STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Living at Home Waiver Transmittal No. 27
March 2, 2012

To: Living at Home Waiver Providers

From: Susan J. Tucker, Executive Director
Office of Health Services

Note: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

Re: Electronic Billing Option for Living at Home Waiver Providers

---

Effective April 4, 2012, claims will no longer be processed by staff of the Living at Home (LAH) Waiver Division. As a result, waiver providers are encouraged to submit claims electronically via eMedicaid, which allows providers secure online access to verify participant eligibility, submit claims for reimbursement, and view remittance advices. Some additional benefits of using eMedicaid include, but are not limited to, faster claims processing time which leads to prompt reimbursement. Information regarding the eMedicaid secure online services for Maryland Medicaid providers can be found at https://encrypt.emdhealthchoice.org/emedicaid.

Please note, the Department of Health and Mental Hygiene (DHMH) does not provide software for electronic billing. Providers may consult with billing software vendors to learn about electronic billing.

Waiver providers may continue to submit paper claims to DHMH for claims processing but will experience longer processing times. Paper claims are generally paid within 4-6 weeks. Providers who choose to submit paper claims must use the CMS-1500 billing form and should send the forms to:

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

Please note that consumer-employed attendant care providers – *providers who are employed by LAH participants* – are not subject to this new procedural option. Consumer-employed providers should continue to submit claims to Administrative Services, Inc. for reimbursement.

Questions regarding the content of this transmittal should be directed to the Living at Home Waiver Program at 410-767-7479.

Enclosure: LAH Waiver Billing Manual

cc: Administrative Services, Inc.
AFSCME

Maryland Department of Health and Mental Hygiene

LIVING AT HOME WAIVER

A HOME and COMMUNITY-BASED SERVICES WAIVER FOR ADULTS WITH PHYSICAL DISABILITIES

A Maryland Medical Assistance Program

BILLING INSTRUCTIONS FOR LIVING AT HOME WAIVER PROVIDERS

February 2012

Welcome to the Living at Home Waiver!

General Information

These billing instructions are for Medical Assistance (also called Medicaid) services covered under the Home and Community-Based Services Living at Home (LAH) Waiver Program. The Waiver is governed by COMAR 10.09.55 and by the federally approved Waiver proposal.

The Maryland Department of Health and Mental Hygiene (DHMH) is the State's lead agency for the Medicaid Program. The LAH Waiver is administered at DHMH. Billing questions may be directed to the Living at Home Waiver Program at 410-767-7479.

This packet was prepared to provide proper billing instructions for Living at Home Waiver services. The next section, "Frequently Asked Billing Questions", contains all of the general information you need to know about billing your Living at Home Waiver services. The "Instructions for Completing the CMS-1500", section beginning on page 7 gives detailed information about completing the CMS-1500 billing form. The final section, "Specific Information for Waiver Services", gives detailed information about LAH services. Please be sure to read this information carefully so that your claims will be appropriately submitted and paid.

Frequently Asked Billing Questions

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

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

1. ***Am I enrolled as a Maryland Medical Assistance Living at Home Waiver provider?***

   If you are interested in enrolling as a Living at Home Waiver provider, contact the LAH Waiver Division at 410-767-7479. Once approved, you will receive an approval letter and a Medical Assistance provider number from DHMH. This letter will include: 1) your 9-digit Medical Assistance provider number; and 2) the types of services you can provide.

   If you render services for more than one waiver program, you need a different Medical Assistance provider number for each waiver program. Look at your approval letter to determine which services to bill with which provider number. **If you have any questions regarding your provider number(s), call the Provider Master File Unit at 410-767-5340.**

2. ***Is the waiver participant enrolled?***

   Prior to providing and/or billing for any waiver services, you must contact the participant's waiver service coordinator to:

   - Verify the participant's waiver eligibility.
   - Request a copy of the participant's plan of service.
   - Check the plan of service to make sure that the service you are providing is on the plan of service. (If the service is NOT on the plan of service, you may not be paid for that service!)
   - Check the plan of service to make sure you are authorized to provide services for the participant. (If you are NOT listed as the authorized provider for the service on the plan of service, you may not provide or bill for the service!)

