District of Columbia Medicaid Bulletin

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INSIDE THIS ISSUE

MAA ANNOUNCES PILOT PRIOR AUTHORIZATION PROJECT

The Medical Assistance Administration (MAA) Office of Quality Management (OQM) is pleased to announce the implementation of a Pilot Prior Authorization Project, effective June 1, 2007. Please refer to MAA Transmittal #07-11, dated April 23, 2007, for details.

The purpose of this project is to continue and further enhance the quality of services delivered by MAA. This project will establish a systematic and centralized point of entry for the authorization of outpatient services; sleep studies, PET scans, and non-cosmetic Botox injections. The Delmarva Foundation, MAA's contracted Quality Improvement Organization (QIO), will facilitate the project and OQM will provide monitoring and oversight.

Physicians, sleep center providers, and PET scan center providers will be required to submit a 719A Form via facsimile (1-866-279-2011) to the Delmarva Foundation Prior Authorization Unit for clinical review and authorization consideration. Notification of authorization will be returned to the requesting provider within three (3) business days. In accordance with Medicaid policy, recipients have the right to appeal any denied services and may contact the Medicaid Program for information on the appeal process.

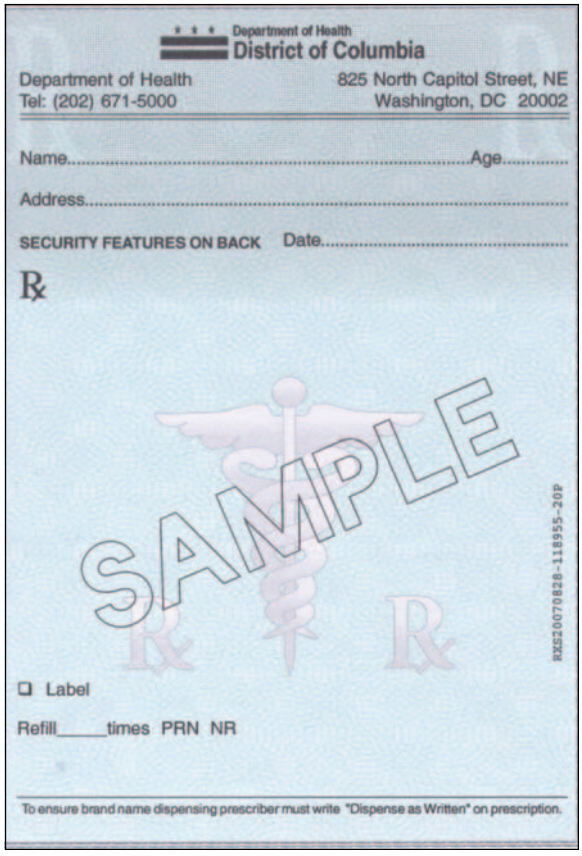
To encourage a seamless transition, upon request, the Affiliated Computer Services (ACS) Provider Relations Unit is available to provide training to physicians and the respective service centers on the completion of the 719A Forms and the prior authorization process.

Additional questions, requests for copies of the project transmittal and requests for 719A Forms should be directed to the ACS Provider Relations Unit at 202-906-8319 or 1-866-752-9233, if outside of DC Metro area. Please direct inquiries pertaining to the authorization process to the Delmarva Foundation Prior Authorization Unit at 1-866-876-3362, ext. 7416.

TAMPER-RESISTANT Rx PADS

Beginning October 1, 2007, the Centers for Medicare and Medicaid Services (CMS) will require the use of tamper-resistant prescription pads for all Medicaid non-electronic prescriptions. The regulations for the new Medicaid mandate are available from CMS and the final provisions have been published as of August 17, 2007.

