GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director and Medicaid Director **Transmittal 23-41**

TO: DC Medicaid Providers

FROM: Melisa Byrd
Senior Deputy Director and Medicaid Director

DATE: **September 8, 2023**

SUBJECT: **Medicaid Update - Request for Determination of Coverage and Pricing**

Purpose

The purpose of this transmittal is to notify District of Columbia (DC) Medicaid providers, stakeholders, manufacturers, contractors, beneficiaries, and DC Government staff of a new process to request coverage of services/items, changes to existing coverage, or an updated reimbursement rate. The coverage and pricing determination process is effective immediately.

Coverage/Pricing Determination

Attached to this transmittal is the "Request for Determination of Coverage and Pricing" form that DC Medicaid providers, stakeholders, manufacturers, contractors, beneficiaries, and DC Government staff can complete to request coverage of items and services not currently covered on the DC Medicaid fee schedule, or changes to units and pricing for existing items that are covered on the DC Medicaid fee schedule. For life-threatening conditions, the requestor may contact the phone number provided at the top of the form. The phone number should **not** be used for routine requests.

The Coverage Determination Committee will review the requested coverage change(s) and make recommendations to the Medicaid Director. The process may take ninety (90) days to six (6) months due to clinical and financial analysis. Once a decision has been rendered, the requestor will be notified of the outcome.

Contact

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

Cc: DC Behavioral Health Association
DC Coalition of Disability Service Providers
DC Health Care Association
DC Home Health Association
DC Hospital Association
DC Primary Care Association

DC Department of Health Care Finance Request for Determination of Coverage and Pricing

Email this form as an attachment to DHCFCoverageTeam@dc.gov.
If this request is in relation to a life-threatening condition, do not use this form. Please call 202-724-8936

Requestor Information

Contact name/Title: _____ **Date:** _____

Organization: **Phone: ( )** _____

Email: _____

CPT/ HCPCS/NDC (List one per form): _____

Request:

- ☐ Coverage From: To:
- ☐ Price From: To:
- ☐ Other
- ☐ Units From: To:
- ☐ Prior authorization From: To:

Specialties and sub-specialties that perform the service:

Site of service:

Diagnosis/Condition for treatment:

Clinical vignette:

Rationale: Include background information and peer-reviewed clinical evidence including sources and full text articles. Information should include evidence for efficacy, safety,and clinical appropriateness. For medication include strength, dose, and dosage form. (Use attachment as needed.)

Ownership/Financial disclosure forms applicable: ☐ Yes, attachment included. ☐ No, not applicable.

- ☐ Approved
- ☐ Not approved
- ☐ Pending, need additional information

Classification: ☐ Medical ☐ DME ☐ Lab ☐ Drugs ☐ Dental ☐ Other

Comments: