter Client Identifier*
Service Activity Status - *Dropdown list of all service statuses, allows multi-select*
Report Data – Select the type of report to be displayed

Output File

EVV Services Rendered Report - Service Activity Detail

Search Criteria:
Service Date From: 06/12/2019
Service Date To: 11/12/2019
Service Program Type: Unknown, CFC, CO, CPAS, ICS, CP, CS, FS, DDA State Funded
Service: Daily Personal Assistant Services, Daily Shared Attendant, Personal Assistant Services, Personal Supports (DDA), Shared Attendant
Exception Type: 29 Exception Types were selected in the input, click + to see all
Agency Name/FEIN: DDA Community Provider1
Provider Locations: APPALACHIAN PARENT ASSOC, INC (test) - 777702399; DDA Billing Location 4 - 787654344; DDA Billing Location 9 - 750395899
Staff Name:
Staff SSN #: Not available for input
Client ID / MA #:
Client SSN #: Not available for input
Client Name:
Service Activity Status: New, Ready, Closed, Needs Authorization, Not Authorized, Pending Provider, Provider In Progress, MDH In Progress, MDH Reviewed, Pending MDH
Client Region: Not available for input
Report Data: Service Activity Detail

Total Records: 79

Service Date	Agency Name	Provider Name	Provider Number	Staff Name	Client Name	Client ID	Client MA #	Program	Service	Service Initiation Source	Start Time	End Time
06/12/2019	DDA Community Provider1	DDA Billing Location 9	750395899	Hinds LOC9 Admin Provider	Gerlach, Moises	1699642OM114120	47857401000	CS	Personal Supports (DDA)	Provider Manual	6/12/2019 6:10 AM	6/12/2019 6:10 PM

Output File continued:

Service Duration (hours)	Units	Service Activity Status	Exception Type	Reason for Manual Entry
12.00		Pending Provider	Provider has exceeded the maximum authorization for the month;	*For Clock-In/Clock-Out:* Forgotten Clock In/Out

Output Parameters:

Service Date	Service
Agency Name	Service Initiation Source
Provider Name	Start Time
Provider Number	End Time
Staff Name	Service Duration (hours)
Client Name	Units
Client ID	Service activity status
Client MA #	Exception Type
Program	Reason for Manual Entry

17.8 Export Report Output

Providers can download the output of any report by selecting the ![icon] icon in the navigation bar. The following export options are available

- Word
- Excel
- PDF
- TIFF file
- MHTML (web archive)
- CSV (comma delimited)
- XML file with report data
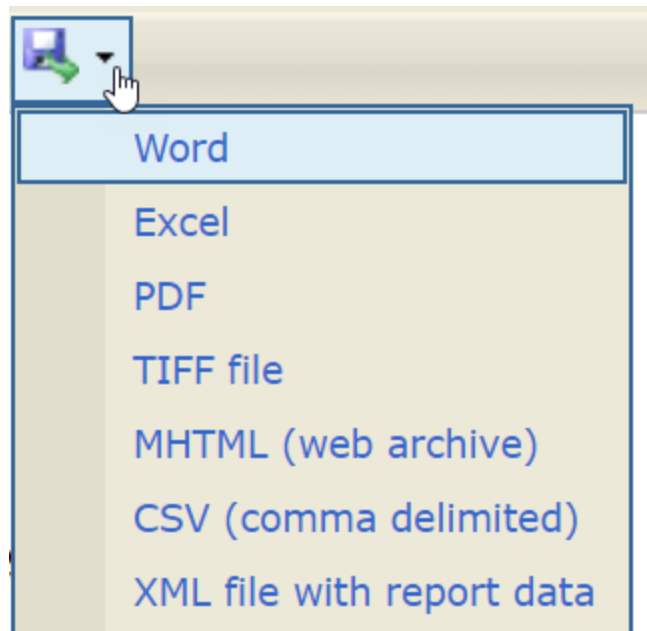
Appendix A DDA Services List

Appendix B Non-EVV Statuses

Appendix C EVV Statuses

Service Status is a workflow status that identifies where an entry is currently in the billing process. A service can only have one status at a given time and following are the list of different Statuses in which an EVV Service can exist:

New: A Service that has been added through ISAS Call-in system has the status of New. A service in this status indicates that it is ready to be processed through Claim creation, unless it is Missing a Clock-in or a Clock-out, which needs to be entered by the Provider before a claim can be submitted.