   Each time you provide a waiver service you should:

   - Verify the participant's Medical Assistance eligibility by calling the Eligibility Verification System (EVS) at 1-866-710-1447. EVS is an automated system that you can use 24 hours a day, 7 days a week. To use EVS, you will need your provider number and either the participant's medical assistance number or the participant's social security number and the date(s) of service. To retrieve an EVS Brochure call 410-767-6024 to request one or go to the internet at: *https://encrypt.emdhealthchoice.org/emedicaid/eDocs/pe/E0003EvsUserGuide.pdf*.

Frequently Asked Billing Questions

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

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

4. ***How do I submit claims for reimbursement?***

Electronic Billing

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

The Department of Health and Mental Hygiene (DHMH) does not provide software for electronic billing. Providers may consult with billing software vendors to learn about electronic billing.

Paper Billing

Providers may continue to submit paper claims to DHMH for claims processing, but will experience longer processing times. Paper claims are generally paid within 4-6 weeks. Providers who choose to submit paper claims must use the CMS-1500 billing form and should send the forms to:

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

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

If you are billing on paper, you must submit all claims for Living at Home Waiver services on the CMS-1500 (08-05), previously called the HCFA-1500. You may purchase these forms from a stationary or office supply store. A sample claim is included on page 10.

Frequently Asked Billing Questions

5. *What waiver services are billed on the CMS-1500?*

All waiver services covered under the Living at Home Waiver, which include:

- Assistive Technology
- Attendant Care Services
- Case Management
- Consumer Training
- Dietitian and Nutritionist Services
- Environmental Accessibility Adaptations
- Environmental Assessments
- Family Training
- Home-Delivered Meals
- Medical Day Care*
- Nursing Supervision of Attendants
- Personal Emergency Response Systems
- Transition Services

*Please note Medical Day Care services are billed through the Medical Assistance Personal Care Services program administered by the Community Long Term Care Division. Billing inquiries should be directed to that department at 410-767-1444.

Filing Limitations

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

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

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

Frequently Asked Billing Questions

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

   To avoid payment delays, you should:

   - Make sure all information entered on the claim form is correct, including your Provider Number and the Participant's Medical Assistance ID Number.
   - If a waiver participant has other insurance besides Medical Assistance, such as Medicare, private insurance, or other health insurance coverage, the participant's other insurance carriers should be contacted to verify if the waiver service is covered. **If the insurer does not cover the waiver service, please indicate "Services not Covered" by inserting Value "K" in Block 11 of the CMS-1500.**

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

   Completed claims should be mailed to the following address:

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

Instructions for Completing the CMS-1500

Instructions for Completing the CMS-1500

Living at Home Waiver providers are required to complete certain blocks on the CMS-1500 in order to receive payment. Table 1 shows all blocks that must be completed on the CMS-1500 form to receive payment for Living at Home Waiver services.

Remember:

- Always use the CMS-1500.
- Use one CMS-1500 form for each waiver participant.
- Be sure that the information entered on the form is legible.
- Be sure that the information entered is correct, especially when entering your Provider Number and the recipient's Medical Assistance ID number.
- Enter all information with blue or black ink.
- **Claims must be submitted within 12 months of the date of service.**

Payment Procedures can be found in COMAR 10.09.55.29.

TABLE 1: Blocks to Complete on CMS-1500 for Billing Living at Home Waiver Services

Block #	Title of Block	Required Entry
1.	Medicare/Medicaid/CHAMPUS/ CHAMPVA/Group Health Plan/FECA Black Lung/Other	Check the box for Medicaid. Also, check the appropriate box(es) for any other type(s) of insurance applicable to this claim.
2.	Patient's Name	Enter participant's last name, first name, and middle initial from the Medicaid Assistance Card (e.g., Doe, John A).
9a.	Other Insured's Policy or Group Number [Participant's Medicaid ID number]	Enter the **participant's 11-digit Medical Assistance ID number** as it appears on the Medical Assistance Card. The Medical Assistance ID number **MUST** appear here, regardless of whether the participant has other health insurance.

