Behavioral Health Billing Manual (Fee for Service)

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Version 2.08

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1 General Information

This section of the District of Columbia Medicaid Provider Manual presents a general overview of the purpose and organization of the manual. Information about the maintenance and distribution of the manual is also included.

1.1 Purpose of the Manual

The purpose of this manual is to provide a general overview and serve as a reference guide for healthcare providers who participate in the District of Columbia (DC) Medicaid Program. Please be advised that this is not intended to be a comprehensive documentation of policies and procedures. The procedures in this manual include specific instructions to file claims for reimbursement and document medical records.

1.2 Policy

Providers are responsible for adhering to the requirements set forth in this manual. The requirements are generated from Federal regulations and the interpretation of these regulations specific to the District and its policy.

1.3 Maintenance

Conduent will maintain this manual with information supplied by the Department of Health Care Finance (DHCF). When a revision occurs, the updated manual will be available to the providers by Conduent via the Web Portal at www.dc-medicaid.com. It is the responsibility of the DC Medicaid provider to review the revisions to the manual and ensure that the policies and procedures are followed.

1.4 Distribution

This manual is available via the Web Portal at www.dc-medicaid.com to all providers who participate in the DC Medicaid program.

1.5 Organization

When a revision occurs to any part of this manual, the revised manual will be posted on the Web Portal at www.dc-medicaid.com. Updates will be reflected in the Revision History table located on page two of the manual. Outdated copies of manuals should be discarded.

Other information that might be helpful when using this manual includes:

- “His” refers to both genders throughout the manual.
- Terms used throughout this manual are defined in the Glossary.
- Addresses and telephone numbers referenced throughout this manual are included in Appendix B (Address and Telephone Directory).

1.6 Department of Health Care Finance Website

To obtain additional Medicaid provider services information, please visit the DHCF Website at www.dhcf.dc.gov.

1.7 Web Portal

The DC Medicaid Web Portal is available to offer online assistance to providers on day-to-day issues. Some of the features included on the Web Portal are:

- Bi-monthly bulletins and transmittals
- Provider Type Specific Billing Tips

- Provider Type Specific FAQ (Frequently Asked Questions)
- Provider Training Modules and Computer Based Training (CBT)
- Latest News/What's Hot
- Online Claim submission
- Prior Authorization inquiry
- Remittance Advice Retrieval
- Beneficiary Eligibility Verification

Access to the DC Web Portal is available 24 hours a day, 7 days a week, 365 days a year. Bookmark the DC Web Portal address of www.dc-medicaid.com in your browser's Favorites the first time you visit the site so you can quickly return again and again.

1.8 Fiscal Agent

The Department of Health Care Finance (DHCF) presently works in conjunction with a contracted fiscal agent, Conduent, to provide accurate and efficient claims processing and payment. In addition, both organizations work together to offer provider support to meet the needs of the District of Columbia's Medicaid community.

The fiscal agent consists of technical and program staff. Technical staff maintains the claims processing operating system, and program staff with the processing of claims and customer service. Other functions include drug rebate analysis and utilization review. The DHCF and the fiscal agent have several systems in place to make contacting our offices easier for the provider.

1.8.1 Telephone Contact

The fiscal agent provides telephone access to providers as shown below. These services include lines for provider inquiries, automated eligibility verification, prior authorizations, payment statuses and assistance with electronic claim submittal. Our call centers are open Monday through Friday, 8 am - 5 pm EST. The Interactive Voice Response (IVR) system is available 24 hours a day, 7 days a week, 365 days a year.

Table 1: Contact List

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 (Email)
Conduent EDI Gateway Services	(866) 407-2005 http://edisolutionsmmis.portal.conduent.com/gcro/

1.8.2 Mailing Contact Information

Providers may contact the fiscal agent via the mail at the addresses listed in Appendix B. These post office boxes should be used for paper claim submittals, adjustment and void requests, provider services, and administrative correspondence.

2 Introduction

The following subsections provide information regarding the DC Medicaid Program.

2.1 District of Columbia Medicaid Program

The DC Medicaid Program is a federally assisted, District-operated program designed to provide comprehensive medical care and services of a high quality at public expense to all eligible residents of the District of Columbia. The DC Medicaid Program, as mandated by the United States Congress, permits eligible individuals the freedom of choice in the selection of a provider of healthcare services who has agreed to the conditions of participation by applying and being accepted as a provider of services.

2.2 Legal Authority

The regulations that govern the DC Medicaid Program are contained in Title XIX of the Social Security Act, 42 U.S.C. 1396, (et siq.) and authorized by enabling legislation P.L. 90-227, 12/27/67.

2.3 Administration

The Department of Health Care Finance (DHCF) is the single state agency responsible for administering the DC Medicaid program.

2.4 Covered Services

The following services, when rendered by eligible providers to eligible beneficiaries, are covered by DC Medicaid:

- Dental
- Doula
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Emergency Services
- Family Planning
- Gender Identity Surgery
- Home and Community Based Services
- Home Health Care
- Hospice
- Inpatient Hospital
- Intermediate Care Nursing Facility (ICF)
- Intermediate Mental Disorder (IMD)
- Laboratory and X-Ray
- Lactation Consultant
- Long Term Acute Care Facility (LTAC)
- Managed Care
- Medical Clinic (hospital and free-standing)
- Medical Day Treatment
- Medical Equipment, Supplies, Prosthesis, Orthotics, and Appliances
- Non-Emergency Transportation Service
- Nurse Practitioner (Midwives, CRNA)
- Optometry
- Organ Transplant (heart, kidney, liver, lung, bone marrow, allogeneic bone marrow)
- Osteopathy
- Out-of-District Services
- Pediatric Palliative Care

- Personal Care
- Pharmacy
- Physician
- Podiatry
- Psychiatric Residential Treatment Facility
- Psychologist
- Skilled Care Nursing Facility (SNF)
- Telemedicine

The DHCF pays for covered services rendered out-of-District borders to eligible District beneficiaries, if any of the following circumstances exist:

- The services are rendered by an enrolled provider in the DC Medicaid Program
- The beneficiary requires emergency medical care while temporarily away from home
- The beneficiary would be risking his health if he waited for the service until he returned home
- Returning to the District would endanger the beneficiary's health
- Whenever it is general practice for beneficiaries in an area of the District to use medical resources in a neighboring state
- DHCF decides, based on the attending physician's advice, that the beneficiary has better access to the type of care he needs in another state

More detailed information regarding the program, its policies and regulations is available from DHCF. Please refer to the Medicaid State Plan and State Plan Amendments available on the DHCF Website at www.dhcf.dc.gov for a complete listing of covered Medicaid services.

2.5 Non-Covered Services

Based on the policies established by DHCF, certain services are not covered by the DC Medicaid Program:

- Patient convenience items
- Meals for family members
- Cosmetic surgery directed primarily at improvement of appearance
- Experimental procedures
- Items or services which are furnished gratuitously, without regard to the individual's ability to pay and without expectation of payment from any source, (i.e., free health screenings)
- Abortions (exceptions include rape, incest, or danger to mother's life)
- Acupuncture
- Chiropractor
- Experimental drugs
- Infertility treatment
- Sterilizations for persons under the age of 21
- Services that are not medically necessary

This list is only an example of the services not covered and should not be considered a complete list. Please refer to the Medicaid State Plan and State Plan Amendments available on the DHCF Website at www.dhcf.dc.gov for a complete listing of non-covered Medicaid services.

2.6 Inquiries

To receive information about the District of Columbia Medicaid Program, contact the DC Medicaid fiscal agent, Conduent. Addresses and telephone numbers are included in Appendix B.

3 Health Information Technology (HIT) Healthcare Reform

The Health Information Technology (HIT) Program Management Office (PMO) at DHCF is aligned with the Health Care Reform & Innovation Administration (HCRIA) and is a resource for both state programs and other public and private users of health information, providing planning, coordination, policy analysis and the development of public/private partnerships for further adoption and integration of health IT in the District of Columbia.

HIT has been proven to have a measurable impact on patient health outcomes, improving provider efficiency and continuity of care delivery. The HIT PMO supports health IT policy and planning, the adoption and use of electronic health records (EHR), and the secure exchange of health information, for the benefit of health care providers, patients, and their families. Additionally, the HIT PMO supports the promotion of technology that can lead to care delivery innovation and reform.

The HIT PMO will take a lead role in identifying how electronic health information can be used to improve clinical quality by integrating it into existing program initiatives.

Key HIT goals include:

- Improving provider, patient and DHCF access to clinical information to enhance care delivery. Better information to support clinical decisions by providers increases the probability of quality outcomes for consumers while reducing costs.
- Improving health outcomes by supporting and expanding use of electronic care management tools.
- Improving data capture and analysis, clinical oversight, reporting and transparency through HIT for organizations which finance health care, including government, private employers, and managed care organizations.

3.1 Health Information Exchange

Through its HIE Policy Board, DHCF is convening stakeholders to assess how DHCF can best facilitate HIE in the District. HIE infrastructure provides the technology, processes, and operations needed to facilitate exchange of health information between provider organizations, District agencies responsible for public and population health, and other stakeholders on behalf of patients. Many organizations within the District have invested in health information technology solutions to support the electronic documentation and management of patient health information. This data is increasingly captured in a structured format utilizing national standards. As patients seek and receive care at multiple organizations, HIE can support the ability to have a more comprehensive understanding of patient health to provide care more effectively.

3.1.1 HIE Services

- **Direct Secure Messaging**: Direct is an easy-to-use, fast, and secure electronic communication service for clinical providers and others who regularly transmit and/or receive protected health information (PHI). Direct looks and operates like email, but with security features such as point-to-point encryption required for PHI. Direct is not a brand name or a company, Direct is a transmission standard developed by the Office of the National Coordinator for Health Information Technology (ONC). DHCF contracts with Orion Health for its Direct. Orion Health is one of the world's most widely deployed HIE companies. Direct is the primary way providers will be notified of a patient encounter.
- **Encounter Notification Service*** (ENS): Providers can receive alerts on a selected panel of patients who are admitted, discharged, or transferred to/from acute care hospitals located in the District of Columbia and Maryland.
- **Provider Query Portal***: Access to real time clinical information including lab results, radiology reports and discharge summaries.

- **Encounter Reporting Service*** (ERS): Reports to hospitals on utilization trends across multiple independent facilities.

*Offered in conjunction with CRISP, the state designated HIE in Maryland.

3.1.2 Partnership with Department of Health

DHCF and the Department of Health (DOH) collaborated on a series of upgrades to DOH's public health reporting infrastructure. The purpose of these upgrades was to offer providers and hospitals the means to electronically report public health data to the city in accordance with Stage 2 Meaningful Use incentives. The types of reporting that were enabled included immunization data, cancer registry, syndromic surveillance (sometimes referred to as bio-surveillance) and electronic laboratory data reporting.

4 PROGRAM INTRODUCTION

The MHRS and ASARS programs are federally assisted programs operated by DBH. The MHRS and ASARS programs are designed to provide comprehensive, high-quality rehabilitative services to all eligible residents of the District of Columbia. These programs permit eligible District residents the freedom of choice in the selection of a provider of behavioral health and substance use disorder (SUD) treatment and recovery services that agreed to the conditions of participation by applying and being certified as a provider of these services.

4.1 Legal Authority

4.1.1 Mental Health & Rehabilitation Services

The Department of Mental Health Establishment Amendment Act of 2001 (DC Official Code § 7-1131 et seq.); 22-A DCMR 34, Mental Health Rehabilitative Services (MHRS), as amended, and 29 DCMR 52, Medicaid Reimbursement for MHRS.

4.1.2 Adult Substance Abuse Rehabilitation

The regulations that govern the DC Medicaid Program are contained in Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq. and authorized by enabling legislation P.L. 90-227, 12/27/67. Title 22, Chapter 63, Certification Standards for Substance Use Disorder Treatment and Recovery Providers contains the substance use disorder treatment and recovery service requirements.

4.2 Administration

DBH administers the MHRS and ASARS programs payment system for the Department of Health Care Finance (DHCF), the District of Columbia agency that administers the Medicaid Program.

4.3 Medicaid Funded Services

4.3.1 Mental Health & Rehabilitation Services

The following core services, when rendered by certified MHRS providers to Medicaid eligible consumers, are covered by MHRS, authorized by DBH, and paid by DHCF:

- Community Support
- Diagnostic Assessment
- Mental Health Therapy (formerly, Counseling)
- Medication / Somatic Treatment

The following specialty services, when rendered by certified MHRS providers to Medicaid eligible consumers and authorized by DBH, are covered by MHRS, and paid by DHCF:

- Assertive Community Treatment (ACT)
- Clubhouse Service
- Community Based Intervention (CBI)
- Crisis Emergency
- Child Parent Psychotherapy for Family Violence (CPP-FV)
- Intensive Day Treatment Services
- Rehabilitation Day Services
- Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

In addition to Community Support within the MHRS taxonomy, other community support services include the following:

4.3.1.1 Supported Employment

DBH provides an evidence-based supported employment program that involves helping adult consumers find and maintain a job. Supported Employment can be provided by a certified MHRS provider that has also been certified by DBH to provide supported employment pursuant to 22 DCMR Chapter A51. Medicaid will only reimburse supported employment (therapeutic).

- Supported employment (therapeutic) activities such as assessment, benefits counseling, follow-along supports, and on-going consumer job coaching shall be billed as community support (H2023 - Supported Employment Therapeutic).
- Supported employment (non-MHRS - vocational) is paid for by DBH local funds under procedure code H2025.

4.3.1.2 Self-Help Peer Support

Consumers who are certified by DBH as certified Mental Health Peer Specialists pursuant to 22 DCMR Chapter A73, will be authorized to provide Medicaid-reimbursable behavioral health rehabilitation services to consumers when working under the supervision of a qualified practitioner. Medicaid-reimbursable MHRS shall be provided in accordance with the requirements of the District's State Medicaid Plan1, Title 22, DCMR Chapter A34, and federal guidelines governing the provision of services by certified mental health peer specialists and billed as Self-Help Peer Support (H0038).

DBH reimburses for covered services provided out-of-the-District to eligible District consumers, under the following circumstances:

- DBH authorized the services, and they are delivered by a certified provider in the DC MHRS Program that is eligible to provide services in that jurisdiction.
- The consumer requires emergency mental health care while temporarily away from their home.
- The consumer would be risking their health if they waited for the service until they returned home; or
- The consumer is under the custody of a District agency and has DC Medicaid.

More detailed information regarding the MHRS program, its policies and regulations are available at the DBH website at www.dbh.dc.gov or by contacting the DBH Network Development Division (ND) at 202-671-3155 or dbhprovider.relations@dc.gov.

4.3.2 Adult Substance Abuse Rehabilitation

The following services, when delivered by certified ASARS providers to Medicaid eligible consumers, are covered by ASARS, authorized by DBH, and paid by the DHCF:

- Adolescent – Community Reinforcement Approach
- Assessment / Diagnostic and Treatment Planning Services
- Clinical Care Coordination
- Crisis Intervention
- Drug Screening
- Medication Assisted Treatment
- Medication Management
- Medically Monitored Intensive Inpatient Withdrawal Management
- Substance Use Disorder Counseling

DHCF pays for covered services provided outside of the District of Columbia to eligible District consumers by providers enrolled in the DC Medicaid program.
More detailed information regarding the program, its policies and regulations is available from DHCF. Please refer to the Medicaid State Plan and State Plan Amendments available on the DHCF website at www.dhcf.dc.gov for a complete listing of covered Medicaid services.

4.4 Non-Medicaid Reimbursable Services Paid by Local Funds

4.4.1 Mental Health & Rehabilitation Services

The following services are authorized and paid by DBH Local Funds in accordance with a provider's contract or Human Care Agreement (HCA):

- Community Psychiatric Supportive Treatment Program – Rehab / Day Services (CPS-Rehab/Day)
- Criminal Justice System (CJS) Jail Diversion
- FLEXN-code services – Services and support provided by Child Choice Provider (see below).
- Integrated Community Care Project (ICCP)
- Mental Health Service – Continuity of Care Treatment Planning, Institution (MHS-CTPI)
- Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI)
- MHS-DTPI (ACT) and MHS-DTPI (CBI)
- Residential Crisis Stabilization
- Supported Employment (non-MHRS vocational)
- Supported Employment Group (non-MHRS Job Club)
- Team Meeting

4.4.1.1 Supported Employment (NON-MHRS Vocational)

DBH provides an evidence-based supported employment program that involves helping adult consumers find and maintain employment. Supported Employment can be rendered by a certified MHRS provider also certified by DBH to provide supported employment pursuant to 22 DCMR Chapter A51.

The following services shall be billed as supported employment (non-MHRS) H2025:

- Intake
- Supported Employment Job Club
- Treatment Team Coordination
- Job Development (if not able to be billed to the Department of Disability Services Rehabilitation Services Agency [RSA])
- Time Limited Job Coaching (if not able to be billed to RSA)

Supported Employment Group (non-MHRS Job Club) is billed under H2025HQ.

4.4.1.2 Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI)

A service to develop a mental health service provider plan for treating a consumer who is not enrolled in ACT or CBI in preparation for discharge from a hospital or other institutional setting (Institutes for Behavioral Disease (IMD) such as Saint Elizabeth's Hospital or Psychiatric Institute of Washington (PIW)); nursing facilities (nursing homes or skilled nursing facilities); rehabilitation centers; residential treatment centers (RTCs); psychiatric residential treatment facilities (PRTFs); or, correctional facilities for defendants or juveniles). It includes modifying goals, assessing progress, planning transitions, discharge planning and addressing other needs after discharge to the community, as appropriate. MHS-DTPI is provided by an MHRS provider through a mental health professional or credentialed staff to a DBH consumer who is in a hospital or other institutional setting. Requires prior authorization from DBH.

4.4.1.3 Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI) – ACT

A service provided by an MHRS Assertive Community Treatment (ACT) provider to a consumer who is enrolled in ACT services and is in a hospital or other institutional setting to develop a mental health service plan for treating a consumer <u>in preparation for discharge</u> from the hospital or other institutional settings. Requires prior authorization from DBH.

4.4.1.4 Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI) – CBI

A service provided by an MHRS Community Based Intervention (CBI) provider to a consumer who is enrolled in CBI services and is in a hospital or other institutional setting to develop a mental health service plan for treating a consumer in preparation for discharge from the hospital or other institutional settings. Requires prior authorization from DBH.

4.4.1.5 Community Psychiatric Supportive Treatment Program – Rehab/Day Services (CPS-REHAB/DAY)

A day treatment program provided in the community to consumers who are in a hospital or other institutional setting and is designed to acclimatize the consumer to community living. Requires prior authorization from DBH.

4.4.1.6 Mental Health Service – Continuity of Care Treatment Planning, Institution (MHS-CTPI)

This code should be used for all continuity of care (non-discharge planning) services for consumers (including ACT and CBI consumers) in institutional settings.

4.4.1.7 Flexible Spending Local Funds Program for Child Choice Providers

Providers that have contracts with DBH as Child Choice Providers are eligible to bill the Department up to the monthly ceiling provided in their contracts. These locally funded services and supports are intended to augment the clinical services and increase the therapeutic benefit to consumers. Child Choice Providers will submit claims for flexible spending reimbursement through the Department's eligibility, enrollment, and authorization system under the billing code FLEXN. Eligibility for reimbursement for FLEXN-code services is determined solely by the contract between DBH and the Child Choice Provider and is subject to the availability of appropriated funds. The FLEXN code and rate are as follows:

Table 2: FLEXN Code and Rate

Service	Code	Rate
Flexible Spending-Child Choice, Local Funds	FLEXN	$0.01

In addition, covered Medicaid services provided to non-Medicaid eligible consumers enrolled in the MHRS program are covered by MHRS and authorized and paid by DBH Local Funds.

4.4.2 Adult Substance Abuse Rehabilitation Services

The following services are authorized and paid by DBH Local Funds in accordance with a provider's contract or Human Care Agreement:

(1) Case Management
(2) Education Support Services.
(3) Environmental Stability.
(4) Life Skills Support Services.
(5) Recovery Coaching.
(6) Recovery Social Activities.
(7) Recovery Support Evaluation.
(8) Recovery Support Management.
(9) Room and Board for Residential SUD Treatment; and
(10) Spiritual Support Services.

4.5 Inquiries

To receive information about the District of Columbia Medicaid Program, contact the DC Medicaid fiscal agent, Conduent. Addresses and telephone numbers are included in Appendix B.

More detailed information regarding MHRS and ASARS programs, policies and regulations is available at the DBH website at www.dbh.dc.gov or by contacting the DBH Network Development Division (ND) at 202- 671-3155 or at dbhprovider.relations@dc.gov.

5 PROVIDER PARTICIPATION INFORMATION

This section of the Manual provides information regarding enrollment and certification of providers to participate in the MHRS or the ASARS programs.

5.1 Provider Eligibility Requirements

5.1.1 Mental Health & Rehabilitation Services

Providers shall meet the DBH certification requirements as outlined in Title 22 DCMR Chapter A34, Mental Health Rehabilitation Services Provider Certification Standards, to be considered for participation in the MHRS Program.

5.1.2 Adult Substance Abuse Rehabilitation

Providers shall meet the DBH certification requirements outlined in Title 22A DCMR Chapter 63, Certification Standards for Substance Use Disorder Treatment and Recovery Providers, to be considered for participation in the ASARS Program.

5.2 Participating Provider

To participate in the MHRS Program or the ASARS Program, providers must be certified by DBH and adhere to the guidelines established by the Department outlined in the MHRS or ASARS Provider Certification Standards and their Human Care Agreements (HCA). At a minimum, certified providers must adhere to the following requirements:

- All applicable federal and District laws and regulations.
- All DBH policies and procedures, including bulletins, and those established by DHCF regarding practice and procedures in compliance with Title XIX.
- All conditions specified in the HCA, signed by the provider and DBH.
- Notification to DBH of any change in the information supplied to enroll in the program (i.e., address, affiliations, additional licenses acquired, etc.); and,
- Assurance of freedom of choice to all consumers of Mental Health Rehabilitation Services or Adult Substance Abuse Rehabilitation Services.

Failure to comply with requirements may lead to a Corrective Action Plan, Notice to Cure, fines, penalties, or other actions in accordance with District and federal laws and regulations.

6 CONSUMER ELIGIBILITY

This subsection provides an overview of consumer eligibility in the Medicaid funded and locally funded MHRS or ASARS Program(s).

6.1 Freedom of Choice of Providers

A consumer may obtain services from any certified MHRS or ASARS Provider that has an HCA with DBH to provide specified services.

In MHRS only, the agency assigned as the consumer's clinical home is responsible for coordinating treatment and obtaining authorization for services provided to the consumer.

6.2 Medicaid Eligibility Determination

The Department of Health Care Finance Medicaid Branch (DHCF) determines beneficiary eligibility for the DC Medicaid Program.

The Office of Information Systems (OIS) operates the District of Columbia Access System (DCAS), which determines and tracks eligibility, providing integrated automated support for several District of Columbia programs, including Medicaid. The DCAS eligibility information is directly linked to the Interactive Voice Response (IVR), making it readily available to providers.

6.3 Eligibility

6.3.1 Medicaid-Funded Mental Health Rehabilitation Services or Adult Substance Abuse Rehabilitation Services

Consumers eligible for Medicaid-funded MHRS or ASARS must meet the following requirements:

(a) Be enrolled in Medicaid or be eligible for enrollment and have an application pending.
(b) Be a bona fide resident of the District, as defined in DC Official Code § 7-131.02(29) (2008 Repl.).
(c) Be a child or youth with behavioral health problems, as defined in DC Official Code § 7-1131.02(1), or an adult with mental illness as defined in DC Official Code § 7-1131.02(24); or an adult with substance use disorder, as defined in DC Official Code X; and
(d) Be assessed as requiring MHRS and/or ASARS by a qualified practitioner.

Eligible consumers of MHRS shall have a primary diagnosis of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) in use by the Department. Persons with a primary substance use disorder diagnosis only are not eligible consumers of MHRS.

Eligible consumers of ASARS shall have a primary diagnosis in the latest diagnostic criteria in the ICD and is in use by the Department. Persons with a primary mental health diagnosis only are not eligible consumers of ASARS.

6.3.2 Locally Funded Mental Health Rehabilitation Services or Adult Substance Abuse Rehabilitation Services

Consumers eligible for locally funded MHRS or ASARS are those individuals who have been assigned a non- reimbursable Medicaid program code from DHCF. These individuals are not eligible for Medicaid funded MHRS, ASARS or are not enrolled in any other third-party insurance program except the DC HealthCare Alliance, and who meet the following requirements:

(a) Be a bona fide resident of the District, as defined in DC Official Code § 7-1131.02(29).
(b) Be a child or youth with Behavioral health problems, as defined in DC Official Code § 7-1131.02(1), or an adult with mental illness as defined in DC Official Code § 7-1131.02(24), or an adult with a substance use disorder defined in DC Official Code X.
(c) Be assessed as requiring MHRS and/or ASARS by a qualified practitioner; and
(d) For individuals nineteen (19) years of age and older, who live in households with a countable income of less than two hundred percent (200%) of the federal poverty level, and for individuals under nineteen (19) years of age, live in households with a countable income of less than three hundred percent (300%) of the federal poverty level.

6.3.3 Medicare Eligible Consumers Who Qualify for Locally Funded Mental Health Rehabilitation Services

Consumers eligible for Medicare remain eligible for the following locally funded MHRS only to the extent these services are not otherwise covered by Medicare:

(a) Community Support, and
(b) Specialized services in 3414.3 of the MHRS Provider Certification Standards.

6.3.4 Prohibition against Billing Medicaid or DBH for Mental Health Rehabilitation Services or Adult Substance Abuse Rehabilitation Services

Providers shall not bill Medicaid or DBH for MHRS or ASARS provided to any consumer who does not meet the eligibility requirements set forth above. Any claims or invoices submitted to DBH that do not meet requirements set forth above will be subject to nonpayment.

6.3.5 Grace Period for New or Lapsed Enrollees of Medicaid

For new enrollees and those enrollees whose Medicaid certification has lapsed[2], there is an eligibility grace period of ninety (90) days from the date of first service for new enrollees, or from the date of eligibility expiration for enrollees who have a lapse in coverage, until the date the DHCF makes an eligibility or recertification determination. In the event the consumer appeals a denial of eligibility or recertification by the DHCF, the Director may extend the ninety (90) day eligibility grace period until the appeal has been exhausted.

Note: New and lapsed enrollees include District residents released from the correctional facilities managed by the District of Columbia Department of Corrections.

The ninety (90) day eligibility grace period may also be extended at the discretion of the Director for other good cause shown. Upon expiration of the eligibility grace period, MHRS or ASARS services provided to the consumer or client are no longer reimbursable by DBH. Nothing in this section alters DBH's timely-filing requirements for claim submissions.

6.4 Eligibility Identification

It is the responsibility of the provider to always verify that the patient is eligible for Medicaid before rendering services.

6.4.1 Medical Assistance Card

When first determined eligible, each Medicaid beneficiary receives a paper Medical Assistance Card from the Economic Security Administration (ESA) containing his name, social security number, date of birth, sex, and an eight-digit identification number, which may include two leading zeroes.

If the beneficiary has provided this information to the eligibility-determining agency, a provider should ask the beneficiary if he has other health insurance coverage not shown on the card. The provider is obligated

to determine that the person to whom care is being rendered is the same individual listed on the eligibility card.