In accordance with this new regulation, the Medical Assistance Administration (MAA) will also require the use of tamper-resistant prescription pads for all non-electronic prescriptions written for the DC Medicaid fee-for-service recipients starting October 1, 2007. To assure compliance, MAA will make available to our prescription writing providers a limited quantity of tamper-resistant prescription pads for use to our recipients. Upon receipt of these pads you are urged to exercise extreme care and secure the pads properly as we prepare to implement the new requirement. After the initial supply of tamper-resistant pads is exhausted, providers will be responsible for replenishing their supply. The regulations for the tamper-resistant prescription pads can be found on the CMS Website at **www.cms.hhs.gov**.



ASSISTANCE FROM THE PROVIDER FIELD REPRESENTATIVE

The ACS Provider Field Representative is available to assist you by telephone, email, or in person with complex billing questions, claims issues, and provider education. However, in an effort to deliver the highest quality service to providers who wish to meet individually with the Provider Field Representative, providers are encouraged to schedule an appointment. Appointments may be scheduled at a time that is convenient for you. When scheduling your appointment, please provide a list of your issues to be covered. This will allow the representative an opportunity to research the issues and be prepared to provide needed assistance to you. To schedule your appointment, please call (202) 906-8319 (inside DC metro area) or (866) 752-9233 (outside DC metro area).

REMINDER- NPI DEADLINE APPROACHING

The National Provider Identifier (NPI) is a unique 10-digit number used to identify health care providers. The NPI eliminates the need for health care professionals to use different numbers when conducting transactions with multiple commercial and government health plans. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all covered entities (i.e., providers, clearinghouses and large health plans) to begin using NPI(s) on standard health care electronic transactions.

Who is responsible for obtaining and using an NPI?
The NPI must be used by HIPAA covered entities which include health plans (examples: Medicare, Medicaid, and private health insurance issuers), health care clearinghouses, and health care providers (individuals and organizations) that conduct electronic transactions. There are two types of health care providers in terms of NPIs:

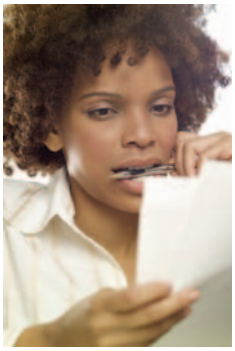
- **Type 1** – Health care providers who are individuals, including physicians, dentists, and ALL sole proprietors. An individual is eligible for only one NPI.
- **Type 2** – Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

How Do I Apply for an NPI?
To apply for an NPI, providers should visit the National Plan and Provider Enumeration System (NPPES) Website at **https://nppes.cms.hhs.gov/NPPES** as soon as possible. You may request a paper application by calling 1-800-465-3203.

If you are an individual who is a health care provider and are incorporated, you may need to obtain an NPI for yourself (Type 1) and an NPI for your corporation or LLC (Type 2).

Organizations must determine if they have "subparts" that need to be uniquely identified in HIPAA standard transactions with their own NPIs. A subpart is a component of an organization that furnishes health care and is not itself a separate legal entity. For more information on subparts, the Centers for Medicare and Medicaid (CMS) has published a document on Medicare Subpart Expectations. This document is available on CMS' Website at http://www.cms.hhs.gov. Once the homepage is accessed, click on the link entitled, "Medicare NPI Implementation" which is on the left-hand side of the homepage. Under downloads, click on "Medicare Subpart Expectations" to view the document in its entirety.

How do I report my NPI?



If you have obtained your NPI(s) with the certification form from the Centers for Medicare and Medicaid Services (CMS), then you are ready to report your NPI(s) to DC Medical Assistance Administration (MAA). Please prepare a facsimile cover page and include the following information in transmitting your NPI information to the ACS Provider Enrollment fax number: (202) 906-8399.

1. The name of a representative in your organization to be contacted
2. A direct telephone number
3. A fax number
4. Email address

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REMINDER - NPI DEADLINE APPROACHING

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5. A copy of the NPI CMS certification form
6. A corresponding 8-digit DC Medicaid Provider Number

The above information may also be mailed to:

Provider Enrollment
P. O. Box 34761
Washington, DC 20043-4761

When do I start using my NPI?

