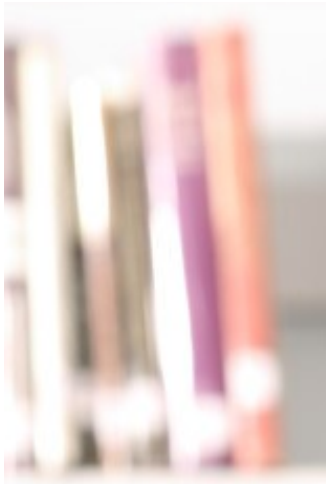
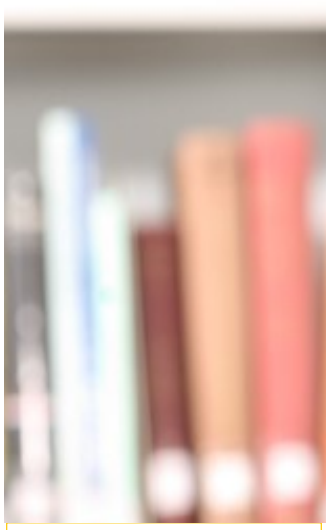
DC Medicaid Bulletin

Bi-monthly Publication for DC Medicaid Providers

Newsletter Date
Volume 15, Issue 4
July - October 2021





Latest News

Attending Provider Enrollment & NPI Requirements for Institutional Claims

The Department of Health Care Finance (DHCF) requires that all institutional claims, whether submitted electronically or by paper, contain the National Provider Identifier (NPI) of an attending physician who is enrolled and in active status as a D.C. Medicaid provider, as of the applicable date of service. This requirement supplements DHCF Transmittal #19-07, which required the NPI of an enrolled attending physician on claims submitted electronically only.

Under 42 C.F.R. § 455.410(b), ordering, referring, and prescribing (ORP) providers are required to "be enrolled as participating providers" with the state Medicaid agency in order for there ordered, referred, and prescribed services to be billable to Medicaid. The Centers for Medicare and Medicaid Services (CMS) interprets this enrollment requirement to include attending physicians supervising care in institutional settings. For such services, the attending physician serves as the ORP provider, and must be enrolled as a D.C. Medicaid provider in order for the subject service to be reimbursed by DHCF.

DHCF will deny claims with dates of service on or after thirty (30) days from the date of **Transmittal #21-36**.

Contact
If you have any questions related to this requirement, please contact Donald Shearer, Director of the DHCF Healthcare Operations Administration at donald.shearer@dc.gov.

Professional Services Billing Codes & Reimbursement Rates for COVID-19 Vaccines – Addition of Third Doses for Pfizer and Moderna Vaccines for Immunocompromised People

Transmittal #21-37 amends guidance provided in Transmittal # 21-26: Professional Services Billing Codes and Reimbursement Rates for COVID-19 Vaccine issued June 30, 2021, to add the codes and rates for the third doses of the Pfizer and Moderna vaccines. CDC recommends that people with moderately to severely compromised immune systems receive an additional dose of mRNA COVID-19 vaccine at least 28 days after a second dose of Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 vaccine. DHCF expects additional CDC guidance on additional doses or booster shots for other population is forthcoming and will issue additional updates as needed.

Billing Codes & Reimbursement
The billing and reimbursement rates for COVID-19 Vaccines are based on the published guidance by CMS. If newer rates are published by CMS or a Medicare Administrator Contractor (MAC), the rates may be updated with retroactive payment adjustments as necessary. CMS only priced the administration of these services as the product is being provided for free initially.

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In accordance with regulations at 42 CFR § 447.15, providers may not balance bill Medicaid beneficiaries amounts additional to the amount paid by the agency plus any deductible, coinsurance or copayment required by the state plan to be paid by the beneficiary.

The table below provides the relevant and most current billing and reimbursement guidance for all COVID-19 vaccines covered by DHCF to date for professional providers. New information is highlighted in bold:

Administration

M0201 (COVID-19 Vaccine Home Admin) is an add-on code for each dose of a vaccination administered in the home setting. Do not report this code for any place of service other than those considered as in-home.