Figure 1: Medical Assistance Card – Front Image

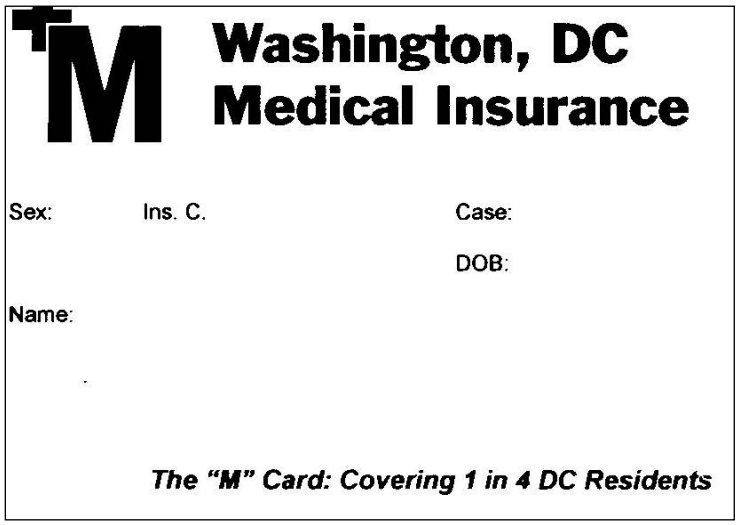
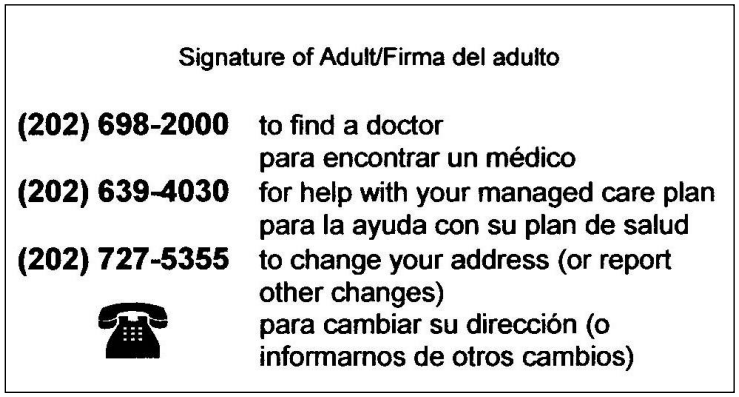


Figure 2: Medical Assistance Card – Back Image



The back of the Medical Assistance Card provides information to the beneficiary that gives specific information relevant to its use.

6.4.2 Notice of Presumptive Eligibility

To encourage greater participation in obtaining prenatal care, DHS clinics and Federally Qualified Health Centers (FQHCs) are authorized to determine pregnant women temporarily (presumptively) eligible for Medicaid while ESA determines her ongoing Medicaid eligibility. The temporary eligibility will allow immediate receipt of all Medicaid-covered ambulatory services that are related to pregnancy and the patient will be issued a dated Notice of Presumptive Eligibility, a copy of which follows.

A District of Columbia Identification Number (DC ID#) will be established/issued no later than fourteen days from the date of the Notice by DHCF. The Interactive Voice Response (IVR) will then respond, "Medicaid Eligible," and claims may be submitted to Conduent. The address is listed in Appendix B.

If you have questions concerning claim submission, please contact the Provider Inquiry Department at Conduent; questions regarding eligibility determinations should be directed to the DHCF. The addresses and telephone numbers are included in Appendix B.

6.4.3 Office of the Health Care Ombudsman and Bill of Rights

An "ombudsman" is a person who investigates problems, makes recommendations for solutions, and helps solve the problem. The District of Columbia's Office of the Health Care Ombudsman and Bill of Rights is here to:

- Help beneficiaries understand their healthcare rights and responsibilities
- Help solve problems with healthcare coverage, access to healthcare and issues regarding healthcare bills
- Advocate for beneficiaries until their healthcare needs are addressed and fixed
- Guide beneficiaries towards the appropriate private and government agencies when needed
- Help beneficiaries in the appeals process
- Track healthcare problems and report patterns in order improve what is causing the problems

The Office of the Health Care Ombudsman and Bill of Rights is an important source of help for any Medicaid beneficiary. In fact, it can help any DC resident with health insurance issues, including people with Medicare, or health insurance. The Office of Health Care Ombudsman and Bill of Rights may be contacted at (877) 685-6391.

6.5 Provider Responsibility

The provider is responsible for the following eligibility verification activities.

6.5.1 Eligibility Verification

It is the responsibility of the provider to ensure the patient is DC Medicaid eligible on the date of service. If a provider supplies services to an ineligible beneficiary, the provider cannot collect payment from DC Medicaid. The provider should verify:

- Beneficiary's name and identification number
- Effective dates of eligibility
- Services restricted to specified providers
- Third-party liability

The provider must verify the beneficiary's eligibility by calling the Interactive Voice Response (IVR) using a touch-tone telephone (telephone number included in Appendix B) and supplying the beneficiary identification number found on the beneficiary's ID card. Beneficiary eligibility may also be verified online via the Web Portal at www.dc-medicaid.com. The IVR and Web Portal receive eligibility information from the District of Columbia Access System (DCAS), which is operated by the Office of Information Systems.

6.5.2 Third-Party Liability

Since DC Medicaid is a payer of last resort, the provider must bill other resources first. Third-party liability (TPL) identifies primary payer resources outside of DC Medicaid who should be billed for the services (i.e., Workmen's Compensation, CHAMPUS, Medicare, private insurance carriers, etc.). Some Third-Party Liability terms are defined as:

- Lien - is put in place to protect Medicaid's interest in the beneficiary's former home and its rights to recover Medicaid spending that result in settlements from inquiries that involve lawsuits
- Subrogation – notice sent out of intent to collect a debt
- Notice of other insurance – is sent when the beneficiary has an insurance policy other than Medicaid. This will not result in loss of Medicaid benefits
- Estate – property owned by a Medicaid beneficiary that can result in Medicaid placing a lien against it to insure the reimbursement of Medicaid funds after the beneficiary's death

When payment or denial of payment from the third party has been received, all documentation related to the action must be attached to the claim when billing DC Medicaid for a service. It is incumbent on the provider to discover if the beneficiary has other resources. Information about TPL must be entered on the claim form and should be kept in the patient's records.

In subrogation cases, DHCF should be notified. All recoveries should be turned over to DHCF immediately to offset payments already made by DHCF on behalf of the beneficiary.

6.5.3 Medicaid Beneficiary Restriction Program

DHCF may restrict a DC Medicaid beneficiary to one designated primary care provider and to one designated pharmacy, when there is documented evidence of abuse or misutilization of services. For the purposes of this program, a primary care provider is a health care practitioner who takes responsibility for the continuous care of a patient, preventive as well as curative. Primary care providers are internists, family practitioners, general practitioners, pediatricians, health maintenance organizations, comprehensive neighborhood health centers, etc.

Medicaid Beneficiary Restriction is a corrective process by which a beneficiary is locked in for one year or more to the services of one designated pharmacy and one designated primary care provider who will be responsible for the management of the beneficiary's total health care. This restriction will not apply when there is need for a second opinion or when there is a medical emergency.

6.5.4 Qualified Medicare Beneficiary (QMB)

Qualified Medicare Beneficiaries (QMBs) are persons who are entitled to Medicare Part A, are eligible for Medicare Part B, and have an income below 100% of the federal poverty level are determined to be eligible for QMB status by their state Medicaid agency. Medicaid pays only the Medicare Part A and B premiums, deductibles, co-insurance, and co-payments for QMBs. Medicaid does not cover dental services or non-covered Medicare services.

6.5.4.1 Qualified Medicare Beneficiary Program

The Qualified Medicare Beneficiary (QMB) Program is a Federal benefit administered at the State level. The District of Columbia reimburses providers for Medicare part A and Part B deductibles and coinsurance payments up to the Medicaid allowed amount for clients enrolled in the QMB program.

Figure 3: QMB Medical Assistance Card – Front Image

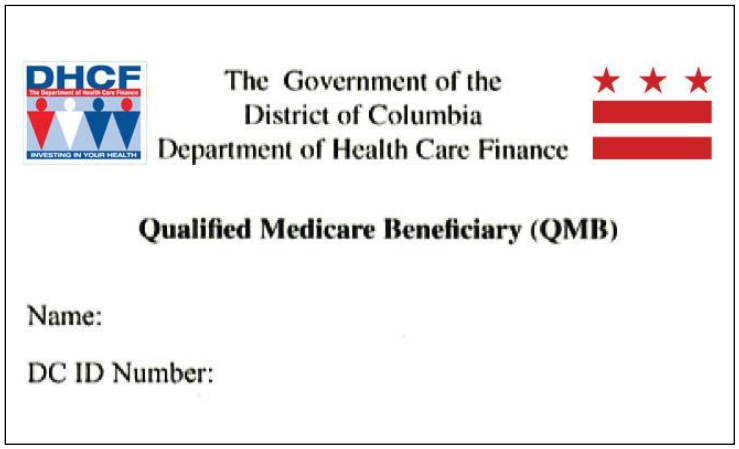


Figure 4: QMB Medical Assistance Card – Back Image

With this card, you are entitled to have Department of Health Care Finance pay for your MEDICARE Part A and B premiums, deductibles, and co-insurance for all Medicare-covered services.

Show this card to your health care provider whenever you show your Medicare card.

It is against the law for this card to be used by or for anyone except the person whose name is printed on the front of the card.

Should you have any questions regarding the QMB benefit including pharmacy, please call GW Counseling Center on (202) 739-0668, the Health Care Ombudsman on 1-877-685-6391 or MEDICARE on 1-800-633-4227. Providers please call (202) 698-2000 for any questions you may have regarding billing or eligibility.

6.5.4.2 Billing for Services Provided to QMB's

All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs must be aware that they may not bill QMBs for Medicare cost-sharing. This includes deductible, coinsurance, and copayments, known as "balance billing." Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost sharing. QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing.

Providers who inappropriately bill QMBs for Medicare cost-sharing are subject to sanctions.

6.5.4.3 Balance Billing of QMBs is prohibited by Federal Law

Under current law, Medicare providers cannot balance bill a QMB. Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing. Refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1128.pdf for additional information.

Specifically, the statute provides that the Medicare payment and any Medicaid payment are considered payment in full to the provider for services rendered to a QMB.

6.6 Discrimination

Federal and District of Columbia regulations require that all programs receiving federal and local assistance comply fully with Title VI of the Civil Rights Act of 1964 and Section 504 of The Rehabilitation Act of 1973 and the regulation at 45 CFR Parts 80 and 84. DBH ensures that no consumer, client or individual in care shall be subjected to discrimination under this plan on the grounds of race, color, national origin, or disability.

6.7 Interrelationship of Providers

Providers are prohibited from referring or soliciting consumers directly or indirectly to other providers for financial consideration. Providers are also prohibited from soliciting, receiving, or offering kickbacks; payments, gifts, bribes, or rebates for purchasing; leasing, ordering, arranging for or recommending purchasing or leasing; ordering for goods, facilities, or items for which payment is made through the DC Medicaid Program. This does not preclude discounts or other reductions in charges by a provider to a practitioner for services such as laboratory and X-ray, so long as the price is properly disclosed and

appropriately reflected in the costs claimed or charges made by a practitioner, as allowed by federal law and regulations.

7 RECORD KEEPING

Providers shall retain for a minimum of ten (10) years (unless otherwise specified), medical and fiscal records that fully disclose the nature and extent of the services rendered to adult consumers. For minors, providers shall retain for medical records that fully disclose the nature and extent of services rendered until the age of majority plus an additional three (3) years. These records must meet all the criteria established. Providers shall make such records readily available for review and copying by District and federal officials or their duly authorized agents. The term “readily available” means that the records must be made available at the provider’s place of business. If it is impractical to review records at the provider’s place of business, upon written request, the provider must forward without charge, the original records, or facsimiles.

7.1 Medical and Treatment Records

Providers who have examined, diagnosed, and treated a consumer or client, shall maintain consumer and client records in accordance with 22-A DCMR § 3410.16, MHRS Provider Certification Standards, or 22-A DCMR 6322.1 on clinical record documentation in DBH’s assigned electronic system of record.

7.2 Fiscal Records

Providers shall retain for a minimum of ten (10) years all fiscal records relating to services rendered to MHRS or ASARS adult consumers. For minors, providers shall retain all fiscal records rendered to MHRS or ASARS minor consumers until the age of majority plus an additional three (3) years. This may include, but is not necessarily limited to, the pricing system used for services rendered to consumers or clients who are Medicaid eligible, and payments made by third-party payers.

7.3 Disclosure of Information

Title XIX is part of the federal Social Security Act. Records and information acquired in the administration of any part of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in the rules and regulation of the U.S. Department of Health and Human Services or upon the express authorization of the Secretary of Health and Human Services.

7.3.1 Mental Health and Rehabilitation Services

A provider may only disclose records or information acquired under the DC MHRS Program in accordance with the DBH Privacy Manual and Procedures; Health Insurance Portability and Accountability Act (HIPAA) (45 CFR 164.512 and Public Law 104-191); and the Mental Health Information Act (MHIA) (DC Code 7- 1201.01 et seq.).

7.3.2 Adult Substance Abuse and Rehabilitation Services

A provider may only disclose records or information acquired under the DC ASARS Program in accordance with the DBH Privacy Manual and Procedures; Health Insurance Portability and Accountability Act (HIPAA) (45 CFR 164.512 and Public Law 104-191); the Mental Health Information Act (MHIA) (DC Code 7-1201.01 et seq.); and 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. This includes both electronic and paper protected health information (PHI).

7.3.3 Penalties for Non-Compliance

Among other penalties, DBH may terminate agreements with providers who fail to maintain and provide medical and fiscal records. Providers may also be subject to notices of infraction including fines, recoupment of payments, decertification as a DBH provider or District Medicaid provider, and federal and District civil and criminal prosecution.

7.4 Division of Program Integrity

DHCF ensures the integrity of the Medicaid program and seeks to identify and reduce waste, fraud, and abuse in the use of Medicaid funds through the activities carried out by the Division of Program Integrity (DPI). The purposes of program oversight are to safeguard against unnecessary, inappropriate, and/or fraudulent use of Medicaid services, identify excessive or inaccurate payments to providers, and ensure compliance with the applicable Medicaid laws, regulations, and policies. The two primary branches of the DPI are the Investigations Branch and the Surveillance/Utilization Branch.

The Investigations Branch is responsible for conducting investigations of alleged violations of policies, procedures, rules, or laws. Complaints may originate from the Office of the Inspector General, the Fraud Hotline, Agency staff, facilities and/or health care practitioners, the public, data analysis, or other sources. Allegations of a criminal nature are referred to the appropriate law enforcement entity. When necessary, the Investigations Section works closely with the District of Columbia Medicaid Fraud Control Unit (MFCU) and other federal or local law enforcement.

The Surveillance/Utilization Branch reviews providers' patterns of care delivery and billing, reviews patterns of beneficiary resource utilization, undertakes corrective actions when needed, and educates providers on relevant laws, regulations, and other program requirements. Specifically, the Surveillance/Utilization Branch conducts audits and reviews of providers suspected of abnormal utilization or billing patterns within the District of Columbia's Medicaid program, recovers overpayments, issues administrative sanctions, and refer cases of suspected fraud for criminal investigation.

Pursuant to the authority set forth in §1902(a) (30) of the Social Security Act, 42 C.F.R. § 455, and 42 C.F.R. § 456, and in conjunction with 29 DCMR § 1300, et seq. and 1900, et seq., the DHCF has established procedures for reviewing the utilization of, and payment for, all Medicaid services. Accordingly, providers are required, upon request, to provide DHCF, designated DHCF agents, the Department of Justice, or the Secretary of Department of Health and Human Services with medical records. In addition, providers must fully cooperate with audits and reviews made by DHCF or their designee to determine validity of claims or the medical necessity of services rendered by the provider.

Any of the above entities have the right to request complete information about the ownership of any contractor with whom the provider has had business transactions. In addition, requests may be made about significant business transactions between the provider and any wholly owned supplier, or subcontractor, during the ten (10) year period from the date of the request. This information must be supplied within 35 days of request.

The reviews involve the utilization of, and payment for, all Medicaid services and may include, but are not limited to the following:

- **Desk Audit-Review –** An audit or review conducted at the Division of Program Integrity. A notification letter with a request for records may be sent to the provider and requires the provider to submit copies of the requested records, if necessary. Audit staff may conduct provider and/or provider personnel interviews by phone. Some examples of desk audits and reviews are clinical reviews, pharmacy third party liability (TPL) audits; hospital outpatient claims audits, hospital credit balance reviews, unit of service limitation reviews, and audits of claims submission patterns.
- **Onsite/Field Audit –** An audit conducted at a provider's place of business. A letter of "intent to audit" or a notification letter can be provided by the Division of Program Integrity auditor(s) to the provider prior to the onsite visit, or when the auditor(s) arrives at the place of business, giving the provider information concerning the audit. Audit staff will make copies of the provider's records when onsite, review provider's billing protocols, and interview the provider and/or provider personnel.

Provider audits may be announced or unannounced. If announced, the Division of Program Integrity will send intent to audit/notification letter to the provider announcing the audit and the time frame of the audit.
When possible, the Division of Program Integrity will coordinate with the provider to minimize inconvenience and disruption of health care delivery during the audit. Providers can prepare by doing the following:

- Provide a temporary workspace for the auditor(s) within reasonable proximity to the office staff and records. Since many of the original documents and records the auditor(s) will need to examine are located at the local department level, the auditor(s) will need a temporary work area with adequate space and lighting. The amount of time needed for the auditor(s) to be physically present at the provider's location will vary from audit to audit.
- Provide a current organization chart of the provider's area of responsibility. This and other information will assist the auditor(s) in gaining an understanding of the provider's administrative structure, nature of its operations and familiarity with its employees.
- Have a designated individual (Clinical Manager, Clinical Administrator, or Administrative Staff Person) available to assist the auditor(s).
- Have all documentation to support billing and reimbursement readily available for the reviewer.
- Have copies of current business license(s) and professional healthcare licenses of all pertinent staff available for the auditor(s).

The auditor(s) analysis of the provider's operation may require that several of the provider's employees at various levels be asked to explain the organization process. In addition to examining hard copy records, it may be necessary for the auditor(s) to make photocopies, and/or obtain samples, of key documents of the provider's files. The confidentiality of records reviewed during the audit (i.e.: payroll data, personnel record details and contractor agreement details, etc.) will be maintained by the auditor(s).
Once the review of provider information and records is completed, the provider is mailed a draft audit report/preliminary clinical review notice. The provider is given 30 days to respond to the draft audit report/preliminary clinical review notice. Once the draft audit/preliminary clinical review notice response time is expired or dispute process is completed, a final audit report/clinical overpayment notice is sent to the provider. This audit report/notice contains the final overpayment amount and additional directives for the provider.

Some audits, specifically those audits which do not require obtaining records from a provider may result only in an overpayment notice being issued to the provider. This notice contains the overpayment amount and additional directives to the provider.

Providers will normally have 30 days (depending on the category of service being delivered and the specific regulations that govern that service) from receipt of the draft audit report or preliminary clinical review notice to dispute the draft audit or preliminary clinical review findings. Providers must submit the dispute in writing, include what findings they are contesting, and supply documentation to support their position.

Providers have 15 days from receipt of the final audit report/clinical review overpayment notice to request an administrative hearing/appeal of the final audit findings. Providers must submit the request in writing, including the basis for contesting the audit, and including a copy of the final audit report. The written request must be served in a manner which provides proof of receipt and must be sent to:

Office of Administrative Hearings
441 4th Street, NW
Suite 450 - North
Washington, DC 20001-2714

There are several Federal government audit/review and program integrity initiatives administered by the Centers for Medicare and Medicaid Services (CMS) or CMS contractors and may include the Office of

Inspector General (OIG). District of Columbia's Medicaid providers may receive notification letters and record requests from CMS contractors advising them they have been selected for an audit or review. These audits or reviews could involve the following programs or contractors:

- **Payment Error Rate Measurement (PERM**) measures improper payments (errors) in Medicaid and the Children's Health Insurance Program (CHIP). The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review. It is important to note that the error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements.
- **Audit Medicaid Integrity Contractors** are entities with which CMS has contracted to conduct post-payment audits of Medicaid providers. The overall goal of the provider audits is to identify overpayments and to decrease the payment of inappropriate Medicaid claims. At the direction of CMS, the Audit MICs audit Medicaid providers throughout the country. The audits ensure that Medicaid payments are for covered services that were provided and properly billed and documented. Audit MICs perform field audits and desk audits.
- **Recovery Audit Contractors** are entities which are required by Section 6411(a) of the Affordable Care Act and contracted through the State Medicaid Agency to audit claims for services furnished by Medicaid providers. These Medicaid RACs must identify overpayments and underpayments.

7.5 Utilization Review

In accordance with Section 1902 (a) (30) of the Social Security Act, DHCF has established procedures for reviewing the utilization of, and payment for, all Medicaid services. Accordingly, providers are required, upon request, to provide DHCF, designated DHCF agents, the Department of Justice, or the Secretary of Department of Health and Human Services with medical records. In addition, providers must fully cooperate with audits and reviews made by DHCF or their designee to determine validity of claims or the medical necessity of services rendered by the provider.

Any of the above entities have the right to request complete information about the ownership of any contractor with whom the provider has had business transactions. In addition, requests may be made about significant business transactions between the provider and any wholly owned supplier, or subcontractor, during the ten (10) year period from the date of the request. This information must be supplied within 35 days of request.

7.6 Consequences of Misutilization and Abuse

If routine utilization review procedures indicate that services have been billed for are unnecessary, inappropriate, contrary to customary standards of practice, or violate Medicaid regulations, the provider will be notified in writing. The provider may need to explain billing practices and provide records for review. Providers will be required to refund payments made by Medicaid if the services are found to have been billed and been paid by Medicaid contrary to policy, the provider has failed to maintain adequate documentation to support their claims or billed for medically unnecessary services.

7.7 Consequences of Fraud

If an investigation by DHCF shows that a provider submitted false claims for services not rendered or aided another in submitting false claims for services not rendered, DHCF will initiate payment suspension and/or termination proceedings pursuant to DC Medicaid regulations. In addition to administrative action, the case record will be referred to the Office of Inspector General for further review and criminal prosecution under District and Federal law. Sanctions for criminal violations will be imposed pursuant to District and Federal law.

7.8 Reporting Fraud, Waste, and Abuse

DHCF is committed to the investigation, prevention, and detection of provider and beneficiary fraud and/or abuse in the Medicaid program. Any related allegations, information, or concerns can be reported to DHCF, Division of Program Integrity at the following contact:

Department of Health Care Finance
Division of Program Integrity
441 Fourth Street, NW Washington, DC 20001
Telephone Number: 202 698-1718
Hotline Phone Number: 877.632.2873
https://www.dc-medicaid.com/dcwebportal/nonsecure/reportFraud

8 LANGUAGE ACCESS

The Language Access Program is housed under the District of Columbia Office of Human Rights (OHR). It exists to eliminate language-based discrimination, enabling DC residents, workers, and visitors to receive equivalent information and services from the DC government, regardless of what language they speak. The Program's scope includes all District agencies that meet the public, and it supports these agencies in providing translation and interpretation services for customers who are limited or non-English proficient (LEP/NEP). The Language Access Program organizes its work into four areas: enforcement, compliance monitoring, technical assistance, and community engagement.

- **Enforcement:** Individuals who believe their language access rights have been violated may file a complaint with OHR. The Program Director personally manages language access complaints and issues written findings after the investigations. The Program Director also works with agencies found in non-compliance to implement corrective actions.
- **Compliance Monitoring:** While the Program covers all District agencies that engage residents, workers, and visitors, it provides additional support to those agencies with major public contact (see "Laws and regulations" for more information on this distinction). With more potential exposure to the LEP/NEP population, agencies with major public contact have extensive language access responsibilities, which are reflected in the applicable laws and regulations. Program staff hold agencies accountable to these directives by monitoring each agency's compliance with them. Staff builds agency capacity for compliance through the development of attainable two-year action plans known as Biennial Language Access Plans (BLAPs). Agencies report quarterly on their BLAPs' progress, and Program staff review these reports. Program staff summarize their findings at the end of each fiscal year in the Annual Compliance Report.
- **Technical Assistance:** Program staff support all District agencies that offer language access services as needed. In addition to responding to individual inquiries from agency members, Program staff regularly provides training on compliance requirements and cultural competency. Staff additionally engage in issue-specific consultations and perform supplemental functions, as necessary.
- **Community Engagement:** To ensure that LEP/NEP residents, workers, and visitors are aware of their language access rights, the Language Access Program conducts outreach in conjunction with community-based organizations that serve immigrant needs. In addition to tabling at events, Program staff regularly delivers "Know Your Rights" trainings. Staff also works closely with members of the DC Language Access Coalition as well as the Consultative Agencies to disseminate information about the Program and create platforms for feedback on the District's translation and interpretation services. Staff also respond directly to inquiries from members of the public on matters related to language access.

8.1 Laws and Regulations

DC's Language Access Program began with the passage of the Language Access Act of 2004. This Act established the Program at the Office of Human Rights, identified covered entities, and enumerated their responsibilities, stipulated requirements for meeting these responsibilities, and outlined mechanisms for compliance monitoring and enforcement. You can view the full text of the Language Access Act of 2004, as updated in 2014, below.

- **DC Language Access Act of 2004 -** https://ohr.dc.gov/sites/default/files/dc/sites/ohr/publication/attachments/LanguageAccessActof2004-English.pdf
- **Language Access Regulations** - https://ohr.dc.gov/sites/default/files/dc/sites/ohr/publication/attachments/FINAL%20REGULATIONS%20-%20October%202014.pdf

The provider network supports DHCF in this effort by adhering to their contractual agreement as specified in section R3. R3 states the following:

Title VI of the Civil Rights Act of 1964 and 45 CFR 84.52(5)(d) requires that all patients receive the same level of care and service regardless of limited or no English proficiency (LEP) or limited or no hearing ability. All providers serving Medicaid beneficiaries are responsible for ensuring interpreter services are available for patients who need them. Federally Qualified Health Centers (FQHCs), hospitals, and other inpatient facilities must have their own interpreter services available for LEP or hearing impaired/deaf patients. Smaller, independent providers with no direct affiliation with such facilities may be eligible to request an interpreter through the Department.

8.2 Coordinating Translation Services

All providers serving Medicaid beneficiaries are responsible for ensuring translations and interpreter services are available for patients who need them. Effective April 7, 2022, Department of Health Care Finance (DHCF) has a new language access and interpretive services contractor, ContextGlobal, Inc.

8.2.1 Interpreter/Communication Access Real-Time (CART) Services Request Form

Please complete and submit the Interpreter Services request form for face-to-face interpretive services to DHCF via fax at 202-722-5685.

Please allow 5-7 business days for approval. If your request is outside of this timeframe, there is no guarantee that an interpreter will be available. However, urgent requests may be fulfilled depending on an interpreter's availability.

For MCO Enrollees: Providers should follow the guidelines established by the enrollee's managed care organization (MCO) for receiving authorization for interpretive services. Please contact below the appropriate MCO for more information:

- AmeriHealth Caritas DC Provider Services: 202-408-2237 or 1-888-656-2383
- Amerigroup DC Provider Services: 202-548-6700
- Health Services for Children with Special Needs (HSCSN) Provider Services: 202-467-2737
- MedStar Family Choice DC Provider Services: 1-855-798-4244
- UnitedHealthcare Community Plan DC Provider Services: 1-888-350-5608

9 ADMINISTRATIVE ACTIONS

The following administrative actions can be taken in response to provider misutilization or fraud and abuse (additional information is available at 29 DCMR § 1300, et seq.):

9.1 Recoupment

If a provider has knowingly billed and been paid for undocumented or unnecessary medical services, DHCF will review the error and determine the amount of improper payment. The provider will be required to either submit payment or provide repayment through DHCF withholding future claims. If the 100% review of disputable claims becomes impractical, random sampling techniques will be implemented to determine the amount of the improper payment. An appeal by a provider is not a sufficient reason to postpone restitution procedures. In addition, the provider is prohibited from billing the beneficiary for amounts the provider is required to repay.