Needs Authorization: This status indicates that the Provider has made a manual service modification but creating a new service, fixing a missing clock-in/out or modifying duration of a previously entered service, and has submitted the change for further review and claim creation. A Service in this status can be edited by Providers prior to MDH starting review.

Provider in Progress: This status indicates that Provider is still working on the Service and has not submitted it to MDH for review. Provider can continue making further edits in this status and claim will not be created until the service is submitted by the Provider by selecting the "Submit Services" action

MDH in Progress: This status indicates that the Service is currently being reviewed by MDH. Providers cannot make any changes to the services in this status

MDH Reviewed: This status indicates that MDH has finished their Review and Approved the Service. This status indicates that service can be processed further for Claim creation. Provider cannot make changes to the Service in this status until a claim is created.

Pending Provider: This status indicates that the service has failed one or more checks and exceptions are assigned to it. A service in this status will *not* be processed for claim creation and requires Provider to take action to resolve or clear the Exception for further processing. See section 14 for more information on exception types and resolving them.

Pending MDH: This status indicates that the service has failed one or more checks and exceptions are assigned to it. A service in this status will *not* be processed for claim creation and requires MDH to take action to resolve or clear the Exception for further processing. See section 14 for more information on exception types and resolving them.

Not Authorized: This status indicates that the Service was not approved by MDH and cannot be processed further. This can happen when staff repeatedly fails to use the ISAS Call-in system beyond the allowed monthly manual request without a reasonable cause, or if the service was wrongly/frequently entered. A "Not Authorized" service cannot be modified.
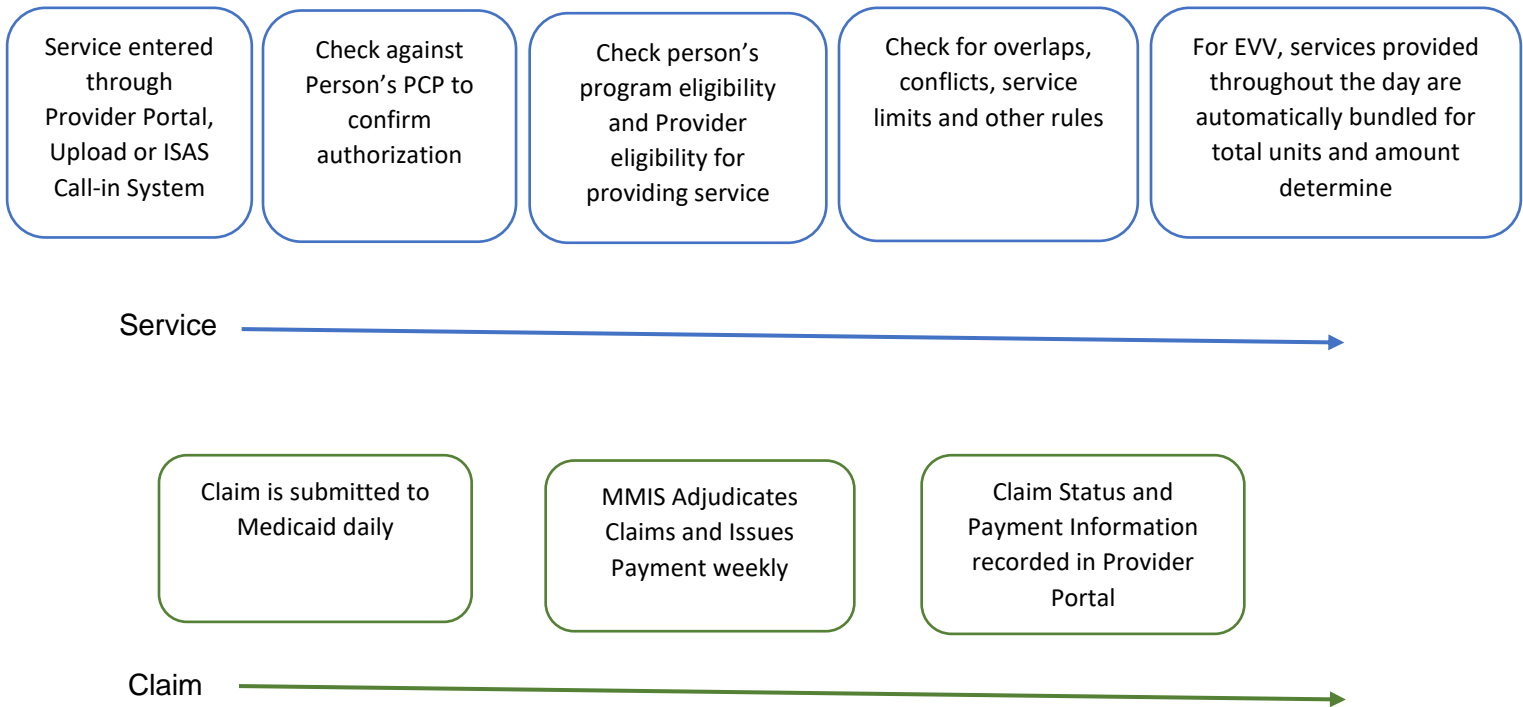
Discarded: This status indicates that Provider has discarded the service and no further actions can be taken on the Service