HCPCS/ CPT	Description	Labeler Name	Effective Date	Max Units	PA Required	Rate for Claims with Date of Service through 03/14/2021	Rates for Claims with Date of Service on or after 3/15/2021
0001A	ADM SARSCOV2 30MCG/0.3ML 1st	Pfizer	12/11/2020	1	No	$16.94	$47.10
0002A	ADM SARSCOV2 30MCG/0.3ML 2nd	Pfizer	12/11/2020	1	No	$28.39	$47.10
0003A	**ADM SARSCOV2 30MCG/0.3ML 3rd**	**Pfizer**	**8/12/2021**	**1**	**No**	**N/A**	**$47.10**
0011A	ADM SARSCOV2 100MCG/0.5ML 1st	Moderna	12/28/2020	1	No	$16.94	$47.10
0012A	ADM SARSCOV2 100MCG/0.5ML 2nd	Moderna	12/28/2020	1	No	$28.39	$47.10
0013A	**ADM SARSCOV2 100MCG/0.5ML 3rd**	**Moderna**	**8/12/2021**	**1**	**No**	**N/A**	**$47.10**
0031A	ADM SARSCOV2 VAC AD26 .5ML	Janssen	2/27/2021	1	No	$28.39	$47.10
M0201	COVID-19 VACCINE HOME ADMIN	N/A	6/8/2021	1	No	N/A	$41.38

Products

Since CMS anticipates that providers will not incur a cost for the products for vaccines initially, CMS will update the payment allowance for the products at a later date. Providers should not bill for the product if they received it for free, thus the following product codes are not covered at this time in the professional fee schedule.

HCPCS/ CPT	Description	Labeler Name
91300	SARSCOV2 VAC 30MCG/0.3ML IM	Pfizer
91301	SARSCOV2 VAC 100MCG/0.5ML IM	Moderna
91303	SARSCOV2 VAC AD26 .5ML IM	Janssen

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Professional Services Billing Codes & Reimbursement Rates for COVID-19 Vaccines – Addition of Third Doses for Pfizer and Moderna Vaccines for Immunocompromised People

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For MCO beneficiaries: Providers should follow instructions provided by the beneficiary's MCO for billing for COVID-19 vaccine administration. MCOs are required to reimburse providers at or above the rates published in this transmittal. Contact the appropriate MCO for more information:

- AmeriHealth Caritas DC Provider Services: 202-408-2237 or 1-888-656-2383
- CareFirst Community Health Plan DC Provider Services: 202-821-1100
- Health Services for Children with Special Needs (HSCSN) Provider Services: 202- 495-7526
- MedStar Family Choice-DC Provider Services: 855-798-4244

Contact

Please refer to the DHCF provider fee schedule available at https://www.dc-medicaid.com for all future updates related to coverage of COVID-19 codes, and for the most up-to-date information on pricing. If you have questions, please contact Amy Xing, Reimbursement Analyst, at amy.xing2@dc.gov or 202-481-3375.

Dental Prior Authorizations

Effective **July 9, 2021**, DC Medicaid FFS dental providers are required to submit prior authorization requests to the Department of Health Care Finance (DHCF) Quality Improvement Organization (QIO), Comagine Health for the following CDT codes:

- D2799 - Provisional Crown - Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression
- D3346 - Retreatment of previous root canal therapy - anterior
- D3348 - Retreatment of Previous Root Canal Therapy - Molar
- D4212 - Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure per Tooth
- D4240 - Gingival Flap Procedure Including Root Planing - Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant
- D4241 - Gingival Flap Procedure Including Root Planing - One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant
- D4249 - Clinical Crown Lengthening - Hard Tissue
- D4342- Periodontal Scaling and Root Planning - One To Three Teeth per Quadrant
- D7970 - Excision Hyperplastic Tissue - Per Arch
- D9951 - Occlusal Adjustment-Limited
- D9952 - Occlusal Adjustment-Complete

Prior Authorization Submission

Please submit all dental procedures that require prior authorization to Comagine Health at https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin. The prior authorization requests must include the following:

1. Completed 719A form
2. Clinical narrative
3. Radiographs
4. Intra-oral photos
5. Periodontal charting, if applicable

Refer to **Transmittal #21-21** for additional information.

FFS Authorization Guidance for SUD Residential Treatment Services

Transmittal #21-22 provides direction to SUD residential treatment providers to assess Medicaid Fee for Service (FFS) beneficiaries (aged 21-64) for IMD stays and obtain an authorization from DHCF's contracted Quality Improvement Organization (QIO), which is currently Comagine Health, for an SUD residential treatment stay beginning July 1, 2021.

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FFS Authorization Guidance for SUD Residential Treatment Services

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Assessment and Level of Care

A Medicaid FFS beneficiary may present for an assessment and level of care determination for SUD at any Department of Behavioral Health (DBH) certified SUD treatment provider.