9.2 Termination

A Provider Agreement can be terminated due to, but not limited to, the following:

- Non-compliance with promulgated regulations of DC Medicaid
- Demonstrated ability to provide services, conduct business, and operate a financially viable entity
- Suspension or termination from Medicare or Medicaid programs within the United States
- Conviction of a Medicaid-related criminal offense
- Disciplinary action entered on the records of the state or District licensing or certifying agency
- Has had a controlled drug license withdrawn
- Has refused to permit duly authorized District or Federal representatives to examine medical or fiscal records
- Has dispensed items or services to excess that could be harmful, grossly inferior in quality, or delivered in an unsanitary manner in an unsanitary environment
- Has falsified information related to a request for payment
- Has knowingly accepted Medicaid reimbursement for services provided to beneficiaries who have borrowed or stolen Medicaid identification cards
- Furnished or ordered services under Medicaid that are more than the beneficiary's needs or that fail to meet professionally recognized standards for health care.

9.2.1 Notification

When a Provider Agreement is terminated, the provider will receive a Notice of Termination from DHCF. The notice will include the reason for the action, the effective date of the action, and the repercussions for the action. Upon notification of termination, the provider may submit all outstanding claims for allowable services rendered prior to the date of termination. These claims must be submitted within 45 days of the effective date of the termination.

In addition, upon termination of the Provider Agreement, Medicaid may release all pertinent information to:

- The Centers for Medicaid and Medicare Services (CMS-formerly known as HCFA)
- District, State, and local agencies involved in providing health care
- Medicaid agencies located in other states
- State and county professional societies
- General public

9.2.2 Consequences of Termination

Upon termination, the provider will be prohibited from receiving payment, either directly or indirectly, from DC Medicaid. This includes payment for professional or administrative services through any group practice, medical, clinic, medical center, individual provider, or other facility.

9.3 Appeal Process

A provider may request a formal review if he disagrees with a decision made by DHCF. 29 DCMR 1300 governing appeals filed by providers are cited in the Provisions for Fair Hearings, DC Code Title 4-210.1 - 4-210.18. Areas that may be appealed include, but are not limited to, the following:

Areas that may be appealed include, but are not limited to, the following:

1) Appeals regarding denial of payment for unauthorized services
2) Appeals regarding termination of a provider agreement
3) Appeals regarding denial of enrollment as a provider in the DC Medicaid or Waiver Programs.

Written requests for appeals must be sent to the address in Appendix B. Appeals regarding termination of the Provider Agreement must be sent in writing to the address listed in Appendix B. A copy of all appeals must be sent to DHCF at the address in Appendix B.

9.4 Reinstatement

The provider must send a written request to the DHCF to be considered for reinstatement. This written request should include statements from peer review personnel, probation officers (where applicable), or professional associates on the provider's behalf. In addition, the provider should include an individual statement of request for reinstatement. All documentation must be sent to DHCF at the address listed in Appendix B.

9.4.1 Criteria for Reinstatement

The DHCF will take the following into consideration when a provider has made a request for reinstatement:

- Severity of the offense
- Negative licensure action
- Court convictions that are Medicaid-related
- Pending, unfulfilled claims or penalties

10 SERVICE AUTHORIZATIONS

This Manual section details the prior authorization and reauthorization processes of MHRS and ASARS for DBH. The Access HelpLine (AHL) Division is responsible for completing the prior authorization and reauthorization process.

10.1 Introduction and Service Authorization Overview

All MHRS and ASARS services require an authorization number for claims submission. Most MHRS and ASARS do not require clinical review by DBH prior to approval of the authorization request. However, if the request for authorization is submitted more than thirty (30) days after the date of service, the request for authorization will be denied as untimely.

When authorization, prior authorization or reauthorization is required, the AHL determines if the provider electronically submitted sufficient clinical justification to substantiate medical necessity. As part of the service authorization process, DBH may request and review the consumer's Plan of Care (formerly called, Individualized Recovery Plan (IRP)/ Individualized Plan of Care (IPC)), Treatment Plan, or other clinical material to evaluate the consumer's or client's level of care needs.

It is the responsibility of the DBH-certified provider to request authorization for MHRS or ASARS services from DBH within thirty (30) days.

Service authorization is a process within the AHL Division whereby clinical staff care coordinators determine if the clinical justification meets medical necessity criteria for services that require authorization, prior authorization, or reauthorization. Authorizations, prior authorizations, and reauthorizations require electronic and sometimes "hard copy" submissions of specific clinical information to be processed. All authorizations, prior authorizations, and reauthorizations are processed routinely by care coordinators or designated staff within the DBH Clinical Services Administration. Some decisions require more in-depth review by the care coordinators.

10.1.1 Provider Obligations Prior To Delivery of Services

On or before the delivery of any service for which prior authorization or reauthorization is required, providers create an electronic authorization request in the DBH eligibility, enrollment, and authorization system by selecting the appropriate service with the correct Authorization Request Screen in INCEDO Provider Connect.

Be responsible for ensuring the correct data entry of the electronic request to include thoroughness of written clinical information.

10.1.2 Key Access Helpline Contacts

The following Quick Reference Guide identifies the Access Helpline Division key points of contact for providers:

Access Helpline Division	Phone
Director, Access HelpLine Division	(202) 671-3105
Clinical Supervisor	(202) 671-3066
General Information (Access HelpLine)	1-888-7WE-HELP
Crisis Intervention, 24/7	1-888-7WE-HELP
Information and Referral (Access HelpLine)	1-888-7WE-HELP
Service Authorization Eligibility and Enrollment	(202) 671-3070

10.2 Prior Authorization and Reauthorization

10.2.1 Services Requiring Prior Authorization

Due to the intensity of certain levels of care, and the resulting increased need for continuity of care, some services require clinical review for justification of medical necessity and authorization prior to the service delivery. Services requiring medical necessity review and authorization prior to their delivery include:

10.2.1.1 Mental Health and Rehabilitation Services

- Assertive Community Treatment (ACT)
- Community Based Intervention (CBI)
- Intensive Day Treatment Service
- Residential Crisis Stabilization[3]

[3] Residential crisis stabilization is not a specific MHRS service; however, it is included in this Manual because it is authorized by the Access HelpLine Division.

10.2.1.2 Adult Substance Abuse Rehabilitation Services

- Adolescent-Community Reinforcement Approach
- Case Management
- Clinical Care Coordination
- Counseling / Therapy – Family Therapeutic with Client Present
- Counseling / Therapy – Family Therapeutic without Client Present
- Counseling / Therapy – Group Psycho-educational
- Counseling / Therapy – Group Therapeutic
- Counseling / Therapy – Individual
- Crisis Intervention
- Drug Screening
- Medication Assisted Therapy
- Medication Management
- Medically Monitored Intensive Inpatient Withdrawal Management

10.2.2 Services Requiring Reauthorization

“Reauthorization” is required for services once a benefit level has been reached OR to continue providing a service that requires prior authorization after an initial authorization period expires. The following services fall in this category:

10.2.2.1 Mental Health and Rehabilitation Services

- Assertive Community Treatment (ACT)
- Child Parent Psychotherapy (CPP)
- Community Based Intervention (CBI)
- Community Support
- Counseling (reauthorization required once benefit level is reached)
- Diagnostic Assessment (reauthorization once benefit level is reached)
- Intensive Day Treatment Service
- Rehabilitation Day Services (required after first ninety (90) units)
- Residential Crisis Stabilization4
- Trauma-Focused Cognitive Behavior Therapy (TF-CBT)

10.2.2.2 Adult Substance Abuse Rehabilitation Services

- Adolescent – Community Reinforcement Approach (ACRA)

- Assessment / Diagnostic and Treatment Planning Diagnostic – Brief
- Assessment / Diagnostic and Treatment Planning Diagnostic – Comprehensive
- Assessment / Diagnostic and Treatment Planning Diagnostic – Ongoing
- Clinical Care Coordination
- Counseling / Therapy – Family Therapeutic with Client Present
- Counseling / Therapy – Family Therapeutic without Client Present
- Counseling / Therapy – Group Therapeutic
- Counseling / Therapy – Group Psycho-educational
- Counseling / Therapy – Individual
- Medication Assisted Therapy
- Medication Management
- Medically Monitored Intensive Inpatient Withdrawal Management

10.3 Processing Authorization Requests

Provider generated electronic service authorization requests are submitted daily in the DBH eligibility, enrollment, and authorization system. Most services will process automatically. Service requests that cannot be processed automatically will be pended for review by DBH Care Coordinators. These requests are reviewed daily.

Services may pend for several reasons. These include limitations set in the MHRS and ASARS Provider Certification Standards, service combinations, documentation of medical necessity, and level of care protocols, which set clinical best practice guidelines for some services. Information on the status of authorizations is available in the DBH eligibility, enrollment, and authorization system under "Authorizations." Providers may review the status of their submitted requests electronically. Further information is available by calling AHL.

10.3.1 Adult Substance Abuse Rehabilitation Services Specific Requirements

10.3.1.1 Adult Substance Abuse Rehabilitation Services Treatment Reauthorization Process

- A SUD treatment provider must submit a reauthorization request via the DBH eligibility, enrollment, and authorization system within ten (10) days of the end of the authorization period.
- The ten (10) day timeframe must coincide with the end of the client's authorization expiring.
- The Reauthorization Review process is conducted by the AHL designee.
- A reauthorization request is required for all levels of care for SUD treatment. If a different level of care for SUD treatment is requested after the initial authorization, a reauthorization must still be submitted.

10.3.1.2 ASARS Treatment Reauthorization Process - Required Documentation

The following items are REQUIRED for all ASARS reauthorization processes:

- Clinical note describing what services are being requested and a clinical justification
- Updated DBH approved assessment tool
- Updated Treatment Plan with an effective end date
- Drug Screen Results
- All documents must be reviewed and signed accordingly by a qualified practitioner prior to submission for reauthorization

AHL must review and decide on all reauthorizations within twenty-four (24) to forty-eight (48) hours.

- Once a reauthorization is approved, AHL will notify the provider and the SUD mailbox via email.

- The chart below indicates the appropriate Reauthorization Plan Duration that should be granted for requests

Table 3: Level of Care (LOC) Authorization

Level of Care	Description	Reauthorization Plan Duration
Level 1.0	AR: Assessments and Referral	90 days
Level 1.0	Outpatient	180 days
Level 2.1	Intensive Outpatient Program	30 days
Level 2.5	Day Treatment	30 days
Level 3.1	Clinically Managed Low-Intensity Residential	30 days
Level 3.3	Clinically Managed Population-Specific High-Intensity Residential	30 days
Level 3.5	Clinically Managed High-Intensity Residential (Adult) or Clinically Managed Medium-Intensity Residential (Youth)	14 days
Level 3.7-WM	Short-term Medically Monitored Intensive Withdrawal Management	2-5 days
Level-R	Recovery Support Services	

10.3.1.3 Recovery Support Services (RSS)

An RSS provider must submit a reauthorization request via DATA/WITS within ten (10) days of the end of the current authorization period.

- The ten (10) daytime frame must coincide with the ending of the client's authorization expiring or a determination that more specific RSS services is needed.
- The Reauthorization Review process is conducted by the AHL or its designee.
- A reauthorization request is required for all RSS.
- Each different request (for services or time) requires a new reauthorization request.

10.3.1.4 Recovery Support Services Required Documentation

The following items are REQUIRED for ASARS reauthorization:

  - Updated Recovery Plan within ninety (90) days and as clinically indicated
  - Clinical Justification Summary entered in DATA/WITS
  - All documents (specifically justification) must be reviewed and signed accordingly by a Qualified Staff member prior to submission for reauthorization
-
- Providers must notify AHL via email that a reauthorization request has been entered
- AHL must review and decide on all reauthorizations within 24/48 hours.
- Once a reauthorization is approved, AHL will notify the provider via email
- The following chart below indicates the appropriate Reauthorization Plan Duration that should be granted for requests

Table 4: LOC Reauthorization

Reauthorization Request Type	Reauthorization Plan Duration
RSS Days Requested for Reauthorization	90 days
Specific Services Requested for Reauthorization	Use the amount requested by Provider

10.4 Insurance and Service Line Unit Settings

10.4.1 Insurance Definitions for Authorization

Services are authorized by and claimed against one (1) of three (3) insurance types in the DBH eligibility, enrollment, and authorization system as follows:

a) DC DBH – DC DBH
b) DC DBH – LocMed Supplemental
c) Medicaid – Medicaid

10.4.2 Definitions

a) DC DBH – DC DBH is local dollar coverage for consumers who DO NOT have Medicaid.
b) DC DBH – LocMed Supplemental is local dollar coverage for consumers who have Medicaid. It is used to pay for non-Medicaid reimbursable services.
c) Medicaid – Medicaid is for consumers who have Medicaid. It is Medicaid dollars used to pay for DBH services that ARE paid by Medicaid.

10.4.3 Selecting the Correct Insurance

For consumers who have Medicaid, all Medicaid eligible services should be set to Medicaid. For consumers who have Medicaid, all local dollar only services should be set to DC DBH – LocMed Supplemental. For consumers who do not have Medicaid, all services should be set to DC DBH.

10.4.4 Coordination of Benefits

If a consumer has private insurance, the claim is denied and returned to the provider for submission to the consumer's or client's private insurance.

10.5 Functional Assessments

10.5.1 Locus and CAFAS for MHRS Services

Per DBH Policy 300.1, Level of Care Utilization System (LOCUS) Evaluation, DBH requires the CSA (Core Service Agency) to complete a LOCUS (for adults) or Child and Adolescent Functional Assessments (CAFAS) (for child/youth) evaluation for each consumer. The Division of Care Coordination uses the LOCUS, CAFAS or any other DBH-approved assessment tool to assist in making level of care determinations for services requiring prior authorization or reauthorization. Submission of the results of a web-based application LOCUS or CAFAS evaluation is required.

DBH policies are available via the internet on the DBH website. To access the DBH policy on the LOCUS or CAFAS, type the following address in the browser box of a computer: www.dbh.dc.gov.

1. Click on "Policies, Procedures and Rules" located under "About DBH"
2. Select DBH Policies
3. Select 300.1D, Level of Care Utilization System (LOCUS/CAFAS) Evaluation policy.

To locate LOCUS/CAFAS provider training information, please see the following link: http://DBH1.dc.gov/node/216512. Documents you can obtain from this site include:

- "Steps to Complete the LOCUS/CAFAS" [PDF] (also available as a PowerPoint presentation)
- CAFAS/LOCUS Training and User Account Request Form Instructions [PDF]
- CAFAS/LOCUS Training Request Form [PDF]
- CAFAS/LOCUS User Account Request Form [PDF]
- DBH Policy for LOCUS/CAFAS [PDF]
- LOCUS/CAFAS Electronic Report Descriptions [PDF]

- Applied Research and Evaluation (ARE) Unit LOCUS/CAFAS Utilization and Reporting Plan [DOC]

Questions about training should be directed to the DBH Training Institute: dbh.training@dc.gov.

General questions about use of the LOCUS or CAFAS should be directed to the Applied Research and Evaluation Unit: are.dbh@dc.gov.

10.6 Authorization Clinical Protocols

Requests for services requiring authorization, prior authorizations, or reauthorization are reviewed by the AHL Division using medical necessity software embedded in the DBH eligibility, enrollment, and authorization system. Reference the medical necessity protocol in Appendix F of this Manual for details and requirements.

10.7 Service Request Dispositions

Requested services are approved, denied, or pended independently of one another. The Benefit Plan number is used to submit claims for any approved service on the Benefit Plan.

If the Benefit Plan has a number, but a service on the plan is denied, the provider will not be able to claim for the denied service irrespective of the Benefit Plan number. Both a Benefit Plan number and an approved service line on the Benefit Plan are required for successful claims submission.

10.7.1 Approved Services

Claims for services that are approved on the Benefit Plan can be forwarded to DBH for processing. Providers can review the status of approved service authorization requests in the DBH eligibility, enrollment, and authorization system.

10.7.2 Pended Services

Service requests that fail the automatic review in in the DBH eligibility, enrollment, and authorization system may pend for review by DBH Care Coordinators. Pended requests are reviewed daily. Authorization requests may be pended for several reasons. These include limitations set in the MHRS Certification Standards, service combinations, documentation of medical necessity, and level of care protocols, which set clinical best practice guidelines for some services. Information on the status of authorizations is available in the DBH eligibility, enrollment, and authorization system under “Authorizations.” Providers may review the status of their submitted Benefit Plans electronically. Further information is available by calling AHL.

In cases of pended authorizations, a DBH Care Coordinator will:

a) Conduct a telephone review within two (2) business days with the requesting clinician or qualified practitioner.
b) Request that the provider forwards additional required clinical information to DBH within three (3) business days to facilitate processing.
c) Deny the request five (5) business days after requesting additional information if additional information is not submitted.

10.7.3 Denied Services

Service requests may be denied for the reasons provided below.

10.7.3.1 Administrative Denials

AHL determines that an administrative denial is warranted based on the following criteria:

- Incomplete documentation to support the request such as no current assessments or valid, updated treatment or recovery plan.
- Ineligible diagnosis or consumer.
- Failure to submit requested documentation within three (3) business days.
- Non-compliance with authorization requirements.
- Untimely submission of the request.

10.7.3.2 Clinical Denials

AHL determines that clinical denials are warranted because of the lack of appropriate clinical justification to meet medical necessity criteria for clinical services

10.7.3.3 Eligibility, Enrollment and Authorization System Denials

Determined by the DBH eligibility, enrollment, and authorization system based on the following criteria:

- Invalid Rate Profile for a Provider
- Expired insurance (and other insurance related denial reasons)
- Units exceed provider's agreement limit

To decrease eligibility, enrollment, and authorization system denials, the provider must only enter one Benefit Plan for any specific date span. Any errors that are created on that plan need to be remedied since adding another plan will create more errors.

In cases where the request for authorization was denied because the authorization request was not within thirty (30) business days of service, the provider shall forward the appeal request in writing to the Director, Division of Care Coordination. The appeal request shall include the consumer's complete name, the INCEDO number, and the date of the request.

10.7.4 Adverse Determination

An adverse determination at Level I occurs when the AHL Clinical Supervisor determines that the clinical documentation supporting the requested service does not meet medical necessity criteria. If the provider disagrees with the decision, the Level II appeal process outlined may be initiated within twenty- four (24) hours of notification of this denial type.

10.7.5 Untimely Submission Denials

All administrative service authorization denials for untimely submission shall be forwarded to the AHL Director in the DBH eligibility, enrollment, and authorization system. The AHL Director shall forward all authorization requests posted after (30) days to the Chief Clinical Officer for disposition.

10.7.6 Supplemental Units Requests

Consumers may need more units of service than the Benefit Plan's maximum settings. Providers can electronically request supplemental units for any service in the DBH eligibility, enrollment, and authorization system.

10.8 Authorization Appeal Process

There are three (3) types of appeals: Reconsideration, Level I Appeal, and Level II Appeal. The Reconsideration Appeal is a provider's opportunity to provide information after an administrative denial in which the AHL did not have sufficient clinical justification to render a medical necessity determination. A Level I Appeal is reviewed at the Division of Care Coordination or service authorization level. A Level II Appeal is reviewed by a DBH Appeal Board.

10.8.1 Reconsiderations and Level I Appeals – Service Authorization

Reconsiderations are made after a denial for administrative or DBH eligibility, enrollment, and authorization system reasons. DBH's eligibility, enrollment, and authorization system notifies the provider of the administrative denial. In the case of an administrative denial, additional information may be requested.

Additional information for the reconsideration should be submitted within three (3) business days to the Care Coordinator requesting the information. Requests in which additional information is not received within five (5) business days will remain denied, and the provider will need to request a Level I Appeal.

Level I Appeal Process	
Provider Responsibility	Submit an electronic request for appeal within fifteen (15) days from the date of initial denial by: • Entering the request in the DBH eligibility, enrollment, and authorization system. • The request is to include the date of filing, the first initial and last name of the consumer or client, the INCEDO number, the specific reason for the denial, date of the denial, and the reason(s) for which the denial occurred.
DBH Clinical Services Administration Responsibility	The Director, AHL, or his or her designee, will review the request and within twenty-four (24) business hours (weekends and holidays excluded) notify the provider of the disposition of the appeal. This will be in the form of an electronic response in the DBH eligibility, enrollment, and authorization system.
Action/Disposition	If the denial of the authorization is supported at the Level I Appeal, the provider may submit a request for a Level II Appeal.

10.8.2 Level II Appeals – DBH Service Authorization Appeal Board

When an adverse determination is made by DBH, the provider may appeal this decision by requesting a Level II Appeal.

Level II Appeal Process	
Provider Responsibility	The provider must submit a request for a Level II appeal within twenty-four (24) hours of notification of an adverse determination by: • Entering the request in the DBH eligibility, enrollment, and authorization system. • The request includes the date of original filing, the first initial and last name of the consumer, the INCEDO number, the denial reason, date of the denial, and the reason(s) for which the denial occurred. • The provider shall submit the consumer's most recent treatment plan, and any relevant clinical information within the past year that supports the authorization request. • The Qualified Practitioner or designated representative may be required to appear before the Appeal Board.

DBH Chief Clinical Officer Responsibility	The DBH Chief Clinical Officer or their designee shall notify the provider electronically in the DBH eligibility, enrollment, and authorization system of the request for a Level II Appeal within twenty-four (24) business hours (excluding weekends and holidays). This notification shall include the date of the Appeal Board Hearing. The Appeal Board will convene within five (5) business days (weekends and holidays excluded).
Action/Disposition	If the denial of the authorization is supported at the Level II Appeal, the provider shall receive written notification within five (5) business days in the DBH eligibility, enrollment, and authorization system stating the specific clinical reasons for the denial of the authorization.
DC Office of Administrative Hearings (OAH)	The consumer has the right to request a hearing from OAH to appeal a denial of Medicaid benefit.

11 CLAIMS PROCESSING PROCEDURES

To ensure that the DC Medicaid claim is processed according to DC Medicaid policy, an advanced Medicaid Management Information System (MMIS) has been developed to adjudicate and price claims. This chapter outlines the claims process.

11.1 Receive and Record

Claims are received by Conduent in one of two media types: paper or electronic. Paper claims are handwritten or generated by computer. Standardized forms have been developed for the submission of services for payment. Standardization ensures appropriate entry and formatting of claims.

DC providers have the option of billing via Web Portal, EDI (Electronic Data Interchange) or paper. WINASAP is software that has been developed by Conduent to give DC Medicaid providers the capability for accelerated submission of Medicaid claims. DC providers may also submit electronic claims by utilizing billing agents, clearinghouses, or other third-party billing software. Submitting claims electronically drastically reduces the time required for Medicaid claims to be prepared for the Medicaid Management Information System (MMIS). Electronic submission eliminates the process of document preparation, mailing, claims receipt, and data entry. Using electronic submission, claims are transmitted directly to EDI or received in electronic format, then uploaded to the MMIS the same day of receipt. Hard copy claims are received in the mailroom where they will undergo a review process.

11.2 Review

After hard copy claims have been received, they are reviewed for essential data. If essential data is missing, the claims will be returned to the provider (RTP). A claim will be rejected if any of the following situations occur:

- Original provider signature is missing (stamped signatures are not acceptable)
- Provider Medicaid identification number is missing
- Beneficiary Medicaid identification number is missing
- Claim submitted on an unaccepted claim form (older claim form version). [Note: DC Medicaid accepts CMS1500, ADA Dental, and UB04 claim forms.]
- Writing not legible

Any claim that is RTP'd will be accompanied by an RTP letter. If the claim was submitted as a paper, the original claim can be corrected. If the claim was originally submitted electronically, it can be resubmitted electronically or be transferred to paper for resubmission.

11.3 Transaction Control Number

The transaction control number (TCN) is a unique tracking number assigned to each accepted claim. Rejected claims, submitted hard copy, or electronically are not assigned a TCN until all errors have been corrected and resubmitted. If the claim was submitted as a hard copy, the original claim can be corrected. If the claim was originally submitted electronically, it can be resubmitted electronically or transferred to paper for resubmission.

Figure 5: TCN Structure

17021	1	0123	000001	7
Julian Date (YYDDD)	Media Type (By Value)	Batch Number (By Position)	Document Number	TCN Type (By Value)
	1 = Web 2 = Electronic Crossover 3 = Electronic Submitted Claim 4 = System Generated 5 = Web w/attachment 6 = Special Batch 7 = Retro-rate 8 = Paper 9 = Paper w/attachment 0 = Encounter	1 = Machine number 2 - 4 = Assigned batch		0 – 4 = PBM 5 - 6 = Available 7 = Original 8 = Credit (void) 9 = Debit (adjustment)

11.4 Input

Claims that have been accepted and have received a TCN are sent to data entry. After data entry operators have keyed these claims, the MMIS starts the editing process. If edits appear, the resolutions unit then works them. Edits give operators the opportunity to correct errors. The claims are then entered into the MMIS for processing.

11.5 Edits

When the claim data has been entered into the MMIS, it is edited to ensure compliance with the following DC Medicaid requirements:

- Provider eligibility
- Beneficiary eligibility
- Valid and appropriate procedure, diagnosis, and drug codes
- Reasonable charges
- Duplicate claims
- Conflicting services
- Valid dates
- Other Medicaid requirements

The status that is assigned to each claim is dependent on compliance with the requirements. The assigned status of each claim will be paid, denied, or suspended.

The Remittance Advice (RA) document sent to providers shows the status of each claim submitted by the provider and entered the MMIS. The claims information is sorted on the RA in the following order:

- Paid original claims
- Paid adjustment claims
- Denied original claims
- Denied adjustment claims
- Suspended claims (in process)
- Paid claims MTD
- Denied claims MTD
- Adjusted claims MTD
- Paid claims YTD
- Denied claims YTD

11.5.1 Approval Notification

Claims that meet all requirements and edits are paid during the next payment cycle. The provider will receive a Remittance Advice (RA) weekly listing all paid, denied, and suspended claims in the system. The provider will also receive a reimbursement check or direct deposit for paid claims. The RA will include claim amounts that have been processed and a total of all paid claims.

Claims previously paid incorrectly may be adjusted or voided. Voids will appear as credits; adjustments will appear as two transactions, debit, and credit.

Adjustments/voids must be initiated by the provider since the provider can only correct errors after the claim has been paid and appears on the RA. It is the responsibility of the provider to make corrections when errors are made.

- The following examples show the importance of adjusting or voiding a previously adjudicated claim on which errors have occurred:
- The provider treated John Smith, but inadvertently coded a Beneficiary Identification Number of Jane Smith who may or may not be the provider's patient. The provider will need to void the claim for Jane Smith and submit an original claim for John Smith giving the correct identification number.
- On the original claim the provider entered the incorrect charge for accommodation. The provider will need to adjust (correct) the claim to obtain the correct reimbursement.
- The provider submits a claim in which an incorrect procedure code was used. In this case, the code was for removal of an appendix. This was not the procedure performed but the claim was paid according to the procedure listed. The provider will need to adjust (correct) this claim via an adjustment and enter the correct code for the procedure performed. This is an important step because should the patient ever require an appendectomy, that claim would otherwise be denied because the record reflects that the appendix had previously been removed.

The provider will be paid by check or direct deposit for all paid claims in accordance with current guidelines. Payments to providers may be increased or decreased by DHCF to accommodate previous overpayments, underpayments, or an audit.