Ready: This is an intermediary status when the Services have passed all validations prior to claim creation and are ready to be picked up by Claim creation process

Closed: This status indicates that the Service has a Claim created, and can only be modified by Adjusting the Claim after the Submitted Claim has been Paid or Rejected

Appendix D Billing Process

Provider Portal Overnight Process Outline – DDA EVV Services

| Service entered through Provider Portal, Upload or ISAS Call-in System | Check against Person's PCP to confirm authorization | Check person's program eligibility and Provider eligibility for providing service | Check for overlaps, conflicts, service limits and other rules | For EVV, services provided throughout the day are automatically bundled for total units and amount determine |

Service ⟶

| Claim is submitted to Medicaid daily | MMIS Adjudicates Claims and Issues Payment weekly | Claim Status and Payment Information recorded in Provider Portal |

Claim ⟶

Appendix E Help

Help tab on the top menu contains links for webinars and documents related to Frequently Asked Questions for different programs and service types.

To access training documents,

1. Select Help tab on the top menu
2. System displays the Training page
3. Click on "Training Information and Webinars" link to access training materials
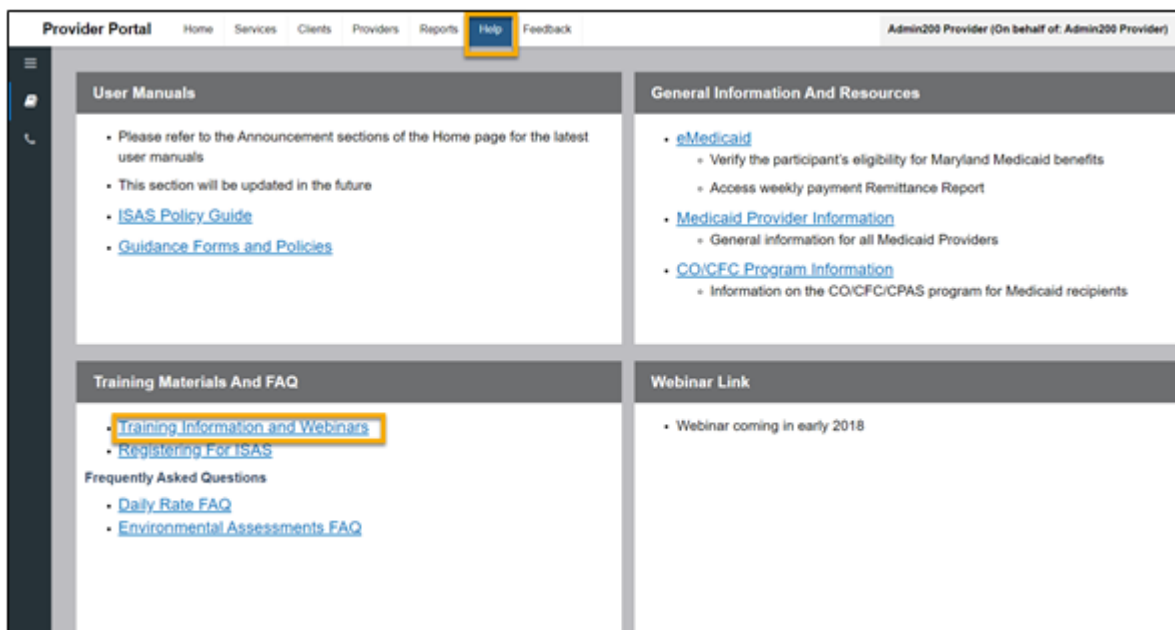
To access contact details of Helpdesk, and DDA Service Desk,