The provider shall check the DC Medicaid eligibility of each individual through DHCF's Interactive Voice Response (IVR) system and/or Medicaid Web Portal, and will perform the initial intake and assessment as described in DBH's Chapter 63 to determine the clinically appropriate level of care for the individual. The provider shall use the Co-Triage assessment tool to determine the initial level of care for individuals seeking SUD treatment.

If the individual requires a residential level of care, the provider shall perform the activities necessary to check bed availability at the SUD residential facility of choice.

If there is bed availability with an SUD residential provider, the intake and assessment site proceeds with the established procedures for connecting the individual to the SUD residential provider in DATA/WITS, in accordance with DBH Policies, Rules, and Bulletins.

Within 48 hours of the individual presenting at the SUD residential treatment provider, the accepting SUD residential treatment provider shall perform the Continuum Assessment, in accordance with DBH's Chapter 63, and submit the initial clinicals (described below) to DHCF's contracted Quality Improvement Organization (QIO), beginning July 1, 2021. The current QIO is Comagine Health. Authorization requests should be submitted to Comagine Health via the provider portal (https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin).

The SUD residential treatment provider shall include the following documents in the request for authorization:

1. A completed Continuum Assessment which will include:
    a. Documentation of an active moderate to severe Substance Use and/or Addictive Disorder per the DSM-V
    b. severe intensity.
2. Additional medical information, including:
    a. Comprehensive urine toxicology screen results;
    b. Pregnancy test results for women (If a woman refuses a pregnancy test, the refusal must be documented and submitted to Comagine Health. Comagine Health may require additional information.); and
    c. The glucose level to validate medical clearance for admission into the SUD residential treatment provider.

Failure to submit all the required documentation may lead to a denial from Comagine Health. Comagine Health may also request additional clinicals from the SUD residential treatment provider. For questions regarding access and use of the Comagine Health provider web portal, please submit a portal access request or question to dcmedicaid@qualishealth.org.

The SUD residential treatment provider shall also perform all required Room & Board authorization requests, documentation, and procedural activities in DATA/WITS, as required by DBH. DBH remains responsible for covering SUD Residential Treatment Room & Board. Medicaid FFS does not cover SUD Residential Treatment Room & Board and Comagine Health does not perform review or respond to authorization requests for Room & Board.

Once Comagine Health receives the authorization request, Comagine Health shall conduct medical necessity reviews and communicate the authorization decisions to SUD residential treatment providers within two (2) business days. Comagine Health will include the authorization span and date(s) of concurrent review, as applicable.

When medical necessity is met, and services are authorized, Comagine Health shall share authorization information with the SUD residential treatment provider. Comagine Health will also conduct continuing stay reviews during the course of the beneficiary's treatment at the SUD residential facility.

In order for the SUD treatment provider to safely discharge the individual, DBH will cover Room & Board for a period of up to 24 hours after the adverse benefit determination is issued. Medicaid FFS does not cover SUD Residential Treatment Room & Board. Failure to discharge the individual and coordinate alternate services may result in non-payment to the SUD residential treatment providers for any services rendered beyond the discharge related authorization period.

Contact

For questions regarding this transmittal, please contact Cavella Bishop, Program Manager, Department of Health Care Finance (DHCF) at cavella.bishop@dc.gov or (202) 724-8936.

Update of Select DME Fee Schedule Rates

Transmittal #21-30 informed the District of Columbia (DC) Medicaid providers that the rates for 335 durable medical equipment (DME) rates have been updated in the DME fee schedule, effective July 1, 2021.

Each year, the District of Columbia Medicaid program updates pricing, and maximum units on certain items in the professional fee schedule. This update includes physician services, physician-administered drugs, durable medical equipment (DME), parenteral/enteral nutrition items and laboratory services. Physician service pricing updates are effective each January 1; updates related to physician-administered drugs, DME, parenteral/enteral nutrition items and laboratory services are effective each April 1. The professional services categorization refers to all providers who submit claims to the DC Medicaid program using the CMS-1500 claims form.

Due to provider response to the 2021 annual fee schedule pricing update, which was effective on April 1, 2021, the decision has been made to reverse the pricing on 334 items included in that update. One additional code, K0739 Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes, has a rate update which is included here as well.

Refer to **Transmittal #21-30** for additional information.