11.5.2 Denied

Claims that do not meet DC Medicaid editing requirements will not be paid. All denied claims are listed on the RA in alphabetical order by beneficiary last name. Denial reasons are listed on the RA as well. Listed below are some examples of denial reasons:

- Beneficiary not eligible on date of service
- Provider not eligible on date of service
- Duplicate claim
- Claim exceeds filing limit

11.5.3 Suspended

Claims that do not meet the editing requirements cannot be paid until discrepancies have been resolved. To verify that the claim is in error, the MMIS assigns a status of "Suspend" which will outline the problem to resolve the issue. Claims will suspend for a variety of reasons; however, the most common reasons for claims to suspend are due to beneficiary eligibility, provider eligibility or the claim must be manually priced. Claims that suspend should not be re-submitted. If a second claim is submitted while the initial claim is in a suspended status, both claims will be suspended. Please allow the suspended claim to be processed and to be reported on the RA as paid or denied before additional action is taken.

Conduent and DHCF resolve all pended claims. The RA will only state that the claim is suspended and will list the exception code.

11.6 Timely Filing

All services to be reimbursed must be billed on the appropriate form, signed, and submitted to Conduent or in the case of presumptive eligibility, DHCF. All hard copy claims must be mailed to their respective P.O. Box, unless otherwise instructed.

The Department of Health Care Finance (DHCF) received approval from the Department of Health & Human Services Center for Medicare and Medicaid Services (CMS) to amend the Medicaid State Plan regarding timely filing of Medicaid claims. Effective October 1, 2012, the timely filing period for Medicaid claims is 365 days from date of service.

Secondary and tertiary Medicaid claims submitted for payment must be submitted within 180 days from the payment date from Medicare or the third-party payer. The Explanation of Benefits (EOB) statement must be attached to the claim.

For claims submitted on or after October 1, 2012, DHCF will not pay any claim with a date of service that is greater than three hundred and sixty-five (365) days prior to the date of submission. All claims for services submitted after 365 days from the date of service will not be eligible for payment. In addition, the amendment outlines the following exceptions to the 365-day timely filing requirement:

- When a claim is filed for a service that has been provided to a beneficiary whose eligibility has been determined retroactively, the timely filing period begins on the date of the eligibility determination.
- Where an initial claim is submitted within the timely filing period but is denied and resubmitted after the end of the timely filing period, the resubmitted claim shall be considered timely filed provided it is received within 365 days of the denial of the initial claim.
- If a claim for payment under Medicare or third-party payer has been filed in a timely manner, DHCF may pay a Medicaid claim relating to the same services within 180 days of a Medicare or third-party payer’s payment.

This amendment to the State Plan applies to all DC Medicaid public, private and out of state providers who submit claims to DHCF.

To avoid denial, all hard copy and electronically submitted claims must be received within 365 days of the date of service.

12 BILLING INFORMATION

This section provides general billing information for use by providers when submitting claims.

12.1 Billing Procedures

Providers must supply their own standard claim form for the services provided. Conduent distributes Prior Authorization (719A) and Medicaid Laboratory Invoice for Ophthalmic Dispensing forms upon request.

The following claim forms are approved for filing claims utilizing the national standards for claim completion for goods or services provided to Medicaid beneficiaries:

- CMS1500
- ADA 2012 Dental Form
- UB-04

12.1.1 Form Availability

Original red CMS1500 and UB04 claim forms may be obtained from office supply stores (i.e., Staples, Office Depot, etc.) and Government Printing Office. The ADA Dental claim form must be obtained from the American Dental Association.

12.1.2 Procedure and Diagnosis Code Sources

The procedure coding system recognized by the Medicaid Program is the Health Care Financing Administration's (HCFA) Common Procedural Coding System (HCPCS) as adopted by DHCF. The HCPCS consists of current year CPT-4 codes and HCFA codes.

Diagnosis numerical coding is required based on the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Refer to Appendix B for address and contact information.

12.2 Electronic Billing

DC Medicaid encourages transmission of claims electronically. Currently, DC Medicaid receives claims in the following media types:

- Web Portal
- EDI
- WINSASAP

To ensure timely processing of payments, electronic claims must be received by Conduent no later than noon every Thursday for processing in the weekly payment cycle.

Conduent has implemented a Web Portal to provide tools and resources to help healthcare providers conduct their business electronically. Electronic claim submission provides for timely submission and processing of claims. It also reduces the rate of pended and denied claims.

Providers who are interested in receiving electronic billing instructions should indicate this interest on their EDI Enrollment application. Procedures specific to electronic billing are sent to providers approved to submit claims in this manner. The EDI X12N companion guides are available for download on the Web Portal. If you are already enrolled in the program and would like information on electronic claims billing, please contact Conduent at the number and address listed in Appendix B.

12.3 Medicare/Medicaid Crossover Billing

When a beneficiary has been determined as dual-eligible (Medicare and Medicaid), Medicare should always be billed first. The Medicare claim must include both the patient's Medicare and Medicaid identification number. After Medicare processes the claim, the claim will be transmitted to Conduent for

processing electronically. The claim must be received by Conduent no later than 180 days after the Medicare paid date as indicated on the Explanation of Medical Benefits (EOMB) statement.

If Medicare is billed for services for a beneficiary who is later identified as having Medicaid coverage, the provider should submit a copy of the Medicare claim to DC Medicaid. Again, the Medicare claim must include the patient's DC Medicaid identification number. The Explanation of Medical Benefits (EOMB) from Medicare must be attached to the claim as proof of payment or denial of payment by Medicare and submitted to Conduent for processing. Refer to Appendix B for the address to submit these claims.

For additional information on Medicare billing, go to www.cms.gov/Medicare/Medicare.html or call Medicare at 800.633.4227.

12.4 Medicare Coinsurance and Deductibles

When billing for a Medicaid patient who is also covered by Medicare for a service that is covered by Medicare, Medicare must be billed first. After Medicare processes the claim, submit a Medicare Crossover claim to Medicaid using the UB-04 or CMS-1500 claim form. Attach the Medicare Explanation of Medical Benefits (EOMB) including the Medicare payment date to the Medicare residuals claim as proof of payment or denial by Medicare.

When billing for Part A coinsurance, you must submit: 1) A UB-04 claim form with all required fields completed; and 2) The Medicare EOMB attached, or the claim will be returned. This will allow Medicaid to utilize all diagnosis and procedure code information to determine Medicaid's payment obligation in accordance with the District's State Plan.

12.5 Medicaid Claims with Third Party Payments

Medicaid is always the payer of last resort. When a beneficiary has insurance from another source, employer or private policy, the provider must bill this source first before submitting to Conduent.

To bill Medicaid, the provider must submit an original claim with a copy of the third-party payers' EOMB attached indicating payment or denial within 180 days of the processing/payment date. When interviewing the patient, the provider should always question the patient about third party resources available to the patient, regardless of the information supplied through the Web Portal and IVR.

In accordance with the DC Medicaid State Plan Amendment, the reimbursement for TPL claims is the difference between the third-party payer's payment and the Medicaid allowed amount, not just the deductible and coinsurance.

12.6 Resubmission of Denied Claims

If a claim has been denied due to reasons other than violations of good medical practice or Medicaid regulations, the claim may be resubmitted. An original claim must be submitted; copies will not be accepted. Only claims, which have appeared on your remittance advice as, denied, can be resubmitted. Claims that are still in a Pend status cannot be resubmitted until they have been denied. Resubmission of a pended claim will result in claims denying for duplicate.

Telephone and/or written claim inquiries regarding non-payment of claims should be made after 45 days from the date the claims were initially submitted to DC Medicaid. Please be certain that the claim in question has not appeared on any subsequent remittance advice before making an inquiry.

Instructions for resubmitting a denied claim are as follows:

- Claims must be received within 365 days after the date of service or in the case of inpatient hospital services, 365 days after the date of discharge. Claims must be resubmitted within 365 days of the RA date on which the claim denied for any reason(s) other than timely filing.

- Complete a new red claim form. A copy of the original claim form will be accepted if it is clear, legible and has been resigned (a copied or stamped signature will not be accepted).
- Correct any errors that caused the original claim to be denied.
- Do not write anything on the claim except what is requested. Any additional information should be submitted in writing and attached to the claim.
- Attach a copy of the Remittance Advice without staples, paper clips or colored highlighting on which the denied claim appears and any other documentation necessary to have the claim paid (e.g., consent form, isolation form). If more than one resubmitted claim appears on a page of the remittance, a copy of that page should be attached to each claim being submitted.
- Forward all resubmitted claims to the appropriate P.O. Box listed in Appendix B.

If you have any questions regarding these procedures, contact Conduent Provider Inquiry at (866) 752-9233 (outside DC metro area) or (202) 906-8319 (inside DC metro area).

12.7 Claim Appeals

A Medicaid claim may be denied for several reasons. It could be due to services not being covered under the plan, the provider submitting a claim for a much higher amount than what Medicaid pays for the service or retro eligibility for a beneficiary.

Providers may appeal any decision made by Medicaid if you believe your claim was inappropriately denied. Do not submit medical records with your appeal unless requested by DHCF. Requests for claim appeals should be sent to the address indicated in Appendix B.

12.8 File Acknowledgement

Conduent uses HIPAA 999 functional acknowledgement transactions to allow the provider to confirm Accept, Accepted with Errors, or Reject, following receipt of 837 claims batches from providers via Provider Connect.

12.9 Modifier Codes

The following modifiers will be used to further identify services that are covered under MHRS and SUD:

Face-to-Face contact with Consumer or Client	No Modifier
Face-to-Face Contact with Collateral Source	UK
Specified Service to Individual/Age 0-21	HA
Behavioral Health Service	HE
Family/Couple with Consumer or Client present	HR
Family/Couple without Consumer or Client present	HS
Group Setting	HQ
Community Residential Facility (CRF) Billing	U1
Funded by Child Welfare Agency – Used by DBH for Functional Family Therapy (FFT) CBI Level IV	HU
Multi-disciplinary Team – Used by DBH for MH Service Discharge Treatment Planning, Institution (MHS-DTP) – ACT	HT
Specialized Behavioral Health Program for High-Risk Population	HK
Physician Team Member	AM
Laboratory-related Service	LR
Follow Up Service	TS
Complex/high tech level of care	TG

Substance Use Program	HF
Two Clients Served	UN
Three Clients Served	UP
Four Clients Served	UQ
Five Clients Served	UR
Integrated Mental Health/SUD	HH
Trauma Related	ST

When a modifier is applicable to a specific service, the modifier code must be used as specified in Appendix A, Service Code/Modifier/Place of Service Table, to be accurately processed. Do not create combinations other than what is reflected in Appendices A through D. The all-inclusive codes for CBI and ACT allow for collateral, family, and telephone contacts to be provided and billed without using modifier codes UK, HR, and HS modifiers.

12.9.1 Services Provided to Collateral Care Givers and Other Professionals That Do Not Include Significant Others or Family When the Consumer Is Present, and When the Consumer Is Not Present

Modifier “UK – Face-to-Face Services provided on behalf of the consumer or client to someone other than the consumer or client” (collateral relationship) should be used to capture services provided to Collateral Care Givers and other professionals. Only face-to-face contact with collateral sources is allowable when using the UK modifier.

12.9.2 Services Provided to Significant Others or Family When the Consumer or Client Is Present, And When the Consumer or Client Is Not Present

Modifier HR indicates Family/Couple contact when the consumer or client is present. Modifier HS indicates Family/Couple contact when the consumer or client is NOT present.

12.10 Procedure Codes

12.10.1 Procedure & Levels of Care Codes

The MHRS and SUD service taxonomies are broken down into levels of care in the DBH eligibility, enrollment, and authorization system. These levels of care are code and rate specific and must be accurately submitted for claims to process.

12.10.2 Mental Health Rehabilitation Services Service Limitations

The table in Appendix A, MHRS Service Limitations, provides a list of MHRS billable services along with the limitations on each.

12.11 Diagnosis Codes

HIPAA requires use of the most current published version of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-10-CM) diagnosis codes for professional claims submission. DBH will consider payment claims containing eligible diagnosis codes outlined in section F01 – F99 of ICD-10 CM.

12.11.1 ICD-10-CM Non-Billable/Non-Specific Diagnosis Codes

Providers should pay special attention to avoid using ICD-10 CM diagnosis codes that may be proper for describing a condition but are not specific enough for billing claims.

A URL like, http://www.icd10data.com/ICD10CM/Codes/F01-F99 can be used to review this information as in the example below:

ICD-10-CM Codes › F01-F99 Mental, Behavioral and Neurodevelopmental disorders › F20-F29 Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders › F20- Schizophrenia ›

2019 ICD-10-CM Diagnosis Code F20

Schizophrenia

2016 2017 2018 2019 Non-Billable/Non-Specific Code

- F20 should not be used for reimbursement purposes as there are multiple codes below it that contain a greater level of detail.
- The 2019 edition of ICD-10-CM F20 became effective on October 1, 2018.
- This is the American ICD-10-CM version of F20 - other international versions of ICD-10 F20 may differ.

12.12 Place of Services Codes

Place of Service Codes shall be used on professional claims to specify the entity where services(s) were rendered. Listed below are place of service code descriptions that DBH accepts.

03	**School**	A facility whose primary purpose is education.
04	**Homeless Shelter**	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
09	**Prison/Correctional Facility**	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either federal, state, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
11	**Office**	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	**Home**	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	**Assisted Living Facility**	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support twenty-four (24) hours a day, seven (7) days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	**Group Home**	A residence, with shared living areas, where consumers or clients receive supervision and other services such as social or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	**Mobile Unit**	A facility or unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, or treatment services.
21	**Inpatient Hospital**	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22	**On Campus- Outpatient Hospital**	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	**Emergency Room - Hospital**	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided
31	**Skilled Nursing Facility**	A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	**Nursing Facility**	A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than to individuals who solely have behavioral health conditions.
51	**Inpatient Psychiatric Facility**	A facility that provides inpatient psychiatric services for the diagnosis and treatment of behavioral illness on a twenty-four (24) hour basis, by or under the supervision of a physician.
52	**Psychiatric Facility – Partial Hospitalization**	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	**Community Behavioral Health Center**	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's behavioral health services area who have been discharged from inpatient treatment at a behavioral health facility; twenty-four (24) hours a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state behavioral health facilities to determine the appropriateness of such admission; and, consultation and education services.
55	**Residential Substance Use Disorder Treatment Facility**	A facility which provides treatment for substance use disorder to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling / therapy, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	**Psychiatric Residential Treatment Center**	A facility or distinct part of a facility for psychiatric care which provides a total twenty-four (24) hour therapeutically planned and professionally staffed group living and learning environment.
57	**Non-residential Substance Use Disorder Treatment Facility**	A location which provides treatment for substance use disorder on an ambulatory basis. Services include individual and group therapy and counseling / therapy, family counseling, laboratory tests, drugs and supplies, and psychological testing.
71	**Public Health Clinic**	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
99	**Other place of service**	Other place of service not identified above.

Providers must include the “place” in the narrative of the progress note whenever “other” (99) is used on a claim. Claims may be denied during a claims audit if “other” (99) is used on a claim as the place of service code, and the “place” is not identified in the narrative of the progress note.

12.12.1 Type of Service Codes

DBH previously used proprietary codes for Type of Service. Under HIPAA, these codes have now been incorporated into the modifier table.

12.13 Same Day Service Reporting

Legitimate “multiple” services (i.e., same services delivered to the same consumer on the same day by the same provider) must be rolled up to one (1) service line on the claim before submitting to DBH. Consequently, DBH will deny a non-rolled up service with a “duplicate” reason code.

The following data elements are validated during duplicate checking: Provider, Consumer, Date of Service, Procedure Code, and Modifier 1.

Important Note: It is important to understand the implications of including Modifier 1 in the duplicate claim validation. If a procedure code is billed with a modifier on the same day as another service that uses the same procedure code without a modifier or with a different modifier, the services will be considered separate services. They should be submitted on the claim as separate service lines and should not be “rolled up.”

Modifier 2 is not incorporated in duplicate checking. Claims for multiple services on the same day that can be validated as non-duplicate by information in Modifier 2 will be adjusted and released through the manual adjudication process.

12.13.1 Same Day Service Combination Billing Limitations

Certain same day core service combinations will not be billed, and same day prior authorization service combinations will not be authorized due to limitations. The table in Appendix A, Same Day Service Combination Billing Limitations, lists the limitations on combining MHRS Services on the same day.

The term “same day” is determined by the same start and end date, or the same ‘date from’ and ‘date to’ of the services.

12.14 Service Units

If the same service, meaning the same HCPCS code and modifier combination, is legitimately provided multiple times, on the same day to the same consumer, the service units must be summed for the date of service, then rounded according to the table as noted below and submitted as one service line on the claim. See Appendices A through D for procedure codes with Medicaid rates.

The actual minutes of the service must be accurately recorded in the consumer’s clinical record. Each encounter for the day should be recorded separately in the clinical record including the start and end time of the encounter. Documentation time is not billable.

12.14.1 Services Based On 15 Minute Units (1 Unit = 15 Minutes)

Applies to the following services:

- Medication / Somatic Treatment (H0034)
- Community Support (H0036)
- Physician Team Member (H0036AM)
- Crisis/Emergency (H2011)
- Multi-Systemic Community Based Intervention CBI Level I (H2033)
- Intensive Home and Community Based Services CBI Level II & III (H2022)

- Functional Family Therapy (FFT) CBI Level IV (H2033HU)
- Assertive Community Treatment (H0039)
- Counseling / Therapy (H0004)
- Team Meeting (DBH20)
- Supported Employment - therapeutic (H2023)
- Supported Employment – non-MHRS vocational (H2025)
- Supported Employment Group (non-MHRS – Job Club) (H2025HQ)
- Self-help/Peer Support (H0038)
- Mental Health Service Discharge Treatment Planning, Institution (H0032)
- Mental Health Service Discharge Treatment Planning, Institution ACT (H0046HT)
- Mental Health Service Discharge Treatment Planning, Institution CBI (H0046HTHA)
- Mental Health Service COC Treatment Planning, Institution (H0032HK)
- Trauma-Focused Cognitive Behavioral Therapy
- Child Parent Psychotherapy for Family Violence
- Case Management (H0006)
- Case Management (HIV) (H0006HKHF)
- Clinical Care Coordination (T1017HF)
- Counseling / Therapy, Group (H0005)
- Counseling / Therapy, Group, Psycho-educational (H2027HQ)
- Counseling / Therapy, Group, Psycho-educational (HIV) (H2027HQHF)
- Counseling / Therapy, Individual, On-site, Behavioral Health Therapy (H0004HF)
- Counseling / Therapy, Individual, Off-site (H0004HFTN)
- Counseling / Therapy, Family with Client (H0004HFHR)
- Counseling / Therapy, Family without Client (H0004HFHS)
- Crisis Intervention (H0007HF)
- Medication Management, Adult (H0016)
- Multi-systemic Therapy for Transition Age Youth (TAY) (ACRA) (ages 21-24)
- Case Management, Recovery Support (T1017)
- Prevention Education Service, Recovery Mentoring, Coaching (H0025HF)
- Training and Skills Development, Life Skills, Individual (H2014)
- Training and Skills Development, Life Skills, Group Substance Use Disorder Services NOS, Spiritual Support Group (H0047HF)
- Psychosocial Rehabilitative Service, Recovery Social Activities, Group (H2017HQ)
- Psychosocial Rehabilitative Service, Education Services, Individual (H2017HF)
- Psychosocial Rehabilitative Service, Education Services, Group (H2017HFHQ)

Services exceeding seven (7) minutes must be rounded to the nearest whole unit in accordance with the following table:

Time Service Provided	Units to bill
0 minutes to 7 minutes	Not billable
8 minutes to 22 minutes	1
23 minutes to 37 minutes	2
38 minutes to 52 minutes	3
53 minutes to 67 minutes	4
68 minutes to 82 minutes	5
83 minutes to 97 minutes	6

12.14.2 Rounding Example

Sample Scenario: A consumer is provided face-to-face community support by the same agency three (3) times during a single day. Community Support Individual is billed at $50 per unit for a fifteen (15) minute service. Since the consumer or client was seen for a total of thirty-three (33) minutes, the provider can bill

for two (2), fifteen (15) minute intervals of community support individual (H0036) at $50 per unit, for a total of $100.

When the “sum and round” methodology is used, the units of service on the bill would be calculated as follows:

Clinician (Staff)	Date of Service	Consumer/Client	Duration	Start Time	Billable Service	Billable Units	Billable Rate
Clinician A	11/5/00	Joe Consumer	7 min.	9:00 am	H0036	---	---
Clinician B	11/5/00	Joe Consumer	23 min.	11:00 am	H0036	---	---
Clinician C	11/5/00	Joe Consumer	3 min.	4:00 pm	H0036	---	---
TOTAL BILLED as one-line item	11/5/00	Joe Consumer	33 min	----	H0036	2	$100

12.14.3 Per Encounter- Based Services

Applies to the following services:

- Behavioral Health Assessment, Ongoing, Risk Rating (H0002)
- Breathalyzer Collection (H0048)
- Diagnostic Assessment (T1023-HE) [An assessment, which is at least three (3) hours in duration]
- Diagnostic Assessment, Comprehensive Adult (H0001)
- Diagnostic Assessment, Brief, Modify Tx Plan (H0001)
- Diagnostic Assessment, Comprehensive Youth (H0001)
- Medication Assisted Therapy,
- Mental Health Screening (H0002) [A brief diagnostic assessment which is forty (40) to fifty (50) minutes in duration] to determine eligibility for admission to a mental health treatment program. This code should not be used for routine, on-going assessments.
- Urinalysis Collection (H0048)

12.14.4 Per Diem- Based Services

Applies to the following services:

- Community Psychiatric Supportive Treatment Program - Rehab/Day Services (CPS-Rehab Day) H0037 - [One (1) day, which shall consist of at least three (3) hours]. This code should be used when a consumer who is in a hospital or other institutional setting receives rehab day services thirty (30) to sixty (60) days prior to discharge as part of the community integration plan.
- Intensive Day Treatment (H2012) [One (1) day, which shall consist of at least five (5) hours]
- Rehabilitation Day Services (H0025) [One (1) day, which shall consist of at least three (3) hours]
- Residential Crisis Stabilization (DBH14) -- for subsequent days
- Residential Treatment, Room & Board (H0043)
- Residential Treatment, Room & Board, Woman w/ 1 Child (H0043)
- Residential Treatment, Room & Board, Woman w/ 2 Children (H0043)
- Residential Treatment, Room & Board, Woman w/ 3 Children (H0043)
- Residential Treatment, Room & Board, Woman w/ 4 Children (H0043)
- Short Term Medically Monitored Inpatient Withdrawal Management (H0010)

12.15 Rate Limits for Crisis Stabilization Services

Service Description	Procedure Code	Modifier	Reimbursement Rate	Minimum Amounts

Brief Psychiatric Emergency (up to 4 hours)	S9484		$236.72 per hour	31m to 4h
Extended Psychiatric Emergency (up to 24 hours)	S9485		$1,095.00 per diem	4h 1m to 24 h
Extended Psychiatric Observation (24 to 72 hours)	S9485		$1,095.00 per diem	24h 1m to 72h
Short-term Psychiatric Stabilization	S9485	U1	$384.94 per diem	No reimbursement for day of discharge
Mobile Crisis Intervention	S9484	U1	$236.72 per hour	31m to 59m, unit limit 24 per day
Behavioral Health Outreach	H0023		$203.51 per service	8m, unit limit 1 per day

12.16 Billing for Multiple Sites

Claims for services provided must use each appropriate billing provider's National Provider Identifier (NPI) number for the billed procedure code(s).

12.17 Reporting Other Carrier Information

Other carrier (i.e., payer) information is required on the current 837P format, if other payers are known to potentially be involved in the paying of the claim. Providers are required by Medicaid to check for applicable insurance for a consumer. Please refer to the national standard HIPAA 837P implementation guide for further information regarding all the other payer data that is required.

Medicaid will continue to be the payer of last resort for Medicaid covered services, and DBH will be the payer of last resort for local funds. Other payer information required on the 837P format is informational only for DBH at this time.

12.17.1 DBH Testing and Approval Process

12.17.1.1 General Information

When implementing a Test 837 claims batch submittal, providers must initiate the request for testing with EDI. To identify common problems across software vendors, providers may be asked to provide information about the software used to create the 837 claims batch.

EDI will be responsible for performing the testing and approval process for each provider. It will be the responsibility of EDI to share the status with the provider. If rejected, these entities will be notified of the reason(s) for the rejection, which could be one of the following:

- HIPAA-mandated and/or ASC X12N requirements are not met
- DBH-specific billing requirements are not met
- Fatal errors (that reject entire batch) sent to providers on Error reports
- Less than 90% of the claims pass DBH Edits
- Duplicate claims contained on the 837P violate the Duplicate Claim Check Policy under HIPAA

Please note subsequent retesting and approval for production claim submission will be required if the provider or their respective software vendor or clearinghouse changes their file creation program.

12.17.2 When a Claim File Is Received by Conduent

When a claim file is received by DBH, the following will occur:

A. If the file meets 5010 format requirements, the provider will receive a 999 acknowledgement in Conduent EDI Online stating that the file is accepted.

B. If the file does not meet 5010 format requirements, the provider will receive a 999 acknowledgement in Conduent EDI Online indicating either:

(a) The file was rejected and needs to be resubmitted, or

(b) The file was accepted with errors. In this case, the file will be processed; however, the claims that have errors will not be paid.

12.17.3 Once the File Is Successfully Imported

Once the file is successfully imported, the following claims processing will occur:

A. If a Local claim is denied during DBH adjudication, the provider must correct the claim and re-bill electronically to DBH.

B. If a claim is denied by DHCF, the provider must make corrections by making an adjustment to the original claim via the DHCF Web Portal.

13 REIMBURSEMENT

DHCF pays for compensable services and items in accordance with established Federal and District Medicaid regulations and fee schedules.

13.1 Rejected Claims

If required data is missing, the claim is listed on an exception (reject) report that is made available to the submitting provider in Conduent EDI Online. The module can be accessed at any time. A claim will be rejected if any of the following situations occur:

- No Benefit Plan on Claim
- No match for the given CPT Code – a) Service code/modifier combination is not recognized by the system; b) Service code billed is not included on Benefit Plan; or c) Benefit Plan date span does not cover date of service.
- Unable to Match Authorization – a) Date of service billed does not fall within authorization date range; b) Service code billed is not included on Benefit Plan; or c) Billing provider is not included on Benefit Plan.
- Unable to Match Member – possible member match identified, but does not match submitted information, or more than one match found, and system cannot determine.

Rejected claims should always be corrected and resubmitted to DBH. (Also see Section 10.4.7 on timely filing).

13.2 Resubmission of Denied Claims

If a claim has been denied due to reasons other than violations of good medical practice or Medicaid regulations, the claim may be resubmitted. An original claim must be submitted; copies will not be accepted. Only claims, which have appeared on your remittance advice as, denied, can be resubmitted. Claims that are still in a Pend status cannot be resubmitted until they have been denied. Resubmission of a pended claim will result in claims denying for duplicate.

Telephone and/or written claim inquiries regarding non-payment of claims should be made after 45 days from the date the claims were initially submitted to DC Medicaid. Please be certain that the claim in question has not appeared on any subsequent remittance advice before making an inquiry.

Instructions for resubmitting a denied claim are as follows:

- Claims must be received within 365 days after the date of service or in the case of inpatient hospital services, 365 days after the date of discharge. Claims must be resubmitted within 365 days of the RA date on which the claim denied for any reason(s) other than timely filing.
- Complete a new red claim form. A copy of the original claim form will be accepted if it is clear, legible and has been resigned (a copied or stamped signature will not be accepted).
- Correct any errors that caused the original claim to be denied.
- Do not write anything on the claim except what is requested. Any additional information should be submitted in writing and attached to the claim.
- Attach a copy of the Remittance Advice without staples, paper clips or colored highlighting on which the denied claim appears and any other documentation necessary to have the claim paid (e.g., consent form, isolation form). If more than one resubmitted claim appears on a page of the remittance, a copy of that page should be attached to each claim being submitted.
- Forward all resubmitted claims to the appropriate P.O. Box listed in Appendix B.