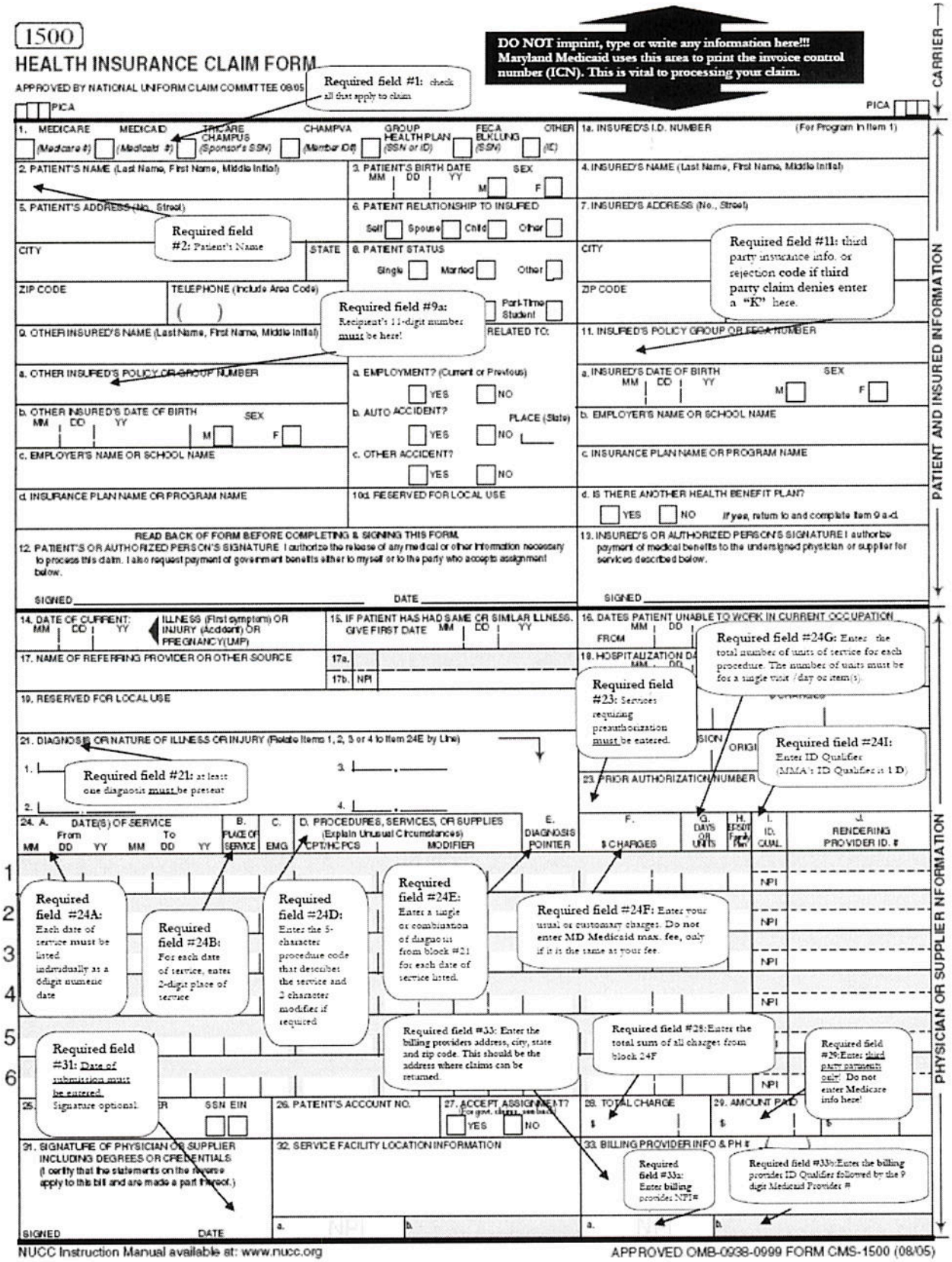
Instructions for Completing the CMS-1500

Block #	Title of Block	Required Entry
11.	Insured's Policy Group of FECA Number	Insert Value "**K**" of the Maryland Medicaid Billing Instructions, in Block 11 of the CMS-1500.
21.	Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, or 4 to Item 24.E. by Line)	Participants are diagnosed as Other Specified Housing or Economic Situation; enter code "**608.00**." If the participant is diagnosed as Other Unspecified Housing or Economic Situation, enter code **"609.00**."
24A.	Date(s) of Service From MM DD YY	Enter each separate date of service as a 6-digit numeric date (e.g. 07 01 07) for month, day, and year under the "**From**" heading. **Leave blank** the space under the "**To**" heading. Each date of service must be listed on a separate line. Ranges of dates **are not** accepted on this form.
24B.	Place of Service	For each waiver service, enter the appropriate place of service code: **11** for provider's office, **12** for participant's residence, or **99** for other facility.
24D.	Procedures, Services, or Supplies CPT/HCPCS	In the block for CPT/HCPCS, enter the 5-digit Medicaid procedure code for the waiver service (e.g., W4000).
24E.	Diagnosis Pointer	In the block for Diagnosis Pointer, enter the corresponding line number from Block 21 (e.g., 1, 2, 3, or 4).