Presently, ACS is designing the modifications to accept the NPI on HIPAA standard transactions. Once the modifications have been completed, you will receive official notification of when you will be able to begin using your NPI on HIPAA standard transactions submitted to Medicaid. In the interim, DC Medicaid will continue to accept the 9-digit DC Medicaid provider number on HIPAA standard transactions. The atypical provider (providers not covered by NPI) will continue to bill using the 9-digit DC Medicaid provider number.

CMS-1500 PAPER CLAIM SUBMISSION

ACS will begin processing CMS-1500 claim forms using Optical Character Recognition (OCR) this fall. OCR technology is widely accepted by commercial and governmental healthcare financing organizations. The District of Columbia Medicaid is implementing this technology in an effort to increase efficiency and accuracy. OCR processing requires that claims be typewritten on "red-drop-out" forms. CMS-1500 claims forms can be purchased from a variety of vendors including forms distributors, print vendors, GPO (Government Printing Office) and office supply companies.

Providers are encouraged to use typewritten "red drop-out" forms for all CMS-1500 claim submissions to prevent possible delays in claims processing if handwritten, photocopied, and other black and white formats are used.

NEW NON-EMERGENCY TRANSPORTATION BROKER

Effective July 20, 2007, the Medical Assistance Administration (MAA) entered into a Non-Emergency Transportation (NET) Broker contract with Medical Transportation Management, Inc. (MTM) to manage and administer NET services for the District's Medicaid eligible fee-for-service recipients. MTM has begun its implementation process and the NET program will be fully operational by October 19, 2007. MAA will continue to manage and administer the NET Program through October 19, 2007, the date when all responsibilities will be transferred to MTM with MAA providing oversight.

Under the new program, transportation providers must contract transportation services with the broker directly. MAA will no longer enroll transportation providers or authorize transportation requests. For additional information or if you have questions, contact Amy Mueller at MTM at (888) 561-8747.

SUBMISSION OF ADJUSTMENTS AND VOIDS

Oftentimes, healthcare providers find it necessary to correct information previously submitted on a Medicaid claim at a later date. This task can be accomplished by submitting an adjustment or void request using the following steps:

- Identify the transaction control number (TCN) of the claim(s) to be adjusted or voided. The TCN is a 17-digit number, which can be retrieved from the remittance advice.
- For adjustments, submit a corrected claim. The corrected claim should represent all services rendered for the date of care. Submitting only additional charges will result in incorrect processing of the claim.
- For voids, submit the claim as originally submitted including all services that were rendered on the service date.
- Once the adjustment and voided claims include the necessary data, indicate the letter A or V for an adjustment or void.
- Following the A or V, there should be a 17-digit TCN with the appropriate adjustment reason code (A 0-07367-00-850-0001-00 C0).

Please Note:

- When submitting an adjustment or void on a CMS 1500, please indicate the TCN to be adjusted or voided in the appropriate format (A 0-07367-00-850-0001-00 C0) in the top left hand corner of the claim.
- When submitting an adjustment or void on a UB-92, please indicate the TCN to be adjusted or voided in the appropriate format (V 0-07367-00-850-0001-00 C0) in field 82.

The following items should be kept in mind when submitting adjustment or voids:

- Denied claims cannot be adjusted
- Provider IDs cannot be adjusted
- Recipient IDs cannot be adjusted
- Adjustment claims must be submitted within one year of the payment date of the original claim
- Voids can be submitted at anytime. There is no time limit on void requests.