1. Select Help tab on the top menu

2. Select the Contacts [phone icon] icon on the left navigation panel view Contacts

Appendix F Reporting Technical Issues in the *LTSSMaryland* Provider Portal

Feedback tool is feature in Provider Portal that allows Providers to submit helpdesk tickets for technical issues and questions they have in the system, and to view the tickets already submitted.

Submit a ticket

Whenever you encounter a system issue or have a question while using the system,

1. Click on Feedback option in the top menu and choose "Create"
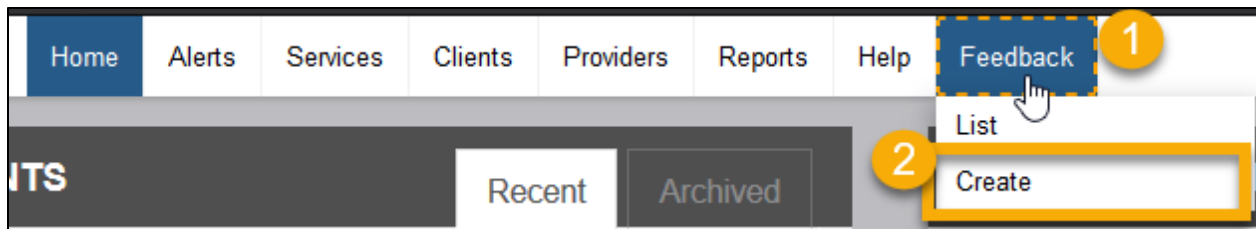
2. System displays a "User Feedback" popup, as shown in the figure below:

USER FEEDBACK

Date Reported:	09/18/2020
Staff Name:	Alex Hamilton
Agency:	Washington Syndicate
Error Url:	https://isasuat.feisystems.com/LTSS/Webs
Type of Concern:*	
Severity:*	

To help us diagnose the cause of this issue and improve this software please provide as much information as possible.

Error Message:* — Describe the error you are seeing. Provide specific details. Please also include your expected results.

Comments: — Please list the steps you took to cause this error to happen. This is helpful for our technical team to pinpoint how and when the problem happens.

Close   Send

3. Choose the type of concern and severity of the issue

Type of Concern:*

- System Error
- Question/Comment
- Unknown

4. Add details describing the issue or the feature you are requesting. If the ticket is for an issue that you have, list the steps that you took until the issue occurs. This will assist helpdesk users to replicating the same issue from their end

5. Add additional comments, if needed

Note: Providers can log a ticket from any page in Provider Portal by simply clicking on the Feedback
🞂 Create option.

View created tickets

To check the details of tickets submitted and their current status (whether they are Open, In progress,
or have been Resolved), follow the below steps