Instructions for Completing the CMS-1500

Block #	Title of Block	Required Entry
24F.	$ Charges	Enter the **total** charge billed for the procedure code (not the cost per unit of service). Do not enter the maximum fee unless that amount is your usual and customary charge. If there is more than one unit of service on a line, the charge entered for this block should be the **total** for all units on this line.
24G.	Days or Units	Enter the number of units of service for each procedure. The number of units must be for a single device, visit, or job.
28.	Total Charge	Enter the sum of the charges shown on all lines for Block 24F.
31.	Signature of Physician or Supplier including Degree or Credentials [Degree]	**Enter the date the CMS-1500 was completed or submitted. A date must be placed in this field in order for the claim to be reimbursed.** Signature by the payee provider's authorized representative is optional. Signature by physician or supplier should include degree or credentials.
33.	Provider's Billing Name, Address, Zip Code, and Phone Number	Enter the name, street, city, and zip code to which the claim may be returned.
33a.	Provider's Medicaid Provider Number [National Provider Identifier]	**Your 9-digit provider number to which payment is made MUST be prefixed with a '5' in order for the claim to be reimbursed** (e.g., 5012345678).
33b.	Provider's Medicaid Provider Number	**Your 9-digit provider number to which payment is made MUST be prefixed with a '1D' in order for the claim to be reimbursed** (e.g., 1D012345678).

Instructions for Completing CMS-1500



Specific Information for Waiver Services

A. Assistive Technology (COMAR 10.09.55.20 and 10.09.55.28)

Procedure Code	Service	Unit of Service	Maximum Rate Per 12-Month Period
W4015	Assistive Technology	1 unit	$6,184.19

Covered Service

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

Limitations

- The total reimbursement by the Program for environmental accessibility adaptations and assistive technology are limited during a 12-month period, with exceptions allowed at the Department's discretion in the following circumstances:
  - The amount exceeds the limit, but will allow the individual to return home from a nursing facility or avoid immediate placement in a nursing facility, and does not exceed the participant's cost neutrality; or
  - Expenditures over the limit annually will reduce the participant's ongoing Medicaid cost of care significantly without exceeding the participant's cost neutrality.
- Reimbursement for a piece of equipment to cost over the amounts indicated shall be preapproved by the Department based on at least two cost estimates from prospective providers.

B. Attendant Care Services (COMAR 10.09.55.17 and 10.09.55.28)

Procedure Code	Service	Unit of Service	Maximum Rate Per Hour
W4000	Attendant Care (agency provider)	1 hour	$16.52 per hour
W4001	Attendant Care (consumer-employed provider)	1 hour	$12.93 per hour

Covered Service

- Definition. "Unit of service" means an hour of service that is preapproved in the plan of service and rendered to a participant by a qualified provider in the participant's home or in a community setting.

Specific Information for Waiver Services

Limitations

- The Program may not reimburse for attendant care services provided under this chapter if:
  - On the same date of service, a participant also received personal care services under COMAR 10.09.20; or
  - Rendered for more than 23 hours for a participant on the same date of service.

C. Consumer Training (COMAR 10.09.55.21 and 10.09.55.28)

Procedure Code	*Service*	*Unit of Service*	*Maximum Rate Per Hour*
W4006	Consumer Training	1 hour	$39.11 per hour

Covered Service

- Definition. "Unit of service" means an hour of service rendered one-on-one by a qualified provider to a participant, not including the time spent by the provider:
  - Planning, preparing, or setting up the training; or
  - Following up after the training.

Limitations

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

D. Dietitian and Nutritionist Services (COMAR 10.09.55.26-2)

Procedure Code	*Service*	*Unit of Service*	*Maximum Rate Per Hour*
W0223	Dietitian and Nutritionist Services	1 hour	$60.32 per hour

Covered Service

- Definition. "Unit of service" means an hour of service rendered one-on-one by a qualified provider for a participant in the participant's home or the provider's office.