Submission of Electronic Adjustment and Voids

Submission of adjustments and voids electronically utilizing WINASAP2003 (WA3) allows transactions to be processed in a much more efficient manner. Please follow the steps indicated below when submitting adjustment and void transactions on WA3:

Adjustments

- Select the claim to be adjusted
- Click the Copy Claim icon at the bottom of the screen (or enter claim if not in list)
- Click in the Bill date field and press the F5 key
- On the Claim Data Screen, select Replacement for Claim Frequency Type Code
- On the Claim Codes Screen, select Other Claim Level Numbers and enter the 17-digit TCN in the Claim Original Reference Number field, and then click OK

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SUBMISSION OF ADJUSTMENTS AND VOIDS

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- Go to the Claim Line Items Screen, make the necessary changes then save claim
- On the Claim Codes Screen, select Other Claim Level Numbers and enter the 17-digit TCN in the Claim Original Reference Number field, and then click OK

Voids

- Select the claim to be voided
- Click the Copy Claim icon at the bottom of the screen (or enter claim if not in list)
- Click in the Bill date field and press F5 key
- Save Claim
- On the Claim Data Screen, select Void, Cancel of Prior Claim for Claim Frequency Type Code
- On the Claim Codes Screen, select Other Claim Level Numbers and enter the 17-digit TCN in the Claim Original Reference Number field, and then click OK

CONTACTING CUSTOMER SERVICE

Our Provider Customer Services' staff is available to assist you Monday through Friday from 8:00 a.m. to 5:00 p.m. In order to obtain information quickly and efficiently, please note the following:

- Our call volume is the lowest between the hours of 8:00 a.m. to 10:00 a.m., and 4:00 p.m. to 5:00 p.m. To obtain faster service, it is recommended that you please call during those times.
- Please have all pertinent information ready when speaking to the Provider Inquiry associate. You will need:
  - Provider number and Tax ID
  - Recipient number
  - Date(s) of service
  - Billed amount
  - Any other information you may need when asking for information (e.g., RA date, PA number, etc.)

- Please do not place the Provider Inquiry associate on hold. If this happens, our staff is instructed to wait only a few seconds before ending the call because they are obligated to move on to respond to other callers.
- We try to provide you with helpful information throughout the year. Please refer to your Bulletins, banner messages, and provider manuals for assistance in understanding the policies and procedures for the DC Medicaid program.
- For recipient eligibility information, use the automated Eligibility Verification System (EVS). You can access up to the minute recipient information quickly by dialing (202) 610-1847 (inside DC metro area) or (866) 752-9233 (outside DC metro area) and follow the instructions provided. When using the EVS, you must have the recipient's ID and your provider numbers available.

REQUESTING WINASAP2003

WINASAP20003 may be downloaded from http://www.acs-gcro.com or you may request a CD be mailed to you by contacting Provider Inquiry at (202) 906-8319 (inside DC metro area) or (866)752-9233 (outside DC metro area).

RETRO-ELIGIBILITY PROCESSING

Initial claims for services provided to District of Columbia fee-for-service recipients must be received by ACS, Medicaid Fiscal Agent, no later than six-months from the ending date of service unless the claim is a retro-eligibility claim. A retro-eligibility fee-for-service claim is considered a timely submission if the initial claim is received by ACS no later than 12-months from the date of eligibility posting; however, retro-eligibility claims must be accompanied by an attachment indicating retro-eligibility status.

PARTIAL REMITTANCE ADVICE

ACS does not routinely mail DC Medicaid remittance advices that exceed 100 pages; however, the banner page and summary page are provided for notification of claim processing. ACS provides a number of efficient options to DC Medicaid providers wishing to obtain a complete copy of the remittance advice.

- **Electronic Remittance** – HIPAA compliant X12N-835 electronic transactions. Contact the ACS EDI Unit at (866) 407-2005 for an EDI application.

- **Electronic Report File** – Access remittance via the web in familiar report format. Contact the ACS EDI Unit at (866) 407-2005 to complete an EDI application for an Internet Data Exchange (IDEX) ID.

- **Remit on CD-ROM** – Familiar report format burned to CD-ROM. Contact the ACS Provider Inquiry Unit at (202) 906-8319 (inside DC metro area) or (866)752-9233 (outside DC metro area).