If you have any questions regarding these procedures, contact Conduent Provider Inquiry at (866) 752-9233 (outside DC metro area) or (202) 906-8319 (inside DC metro area).

13.3 Claim Appeals

A Medicaid claim may be denied for several reasons. It could be due to services not being covered under the plan, the provider submitting a claim for a much higher amount than what Medicaid pays for the service or retro eligibility for a beneficiary. Providers may appeal any decision made by Medicaid if you believe your claim was inappropriately denied.

Do not submit medical records with your appeal unless requested by DHCF. Requests for claim appeals should be sent to the address indicated in Appendix B.

13.4 Maximum Fees or Rates

The maximum fees or rates shall be the lower of the provider's charge to the public, the upper limits set by Medicare, or the fees/rates established by DHCF.

13.5 Changes in Fees or Rates

DC Medicaid must provide the public with a 30-day notice of a fee or rate category change that affects DC Medicaid expenditures. The expenditure must be affected by one percent or more within the twelve months following the effective date of the change to apply to this provision.

The regulation recognizes the following exceptions:

- Changes affecting single providers, such as a change in the reimbursement rate for a hospital
- Changes in response to a court order
- Changes in the Medicare level of reimbursement
- Changes in the annual prospective payment rate
- Current methods of payment with a built-in inflation factor

13.6 Payment Inquiries

Providers may inquire regarding payment of claims. Inquiries must include the TCN, the RA payment date, the provider's DC Medicaid identification number or NPI (this information appears on the provider's RA). Providers should address payment inquiries to the address listed in Appendix B. Telephone inquiries will be directed to Conduent (the telephone number is included in Appendix B).

13.7 Coordination of Benefits

The DC Medicaid Program is a "payer of last resort" program. DC Medicaid benefits will be reduced to the extent that benefits may be available through other Federal, State, or local programs or third-party liability to which the beneficiary may otherwise be entitled. Verify eligibility before rendering services to ensure proper coordination of benefits. Instructions for billing DC Medicaid after the other source has made payment are contained in this manual.

13.7.1 Benefit Programs

Providers must make reasonable efforts to obtain enough information from the beneficiary regarding primary coverage. Medical resources that are primary third parties to DC Medicaid include Medicare, Civilian Health, and Medical Program of the Uniformed Services (CHAMPUS), Blue Cross & Blue Shield, commercial insurance, VA benefits, and Workman's Compensation.

13.7.2 Coordination of Payment

The provider must obtain the following information to bill a third party:

- Insurer's name and address
- Policy or Group identification number
- Patient and/or patient's employer's address.

If the District of Columbia Medicaid fee rate is more than the third-party fee or rate, the provider can bill DC Medicaid for the difference by submitting a claim and attaching all documentation relating to the payment. If a third-party resource refuses to reimburse the provider, DC Medicaid can be billed by receiving a claim with attached documentation relating to the refusal.

If a Medicaid beneficiary has Medicare coverage, DC Medicaid can be billed for charges that Medicare applied to the deductible and/or co-insurance. Payment will be made in accordance with the patient liability amount adjudicated by DC Medicaid.

13.8 Levies

The Office of Tax and Revenue (OTR) has implemented a program that automatically intercepts payments to collect outstanding tax debts owed by contractors, providers and vendors doing business with the District of Columbia. The Department of Health Care Finance works with the Office of Tax and Revenue to ensure provider payments are offset until a payment agreement is in place with the Office of Tax and Revenue.

13.9 Paid-in-Full

Compensable service and item payments made from the DC Medicaid Program to providers are considered paid-in-full. A provider who seeks or accepts supplementary payment of any kind from the DC Medicaid Program, the beneficiary, or any other person will be required to return the supplementary payment. The provider may, however, seek supplemental payment from beneficiaries who are required to pay part of the cost (co-payment). For example, beneficiaries must pay $1.00 for generic and $3.00 for brand name for each prescription (original and refills) for patients who are 21 years of age or older. However, a provider may bill a Medicaid beneficiary for non-compensable service or item if the beneficiary has been notified by the provider prior to dispensing the service or item that it will not be covered by DC Medicaid.

Some charges are the beneficiary's responsibility and may be billed. The following list is not all-inclusive.

- The beneficiary is responsible for all expenses for non-covered services, such as services that are not covered under the scope of the Medicaid program, or services received more than program benefit limitations. The beneficiary is responsible for services received during a period of ineligibility. Before rendering non-covered services, the beneficiary must be informed of the pending charges.
- Any applicable cost-sharing amount applied by the Medicaid program is the responsibility of the beneficiary.
- Beneficiaries enrolled in managed care programs that insist upon receiving services that are not authorized by the primary care provider (PCP) may be required to pay for such services.
- The beneficiary, or responsible adult, is held accountable and responsible for knowingly allowing or continuing to allow an unauthorized person to use a Medicaid card or beneficiary's identity to obtain benefits otherwise not allowed. Any charges to or payments by DHCF for services requested and/or received to defraud the provider of services and/or Medicaid are billable to the cardholder or his/her responsible party, or the imposter.

Crossover claims pay at the lesser amount based upon the formulas listed below by claim type:

Table 5: Crossover Pricing Logic

Claim Type	Pricing Logic	Example
Medicare Part-B (CMS1500)	Reimbursement amount will equal thelesser of (MEDICARE COINSURANCE + MEDICARE DEDUCTIBLE) OR (MEDICAID ALLOWED AMOUNT –MEDICARE PAID)	Coinsurance: $29.60 Medicare Deductible: $0.00 Medicaid allowed charges: $138.98Medicare Paid: $118.38 Difference: $20.60 Provider payment = $20.60
Medicare Part-B (CMS1500) Other	Reimbursement amount will equal thelesser of (MEDICARE COINSURANCE + MEDICARE DEDUCTIBLE) OR (MEDICAID ALLOWED AMOUNT –MEDICARE-PAID)	Coinsurance: $22.10 Medicare Deductible: $0.00 Medicaid allowed charges: $22.00 Medicare Paid: $27.90 Difference: -$5.90 Claim denies for 5318 - calculated ALLOWED AMOUNT is zero or the calculated ALLOWED AMOUNT lessTPL is zero
FQHC Medicare Part B (CMS-1500) QMB Beneficiaries	Reimbursement amount will be full coinsurance and deductible.	
Outpatient Crossover	Reimbursement-amount will equal thelesser of (MEDICARE COINSURANCE + MEDICARE DEDUCTIBLE) OR (MEDICAID ALLOWED AMOUNT –MEDICARE PAID)	Coinsurance: $18.57 Medicare Deductible: $0.00 Medicaid allowed charges: $137.01Medicare Paid: $74.25 Difference: $62.76 Provider payment = $18.57
LTC/Inpatient Crossover	Lesser than amount rules do not apply. Reimbursement amount will be fullcoinsurance and deductible.	

Providers are prohibited from billing for any patient responsibility for a beneficiary dually enrolled in Medicare and Medicaid.

13.10 Method of Payment

The DC Medicaid Program makes direct payments to eligible providers for compensable medical care and related items dispensed to eligible beneficiaries. To be reimbursed for an item or service, the provider must be eligible to provide the item or service on the date it is dispensed, and the beneficiary must be eligible to receive the item or service on the date the item or service was furnished. Payment shall not be made to a provider directly or by power of attorney.

13.10.1 Reassignment

DC Medicaid will not make payment to a collection agency or a service bureau to which a provider has assigned his accounts receivable; however, payment may be made if the provider has reassigned his claim to a government agency or if the reassignment has been ordered by a court.

13.10.2 Business Agents

DC Medicaid will not make payment to a billing service or accounting firm that receives payment in the name of or for the provider.

13.10.3 Employers

DC Medicaid will pay a practitioner through his employer if he is required, as a condition of his employment, to turn over his fees. Payment may also be made to a facility or other entity operating an organized health care delivery system if a practitioner has a contract under which the facility or entity submits the claim.

14 Telemedicine Services

The D.C. Telehealth Reimbursement Act of 2013 directs Medicaid to "cover and reimburse for healthcare services appropriately delivered through telehealth if the same services would be covered when delivered in person." Per the Act, telehealth is defined as the delivery of healthcare services using interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment, provided, that services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions are not included. For the purposes of coverage by the Department of Health Care Finance (DHCF), telehealth and telemedicine shall be deemed synonymous.

The purpose of providing Medicaid reimbursement for medically necessary services via telemedicine is to improve beneficiaries':

1. Access to healthcare services, with the aim of reducing preventable hospitalizations and emergency department utilization.
2. Compliance with treatment plans.
3. Health outcomes through timely disease detection and review of treatment options; and
4. Choice for care treatment in underserved areas.

Effective June 23, 2016 (for services rendered on or after that date), the District of Columbia Medical Assistance Program ("the Program") will reimburse eligible providers for eligible healthcare services rendered to Program participants via telemedicine in the District of Columbia. The Program will implement this telemedicine service for both providers and participants in the fee-for-service program.

Providers must be enrolled in the Program and licensed, by the applicable Board, to practice in the jurisdiction where services are rendered. For services rendered outside of the District, providers shall meet any licensure requirements of the jurisdiction where he/she is physically located and the jurisdiction where the patient is physically located.

14.1 Telemedicine Service Model

Telemedicine is a service delivery model that delivers healthcare services through a two-way, real time interactive video-audio communication for the purpose of evaluation, diagnosis, consultation, or treatment. Eligible services can be delivered via telemedicine when the beneficiary is at the originating site with an eligible provider at the originating site/ while the eligible "distant" provider renders services via the audio/video connection. The Program will not reimburse for service delivery using audio-only telephones, e-mail messages, or facsimile transmissions.

Pursuant to the D.C. Telehealth Reimbursement Act of 2013, the Program will not reimburse for service delivery using e-mail messages or facsimile transmissions.

14.2 Participant Eligibility

The program shall reimburse approved telemedicine providers only if participants meet the following criteria:

1. Participants must be enrolled in the District of Columbia Medical Assistance Program.
2. Participants must be physically present at the originating site at the time the telemedicine service is rendered: and
3. Participants must provide written or verbal consent to receive telemedicine services in lieu of in-person healthcare services, consistent with all applicable District laws.

A provider shall document the beneficiary’s consent to receive telemedicine services. Written consent includes any method that documents in writing the beneficiary’s agreement to receive the service via telemedicine, including but not limited to an e-mail, text message, or signed PDF. If verbal consent is obtained, a detailed service note that describes the beneficiary’s verbal consent is required.

14.3 Provider Site Eligibility

An originating site shall include the following provider types and settings:

- Hospital
- Nursing Facility
- Federally Qualified Health Center
- Clinic
- Physician Group/Office
- Nurse Practitioner Group/Office
- District of Columbia Public Schools (DCPS)
- District of Columbia Public Charter Schools (DCPCS)
- Mental Health Rehabilitation Service (MHRS) provider, Adult Substance Abuse Rehabilitation Service (ASARS) provider, and Adolescent Substance Abuse Treatment Expansion Program (ASTEP) provider
- The beneficiary's home or other settings identified in guidance published on the DHCF website at dhcf.dc.gov.

A distant site provider shall include, but is not limited to, the following provider types, including any distant site provider staff rendering services remotely:

- Hospital
- Nursing Facility
- Federally Qualified Health Center
- Clinic
- Physician Group/Office
- Nurse Practitioner Group/Office
- DCPS
- DCPCS
- MHRS provider, ASARS provider, and ASTEP provider

At the discretion of the rendering provider, personnel delivering telemedicine services may work remotely, if all other requirements in the rule are met.

14.4 Provider Reimbursement

D.C. Medicaid enrolled providers are eligible to deliver telemedicine services, using fee-for-service reimbursement, at the same rate as in-person consultations. All reimbursement rates for services delivered via telemedicine are consistent with the District's Medical State Plan and implementing regulations.

Telemedicine providers will submit claims in the same manner the provider uses for in person services.

When billing for services delivered via video-audio telemedicine, distant site providers shall enter the "GT" procedure modifier on the claim.

When billing for any audio-only telemedicine services, distant site providers shall enter the "93" procedure modifier on the claim.

Additionally, the distant site provider must appropriately specify the place of service (POS) using the following POS codes:

- In the event the beneficiary's home is the originating site, the distant site provider must specify the place of service "10" which is defined as "telehealth provided in patient's home".
- In the event a DCPS or a DCPCS is the originating site, the distant site provider must specify the place of service "03" which is defined as "school".

- In the event the beneficiary is at any other eligible originating site (see section IV above), the distant site provider must specify the place of service “02” which is defined as “telehealth provided other than in patient’s home”. When utilizing place of service “02”, the distant site provider must also report the National Provider Identifier (NPI) of the originating site provider in the “referring provider” portion of the claim.

Services billed where telemedicine is the mode of service delivery, but the claim form and/or service documentation do not indicate telemedicine (using the appropriate procedure modifiers and appropriate POS codes) are subject to disallowances during an audit.

Effective March 1st, 2023, District health care providers rendering services to beneficiaries in Medicaid fee-for-service, Medicaid managed care, Health Care Alliance, and Immigrant Children’s programs must comply with these revised billing requirements.

Refer to **Transmittal #23-11** for additional information.

14.5 Federally Qualified Health Center (FQHC) Reimbursement

- In accordance with the District’s Prospective Payment System (PPS) or alternative payment methodology (APM) for FQHCs, the following reimbursement parameters will be established for the purposes of telemedicine in the District:
- Originating Site: An FQHC provider must deliver an FQHC-eligible service to be reimbursed the appropriate PPS, APM, or fee-for-service (FFS) rate at the originating site.
- Distant Site: An FQHC provider must deliver an FQHC-eligible service to be reimbursed the appropriate PPS, APM, or FFS rate; and
- Originating and Distant Site: If both the originating and the distant site are FQHCs, for both to receive reimbursement, each site must deliver a different PPS or APM service (e.g., medical, or behavioral). If both sites submit a claim for the same PPS or APM service (e.g., medical), then only the distance site will be eligible to receive reimbursement.

14.6 Education-Related Services Reimbursement

The scope of covered Medicaid telemedicine services includes individual fee-for-service providers that deliver services under the Office of the State Superintendent of Education (OSSE) through the Strong Start DC Early Intervention Program (DC EIP). OSSE shall only bill for distant site services that are allowable healthcare services to be delivered by the individual fee-for-service providers delivering DC EIP services under them and can be delivered at the standard of care via telemedicine.

In accordance with the DCPS/DCPCS Medicaid payment methodology, the following reimbursement parameters will be established for the purposes of telemedicine in the District:

- The LEA shall only bill for distant site services that are allowable healthcare services to be delivered at DCPS/DCPCS and can be delivered at the standard of care via telemedicine.
- The LEA shall provide an appropriate primary support professional to attend the medical encounter with the member at the originating site. In instances where it is clinically indicated, an appropriate healthcare professional shall attend the encounter with the member at the originating site.

14.7 Covered Services

Services that can be delivered via telemedicine include:

- Evaluation and management.
- Consultation of an evaluation and management of a specific healthcare problem requested by an originating site provider.
- Behavioral healthcare services including, but not limited to, psychiatric evaluation and treatment, psychotherapies, and counseling; and,

- Speech therapy.

The provider shall determine if the service can be delivered at the standard of care via telemedicine.

14.8 Excluded Services

The Program will not reimburse telemedicine providers for the following:

- Incomplete delivery of services via telemedicine, including technical interruptions that result in partial service delivery
- When a provider is only assisting the beneficiary with technology and not delivering a clinical service
- For a telemedicine transaction fee and/or facility fee
- For store and forward and remote patient monitoring

14.9 Technical Requirements

Providers delivering healthcare services through telemedicine shall adopt and implement technology in a manner that supports the standard of care to deliver the required service. Equipment utilized for telemedicine must be of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face encounter for professional medical services.

Providers shall, at a minimum, meet the following technology requirements:

- A telemedicine provider that utilizes audio-only communication methods shall use audio equipment that ensures clear communication and includes echo cancellation
- A telemedicine provider that utilizes video-audio communication methods shall:
    - Use a camera that can manually, or, under remote control, provide multiple views of a patient with the capability of altering the resolution, focus, and zoom requirements according to the consultation.
    - Use audio equipment that ensures clear communication and includes echo cancellation.
    - Ensure internet bandwidth speeds sufficient to provide quality video to meet or exceed 15 frames per second.
    - Use a display monitor size sufficient to support diagnostic needs used in the telemedicine service; and
    - Use technology that creates video and audio transmission with less than 300 milliseconds.
    - When a beneficiary's home is the originating site, the distant site provider shall ensure the technology in use meets the minimum requirements set forth in Subsection 910.13.

14.10 Medical Records

The originating and distant site providers shall maintain documentation in the same manner as during an in-person visit or consultation, using either electronic or paper medical records, which shall be retained for a period of ten (10) years or until all audits are completed, whichever is longer.

14.11 Confidentiality

A telemedicine provider shall develop a confidentiality compliance plan in accordance with guidance from the Department of Health and Human Services, Office of Civil Rights, available at: http://www.hhs.gov/sites/default/files/hipaa-simplification-201303.pdf to incorporate appropriate administrative, physical, and technical safeguards around data encryption (both in transit and at rest) and to protect the privacy of telemedicine participants and ensure compliance with the Health Insurance, Portability, and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act of 2009.

15 BEHAVIORAL HEALTH PROGRAM OVERVIEW

The MHRS and ASARS programs are federally assisted programs operated by DBH. The MHRS and ASARS programs are designed to provide comprehensive, high-quality rehabilitative services to all eligible residents of the District of Columbia. These programs permit eligible District residents the freedom of choice in the selection of a provider of behavioral health and substance use disorder (SUD) treatment and recovery services that agreed to the conditions of participation by applying and being certified as a provider of these services.

15.1 Legal Authority

15.1.1 Mental Health & Rehabilitation Services

The Department of Mental Health Establishment Amendment Act of 2001 (DC Official Code § 7-1131 et seq.); 22-A DCMR 34, Mental Health Rehabilitative Services (MHRS), as amended, and 29 DCMR 52, Medicaid Reimbursement for MHRS.

15.1.2 Adult Substance Abuse Rehabilitation

The regulations that govern the DC Medicaid Program are contained in Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq. and authorized by enabling legislation P.L. 90-227, 12/27/67. Title 22, Chapter 63, Certification Standards for Substance Use Disorder Treatment and Recovery Providers contains the substance use disorder treatment and recovery service requirements.

15.1.3 Administration

DBH administers the MHRS and ASARS programs payment system for the Department of Health Care Finance (DHCF), the District of Columbia agency that administers the Medicaid Program.

15.2 Medicaid Funded Services

15.2.1 Mental Health & Rehabilitation Services

The following core services, when rendered by certified MHRS providers to Medicaid eligible consumers, are covered by MHRS, authorized by DBH, and paid by DHCF:

- Community Support
- Diagnostic Assessment
- Mental Health Therapy (formerly, Counseling)
- Medication / Somatic Treatment

The following specialty services, when rendered by certified MHRS providers to Medicaid eligible consumers and authorized by DBH, are covered by MHRS, and paid by DHCF:

- Assertive Community Treatment (ACT)
- Clubhouse Service
- Community Based Intervention (CBI)
- Crisis Emergency
- Child Parent Psychotherapy for Family Violence (CPP-FV)
- Intensive Day Treatment Services
- Rehabilitation Day Services
- Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

In addition to Community Support within the MHRS taxonomy, other community support services include the following:

15.2.1.1 Supported Employment

DBH provides an evidence-based supported employment program that involves helping adult consumers find and maintain a job. Supported Employment can be provided by a certified MHRS provider that has also been certified by DBH to provide supported employment pursuant to 22 DCMR Chapter A51. Medicaid will only reimburse supported employment (therapeutic).

- Supported employment (therapeutic) activities such as assessment, benefits counseling, follow-along supports, and on-going consumer job coaching shall be billed as community support (H2023 - Supported Employment Therapeutic).
- Supported employment (non-MHRS - vocational) is paid for by DBH local funds under procedure code H2025 (see Section 2.5 below).

15.2.1.2 Self-Help Peer Support

Consumers who are certified by DBH as certified Mental Health Peer Specialists pursuant to 22 DCMR Chapter A73, will be authorized to provide Medicaid-reimbursable behavioral health rehabilitation services to consumers when working under the supervision of a qualified practitioner. Medicaid-reimbursable MHRS shall be provided in accordance with the requirements of the District's State Medicaid Plan1, Title 22, DCMR Chapter A34, and federal guidelines governing the provision of services by certified mental health peer specialists and billed as Self-Help Peer Support (H0038).

DBH reimburses for covered services provided out-of-the-District to eligible District consumers, under the following circumstances:

- DBH authorized the services, and they are delivered by a certified provider in the DC MHRS Program that is eligible to provide services in that jurisdiction.
- The consumer requires emergency mental health care while temporarily away from their home.
- The consumer would be risking their health if they waited for the service until they returned home; or
- The consumer is under the custody of a District agency and has DC Medicaid.

More detailed information regarding the MHRS program, its policies and regulations are available at the DBH website at www.dbh.dc.gov or by contacting the DBH Network Development Division (ND) at 202-671-3155 or dbhprovider.relations@dc.gov.

15.2.2 Adult Substance Abuse Rehabilitation

The following services, when delivered by certified ASARS providers to Medicaid eligible consumers, are covered by ASARS, authorized by DBH, and paid by the DHCF:

- Adolescent – Community Reinforcement Approach
- Assessment / Diagnostic and Treatment Planning Services
- Clinical Care Coordination
- Crisis Intervention
- Drug Screening
- Medication Assisted Treatment
- Medication Management
- Medically Monitored Intensive Inpatient Withdrawal Management
- Substance Use Disorder Counseling

DHCF pays for covered services provided outside of the District of Columbia to eligible District consumers by providers enrolled in the DC Medicaid program.

More detailed information regarding the program, its policies and regulations is available from DHCF. Please refer to the Medicaid State Plan and State Plan Amendments available on the DHCF website at www.dhcf.dc.gov for a complete listing of covered Medicaid services.

The State Plan Amendment (SPA) governing is available at the DC Department of Department of Health Care Finance website at https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DHCFStatePlanAttach3-1aSup6%20%281%29_0.pdf.

15.3 Non-Medicaid Reimbursable Services Paid by Local Funds

15.3.1 Mental Health & Rehabilitation Services

The following services are authorized and paid by DBH Local Funds in accordance with a provider's contract or Human Care Agreement (HCA):

- Community Psychiatric Supportive Treatment Program – Rehab / Day Services (CPS-Rehab/Day)
- Criminal Justice System (CJS) Jail Diversion
- FLEXN-code services – Services and supports provided by Child Choice Provider (see below).
- Integrated Community Care Project (ICCP)
- Mental Health Service – Continuity of Care Treatment Planning, Institution (MHS-CTPI)
- Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI)
- MHS-DTPI (ACT) and MHS-DTPI (CBI)
- Residential Crisis Stabilization
- Supported Employment (non-MHRS vocational)
- Supported Employment Group (non-MHRS Job Club)
- Team Meeting

15.3.1.1 Supported Employment (Non-MHRS Vocational)

DBH provides an evidence-based supported employment program that involves helping adult consumers find and maintain employment. Supported Employment can be rendered by a certified MHRS provider also certified by DBH to provide supported employment pursuant to 22 DCMR Chapter A51.

The following services shall be billed as supported employment (non-MHRS) H2025:
Intake

- Supported Employment Job Club
- Treatment Team Coordination
- Job Development (if not able to be billed to the Department of Disability Services Rehabilitation Services Agency [RSA])
- Time Limited Job Coaching (if not able to be billed to RSA)

Supported Employment Group (non-MHRS Job Club) is billed under H2025 HQ.

15.3.2 Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI)

A service to develop a mental health service provider plan for treating a consumer who is not enrolled in ACT or CBI in preparation for discharge from a hospital or other institutional setting (Institutes for Behavioral Disease (IMD) such as Saint Elizabeth's Hospital or Psychiatric Institute of Washington (PIW)); nursing facilities (nursing homes or skilled nursing facilities); rehabilitation centers; residential treatment centers (RTCs); psychiatric residential treatment facilities (PRTFs); or, correctional facilities for defendants or juveniles). It includes modifying goals, assessing progress, planning transitions, discharge planning and addressing other needs after discharge to the community, as appropriate. MHS-DTPI is provided by an MHRS provider through a mental health professional or credentialed staff to a DBH consumer who is in a hospital or other institutional setting. Requires prior authorization from DBH.

15.3.2.1 Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI) – ACT

A service provided by an MHRS Assertive Community Treatment (ACT) provider to a consumer who is enrolled in ACT services and is in a hospital or other institutional setting to develop a mental health service plan for treating a consumer in preparation for discharge from the hospital or other institutional settings. Requires prior authorization from DBH.

15.3.2.2 Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI) – CBI

A service provided by an MHRS Community Based Intervention (CBI) provider to a consumer who is enrolled in CBI services and is in a hospital or other institutional setting to develop a mental health service plan for treating a consumer in preparation for discharge from the hospital or other institutional settings. Requires prior authorization from DBH.

15.3.2.3 Community Psychiatric Supportive Treatment Program – Rehab/Day Services (Cps-Rehab/Day)

A day treatment program provided in the community to consumers who are in a hospital or other institutional setting and is designed to acclimatize the consumer to community living. Requires prior authorization from DBH.

15.3.2.4 Mental Health Service – Continuity of Care Treatment Planning, Institution (MHS-CTPI)

This code should be used for all continuity of care (non-discharge planning) services for consumers (including ACT and CBI consumers) in institutional settings.

15.3.2.5 Flexible Spending Local Funds Program for Child Choice Providers

Providers that have contracts with DBH as Child Choice Providers are eligible to bill the Department up to the monthly ceiling provided in their contracts. These locally funded services and supports are intended to augment the clinical services and increase the therapeutic benefit to consumers. Child Choice Providers will submit claims for flexible spending reimbursement through the Department's eligibility, enrollment, and authorization system under the billing code FLEXN. Eligibility for reimbursement for FLEXN-code services is determined solely by the contract between DBH and the Child Choice Provider and is subject to the availability of appropriated funds. The FLEXN code and rate are as follows:

Table 6: FLEXN Code and Rate

Service	Code	Rate
Flexible Spending-Child Choice, Local Funds	FLEXN	$0.01

In addition, covered Medicaid services provided to non-Medicaid eligible consumers enrolled in the MHRS program are covered by MHRS and authorized and paid by DBH Local Funds. Also see Section for Consumer Medicaid Certification.

15.3.3 Adult Substance Abuse Rehabilitation Services

The following services are authorized and paid by DBH Local Funds in accordance with a provider's contract or Human Care Agreement:

(1) Case Management
(2) Education Support Services.
(3) Environmental Stability.
(4) Life Skills Support Services.
(5) Recovery Coaching.
(6) Recovery Social Activities.
(7) Recovery Support Evaluation.

(8) Recovery Support Management.
(9) Room and Board for Residential SUD Treatment; and
(10) Spiritual Support Services.

15.4 Inquiries

More detailed information regarding MHRS and ASARS programs, policies and regulations is available at the DBH website at www.dbh.dc.gov or by contacting the DBH Network Development Division (ND) at 202.671.3155 or at dbhprovider.relations@dc.gov.