E. Environmental Accessibility Adaptations (COMAR 10.09.55.18 and 10.09.55.28)

Procedure Code	*Service*	*Unit of Service*	*Maximum Rate Per 12-Month*
W4008	Environmental Accessibility Adaptations	1 unit	$6,184.19

Covered Service

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

Specific Information for Waiver Services

Limitations

- The total reimbursement by the Program for environmental accessibility adaptations and assistive technology combined is limited to the amount specified per participant during a 12-month period, with exceptions allowed at the Department's discretion in the following circumstances:
  - The amount exceeds the limit, but will allow the individual to return home from a nursing facility or avoid immediate placement in a nursing facility, and does not exceed the participant's cost neutrality under Regulation .27E of this chapter; or
  - Expenditures over the limit annually will reduce the participant's ongoing Medicaid cost of care significantly without exceeding the participant's cost neutrality.
- Reimbursement for a piece of equipment estimated to cost over the amounts indicated shall be preapproved by the Department based on at least two cost estimates from prospective providers.
- Reimbursement by the Program for environmental accessibility adaptations is limited to modifying two residences of the participant in every 3 consecutive years.

F. Environmental Assessments (COMAR 10.09.55.26)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Unit***
W0225	Environmental Assessment	1 hour	$383.80 per assessment

Covered Service

- Definition. "Unit of service" means the completion of:
  - An on-site environmental assessment of a home or residence where the participant lives or will live as a participant; and
  - A form approved by the Program.

G. Family Training (COMAR 10.09.55.22 and 10.09.55.28)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Hour***
W4003	Family Training (agency provider)	1 hour	$37.75 per hour
W4004	Family Training (self-employed provider)	1 hour	$25.90 per hour

Covered Service

- Definitions. "Unit of service" means an hour of service rendered by a qualified provider to one or more family members at the same time in the participant's home or the provider's office, regardless of the number of family members trained at one time, not including the time spent by the provider:
  - Planning, preparing, or setting up the training; or

Specific Information for Waiver Services

- Following up after the training.
- "Family member" means an individual who:
  - Lives with or provides assistance to the participant; and
  - Is not paid to provide the care.

Limitations

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

H. Home-Delivered Meals (COMAR 10.09.55.26-1)

Procedure Code	*Service*	*Unit of Service*	*Maximum Rate Per Unit*
W0224	Home-Delivered Meals	1 hour	$5.48 per meal

Covered Service

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

I. Medical Day Care (COMAR 10.09.55.24 and 10.09.07.06)

Procedure Code	*Service*	*Unit of Service*	*Maximum Rate Per Unit*
S5102	Medical Day Care	1 day	$71.08 per day

Covered Service

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

J. Nursing Supervision of Attendants (COMAR 10.09.55.25 and 10.09.55.28)

Procedure Code	*Service*	*Unit of Service*	*Maximum Rate Per Hour*
W4017	Nursing Supervision (agency provider)	1 hour	$37.75
W4018	Nursing Supervision (self-employed provider)	1 hour	$25.90

Covered Service

- Definition. "Unit of service" means an hour of service rendered one-on-one by a nurse monitor for a participant in the participant's home or another community-based setting where attendant care services are received.

Specific Information for Waiver Services

Limitations

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

K. Personal Emergency Response Systems (COMAR 10.09.55.19 and 10.09.55.28)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Unit***
W4010	Personal Emergency Response Systems	1 unit	$1,101.91
W4013	Personal Emergency Response Systems (maintenance)	1 month	$45.00 monthly
W4012	Personal Emergency Response Systems (monitoring)	1 month	$45.00 monthly
W4011	Personal Emergency Response Systems (with motion detector)	1 unit	$1,322.28

Covered Service

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

Limitations

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

L. Transitional Services (COMAR 10.09.55.23 and 10.09.55.28)

Procedure Code	***Service***	***Unit of Service***	***Maximum Rate Per Unit***
T2038	Transition Services	1 unit	$3,000 one-time expense

Covered Services

- Definition. "Unit of service" means a one-time service that is:
  - Not otherwise available under the waiver;
  - Approved in the plan of service; and

Specific Information for Waiver Services

- Rendered to an individual by a qualified provider to assist the participant in transitioning from a nursing facility to a community residence.

Limitations

- Reimbursement by the Program for transitional services is limited to a one-time expense of $3,000 per participant, with exceptions allowed at the Department's discretion.