Navigation: Home Page 🞂 Feedback 🞂 List
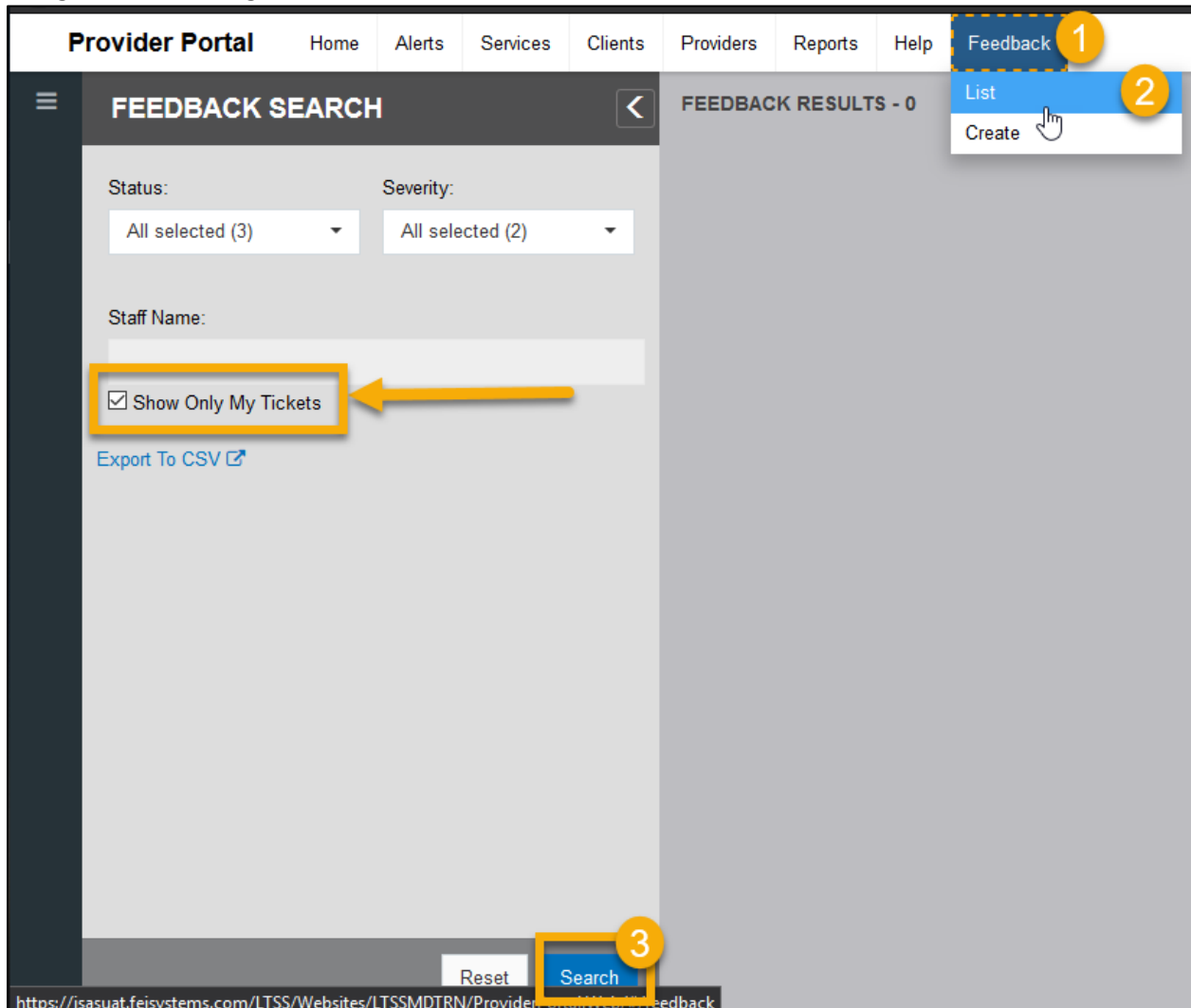
To view the tickets you have created,