- **Remit reprint** – Reprint of remittance advice (paper). Contact the ACS Provider Inquiry Unit at (202) 906-8319 (inside DC metro area) or (866)752-9233 (outside DC metro area).

PROVIDER TRAINING SCHEDULE

General Information
ACS offers a variety of Medicaid provider billing workshops throughout the year. Basic training workshops provide a general overview of Medicaid billing for new billers. Specialty Training Workshops provide more detailed billing training based on specific provider type and provider needs.

Many topics are covered in the trainings, including an overview of the District of Columbia Medicaid Program, billing instructions, eligibility issues, TPL, prior authorizations, crossovers, remittance advices, claims processing, electronic billing, and other billing issues.

Who Should Attend?
The provider billing workshops are designed for new or experienced billers, admission personnel, office managers, and other billing personnel. Attendees can choose between the Basic Workshops, which begin at 10:00 a.m. and end at 12:00 p.m. and Specialized Training Workshops that last from 2:00 p.m. to 4:00 p.m. Providers are encouraged to arrive 15 minutes prior to the start of a session.

Do I need Reservations?
Yes, reservations are required for all workshops. Contact ACS Provider Services at (202) 906-8319 (inside DC Metro area) or (866) 752-9233 (outside DC Metro area) or you may complete the ACS Medicaid Workshop Registration Form located on page 9.

What About Other Training?
ACS Field Services also offers individual provider visits/trainings on an on-going basis. These visits are available to new providers, as well as existing providers with Medicaid billing issues. To request a field service visit to your office or to request training at the ACS location, please complete and return an ACS Provider Visit Request Form located on page 10 or feel free to contact ACS Provider Services at (202) 906-8319 (inside DC Metro area) or (866) 752-9233 (outside DC Metro area). ACS Provider Field Services will contact you to schedule a visit and discuss the type of issues to be addressed.

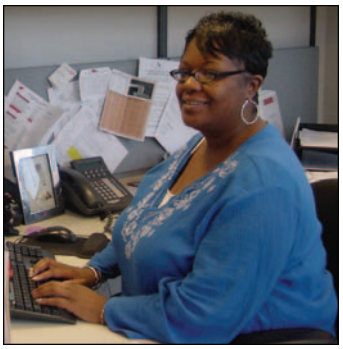
***Note: All monthly workshops are held at the ACS Training Room, 750 First Street NE, Suite 1020, Washington, DC 20002.**

(Registration Form listed on next page)

Training Schedule

Provider Type	Date	Overview
ICF/MR	**Nov. 12-16**	Covers CMS1500/UB92 billing procedures, common billing issues, and guidelines for ICF/MR providers.
Practitioners	**Dec. 3-7**	Covers CMS1500 billing procedures, common billing issues, and guidelines for Physician, Independent Lab, Nurse Practitioner, and Independent Radiologist providers.

INTRODUCING…WHO'S WHO @ ACS



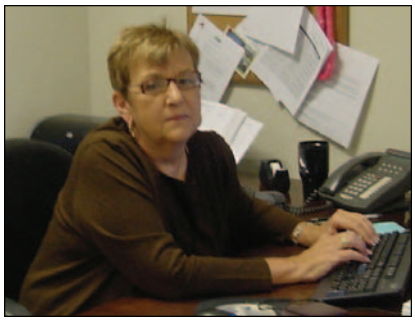
Jacqueline Edwards: New Provider Relations Manager

Jackie Edwards joined the DC FAS Medicaid operations as the new Provider Relations Manager on August 6, 2007. She brings with her over 22 years of customer service experience, 13 years of healthcare experience, and 12 years experience in a leadership role. In the role of Provider Relations Manager, she is responsible for overseeing the operation of Provider Inquiry, EDI, Provider Enrollment and Provider Field Services. Mrs. Edwards' goal is to improve the quality of service that has been provided to the provider community.