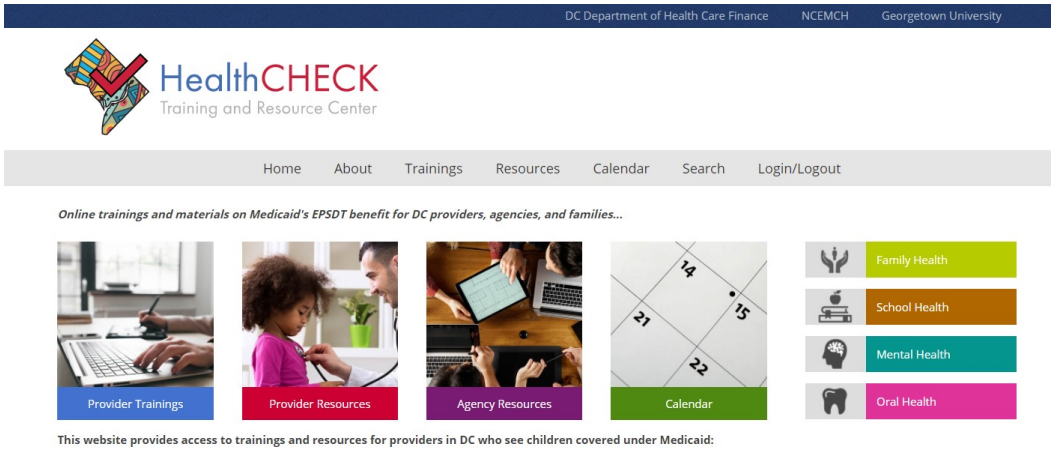
If you have questions regarding this fee schedule update, please contact Amy Xing, Reimbursement Analyst, Office of Rates, Reimbursement and Financial Analysis (ORRFA) Department of Health Care Finance (DHCF), at amy.xing2@dc.gov, or via telephone at (202) 481-3375.

Fluoride Varnish Training

For young children who have not yet established a dental home, primary care providers are the first line of defense for providing oral health care. Trained primary care providers may provide fluoride varnish applications for children under three up to four times per year. Fluoride varnish training and more information can be accessed at www.dchealthcheck.net. If you have any questions on EPSDT provider training requirements, please contact HealthCheck@dc.gov.

Pediatricians and EPSDT Providers - Have You Completed Your HealthCheck Training?

All Primary Care Providers serving Medicaid beneficiaries under the age of 21 are required to complete HealthCheck training every two years. The web-based training can be accessed at www.dchealthcheck.net and provides 5 free CME credits. Visit www.dchealthcheck.net today to complete your HealthCheck training requirement and to browse the available provider resources.



Important Numbers & Addresses

Conduent Provider Inquiry **PO Box 34734** **Washington, DC 20043-4734**	(202) 906-8319 (inside DC metro area) (866) 752-9233 (outside DC metro area) (202) 906-8399 (Fax) **providerinquiry@conduent.com**	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
Maximus Provider Enrollment **1111 14th St. NW, Ste. 720** **Washington, DC 20005**	(844) 218-9700 (toll-free) **www.dcpdms.com**	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
Magellan Pharmacy Benefits Management	Technical Assistance: (800) 272-9679 Clinical Assistance: (800) 273-4962 **www.dc-pbm.com**	Hours of Operation 24/7/365
Conduent EDI Gateway Services	(866) 407-2005 **www.acs-gcro.com** **edisupportdc@conduent.com**	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
Transportation Broker Medical Transportation Management (MTM)	(888) 561-8747 (866) 796-0601 (to schedule appointment) **www.mtm-inc.net/index.asp**	
Dental Help Line	(866) 758-6807	
Medicaid Fraud Hotline	(877) 632-2873	
Health Care Ombudsman	(877) 685-6391	
Conduent Provider Field Services	**dc.providerreps@conduent.com**	

Claims Department	
UB04 Claim Forms	PO Box 34693 Washington, DC 20043-4693
CMS1500 Claim Forms	PO Box 34768 Washington, DC 20043-4768
ADA and Pharmacy Claim Forms	PO Box 34714 Washington, DC 20043-4714
Adjustment/Void Forms	PO Box 34706 Washington, DC 20043-4706
Medicare Crossover Claim Forms	PO Box 34770 Washington, DC 20043-4770
278 Prior Authorization Transaction Attachments	PO Box 34756 Washington, DC 20043-4756
837 Claim Transaction Attachments	PO Box 34631 Washington, DC 20043-4631
Claim Appeals	PO Box 34734 Washington, DC 20043-4761

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