16 1115 Behavioral Health Transformation Demonstration Waiver

16.1 Overview

DHCF, in partnership with the Department of Behavioral Health (DBH), submitted a Section 1115 Behavioral Health Transformation Demonstration Program (demonstration program) application to the Centers for Medicare and Medicaid Services (CMS) on June 3, 2019, and received federal approval on November 6, 2019. Under the demonstration program, the District received authority to provide new behavioral health services reimbursed by the Medicaid program between January 1, 2020, and December 31, 2024. Waiver expenditure authority for services not covered under Section 8608 will expire by December 31, 2021. The District plans to seek CMS approval to convert authority for Medicaid coverage of expiring services to the District of Columbia Medicaid State Plan.

The goals of this demonstration program are to increase access to a broader continuum of behavioral health services for District Medicaid beneficiaries, advance the District's goals in the Opioid Strategic Plan, Live, Long DC, and support movement towards a more person-centered system of physical and behavioral health care. The demonstration program will test whether the expenditure authority granted, in addition to other concurrent behavioral health delivery system enhancements and re-design efforts, results in increased access to behavioral health care services and improved behavioral health outcomes for District Medicaid beneficiaries diagnosed with substance use disorders (SUD), serious mental illness (SMI), and serious emotional disturbance (SED). Further information on the demonstration program, including CMS' notice of approval and the special terms and conditions governing District of Columbia's implementation of the demonstration program, are available on DHCF's website at https://dhcf.dc.gov/1115-waiverinitiative.

16.2 Eligibility Requirements

The demonstration program does not amend or change District of Columbia Medicaid eligibility requirements, standards, or methodologies set forth under the District of Columbia Medicaid State Plan and applicable regulations under Title 29 of the District of Columbia Municipal Regulation (DCMR).

Services outlined in this chapter will be available to individuals enrolled in District of Columbia Medicaid Program to the extent that the individual meets the criteria established for the service.

16.3 Reimbursement

To receive Medicaid reimbursement, each demonstration program services provider shall enter into a provider agreement with DHCF and comply with the screening and enrollment requirements set forth in Chapter 94 (Medicaid Provider and Supplier Screening, Enrollment, and Termination) of Title 29 DCMR.

Effective January 1, 2020, reimbursement for services set forth shall be made according to the District of Columbia Medicaid fee schedule available online at www.dc-medicaid.com. All future updates to Medicaid reimbursement rates for demonstration program services shall comply with the public notice requirements set forth under Section 988 of Chapter 9 of Title 29 DCMR and be posted to the DHCF website at www.dhcf.dc.gov.

The Medicaid provider enrollment system will be able to accept new provider type applications beginning December 21, 2019. The Department of Health Care Finance (DHCF) will prioritize newly eligible provider type applications in the upcoming month. Providers may begin billing DC Medicaid for reimbursement only once they receive an approved DC Medicaid provider number. Details regarding the information needed to complete the Medicaid provider enrollment is provided below.

Newly Eligible Provider Types
Group 1

- Psychologists
- Licensed Independent Social Workers
- Licensed Professional Counselors
- Licensed Marriage and Family Therapists

Group2

- Psychosocial Rehabilitation Service Providers (Clubhouse)

Group3

- Recovery Support Services Providers

Refer to **Transmittal #19-25** for enrollment criteria available at www.dc-mediciad.com > Provider Bulletins/Transmittals.

16.4 Program Services – Psychosocial Rehabilitation (Clubhouse)

Psychosocial rehabilitation (also known as "Clubhouse") services are behavioral, cognitive, or supportive interventions that assist individuals with the development of social networking, independent living, budgeting, self-care, and other skills to enable independent living and ongoing employment. Services under this section shall become effective January 1, 2020.

Individuals eligible to receive psychosocial rehabilitation services are Medicaid recipients who meet the requirements set forth in Chapter 34 and Chapter 39 of Title 22-A DCMR.

Psychosocial rehabilitation services shall be delivered in accordance with the requirements set forth in Chapters 34 and 39 of Title 22-A DCMR.

Psychosocial rehabilitation service providers shall be certified in accordance with the requirements set forth in Chapters 34 and 39 of Title 22-A DCMR.

16.4.1 Delivering Clubhouse Services via Telemedicine

On August 14, 2020, DHCF issued final rulemaking to amend Section 910 of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations entitled "Medicaid-Reimbursable Telemedicine Services." The rulemaking made changes to District Medicaid telemedicine requirements to:

- Allow services to be provided through telemedicine in a beneficiary's home.
- Establish the requirements for technology to home-related telemedicine services; and
- Clarify that the standards set forth in Section 910, and any corresponding requirements set forth under the terms of the managed care contract, also apply to minimum program requirements implemented under the District's Medicaid managed care program.

Guidance issued on March 12, 2020, clarified that it is acceptable for providers who render services to do so remotely so long as telemedicine services can be rendered at the standard of care per requirements from the DC Department of Health (DC Health) and relevant professional licensure boards.
In consideration of the special circumstances surrounding the COVID-19 public health emergency, DHCF is issuing new standards for the virtual delivery of Clubhouse services during public health emergency.

This guidance provides that Clubhouse services can be reimbursed by Medicaid when delivered via telemedicine during the public health emergency if they meet the following conditions. First, the services must meet the program requirement of three hours of contact delivered during the Work-Ordered Day, including both direct engagement and unsupervised assignments, as indicated in greater detail below.

Second, the services must adhere to Clubhouse International guidance around the maintenance of Virtual Clubhouse communities. Third, the services must adhere to DBH Clubhouse guidance and DHCF telemedicine guidance and be documented in accordance with the standards outlined in Transmittal #20-37. Additional details on these requirements are provided below.

- There must be three hours of engagement delivered during the Work-Ordered Day.
    - The three hours of service does not need to be contiguous.
    - Up to one hour of unsupervised assignments can count toward the three-hour requirement, if clinical staff engage members and document experience, as noted below.
- The services provided must adhere to Clubhouse International guidance regarding practices to maintain Virtual Clubhouse communities.
- Services provided must be documented consistent with the following requirements:
    - Consent to treatment when given verbally is documented in the electronic health record indicating the date and time consent was secured.
    - Unsupervised assignments must be documented in a separate encounter note with detailed information outlining staff engagement with members and indicating the status of the assignment, the time the member spent working on it, and the member's response to the assignment.
    - When provided non-contiguously, each service should be documented in a separate encounter note.
- Comply with general documentation requirements applicable to all telemedicine services, including use of the "GT" procedure modifier and place of service code "02".

Refer to Transmittal #20-37 for additional information.

16.5 Program Services - Trauma Recovery Empowerment Model

Trauma Recovery Empowerment Model ("TREM") is a structured group therapy intervention for individuals who have survived trauma and have substance use disorders or mental health conditions.

Effective March 1, 2020, individuals eligible to receive TREM services shall be Medicaid beneficiaries who meet requirements set forth in Chapter 34 or Chapter 63 of Title 22-A DCMR.

Medicaid reimbursable TREM services shall include therapy sessions focused on:

- Empowerment, self-comfort, and accurate self-monitoring, as well as ways to establish safe physical and emotional boundaries.
- The trauma experience and its consequences; and
- Skills building, including emphasis on communication style, decision making, regulating overwhelming feelings, and establishing safer, more reciprocal relationships.

TREM services shall be furnished by a TREM provider certified in accordance with the requirements set forth in Chapter 34 or Chapter 63 of Title 22-A DCMR. TREM provider staff must complete DBH-approved TREM training.

16.6 Program Services – Trauma Systems Therapy

Trauma Systems Therapy (TST) is a comprehensive, phase-based treatment program for children and adolescents who have experienced traumatic events or who live in environments with ongoing stress or traumatic reminders.

Effective March 1, 2020, Medicaid reimbursable TST services shall include:

- Psychotherapy.
- Home or community-based stabilization.
- Emotion regulation skills training; and
- Consultation with the psychopharmacologic treatment team.

Medicaid beneficiaries who meet the requirements set forth in Chapter 34 of Title 22-A DCMR shall be eligible to receive Trauma Systems Therapy (TST) services, as provided under the Demonstration Program.

TST services shall be furnished by providers that have been certified by DBH in accordance with requirements set forth in Chapter 34 of Title 22-A DCMR. TST provider staff must complete DBH-approved TST training.

16.7 Program Services – Recovery Support Services

Recovery support Services are non-clinical services and supports designed to support and maintain ongoing recovery from a substance use disorder (SUD). Services under this section shall become effective January 1, 2020.

Medicaid reimbursable recovery support services shall include:

- Recovery Support evaluation.
- Goal setting.
- Case management.
- Coaching.
- Counseling; and
- Other services designed to assist individuals with SUD with successful implementation of their recovery plan in either individual or group settings, provided in accordance requirements set forth in Chapter 63 of Title 22-A DCMR.

Medicaid beneficiaries eligible to receive recovery support services shall meet the following criteria:

- Have a diagnosis of a SUD who are currently in treatment or have moved into recovery from substance use disorder; or
- Be self-identified with having a SUD, but assessed, in accordance with Chapter 63 of Title 22-A DCMR, as not needing treatment.

Recovery support services shall be furnished by Medicaid-enrolled providers certified as recovery support service providers in accordance with Chapter 63 of Title 22-A DCMR.

Recovery support provider qualified staff include:

- Certified recovery coaches.
- Certified peer specialists; and
- Other qualified providers authorized under Chapter 63 of Title 22-A DCMR.

16.8 Program Services – Supported Employment Services for Individuals with Serious Mental Illness

Supported employment is an evidence-based practice that:

- Provides ongoing work-based vocational assessment, job development, job coaching, treatment team coordination, and vocational and therapeutic follow-along support.
- Involves community-based employment, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the consumer.
- Provides services at various work sites; and
- Provides part-time and full-time job options that are diverse, competitive, and integrated with co-workers without disabilities; are based in business or employment settings that have permanent status rather than temporary or time-limited status; and which pay at least minimum wage.

Effective February 1, 2020, Medicaid reimbursable vocational supported employment services shall include the following, as defined in Chapter 37 of Title 22-A DCMR:

- Intake.
- Vocational Assessment.
- Individualized Work Plan Development.
- Treatment Team Coordination.
- Disclosure Counseling.
- Job Development.
- Job Coaching; and
- Vocational Follow-Along Supports for the beneficiary and employer.

Individuals shall be assessed for supported employment services by an entity designated by DBH.

The designated assessment entity shall conduct the needs-based assessment in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR and shall conduct a reassessment at least every one-hundred eighty (180) days or upon significant change in the beneficiary's condition.

The designated assessment entity shall also be responsible for developing the person-centered plan of care, as identified in § 8607.3(c), in accordance with federal regulations under 43 CFR § 441.725 and requirements set forth in Chapter 37 of Title 22-A DCMR.

The person-centered plan of care must be reviewed and revised by the designated assessment entity in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR.

The designated assessment entity shall also assist the Medicaid beneficiary in identification and selection of a supported employment provider.

The assessment and the person-centered plan of care shall be reviewed by DBH, consistent with the requirements set forth in Chapter 37 of Title 22-A DCMR prior to initiation of supported employment services.

Following review and approval of the assessment information and person-centered plan of care, DBH shall issue an authorization for the initiation of supported employment services by the beneficiary-selected supported employment provider, in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR.

The designated assessment entity shall inform the beneficiary of his or her eligibility for supported employment services.

Supported employment providers shall be certified in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR.

A supported employment provider shall develop an Individualized Work Plan for each Medicaid beneficiary receiving supported employment services, in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR.

A Medicaid beneficiary shall not receive supported employment services if they reside in an institutional setting or any setting that is not in compliance with the Home and Community-Based Services (HCBS) setting requirements consistent with 42 CFR § 441.301.

16.9 Program Services – Services Provided in Institutions for Mental Disease for Medicaid Beneficiaries Aged 21-64

Medicaid reimbursable treatment provided in inpatient or residential treatment settings that qualify as institutions for mental disease (IMD) shall include services which:

- Are medically necessary to diagnose, treat, or stabilize the underlying illness, condition, or disease.

- Identified within and provided in accordance with an individualized plan of care; and
- Authorized under the District of Columbia Medicaid State Plan or a waiver thereof.

Medicaid beneficiaries are eligible for services provided within an IMD under the demonstration program when they:

- Are aged twenty-one (21) to sixty-four (64).
- Require short-term inpatient or residential treatment to resolve or ameliorate the symptoms associated with the acute phase of a behavioral health crisis, as determined by a qualified practitioner practicing in accordance with licensure requirements, as set forth under the District of Columbia Health Occupations Revision Act of 1985 and applicable regulations.

The individualized plan of care identified in § 8608.1(b) shall be developed by a multi-disciplinary team of practitioners following diagnosis of the beneficiaries underlying condition and comprehensive assessment of the beneficiary's treatment needs.

The multi-disciplinary team shall include psychiatrists, psychologists, advanced practice registered nurses, and other qualified providers practicing in accordance with licensure requirements, as set forth under the District of Columbia Health Occupations Revision Act of 1985 and applicable regulations.

District inpatient and residential behavioral health service providers shall be licensed or certified in accordance with the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48, D.C. Official Code §§ 44- 501 et seq.) or otherwise applicable licensure or certification requirements as set forth under District law.

Eligible providers must meet the definition of an institution for mental disease as set forth at 42 CFR § 435.1010.

Inpatient mental health and SUD treatment shall be delivered by a facility that meets the conditions of participation set forth in 42 CFR § 482 and be either:

- A licensed or certified facility that meets the conditions of participation; or
- Accredited by nationally recognized accreditation entity by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

Residential SUD treatment shall be delivered by a certified facility that, as assessed by the District or a nationally recognized accreditation entity, delivers care consistent with requirements under Chapter 63 of Title 22-A DCMR.

Residential mental health treatment shall be delivered by a facility that, as assessed by the District or a nationally recognized accreditation organization, delivers care consistent with nationally recognized, mental health-specific program standards for residential treatment facilities.

To be eligible for Medicaid reimbursement, inpatient and residential SUD treatment providers must provide Medication Assisted Treatment (MAT) services directly or facilitate the provision of MAT services by providing transportation for beneficiaries to obtain medications at a MAT provider and participating in the coordination of care in conjunction with MAT providers.

Effective January 1, 2020, Medicaid reimbursement for services provided in an IMD located in the District of Columbia shall be made according to the District of Columbia Medicaid fee schedule available online at https://www.dcmedicaid.com/dcwebportal/home.

DHCF shall reimburse IMD providers located outside the District of Columbia at the rate established by the Medicaid State Agency where the IMD is located.

For Medicaid beneficiaries enrolled in a District Medicaid Managed Care Plan, DHCF shall only provide fee-for-service reimbursement to eligible providers for IMD stays that exceed the stays reimbursed by the Medicaid Managed Care Plan, pursuant to "in lieu of" requirements set forth under 42 CFR § 438 and subject to provide guidance provided by DHCF on its website at www.dhcf.dc.gov.

DHCF will provide services for a targeted statewide average length of stay of thirty (30) days in inpatient and residential treatment settings.

IMD stays for the treatment of SMI that exceed sixty (60) days are not Medicaid reimbursable.

Medicaid fee-for-service reimbursement for IMD stays shall be authorized by DHCF or its designee. DHCF or its designee shall provide oversight of total length of stay by conducting concurrent utilization reviews.

Inpatient SUD treatment services shall be billed on a per diem basis. Residential SUD treatment services shall be billed on a per unit basis.

Inpatient SMI treatment services shall be billed on a per diem basis.

Reimbursement under this section is available for acute inpatient or residential treatment provided in settings that qualify as IMDs. Medicaid reimbursement for long-term residential or long-term inpatient treatment is not available under this section.

Effective April 1, 2020, IMD providers are required, as a condition of reimbursement for services authorized under this chapter, to participate through a formal agreement with a registered HIE entity of the DC Health Information Exchange (DC HIE), defined in Chapter 87 of Title 29 DCMR. Once they become a participating provider, IMD providers must also participate in a reporting process via the DC HIE throughout the demonstration period, in accordance with provider guidance published to the DHCF website at www.dhcf.dc.gov.

Medicaid reimbursement for services provided in general hospitals, intermediate care facilities, nursing facilities, or skilled nursing facilities is not governed or authorized under this section.

Medicaid reimbursement is not available for services provided to beneficiaries who are involuntarily residing in an inpatient or residential treatment facility by operation of criminal law.

16.9.1 Reimbursement for Fee-For-Service IMD Services for Medicaid Enrolled Individuals Aged 21-64

To support the implementation of the District's approved Behavioral Health Transformation Demonstration program on January 1, 2020, DHCF published emergency proposed rulemaking in the November 29, 2019, issue of the DC Register. In accordance with the requirements set forth in Title 29 of the DCMR, Chapter 86 (Behavioral Health Demonstration Program), DHCF shall provide Medicaid fee-for-service reimbursement for medically necessary services provided to enrolled individuals, aged 21-64, in an IMD, who require short-term inpatient or residential treatment to resolve or ameliorate the symptoms associated with the acute phase of a behavioral health crisis.

Covered IMD services under the demonstration include psychiatric hospitalizations, SUD residential treatment, and withdrawal management services. Additional detail is included in DHCF **Transmittal #19-26**.

Medicaid fee-for-service billing guidance for IMD services under this demonstration program is available on DHCF's website at https://dhcf.dc.gov/1115-waiver-initiative.

16.9.2 Settings that Qualify as Institutions for Mental Disease

Only services provided in a setting that qualifies as an institution for mental disease (IMD) will be eligible for reimbursement under the waiver when provided to certain adult populations, as noted above. DHCF or its designee will determine whether a facility qualifies as an IMD.

An IMD is defined as any "hospital, nursing facility, or other institution of more than sixteen (16) beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."1 Services provided in settings that do not qualify as IMDs are subject to separate requirements than those set forth for Medicaid coverage of IMDs under this demonstration program. DHCF will apply the criteria noted below to determine whether a facility meets the 16-bed and service definition to qualify as an IMD subject to waiver requirements.

A. 16 Bed Test:

In determining whether a facility/entity is operating more than sixteen (16) beds for the purpose of determining whether the facility/entity qualifies as an IMD (not a non-IMD portion of a larger entity or a non-IMD, separate facility), DHCF will examine:

- The governance/administrative control of the facilities/entity (Are all components controlled by a single officer or body?)
- Medical direction (Does one medical officer control give direction to staff across the entity?) • Licensure (Are facilities separately licensed?)
- Organizational or operational structure across facilities/entity

B. Service Definition:

In accordance with guidance set forth by the U.S. Department of Health and Human Services (HHS) in the State Medicaid Manual, an IMD is any institution that is, by its overall character, a facility established and maintained primarily for the care and treatment of individuals with behavioral health conditions. Services provided in general hospitals, intermediate care facilities, nursing facilities, or skilled nursing facilities are not included in the waiver's coverage of IMD services because these facilities are not IMDs. These Medicaid-reimbursable services are therefore not governed under this demonstration program's coverage of services provided in IMDs.

DHCF or its designee will use the following guidelines, to evaluate whether the overall character of a facility is that of an IMD based on whether the facility:

- Is licensed or accredited as a behavioral health facility.
- Is under the jurisdiction of the state's behavioral health authority.
- Specializes in providing behavioral health care and treatment.
- Has a large proportion of staff specialized in psychiatric/psychological training.
- Is established or maintained primarily for the care and treatment of individuals with behavioral health diagnoses; or
- Has more than fifty percent (50%) of all its patients admitted based on a current need for institutionalization because of behavioral diseases.

DHCF will maintain and post a list of known facilities/entities in the District of Columbia that qualify as IMDs on its website at www.dhcf.dc.gov.

Unlisted or new behavioral health residential or inpatient treatment providers interested in billing Medicaid as an IMD under this demonstration should contact Natasha Lewis, Manager of the Division of Public and Provider Services in DHCF's Health Care Operations Administration, at mailto:natasha.lewis@dc.gov or (202) 698-2006 for additional information. Providers in the District seeking to deliver withdrawal management or residential SUD treatment as an IMD must be certified by the DC Department of Behavioral Health before enrolling as a Medicaid provider. Prospective providers can obtain an application form to become certified by DBH by contacting Christine Phillips at (202) 299-5354 or Christine.phillips@dc.gov.

16.9.3 Requirements for IMD Stays

Categorization of stays in an IMD will impact reimbursement under this demonstration. For purposes of this demonstration program, DHCF defines a stay as the continuous period spanning an individual's admission into an IMD and ending upon their discharge from the IMD. The length of stay is defined as the number of days between admission and discharge from the same IMD. Some IMD stays will be subject to additional requirements under this demonstration.

A. Types of IMD Stays

This demonstration program sets forth separate requirements for stays primarily relating to serious mental illness (SMI) or substance use disorder (SUD). For purposes of this demonstration, a stay will be categorized as an SUD stay if it is authorized by DHCF or its designee to primarily treat or ameliorate behaviors or conditions resulting from substance use or abuse. Conversely, an IMD stay will be categorized as an SMI stay if it is authorized by DHCF or its designee to primarily treat or ameliorate behaviors or conditions resulting from mental illness. The categorization of the type of stay affects the length of stay requirements that govern whether Medicaid can reimburse for an IMD stay, as well as other requirements as outlined below and in accordance with 29 DCMR 8608.24.

B. Length of Stay Requirements

In accordance with the federal Special Terms and Conditions (STCs) authorizing this demonstration, DHCF is required to provide IMD services in a manner to ensure a targeted statewide average length of stay of no more than thirty (30) days. In accordance with the STCs, CMS or DHCF may establish additional limitations on total lengths of stay to ensure adherence to the statewide average of thirty (30) days. Under this demonstration, total length of stay will be determined based on medical need for IMD services. DHCF or its designee shall provide oversight of total length of stay by conducting concurrent utilization reviews.

Medicaid reimbursement under this demonstration is available for short term, acute inpatient or residential treatment provided in settings that qualify as IMDs. Medicaid reimbursement for long-term residential or long-term inpatient treatment is not available. Under the STCs, SMI-related IMD stays that exceed sixty (60) days are not reimbursable by Medicaid under this demonstration. Local reimbursement may be available for stays outside the scope of this demonstration program, in accordance with provider agreements or conditions established by the DBH. Providers with questions regarding the scope of local reimbursement should contact their assigned DBH Network Development Specialist.

C. Additional Requirements for SMI-related IMD Stays

This demonstration has additional requirements for IMD stays related to SMI. These requirements are meant to improve care coordination and transitions into community-based care upon discharge. To remain in compliance with the waiver implementation plan approved by CMS for SMI-related stays, IMDs must:

- Assess beneficiaries' housing situations and coordinate with housing services providers when needed and available; and,
- Contact beneficiaries and community-based providers within 72 hours post discharge. The facility should use the most effective means possible, for example via email, phone call, or text.

16.9.4 Prior Authorization and Concurrent Review Process

This section supplements information provided in DHCF Transmittal #19-26.

Medicaid fee-for-service reimbursement for an IMD stay will be authorized by DHCF or its designee. Fee-for-service Medicaid utilization review is currently conducted through a contract with DHCF's Quality Improvement Organization (QIO). The current QIO, Comagine Health, uses American Society of Addiction Medicine (ASAM) Criteria for IMD authorizations and concurrent reviews.

Many IMD providers are already providing services to Medicaid beneficiaries under 21 and over 65, who are not subject to the IMD exclusion. DHCF's preauthorization process for services under this demonstration will mirror the process providers are already following for beneficiaries not impacted by this demonstration program.

IMD providers will continue to submit preauthorization requests using the QIO's provider portal. The QIO will issue preauthorization for one patient per submission. Required information will include:

- The treatment plan regarding the admission (when requesting stay continuation, submit the treatment plan to include the behavior or reason for the extended admission).
- The lab records which are pertinent to the stay request; and
- The beneficiary's current medication record

For issues accessing the QIO provider portal, contact Comagine Health at 1-800-251-8890.

DBH's Access HelpLine and Integrated Care Team will retain its role in providing clinical assistance to IMDs for those clients admitted under an FD-12 status.

Additional guidance related to prior authorization of residential SUD treatment will be provided in a subsequent transmittal.

16.9.5 Impact on Medicaid Managed Care: "In Lieu of" Services

This section supplements information provided in DHCF Transmittal #19-26.

Federal Medicaid managed care requirements at 42 CFR 438.6(e) allow DHCF to continue to make capitation payments on behalf of an individual that spends part of the calendar month in an IMD. As a result, non-elderly adult Medicaid beneficiaries, aged 21-64, who are enrolled and receiving their Medicaid services through one of the District's Medicaid MCOs, have had access to medically necessary treatment in IMD settings, if certain requirements are met.

Under the demonstration, MCOs continue to be responsible for authorization and reimbursement of IMD stays for their enrollees that are within the scope of "in lieu of" services. DHCF does not require MCOs to contract with all IMDs or specific IMD providers. However, the managed care contract governs and details MCO responsibility to maintain adequate provider networks for services outlined under the contract. Given the expanded scope of services under the demonstration, District Medicaid MCOs may find a need to adjust their provider contracts to ensure they meet the adequacy of the provider network standard.

Effective January 1, 2020, as indicated in DHCF Transmittal #19-26, MCOs continue to be responsible for coverage of "in lieu of" services in accordance with the requirements set forth in the Managed Care Provider Agreement. The demonstration program does not make substantive changes to the scope of MCO responsibility for services provided within the scope of "in lieu of" services.

However, stays that exceed the scope of "in lieu of" services shall be fully reimbursable as fee-for-service Medicaid encounters, in accordance with limitations set forth in section III of the revised DHCF Transmittal #19-31. Stays that exceed the scope of "in lieu of" services must be authorized by DHCF or its designee in accordance with the requirements set forth in section IV found in the revised DHCF Transmittal #19-31.

16.10 Program Services Licensed Behavioral Health Practitioners

Effective January 1, 2020, the following licensed behavioral health providers shall be eligible to enroll in the District of Columbia Medicaid Program and provide behavioral health services, regardless of program affiliation:

- Psychologists.
- Licensed Independent Clinical Social Workers.
- Licensed Professional Counselors; and

- Licensed Marriage and Family Therapists.

Medicaid reimbursement will be available for the following services, when provided to an eligible Medicaid beneficiary by a licensed behavioral health practitioner identified in § 8609.1, practicing within the scope of their licensure, in accordance with requirements set forth under the District of Columbia Health Occupations Revision Act of 1985, District of Columbia Official Code Title 3, Chapter 12 Sections 3-1201.01-3-1213.13, 3-1251.01-3.1251.16 and applicable regulations:

- Assessment, Diagnostic, and Screening services; and
- Psychological Testing.

Medicaid reimbursement will be available for the following services, when provided to an eligible Medicaid beneficiary diagnosed with a serious emotional disturbance, SMI, or SUD by a licensed behavioral health practitioner identified in § 8609.1 practicing within the scope of their licensure, in accordance with requirements set forth under the District of Columbia Health Occupations Revision Act of 1985 District of Columbia Official Code Title 3, Chapter 12 Sections 3-1201.01-3-1213.13, 3-1251.01-3.1251.16 and applicable regulations:

- Counseling and Psychotherapy; and
- Treatment Planning and Care Coordination.

Medicaid reimbursement rates for fee-for-service behavioral health services provided in accordance with this section shall be eighty percent (80%) of the rates paid by the Medicare Program. The reimbursement rates for behavioral health services shall be posted on Department of Health Care Finance's website at www.dc-medicaid.com and updated annually.

DHCF shall consider the following factors to establish the Medicaid reimbursement rate for procedure codes that do not fall within the Medicare fee schedule:

- Practitioner fees.
- Fee schedules from other states.
- Similar procedures with established fees; or
- Private insurance payments.