Tyesha Nichols: New Provider Relations Supervisor

Tyesha Nichols joined the DC FAS Medicaid operations on August 6, 2007, as the new Provider Relations Supervisor. As the Provider Relations Supervisor, Ms. Nichols works closely with the Provider Relations Manager, Jacqueline Edwards to ensure that the Provider Relations Department runs smoothly and effectively.

Ms. Nichols is specifically responsible for day-to-day operations overseeing the call centers for Provider Enrollment, Provider Inquiry and EDI Technical Support. She is also accountable for facilitating new provider applications, resolving provider claims issues, as well as claim appeals.



Cindy Bencivenni: New Systems Implementation Manager

Cindy Bencivenni has over 30 years of system design and management experience, in the area of MMIS development, implementation, and maintenance. Before joining the DC MMIS project, she has worked extensively with numerous state Medicaid agencies for MMIS development and operations, including the Nevada Medicaid, New Jersey Division of Medical Assistance and Health Services, Kentucky Cabinet for Health Services, Mississippi Division of Medicaid, Alaska Division of Medical Assistance, Missouri Division of Medical Services, District of Columbia Medical Assistance Administration, West Virginia Office of Medical Services, Delaware Department of Health and Social Services, and New Mexico Medical Assistance Division.

IMPORTANT NUMBERS AND ADDRESSES

Provider Inquiry PO Box 34734 Washington, DC 20043-4761	(202) 906-8319 (inside DC metro area) (866) 752-9233 (outside DC metro area) (202) 906-8399 (Fax)	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
Provider Enrollment PO Box 34761 Washington, DC 20043-4761	(202) 906-8318 (inside DC metro area) (866) 752-9231 (outside DC metro area) (202) 906-8399 (Fax)	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
ACS EDI Gateway Services	(866) 407-2005 http://www.acs-gcro.com	Hours of Operation Monday - Friday 8:00 am - 5:00 pm

Claims Department	
UB92 Claim Forms	PO Box 34693 Washington, DC 20043-4761
CMS1500 Claim Forms	PO Box 34768 Washington, DC 20043-4761
ADA and Pharmacy Claim Forms	PO Box 34714 Washington, DC 20043-4761
Adjustment/ Void Forms	PO Box 34706 Washington, DC 20043-4761
Medicare Crossover Claim Forms	PO Box 34770 Washington, DC 20043-4761
278 Prior Authorization Transaction Attachments	PO Box 34756 Washington, DC 20043-4761
837 Claim Transaction Attachments	PO Box 34631 Washington, DC 20043-4761

The *Medicaid Bulletin* is published bi-monthly by the District of Columbia Medical Assistance Administration and ACS Government Healthcare Solutions.

To obtain back issues, write to:
Attn: Publications
ACS Government Healthcare Solutions
750 First St. NE, Suite 1020
Washington, DC 20002
Email: dcmedicaid.news@acs-inc.com

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DC Medicaid Workshop Registration Form

Seminar Date & Time _____

Attendee(s) Name _____

Medicaid Provider # _____

Provider Name _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

Email _____

Please fax completed form to (202) 906-8399
Attn: Publication Coordinator

ONLINE PROVIDER SATISFACTION SURVEY

Are you satisfied with the level of service you receive from the Provider Inquiry unit? Do the DC Medicaid Publications you receive meet your needs? Do you have any suggestions for Medicaid training topics?

We want to hear from you. Simply type the address below into your web browser and a welcome page will appear. The survey should only take three to four minutes to complete. All response will be anonymous. Your feedback helps us improve our service.

Go to: http://www.zoomerang.com/recipient/survey-intro.zgi?p=WEB224C6T7ZLET.

Provider Feedback Form

Provider Name _____

Provider Type _____

Medicaid Provider # _____

Phone _____

_____

Comments _____

_____

Please fax completed form to (202) 906-8399
Attn: Provider Services Manager

750 First Street, NE
Suite 1020
Washington, DC 20002

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District of Columbia
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Fax: 202-610-3209
www.dchealth.dc.gov