1. Navigate to Feedback Search page

2. By default, the search panel has "Show Only My Tickets" selected, as shown in the figure above.
3. Click the Search button. All tickets that you created appear in the search results.
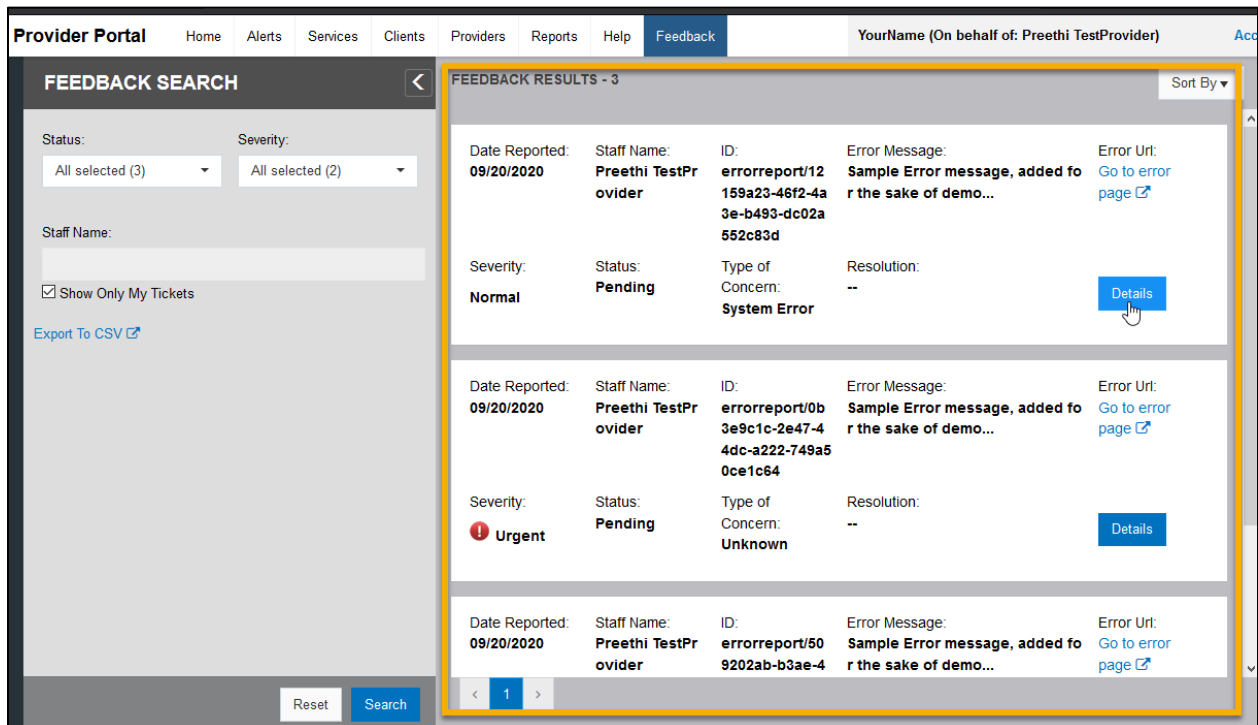
4. Click on Details on any ticket in the search result to view additional information about the it.

View tickets submitted by staff in your agency

Admin users can view tickets submitted by others in their agency to track and resolve issues.

If you have an Admin Provider role,

1. Click on Navigate to Feedback Search page
2. Uncheck "Show Only My Tickets" option in the search panel and click Search

3. Enter the first or last name of staff in the Staff Name field.
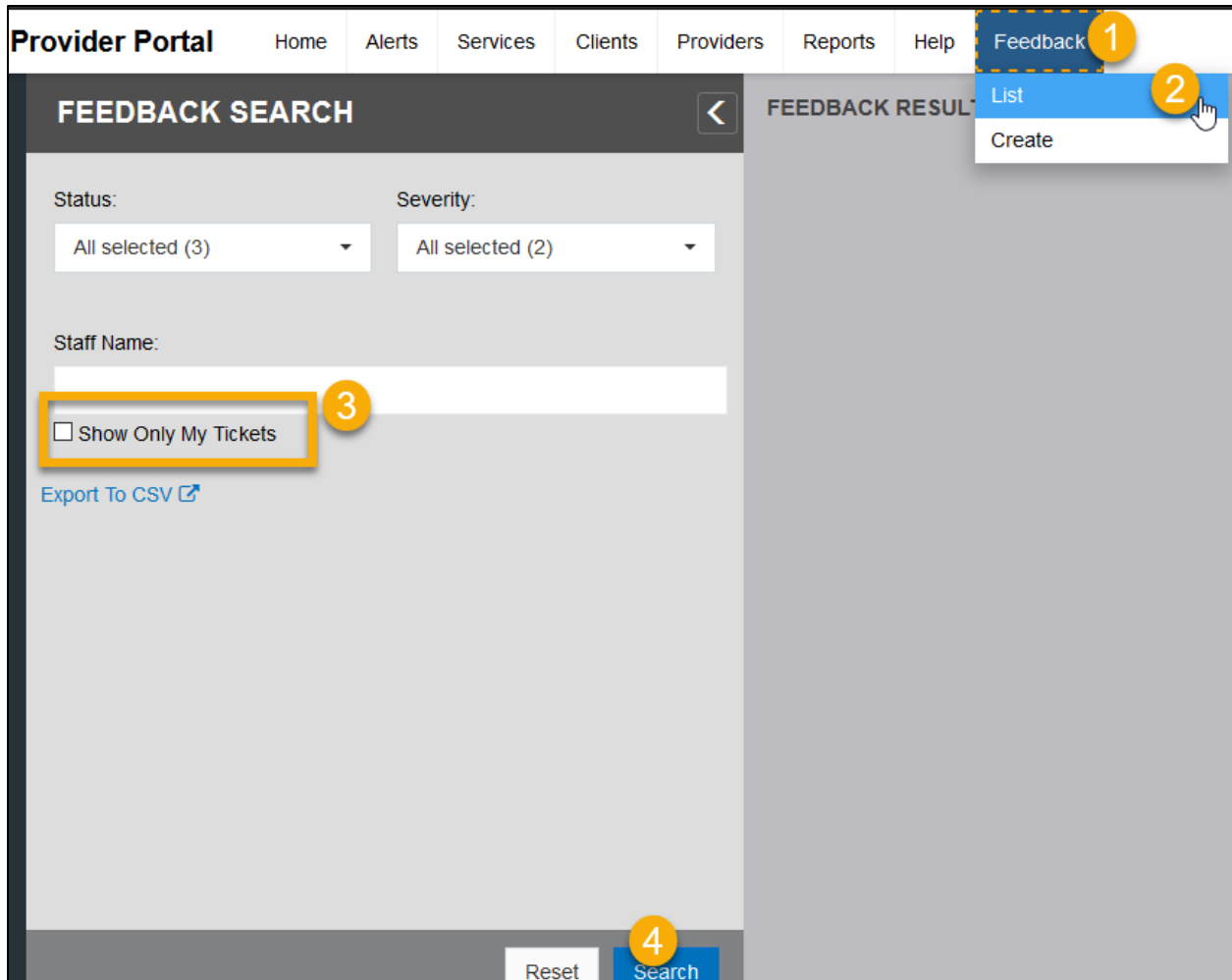   a. Note: Leave this field blank if you would like to search for tickets created by all staff that you have access to.
4. Click Search
5. System displays matching tickets in the search result. You can click on Details button on any ticket in the search results to view additional details about it.

Appendix G Identifying Program Type for Services

There are 3 different reference to program types in LTSS as detailed below

1. PCP Program: The program type which is associated with the Person-Centered Plan (PCP) active on the Date of Service
2. MMIS Program: This is the waiver program that the person is enrolled in by Medicaid, determined by the Special Program Code that is set up in MMIS

3. LTSS Program: The program enrollment in LTSS for the Date of Service

In certain cases when there is a mismatch of these programs, for example a PCP is approved for the CP program type with CP enrollment completed in LTSS, but the person's MMIS program is CS (Special Program codes CSM, CSW), the mismatch will be flagged as an exception on the service, holding off billing. Providers will be required to contact the Person's assigned CCS coordinator to resolve exceptions around the Participant's LTSS Program, PCP Program or waiver Program mismatch (Refer Section 9.2 for Exceptions on non-EVV services and Section 14.2 for exceptions on EVV Services).

Appendix H Invoice Process for State Only Payments via LTSSMaryland

Purpose:

With the transition into LTSSMaryland, State-Only payments for services billed in LTSSMaryland will be processed using the procedures outlined in this guidance.

Guidance:

● Invoices for relevant services will be generated from LTSS on the 1st of the month following the date of service (i.e. Services rendered in Oct 2020 will be on the Nov 2020 report).

● A provider may submit a service invoice at any point during the state fiscal year.

● Invoices are to be signed and forwarded to the electronic mailbox designated by DDA.

● Invoices will be processed on a monthly basis by DDA.

Process:

For an invoice to be processed the provider will need to submit all of the following:

1. An electronic copy of the invoice.

2. The invoice must contain a "Bill To" address.

3. The invoice must be signed in blue ink.

4. The invoice should be accompanied by the state payment report out of LTSS as supporting documentation.

Submission Address:

Once completed, the signed invoice and supporting documentation should be emailed electronically to: Accounts_payable.dda@maryland.gov