16.11 Medication Assisted Treatment Beneficiary Cost Sharing

Medicaid amount, duration, and scope requirements, as set forth under § 1902(a)(10)(B) of the SSA, and comparability requirements, as set forth under §§ 1902(a)(10) and 1902(a)(17) are waived under this demonstration program to enable the DHCF to exempt beneficiaries receiving SUD treatment under this demonstration from one-dollar ($1) pharmacy cost-sharing requirements when they are receiving prescriptions associated with MAT.

There shall be no Medicaid beneficiary cost-sharing for prescriptions associated with the provision of MAT services.

Medicaid reimbursement for prescriptions associated with the provision of MAT services shall increase by the cost-sharing amount set forth in the District of Columbia Medicaid State Plan fee-for-service pharmacy services.

Effective January 1, 2020, DHCF shall increase fee-for-service pharmacy provider reimbursement rates for prescriptions associated with provision of MAT services by the cost-sharing amount identified in § 8613.3.

16.12 Recordkeeping

Each provider of demonstration program services shall establish and implement a privacy plan to protect the privacy and confidentiality of a beneficiary's records.

The disclosure of information by a provider of demonstration program services shall be subject to all provisions of applicable District and federal laws governing the privacy and security of health and personal information.

Each provider of demonstration program services shall maintain complete beneficiary records, financial records covering its operations, and individual treatment plans, in accordance with the service requirements set forth, and shall maintain each record for a period of no less than ten (10) years.

16.13 Access to Records

Each Medicaid-enrolled provider of waiver services shall maintain beneficiary records and individual treatment plans in a manner that will render them amenable to audit and review by the U.S. Department of Health and Human Services, DHCF, DBH, and their authorized designees or agents. Providers must allow appropriate DHCF personnel, DBH personnel, representatives of the U.S. Department of Health and Human Services, and other authorized designees or officials of the District of Columbia government and federal government full access to all records upon request and during announced or unannounced audits or reviews.

16.14 Audits and Reviews

This section sets forth the requirements for audits and reviews of demonstration program services set forth in this chapter. DHCF, or its designee, shall perform regular audits of eligible providers to ensure that Medicaid payments are consistent with efficiency, economy, and quality of care, and made in accordance with federal and District conditions of payment. The audits shall be conducted at least annually and when necessary to investigate and maintain program integrity.

DHCF, or its designee, shall perform routine audits of claims, by statistically valid scientific sampling, to determine the appropriateness of inpatient and residential services rendered and billed to Medicaid to ensure that Medicaid payments can be substantiated by documentation that meets the requirements set forth in this rule, and made in accordance with federal and District rules governing Medicaid.

The audit process may utilize statistically valid sampling methods to ensure that a statistically valid sample is drawn when the audit is based on claims sampling. The audit process may review all claims by type, time-period, or other criteria established by DHCF or other entities. Statistically valid and commonly accepted standards methods for calculating overpayments will be followed. If DHCF denies a claim during an audit, DHCF shall recoup, by the most expeditious means available, those monies erroneously paid to the provider for denied claims, following the process for administrative review as outlined below:

- DHCF shall issue a Notice of Proposed Medicaid Overpayment Recovery (NPMOR), which sets forth the reasons for the recoupment, including the specific reference to the sections of the statute, rules, or provider agreement, the amount to be recouped, and the procedures for requesting an administrative review.
- The Provider shall have thirty (30) days from the date of the NPMOR to submit documentary evidence and written argument to DHCF against the proposed action.
- The documentary evidence and written argument shall include a specific description of the item to be reviewed, the reason for the request for review, the relief requested, and documentation in support of the relief requested.
- Based on review of the documentary evidence and written argument, DHCF shall issue a Final Notice of Medicaid Overpayment Recovery (FNMOR).
- Within fifteen (15) days

- Within fifteen (15) days of receipt of the FNMOR, the Provider may appeal the written determination by filing a written notice of appeal with the Office of Administrative Hearings (OAH), 441 4th Street, N.W., Suite 450 North, Washington, D.C. 20001: and
- Filing an appeal with the OAH shall not stay any action to recover any overpayment.

All participant, personnel, and program administrative and fiscal records shall be maintained so that they are accessible and readily retrievable for inspection and review by authorized government officials or their agents, as requested. DHCF shall retain the right to conduct audits or reviews at any time and audits or reviews may be announced or unannounced.

All records and documents required to be kept under this chapter and other applicable laws and regulations which are not maintained or accessible in the operating office visited during an audit shall be produced for inspection within twenty-four (24) hours, or within a shorter reasonable time if specified, upon the request of the auditing official.

The failure of a provider to release or to grant access to program documents and records to the DHCF auditors in a timely manner, after reasonable notice by DHCF to the provider to produce the same, shall constitute grounds to terminate the Medicaid Provider Agreement. This provision in no way limits DHCF's ability to terminate any Medicaid Provider Agreement for any other reason.

As part of the audit process, documents providers shall grant access, which may include, but is not limited, to the following:

- Relevant financial records.
- Statistical data to verify costs previously reported.
- Program documentation.
- A record of all service authorization and prior authorizations for services.
- A record of all requests for change in services.
- Any records listed in § 8614, in addition to any other records relating to the adjudication of claims, including, the number of units of the delivered service, the period during which the service was delivered and dates of service, and the name, signature, and credentials of the service provider(s); and
- Any record necessary to demonstrate compliance with rules, requirements, guidelines, and standards for implementation and administration of demonstration program services.

Nothing in this rule affects a provider’s independent legal obligation under this chapter and federal and District law to self-identify overpayments and repay within sixty (60) days of discovery.

16.15 Quality Oversight and Provider Reporting

Medicaid reimbursement for services provided under this chapter are authorized under Section 1115(a)(2) of the SSA and are subject to evaluation and monitoring requirements consistent with the terms and conditions of the authorized demonstration.

As a condition of reimbursement for services authorized under this chapter, providers are required to report any clinical, billing, or utilization information related to provision of service authorized under this chapter to DHCF, its designee, or CMS upon request.

DHCF shall publish and maintain provider guidance regarding quality oversight and provider reporting requirements, or subsequent changes, on the DHCF website at www.dhcf.dc.gov.

16.16 Reimbursement Rate Changes for Behavioral Health Services

Purpose

Transmittal #24-08 notified DC Medicaid Providers, including Mental Health Rehabilitative Services (MHRS), Adult Substance Use Rehabilitative Services (ASURS), and Free-Standing Mental Health Clinic (FSMHC) providers, that the District of Columbia Medicaid Fee Schedule will be updated for the services listed herein.

Additionally, this transmittal notifies all DC Medicaid providers that the Fee Schedule will be updated to add codes for a new service: Attachment and Biobehavioral Catchup (ABC). ABC will be added as a preventive service under the Medicaid State Plan, upon the approval of a State Plan Amendment by the Centers for Medicare and Medicaid Services (CMS). The changes outlined in this transmittal are effective February 1, 2024.

Details
The reimbursement methodology changes, new service, and rate updates outlined in this transmittal are the result of the behavioral health rate study between the Department of Behavioral Health (DBH) and the Department of Health Care Finance (DHCF). As a part of this work, DBH and DHCF have decided to add ABC as a new preventive service covered under the Medicaid state plan; update the reimbursement methodology for the existing Psychosocial Rehabilitation ("Clubhouse") Service, Rehabilitation Day Services, and Methadone services delivered in Opioid Treatment Programs; and update rates of other select MHRS, ASURS, and FSMHC services.

Reimbursement Methodology Changes
Clubhouse, Rehabilitation Day, and Methadone in Opioid Treatment Programs will have new reimbursement units, effective February 1, 2024. The services will be reimbursed as follows:

- Psychosocial Rehabilitation ("Clubhouse") Service: now reimbursed using a fifteen (15) minute unit. A maximum of twenty-four (24) units may be billed in a day.
- Rehabilitation Day Service: now reimbursed using a one (1) hour unit. A maximum of six (6) units may be billed in a day.
- Methadone Service in Opioid Treatment Programs: now reimbursed using a per-service unit. The unit is inclusive of the cost of the medication and medication administration.

DHCF is also promulgating rules that update and outline additional reimbursement requirements in Chapters 52 and 91, Title 29 of the District of Columbia Municipal Regulations (DCMR).

New Service: Attachment and Biobehavioral Catchup
ABC will be added as a preventive services benefit in the District's Medicaid State Plan. The service is for parents and caregivers of infants and youth between the ages of six (6) months and two (2) years who have experienced early maltreatment or disruptions in care. The service is provided by Parent Coaches, as defined in the Medicaid State Plan, and aims to improve attachment between the parent/caregiver and child. ABC generally consists of one (1) hour sessions once a week for ten (10) weeks. Further information on the service and reimbursement requirements will be established in forthcoming rulemaking at Section 942 of Chapter 9, Title 29 DCMR.

Reimbursement Rates
In accordance with requirements set forth in Section 9104 of Chapter 91 and Section 988 of Chapter 9 of Title 29 of DCMR, DHCF announces the Medicaid reimbursement rates for the services listed in the tables below. The tables provide a listing of the procedure codes, modifiers, and new rates for services.

Additionally, effective February 1, 2024, DHCF will sunset the HCPCS codes for MHRS, ASURS, and FSMHC "Counseling/Therapy" services, and transition to the use of CPT codes, as described in the tables below. Historically, DHCF has used H0004 with different modifiers to reimburse MHRS and ASURS providers for Counseling/Therapy services. DHCF has decided to transition to the use of CPT codes to streamline billing practices for providers by aligning Counseling/Therapy service codes and rates across MHRS, ASURS, and FSMHC provider types.

The procedure codes and their rates covered under this transmittal are listed in the following tables. The Medicaid fee schedule for these services is located on the DHCF website at https://www.dc-medicaid/com/dcwebportal/nonsecure/feeScheduleInquiry.

Sunsetting Procedure Code Listing: MHRS

Service Description	Proc Code	Modifier
Counseling Group	H0004	HQ
Counseling Group	H0004	GT, HQ
Counseling On-site Individual	H0004	
Counseling On-site Individual	H0004	GT
Counseling On-site Family without Consumer	H0004	HS
Counseling On-site Family without Consumer	H0004	GT, HS
Counseling On-site Family with Consumer	H0004	HR
Counseling Off-site Individual	H0004	HE, TN

Sunsetting Procedure Code Listing: MHRS for Deaf and Hard of Hearing

Service Description	Proc Code	Modifier
Counseling Group	H0004	HK HQ
Counseling on-site Individual	H0004	HK
Counseling on-site Family without Consumer	H0004	HK HS
Counseling on-site Family with Consumer	H0004	HK, HR

Sunsetting Procedure Code Listing: ASURS

Service Description	Proc Code	Modifier
Counseling, Group	H0005	
Counseling Group	H0005	GT
Counseling, Group, Psycho-educational	H2027	HQ
Counseling, Group, Psycho-educational	H2027	GT HQ
Counseling, Group, Psycho-educational (HIV)	H2027	HF HQ
Counseling, Individual, On-site, Behavioral Health Therapy	H0004	HF
Counseling, Individual, Off-site	H0004	HF, TN
Counseling, Family with Client	H0004	HF, HR
Counseling, Family without Client	H0004	HF, HS

Sunsetting Procedure Code Listing: ASURS for Deaf and Hard of Hearing

Service Description	Proc Code	Modifier
Counseling, Group	H0005	HK
Counseling, Group, Psycho-educational	H2027	HK HQ
Counseling, Individual, On-site, Behavioral Health Therapy	H0004	HF, HK
Counseling, Individual, Off-site	H0004	HF, HK, TN
Counseling, Family with Client	H0004	HF, HK, HR
Counseling, Family without Client	H0004	HF, HK, HS

Attachment and Biobehavioral Catchup

Service Description	Proc Code	Modifier	New Rate
Parenting classes, non-physician provider, per session	S9444	HS	$108.76
Parenting classes, non-physician provider, per session	S9444	HA	$108.76

Community-Based Intervention (CBI): MHRS

Service Description	Proc Code	Modifier	New Rate
Multisystemic therapy for juveniles, per 15 minutes	H2033		$62.28
Community-based wrap-around services, per diem	H2022		$59.95
Multisystemic therapy for juveniles, per 15 minutes	H2033	HU	$52.77

Rehabilitation Day: MHRS

Service Description	Proc Code	Modifier	New Rate
Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)	H0025		$54.82

Clubhouse: MHRS

Service Description	Proc Code	Modifier	New Rate
MH Clubhouse Services per 15 min	H2030		$11.90

Brief Screening Assessment: MHRS

Service Description	Proc Code	Modifier	New Rate
Assessment of emotional or behavioral problems	96127		$11.96
Alcohol and/or substance abuse screening and intervention, 15-30 minutes	99408		$55.01
Alcohol and/or substance abuse screening and intervention, more than 30 minutes	99409		$95.67

Brief Screening Assessment: ASURS

Service Description	Proc Code	Modifier	New Rate
Assessment of emotional or behavioral problems	96127		$11.96
Alcohol and/or substance abuse screening and intervention, 15-30 minutes	99408		$55.01
Alcohol and/or substance abuse screening and intervention, more than 30 minutes	99409		$95.67

Brief Screening Assessment: FSMHC

Service Description	Proc Code	Modifier	New Rate
Assessment of emotional or behavioral problems	96127		$11.96
Alcohol and/or substance abuse screening and intervention, 15-30 minutes	99408		$55.01
Alcohol and/or substance abuse screening and intervention, more than 30 minutes	99409		$95.67

Counseling & Therapy Grouping: MHRS

Service Description	Proc Code	Modifier	New Rate
Family psychotherapy without patient, 50 minutes	90846		$121.11
Family psychotherapy with patient, 50 minutes	90847		$121.11
Psychoanalysis	90845		$145.34
Preventive medicine counseling, typically 15 minutes	99401		$36.33
Preventive medicine counseling, typically 30 minutes	99402		$72.67
Preventive medicine counseling, typically 45 minutes	99403		$109.01
Preventive medicine counseling, typically 1 hour	99404		$145.34
Psychotherapy, 30 minutes	90832		$72.67

Psychotherapy with evaluation and management visit, 30 minutes	90833		$58.13
Psychotherapy, 45 minutes	90834		$109.01
Psychotherapy with evaluation and management visit, 45 minutes	90836		$87.20
Psychotherapy, 1 hour	90837		$145.34
Psychotherapy with evaluation and management visit, 1 hour	90838		$96.89
Psychotherapy for crisis, first hour	90839		$145.34
Psytx crisis ea addl 30 min	90840		$72.67
Multiple-family group psychotherapy	90849		$36.33
Group psychotherapy	90853		$36.33

Counseling & Therapy Grouping: ASURS

Service Description	Proc Code	Modifier	New Rate
Family psychotherapy without patient, 50 minutes	90846		$121.11
Family psychotherapy with patient, 50 minutes	90847		$121.11
Psychoanalysis	90845		$145.34
Preventive medicine counseling, typically 15 minutes	99401		$36.33
Preventive medicine counseling, typically 30 minutes	99402		$72.67
Preventive medicine counseling, typically 45 minutes	99403		$109.01
Preventive medicine counseling, typically 1 hour	99404		$145.34
Psychotherapy, 30 minutes	90832		$72.67
Psychotherapy with evaluation and management visit, 30 minutes	90833		$58.13
Psychotherapy, 45 minutes	90834		$109.01
Psychotherapy with evaluation and management visit, 45 minutes	90836		$87.20
Psychotherapy, 1 hour	90837		$145.34
Psychotherapy with evaluation and management visit, 1 hour	90838		$96.89
Psychotherapy for crisis, first hour	90839		$145.34
Psytx crisis ea addl 30 min	90840		$72.67
Multiple-family group psychotherapy	90849		$36.33
Group psychotherapy	90853		$36.33

Counseling & Therapy Grouping: FSMHC

Service Description	Proc Code	Modifier	New Rate
Family psychotherapy without patient, 50 minutes	90846		$121.11
Family psychotherapy with patient, 50 minutes	90847		$121.11
Psychoanalysis	90845		$145.34
Preventive medicine counseling, typically 15 minutes	99401		$36.33
Preventive medicine counseling, typically 30 minutes	99402		$72.67

Preventive medicine counseling, typically 45 minutes	99403		$109.01
Preventive medicine counseling, typically 1 hour	99404		$145.34
Psychotherapy, 30 minutes	90832		$72.67
Psychotherapy with evaluation and management visit, 30 minutes	90833		$58.13
Psychotherapy, 45 minutes	90834		$109.01
Psychotherapy with evaluation and management visit, 45 minutes	90836		$87.20
Psychotherapy, 1 hour	90837		$145.34
Psychotherapy with evaluation and management visit, 1 hour	90838		$96.89
Psychotherapy for crisis, first hour	90839		$145.34
Psytx crisis ea addl 30 min	90840		$72.67
Multiple-family group psychotherapy	90849		$36.33
Group psychotherapy	90853		$36.33

Methadone Clinic Services: ASURS

Service Description	Proc Code	Modifier	New Rate
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020	HF	$18.57
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020	TV	$129.99
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020	UB	$259.98
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020	TS	$389.97
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020	HG	$519.96

Community-Based Intervention (CBI): MHRS for Deaf and Hard of Hearing

Service Description	Proc Code	Modifier	New Rate
Multisystemic therapy for juveniles, per 15 minutes	H2033	HK	$84.08
Community-based wrap-around services, per diem	H2022	HK	$80.93
Multisystemic therapy for juveniles, per 15 minutes	H2033	HU-HK	$71.24

Rehabilitation Day: MHRS for Deaf and Hard of Hearing

Service Description	Proc Code	Modifier	New Rate
Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)	H0025	HK	$74.01

Clubhouse: MHRS for Deaf and Hard of Hearing

Service Description	Proc Code	Modifier	New Rate
MH Clubhouse Services per 15 min	H2030	HK	$16.07

Brief Screening Assessment: MHRS for Deaf and Hard of Hearing

Service Description	Proc Code	Modifier	New Rate
Assessment of emotional or behavioral problems	96127	HK	$16.15
Alcohol and/or substance abuse screening and intervention, 15-30 minutes	99408	HK	$74.26
Alcohol and/or substance abuse screening and intervention, more than 30 minutes	99409	HK	$129.15

Brief Screening Assessment: ASURS Deaf and Hard of Hearing

Service Description	Proc Code	Modifier	New Rate
Assessment of emotional or behavioral problems	96127	HK	$16.15
Alcohol and/or substance abuse screening and intervention, 15-30 minutes	99408	HK	$74.26
Alcohol and/or substance abuse screening and intervention, more than 30 minutes	99409	HK	$129.15

Counseling & Therapy Grouping: MHRS for Deaf and Hard of Hearing

Service Description	Proc Code	Modifier	New Rate
Family psychotherapy without patient, 50 minutes	90846	HK	$163.50
Family psychotherapy with patient, 50 minutes	90847	HK	$163.50
Psychoanalysis	90845	HK	$196.21
Preventive medicine counseling, typically 15 minutes	99401	HK	$49.05
Preventive medicine counseling, typically 30 minutes	99402	HK	$98.10
Preventive medicine counseling, typically 45 minutes	99403	HK	$147.16
Preventive medicine counseling, typically 1 hour	99404	HK	$196.21
Psychotherapy, 30 minutes	90832	HK	$98.10
Psychotherapy with evaluation and management visit, 30 minutes	90833	HK	$78.48
Psychotherapy, 45 minutes	90834	HK	$147.16
Psychotherapy with evaluation and management visit, 45 minutes	90836	HK	$117.72
Psychotherapy, 1 hour	90837	HK	$196.21
Psychotherapy with evaluation and management visit, 1 hour	90838	HK	$130.80
Psychotherapy for crisis, first hour	90839	HK	$196.21
Psytx crisis ea addl 30 min	90840	HK	$98.10
Multiple-family group psychotherapy	90849	HK	$49.05
Group psychotherapy	90853	HK	$49.05

Counseling & Therapy Grouping: ASURS for Dear and Hard of Hearing

Service Description	Proc Code	Modifier	New Rate
Family psychotherapy without patient, 50 minutes	90846	HK	$ 163.50
Family psychotherapy with patient, 50 minutes	90847	HK	$ 163.50
Psychoanalysis	90845	HK	$ 196.21
Preventive medicine counseling, typically 15 minutes	99401	HK	$ 49.05
Preventive medicine counseling, typically 30 minutes	99402	HK	$ 98.10
Preventive medicine counseling, typically 45 minutes	99403	HK	$ 147.16
Preventive medicine counseling, typically 1 hour	99404	HK	$ 196.21
Psychotherapy, 30 minutes	90832	HK	$ 98.10
Psychotherapy with evaluation and management visit, 30 minutes	90833	HK	$ 78.48
Psychotherapy, 45 minutes	90834	HK	$ 147.16
Psychotherapy with evaluation and management visit, 45 minutes	90836	HK	$ 117.72
Psychotherapy, 1 hour	90837	HK	$ 196.21
Psychotherapy with evaluation and management visit, 1 hour	90838	HK	$ 130.80
Psychotherapy for crisis, first hour	90839	HK	$ 196.21
Psytx crisis ea addl 30 min	90840	HK	$ 98.10
Multiple-family group psychotherapy	90849	HK	$ 49.05
Group psychotherapy	90853	HK	$ 49.05

Methadone Clinic Services: ASURS for Deaf and Hard of Hearing

Service Description	Proc Code	Modifier	New Rate
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020	HF-HK	$25.07
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020	TV-HK	$175.49
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020	UB-HK	$350.97
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020	TS-HK	$526.46
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020	HG-HK	$701.95

Transition Planning

Service Description	Proc Code	Modifier	New Rate
Other specified case management service not elsewhere classified	G9012		$1,435.37

Transition Planning for Deaf and Hard of Hearing

Service Description	Proc Code	Modifier	New Rate
Other specified case management service not elsewhere classified	G9012	HK	$1,937.75

17 CONSUMER ELIGIBILITY

This subsection provides an overview of consumer eligibility in the Medicaid funded and locally funded MHRS or ASARS Program(s).

17.1 Freedom of Choice of Providers

A consumer may obtain services from any certified MHRS or ASARS provider that has an HCA with DBH to provide specified services.

In MHRS only, the agency assigned as the consumer's clinical home is responsible for coordinating treatment and obtaining authorization for services provided to the consumer.

17.2 Eligibility Determination

The Department of Health Care Finance Medicaid Branch (DHCF) determines beneficiary eligibility for the DC Medicaid Program.

The Office of Information Systems (OIS) operates the District of Columbia Access System (DCAS), which determines and tracks eligibility, providing integrated automated support for several District of Columbia programs, including Medicaid. The DCAS eligibility information is directly linked to the Interactive Voice Response (IVR), making it readily available to providers.

17.3 Eligibility

17.3.1 Medicaid-Funded Mental Health Rehabilitation Services or Adult Substance Abuse Rehabilitation Services

Consumers eligible for Medicaid-funded MHRS or ASARS must meet the following requirements:

a) Be enrolled in Medicaid or be eligible for enrollment and have an application pending.
b) Be a bona fide resident of the District, as defined in DC Official Code § 7-131.02(29) (2008 Repl.).
c) Be a child or youth with behavioral health problems, as defined in DC Official Code § 7-1131.02(1), or an adult with mental illness as defined in DC Official Code § 7-1131.02(24); or an adult with substance use disorder, as defined in D.C Official Code X; and
d) Be assessed as requiring MHRS and/or ASARS by a qualified practitioner.

Eligible consumers of MHRS shall have a primary diagnosis of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) in use by the Department. Persons with a primary substance use disorder diagnosis only are not eligible consumers of MHRS.

Eligible consumers of ASARS shall have a primary diagnosis in the latest diagnostic criteria in the ICD and is in use by the Department. Persons with a primary mental health diagnosis only are not eligible consumers of ASARS.

17.3.2 Locally Funded Mental Health Rehabilitation Services or Adult Substance Abuse Rehabilitation Services

Consumers eligible for locally funded MHRS or ASARS are those individuals who have been assigned a non- reimbursable Medicaid program code from DHCF. These individuals are not eligible for Medicaid funded MHRS, ASARS or are not enrolled in any other third-party insurance program except the DC HealthCare Alliance, and who meet the following requirements:

a) Be a bona fide resident of the District, as defined in DC Official Code § 7-1131.02(29).
b) Be a child or youth with Behavioral health problems, as defined in DC Official Code § 7-1131.02(1), or an adult with mental illness as defined in DC Official Code § 7-1131.02(24), or an adult with a substance use disorder defined in DC Official Code X.
c) Be assessed as requiring MHRS and/or ASARS by a qualified practitioner; and
d) For individuals nineteen (19) years of age and older, who live in households with a countable income of less than two hundred percent (200%) of the federal poverty level, and for individuals under nineteen (19) years of age, live in households with a countable income of less than three hundred percent (300%) of the federal poverty level.

17.3.3 Medicare Eligible Consumers Who Qualify for Locally Funded Mental Health Rehabilitation Services

Consumers eligible for Medicare remain eligible for the following locally funded MHRS only to the extent these services are not otherwise covered by Medicare:

a) Community Support, and
b) Specialized services in 3414.3 of the MHRS Provider Certification Standards.

17.3.4 Prohibition against Billing Medicaid or DBH for Mental Health Rehabilitation Services or Adult Substance Abuse Rehabilitation Services

Providers shall not bill Medicaid or DBH for MHRS or ASARS provided to any consumer who does not meet the eligibility requirements set forth above. Any claims or invoices submitted to DBH that do not meet requirements set forth above will be subject to nonpayment.

17.3.5 Grace Period for New or Lapsed Enrollees of Medicaid

For new enrollees and those enrollees whose Medicaid certification has lapsed, there is an eligibility grace period of ninety (90) days from the date of first service for new enrollees, or from the date of eligibility expiration for enrollees who have a lapse in coverage, until the date DHCF makes an eligibility or recertification determination. In the event the consumer appeals a denial of eligibility or recertification by the DHCF, the Director may extend the ninety (90) day eligibility grace period until the appeal has been exhausted.

Note: New and lapsed enrollees include District residents released from correctional facilities managed by the District of Columbia Department of Corrections.

The ninety (90) day eligibility grace period may also be extended at the discretion of the Director for other good cause shown. Upon expiration of the eligibility grace period, MHRS or ASARS services provided to the consumer or client are no longer reimbursable by DBH. Nothing in this section alters DBH's timely-filing requirements for claim submissions.

17.4 Discrimination

Federal and District of Columbia regulations require that all programs receiving federal and local assistance comply fully with Title VI of the Civil Rights Act of 1964 and Section 504 of The Rehabilitation Act of 1973 and the regulation at 45 CFR Parts 80 and 84. DBH ensures that no consumer, client or individual in care shall be subjected to discrimination under this plan on the grounds of race, color, national origin, or disability.

17.5 Interrelationship of Providers

Providers are prohibited from referring or soliciting consumers directly or indirectly to other providers for financial consideration. Providers are also prohibited from soliciting, receiving, or offering kickbacks;

payments, gifts, bribes, or rebates for purchasing; leasing, ordering, arranging for or recommending purchasing or leasing; ordering for goods, facilities, or items for which payment is made through the DC Medicaid Program. This does not preclude discounts or other reductions in charges by a provider to a practitioner for services such as laboratory and X-ray, so long as the price is properly disclosed and appropriately reflected in the costs claimed or charges made by a practitioner, as allowed by federal law and regulations.

18 Completing the CMS1500 Claim Form

The Center for Medicaid and Medicare Services mandates the use of the Health Insurance Claim Form (CMS-1500). To be reimbursed for services rendered on behalf of DC Medicaid beneficiaries, clinics, DME suppliers must complete and file a CMS-1500 claim form with Conduent.

The new CMS-1500 (version 02/12) claim form is to be used to bill DC Medicaid covered services. After April 1, 2014, the District of Columbia Medicaid program will accept this CMS-1500 claim form only. No other versions of the form will be accepted after this date. These instructions describe the information that must be entered in the minimum required fields of the CMS-1500 (version 02/12) claim form.

The following instructions outline specifically the use of the form when billing for clinic-related services. These instructions may vary from the instructions included on the form to meet the specific requirements to reimburse providers for the services they have performed for DC Medicaid beneficiaries.

Note: All paper CMS1500 and UB04 claims received on and after May 1, 2010, must be submitted on the original red and white claim form. Red claims forms may be purchased from any office supply store or the Government Printing Office. Black and white versions of the claim forms will not be accepted and will be returned to the providers (RTP'd) with a request to resubmit on the proper claim form.

Table 7: CMS1500 Claim Form Instructions

Field #	Field Description	Guideline
1	Health Insurance Box	Select Medicaid
1a	Insured's ID Number	Enter the patients' eight-digit DC Medicaid identification number excluding the leading zeroes. Verify the beneficiary's Medical Assistance Card to make certain that you have the beneficiary's correct and complete DC Medicaid Identification number and that the individual is eligible for the month in which the services are being provided. You may call the Interactive Voice Response (IVR) system or visit www.dc-medicaid.com to verify eligibility. Receipt of a prior authorization does not verify beneficiary eligibility.
2	Patient's Name	Enter the patient's last name, first name, and middle initial as it appears on their Medical Assistance card.
3	Patient's Birth Date	Enter the patient's birth date and select the appropriate gender
4	Insured's Name (Last Name, First, Name, Middle Initial)	Not required for processing
5	Patient's Address	Not required for processing
6	Patient's Relationship to Insured	Not required for processing
7	Insured's Address	Not required for processing
8	Reserved for NUCC Use	Not required for processing
9	Other Insured's Name	If the patient has other health insurance coverage, enter the name of the policyholder in last name, first name, middle initial format
9a	Other Insured's Policy or Group Number	Enter the policy number
9b	Reserved for NUCC Use	Not required for processing
9c	Reserved for NUCC Use	Not required for processing
9d	Insurance Plan Name or Program Name	Enter the name of the plan/program
10	Is Patient's Condition Related to	
10a	Employment (Current or Previous)	Select the appropriate box to indicate if the patient's condition is an employment related injury

Field #	Field Description	Guideline
10b	Auto Accident	Select the appropriate box to indicate if the patient's condition is related to an auto accident
10c	Other Accident	Select the appropriate box to indicate if the patient's condition is related to a different type of accident
10d	Claim Codes (Designated by NUCC)	Not required for processing
11	Insured Policy Group or FECA No.	Enter the policy group or FECA number
11a	Insured's Date of Birth and Sex	Not required for processing
11b	Other Claim ID	Not required for processing
11c	Insured Plan Name or Program Name	Enter the name of the insurance company or program name
11d	Is There Another Health Benefit Plan	Select the appropriate box
12	Patient's Signature	Enter the signature or "signature on file" and include the date in MMDDYY format
13	Insured's or Authorized Person's Signature	Not required for processing
14	Date of Current Illness	Not required for processing
15	Other Date	Not required for processing
16	Dates Patient Unable to Work In Current Occupation	Not required for processing
17	Name of Referring Provider or Other Source	Enter the name (First Name, Middle Initial, Last Name) of the referring provider, if applicable.
17a	ID#	If using NPI in field 17b, enter the taxonomy code in 17a and the qualifier "ZZ" in the box to the left.
17b	NPI #	Enter the referring provider's NPI.
18	Hospitalization Dates Related to Current Services	Enter the admission/discharge dates in MMDDYY format if the services are related to hospitalization
19	Additional Claim Information (Designated by NUCC)	When billing for waiver services, enter "03" special program code.
20	Outside Lab? $Charges	Not required for processing
21	Diagnosis or Nature of Illness or Injury	Enter the 9 if billing with ICD-9 codes or 0 if billing with ICD-10 in the ICD diagnosis indicator to identify which version of ICD codes is being reported. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the appropriate numeric diagnosis code.
22	Resubmission Code or Original Ref. No.	Not required for processing
23	Prior Authorization Number	Enter the 10-digit prior authorization number if applicable
24A	Shaded area	Enter the NDC qualifier "N4" and the 11-digit NDC number in the shaded (top portion) of field 24 for physician administered drugs, if applicable.
24A	Date(s) of Service	Enter the FROM and TO date of the service(s) in MMDDYY format.
24B	Place of Service	For each line, enter the one code that best describes the place of service: 01 Pharmacy 02 Telehealth 03 School 04 Homeless Shelter 05 HIS Free-Standing Facility 06 HIS Provider-Based Facility 07 Tribal 638 Free-Standing Facility 08 Tribal 638 Provider-Based Facility

Field #	Field Description	Guideline
		09 Prison 10 Telehealth Provided in Patient's Home 11 Office 12 Home 13 Assisted living facility 14 Group Home 15 Mobile Unit 16 Temporary Lodging 17 Walk-in retail Clinic 18 Worksite 19 Off Campus Outpatient Hospital 20 Urgent Care 21 Inpatient hospital 22 Outpatient Hospital 23 Emergency Room Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance Land 42 Ambulance Air or Water 49 Independent Clinic 50 FQHC 51 Inpatient Psychiatric Facility 52 Psych Facility Partial Hospital 53 Community Mental Health Center 54 Intermediate Care Facility 55 Residential Substance Abuse Treatment Center 56 Psychiatric Resident Treatment Center 57 Non-Resident Substance Abuse 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End State Renal Disease Treatment Facility 71 State Local Public Health Clinic 72 Rural Health 81 Independent Laboratory 99 Other
24C	EMG	Not required for processing
24D	Procedures, Services, or Supplies	Enter the CPT or HCPCS code(s) and modifier (if applicable).
24E	Diagnosis Pointer	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters are applicable. ICD codes must be entered in Item Number 21 only. Do not enter them in 24E.

Field #	Field Description	Guideline
		Enter letters left justified in the field. Do not use commas between the letters (i.e., ABCD, etc.).
24F	$ Charges	Enter the usual and customary charges of the services being billed, right justified. Enter “00” in the cents area if the amount is a whole number.
24G	Days or Units	Enter the number of days or units.
24H	EPSDT Family Plan.	Not required for processing
24I	ID Qualifier (shaded area)	If using NPI in field 24J, enter the qualifier “ZZ”. If using a DC Medicaid provider ID for an atypical provider, enter the qualifier “1D”.
24J	Rendering Provider ID (shaded area)	Enter the taxonomy code of servicing provider if NPI was entered in 24J (white area); otherwise, enter the DC Medicaid provider ID if an atypical provider.
24J	NPI	Enter the rendering provider’s NPI.
25	Federal Tax ID Number	Enter the appropriate social security number or employer identification number
26	Patient’s Account Number	Not required for processing
27	Accept Assignment	Not required for processing
28	Total Charge	Enter the total of column 24F.
29	Amount Paid	Enter the amount received from other healthcare plan
30	Rsvd for NUCC Use	Not required for processing
31	Signature of Physician or Supplier	Enter the signature of provider of service or supplier, or his/her representative and the 6-digit date. This is a required field; however, the claim can be processed if the following is true: if a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature. Must include the date.
32	Service Facility Location Information	Not required for processing
32a	NPI	Not required for processing
32b	Other ID	Not required for processing
33	Billing Provider Info & Ph #	Enter the billing address for the pay-to-provider and include ZIP+4.
33a	Billing NPI	Enter the pay-to-provider’s NPI.
33b	Billing Provider	If using NPI in field 33a, enter the taxonomy code in 33b and the qualifier “ZZ” in the box to the left. If using a DC Medicaid provider ID for an atypical provider, enter the DC Medicaid provider ID in field 33a and the qualifier “1D” in the box to the left.

`

Figure 6: Sample CMS-1500 Claim Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

18.1 Delivery and Billing Requirements to Receive Reimbursement for Assertive Community Treatment (ACT)

Transmittal #23-39 informs all Assertive Community Treatment (ACT) providers of changes the District Medicaid program is implementing to update billing, reimbursement, and service delivery requirements for ACT. Providers must meet the requirements outlined in the transmittal to receive reimbursement. This policy is effective for services delivered on or after September 1, 2023.

Details
The Department of Health Care Finance (DHCF) and the Department of Behavioral Health (DBH) are working on efforts to redesign the behavioral health system in the District. The systematic changes will include Mental Health Rehabilitation Services (MHRS) and Adult Substance Use Disorder Rehabilitation Services (ASURS) in managed care contracts. Currently, beneficiaries enrolled in managed care do not receive MHRS and ASURS through their managed care plan.

In addition to benefit carve-in, DHCF has revisited various rate methodologies for MHRS and ASURS, including ACT. ACT is an intensive and highly specialized, community-based service provided by an interdisciplinary team, to adults with serious and persistent mental illness, who experience or are at risk of experiencing inpatient hospitalization. Because ACT is provided in a team model with high utilization, District agencies, ACT providers, and community stakeholders expressed a preference to shift away from a fifteen (15)-minute billing unit. The new payment methodology will allow ACT providers to deliver services in a more dynamic and person-centered approach, while maintaining the intensity and frequency of services indicated by the ACT Model, with an enhanced rate commensurate to the effort necessary to treat some of the District's most vulnerable residents.

New Policy
DHCF is changing the billing and reimbursement structure for ACT, moving from a fifteen (15) minute billing unit to a calendar month reimbursement. To support this change, DHCF and DBH are implementing new billing processes, as well as additional service delivery requirements for providers to receive reimbursement.

18.1.1 Billing and Reimbursement

Beginning September 1, 2023, ACT will be billed using a calendar month unit. To receive reimbursement, an ACT team must have at least eight contacts with the client enrolled in ACT during the month and must also meet the service delivery requirements outlined below.

The new rates for ACT are as follows:

Service	Procedure Code	Modifier	Rate
ACT	H0040	--	$2,375.43
ACT – Deaf/Hard of Hearing	H0040	HK	$3,206.83

18.1.2 Submitting Claims Under the New Reimbursement Methodology

Billing during September 2023: DHCF and DBH understand that adjusting to the new reimbursement methodology and requirements will take time. To support providers and beneficiaries during the first month of implementation, providers may receive half of the new reimbursement rate up front upon submission of a claim to DHCF, using the following process:

	Servicing Provider	Procedure Code
Line 1	The NPI of one of the providers seeing the client must be reflected on the claim.	H0039 X1

	The line must represent a single date of service within the implementation month; the claim must be billed with only one line.	

Full month billing: ACT teams will submit a single claim that captures the entire month of services for each individual enrolled in ACT. Claims should only be submitted at the end of the month. The claim should be structured as follows:

	Servicing Provider	Procedure Code
Line 1	An MD from the agency will be listed as the servicing provider, include the total units and span billing for all dates of service on the claim.	H0040
Lines 2 – X	The individual provider performing the service will be listed as the servicing provider and should include their NPI number. Each line should represent a single contact.	H0039

Each claim must reflect the following information:

- Each contact and the respective servicing provider will be tracked on the claims using the procedure code H0039.
    - Up to two contacts may be provided in a single day.
    - If two contacts are provided in a single day by a single provider, the modifier “XE” should be used on the line with the corresponding H0039.
    - H0039 should be billed at $0.01.
- At least eight (8) payable units of H0039 must be reflected on the claim to receive reimbursement.
- The date of service on each line must fall within the month.
- Any services that were provided beyond the minimum eight (8) contacts required for payment during the month.

Service Delivery Requirements

To receive reimbursement, the eight (8) required contacts provided during the month must meet the following requirements:

- A minimum of five (5) contacts must be face to face and in person.
- A maximum of three (3) contacts may be collateral contacts. Collateral contacts may be delivered via telehealth or in person.
- A minimum of three (3) contacts must be made by any of the qualified practitioners for ACT.
    - Qualified Practitioners: Psychiatrists, Psychologists, Licensed Independent Clinical Social Workers (LICSWs), Advanced Practice Registered Nurses (APRNs), Licensed Independent Social Workers (LISWs), Licensed Professional Counselors (LPCs), Registered Nurses (RNs), Licensed Marriage and Family Therapists (LMFTs), Licensed Graduate Social Workers (LGSWs), Licensed Graduate Professional Counselors (LGPCs), Psychology Associates, and Certified Addiction Counselors (CACs) I and II.
    - Credentialed staff may provide ACT service components under the supervision of an independently licensed qualified practitioner.
- Each consumer must have one (1) scheduled appointment with the Psychiatrist or APRN during the service period.
    - Providers will not be penalized for a missed appointment; however, a missed appointment will not count as a contact.
    - The Psychiatrist/APRN contact is the only non-collateral ACT contact that may be completed via telehealth.
- Up to two (2) contacts per day may count towards the eight (8) required contacts during the month.

Although conditions of payment are outlined above for each member of the ACT Team, the broader expectations of each team member, throughout the course of treatment, should align with the ACT model of care. All services must be delivered in accordance with requirements set forth in Chapter 34 of Title 22-A DCMR, and all contacts past the eight (8) required for payment should be documented. Activities that constitute a contact are described in Memorandum on Updates for Assertive Community Treatment and will be finalized through rulemaking from the Department of Behavioral Health.

Prior Authorization
Providers must still obtain prior authorization for beneficiaries to be enrolled in ACT. Historically, DBH has been the agency responsible for prior authorization. They will remain responsible for ACT prior authorizations until further notice.

Effective Date and Provider Support.
The policy changes outlined in this transmittal will become **effective for all services delivered on or after September 1, 2023.** All ACT providers will be expected to meet these requirements to receive reimbursement.

However, DHCF and DBH appreciate that full compliance may not be immediately achievable, given the changes to requirements. DHCF and DBH will partner with providers during a transition period from September 1, 2023, through January 31, 2024, to ensure the successful implementation of ACT. Please refer to the Memorandum on Updates for Assertive Community Treatment for more information. DBH will continue to be the lead agency for certification standards and performance of the ACT provider network.

Refer to **Transmittal #23-39** for additional information.

19 Remittance Advice

The remittance advice is a computer-generated document that displays the status of all claims submitted to the fiscal agent, along with a detailed explanation of adjudicated claims. This document is designed to permit accurate reconciliation of claim submissions. The remittance advice, which is available weekly, can be received electronically through the Web Portal.

- Mailer Page
- Header Page
- Provider Messages
- Claim Detail Report will include the following when applicable:
- Paid/Denied Claims
- Suspended Claims
- Provider Adjustments/Legends

Figure 7: Remittance Advice Mailer Page

```
1022800000################### DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF) ####################PAGE:        440
                                  MEDICAID MANAGEMENT INFORMATION SYSTEM
                                           REMITTANCE ADVICE


                      [1]
PLEASE SEND INQUIRIES TO: DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)
                         %ACS%                PROVIDER RELATIONS
                         P.O. BOX 34761
                         WASHINGON,DC 20043-4761
 TELEPHONE:             (202) 906-8319 OR (866) 752-9233
 WEB PORTAL:             HTTP://WWW.DC-MEDICAID.COM









        PHYSICIAN PRACTIONER, M.D  [2]
        P.O. BOX 812300
        WASHINGTON, DC, 20017   [3]
```

Table 8: Remittance Advice Mailer Page Table

FIELD NAME	Field #	DESCRIPTION
PLEASE SEND INQUIRES TO	1	Fiscal Agent Services Name/Address/City/State/Zip, contact phone number and the Web Portal address.
PROVIDER NAME	2	The name of the provider receiving the remittance advice
PROVIDER ADDRESS 1	3	Provider remit mailing address first address line
PROVIDER ADDRESS 2	3	Provider remit mailing address second address line
PROVIDER CITY	3	Provider Remit Mailing address city

PROVIDER STATE	3	Provider Remit Mailing address state
PROVIDER ZIP	3	Provider Remit Mailing address zip code

Figure 8: Remittance Advice Header Page

```
102551100000******************** DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF) ********************PAGE:        441
                                MEDICAID MANAGEMENT INFORMATION SYSTEM
                                         REMITTANCE ADVICE


PAY TO PROVIDER NUMBER:                          022800000 [1]
                                                 PHYSICIAN PRACTICIONER, M.D  [2]
                                                 P.O. BOX 812300
                                                 WASHINGTON, DC,   20017  [3]

                                                (FOR CHANGE OF ADDRESS, DOWNLOAD FORM FROM WEB PORTAL)
                                                          PLEASE SEND INQUIRIES TO: DISTRICT OF COLUMBIA - DHCF
                                                                                    ACS STATE HEALTCHARE-PROVIDER RELATIONS
                                                                     [4]            P.O. BOX 34761
                                                                                    WASHINGTON, DC 20043-4761
                                                           TELEPHONE:               (202) 906-8319 OR (866) 752-9233
                                                           WEB PORTAL:              HTTP://DC-MEDICAID.COM
PAYMENT ACCOMPANIES REMITTANCE
TOTAL ASSOCIATED PAYMENT:                $177.31 [5]                PAYMENT DATE:          08/03/2009 [6]
PAID TO PROVIDER TAX ID:          123456789    [7]
FOR CLAIMS PAID THROUGH:          08/03/2009   [8]


                                                 PHYSICIAN PRACTICIONER, M.D
                                                 P.O. BOX 812300
                                                 WASHINGTON, DC,   20017
```

Table 9: Remittance Advice Header Page Table

FIELD NAME	Field #	DESCRIPTION
PAY TO PROVIDER NUMBER	1	The number of the provider or group who is to receive payment. The pay to provider is not necessarily the same as the provider who performed the service. This provider number also appears in the very top left of the header page.
PROVIDER NAME	2	The name of the provider receiving the remittance advice
PROVIDER ADDRESS 1	3	Provider remit mailing address first address line
PROVIDER ADDRESS 2	3	Provider remit mailing address second address line
PROVIDER CITY	3	Provider Remit Mailing address city
PROVIDER STATE	3	Provider Remit Mailing address state
PROVIDER ZIP	3	Provider Remit Mailing address zip code
PLEASE SEND INQUIRES TO	4	Fiscal Agent Services Name/Address/City/State/Zip, contact phone number and the Web Portal address.
TOTAL ASSOCIATED PAYMENT	5	Total amount of the cycle check/EFT
PAYMENT DATE	6	This is the payment date of the check /EFT
PAID TO PROVIDER TAX ID	7	The federal tax ID of the provider or group who is to receive payment.
FOR CLAIMS PAID THROUGH	8	CYCLE RUN DATE

Provider Messages

The third page of the RA, as shown below, is used to display messages from DHCF and the FA to Medicaid providers. This page is used to address changes in billing procedures or program coverage. Not all RAs will contain a message. Any information listed here will be valuable in facilitating the filing of claims to Medicaid and to provide information on the Medicaid program.

Page Header Information
The Remittance Advice will consist of three different sections: Paid/Denied Claims, Suspended Claims, and Provider Adjustments/Legends Page. The Page Header information will be similar throughout the Remittance Advice; however, the last line in the top middle section of the RA header will indicate the specific section of the RA. The similar fields are as follows:

Figure 9: Remittance Advice Provider Messages

```
DATE:        08/03/09   [1]   DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)        PAGE:  00000003 [5]
PROVIDER NO: 022222222  [2]         MEDICAID MANAGEMENT INFORMATION SYSTEM                   RPT PAGE: 000000442 [6]
REMITTANCE:  00438970   [3]                    REMITTANCE ADVICE                            REMIT SEQ:  00000054 [7]
NPI NUMBER: 130000000   [4]                     PROVIDER MESSAGES
   ************************************************************************************************************
   This is a test message.
   ************************************************************************************************************
```

Table 10: Remittance Advice Provider Messages Table

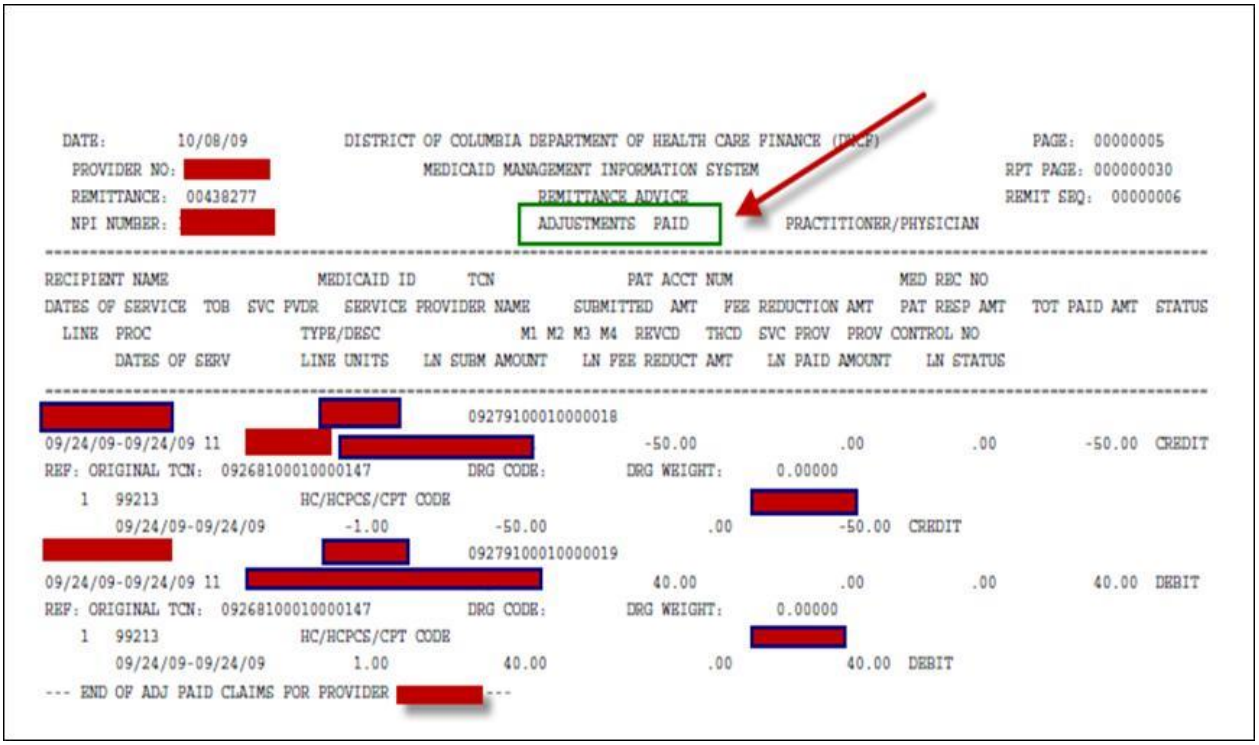
FIELD NAME	Field #	DESCRIPTION
DATE	1	This is the process date used for reporting purposes
PROVIDER NO	2	The number of the provider or group who is to receive payment. The pay to provider is not necessarily the same as the provider who performed the service.
REMITTANCE	3	The remittance advice number uniquely identifies the remittance Advice prepared for this provider for a given payment cycle.
NPI NUMBER	4	The pay to provider's National Provider Identifier (NPI)
PAGE	5	Page number within each provider's report
RPT PAGE	6	Page number across all provider's reports
REMIT SEQ	7	Sequential number produced for this RA cycle

Claim Detail Report
Paid/Denied Claims
Paid claims are line items passing final adjudication. Claims may be paid as submitted or at reduced amounts according to the Medicaid program's reimbursement methodology. Reduced payments will be noted on the RA with the corresponding edit code for explanation.

Denied claims represent those services that are unacceptable for payment. Denials may occur if the fiscal agent cannot validate claim information, if the billed service is not a program benefit, or if a line item fails the edit/audit process. Denied claims may be reconsidered for payment if a health care provider submits corrected or additional claim information. Services denied on the RA appear on one line. A

service may be reconsidered for payment if errors were made in submitting or processing the original claim.

Figure 10: Remittance Advice Paid Claims



```
DATE:        10/08/09        DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)        PAGE:  00000005
 PROVIDER NO:                    MEDICAID MANAGEMENT INFORMATION SYSTEM                     RPT PAGE: 000000030
 REMITTANCE:  00438277                        REMITTANCE ADVICE                              REMIT SEQ:  00000006
 NPI NUMBER:                                ADJUSTMENTS  PAID        PRACTITIONER/PHYSICIAN
-----------------------------------------------------------------------------------------------------------------
RECIPIENT NAME              MEDICAID ID      TCN              PAT ACCT NUM                MED REC NO
DATES OF SERVICE  TOB  SVC PVDR   SERVICE PROVIDER NAME    SUBMITTED  AMT   FEE REDUCTION AMT   PAT RESP AMT   TOT PAID AMT  STATUS
 LINE  PROC                TYPE/DESC              M1 M2 M3 M4  REVCD   THCD  SVC PROV  PROV CONTROL NO
       DATES OF SERV       LINE UNITS    LN SUBM AMOUNT    LN FEE REDUCT AMT    LN PAID AMOUNT    LN STATUS
-----------------------------------------------------------------------------------------------------------------
                                         09279100010000018
09/24/09-09/24/09 11                          -50.00              .00           .00         -50.00  CREDIT
REF: ORIGINAL TCN:  09268100010000147    DRG CODE:        DRG WEIGHT:     0.00000
   1  99213              HC/HCPCS/CPT CODE
      09/24/09-09/24/09        -1.00          -50.00              .00          -50.00  CREDIT
                                         09279100010000019
09/24/09-09/24/09 11                           40.00              .00           .00          40.00  DEBIT
REF: ORIGINAL TCN:  09268100010000147    DRG CODE:        DRG WEIGHT:     0.00000
   1  99213              HC/HCPCS/CPT CODE
      09/24/09-09/24/09         1.00          40.00              .00          40.00  DEBIT
--- END OF ADJ PAID CLAIMS FOR PROVIDER          ---
```

Table 11: Remittance Advice Paid Claims Table

FIELD NAME	Field #	DESCRIPTION
BENEFICIARY NAME	1	Patient name
MEDICAID ID	2	Medicaid's beneficiary ID for this patient
TCN	3	Transaction control number uniquely identifies the claim
PAT ACCT NUM	4	Patient account number as indicated on the claim by the provider
MED REC NO	5	The submitting provider's medical record number refers to this claim. This number is printed on the RA to assist providers in identifying the patient for whom the service was rendered.
DATES OF SERV	6	First and last dates of service for this claim
TOB	7	Type of bill. Depending on the type of claim submitted, the code will either be the facility type code or place of service code.
SVC PVDR	8	Servicing provider ID
SVC PVDR NAME	9	Servicing provider name
SUBMITTED AMT	10	Total charges submitted for this TCN
FEE REDUCTION AMT	11	The difference between the submitted amount and the paid amount
PAT RESP AMT	12	Amount payable by patient
TOT PAID AMT	13	Total amount paid on this TCN. (For balancing, this should equal Submitted Charges minus Adjustments.)

FIELD NAME	Field #	DESCRIPTION
STATUS	14	Claim Status (Paid – Denied – Suspended)
LINE	15	The line-item number on the claim
PROC	16	The line-item procedure code if applicable.
TYPE/DESC	17	The type of code listed in the procedure code (PROC) field.
M1, M2, M3, M4	18	The procedure code modifiers.
REVCD	19	The line-item revenue code if applicable.
THCD	20	The tooth code if applicable.
SVC PROV	21	The line-item servicing provider ID
PROV CONTROL NO	22	The line-item control number submitted in the 837 which is utilized by the provider for tracking purposes. (REF02 qualifier 6R in 835)
DATES OF SERV	23	First and last dates of service for this line item
LINE UNITS	24	Number of units
LN SUBM AMOUNT	25	The line item submitted amount.
FEE REDUCTION AMT	26	The difference between the submitted amount and the paid amount
LN PAID AMOUNT	27	Amount paid for this line item
LN STATUS	28	The line-item status

Figure 11: Remittance Advice Adjustments

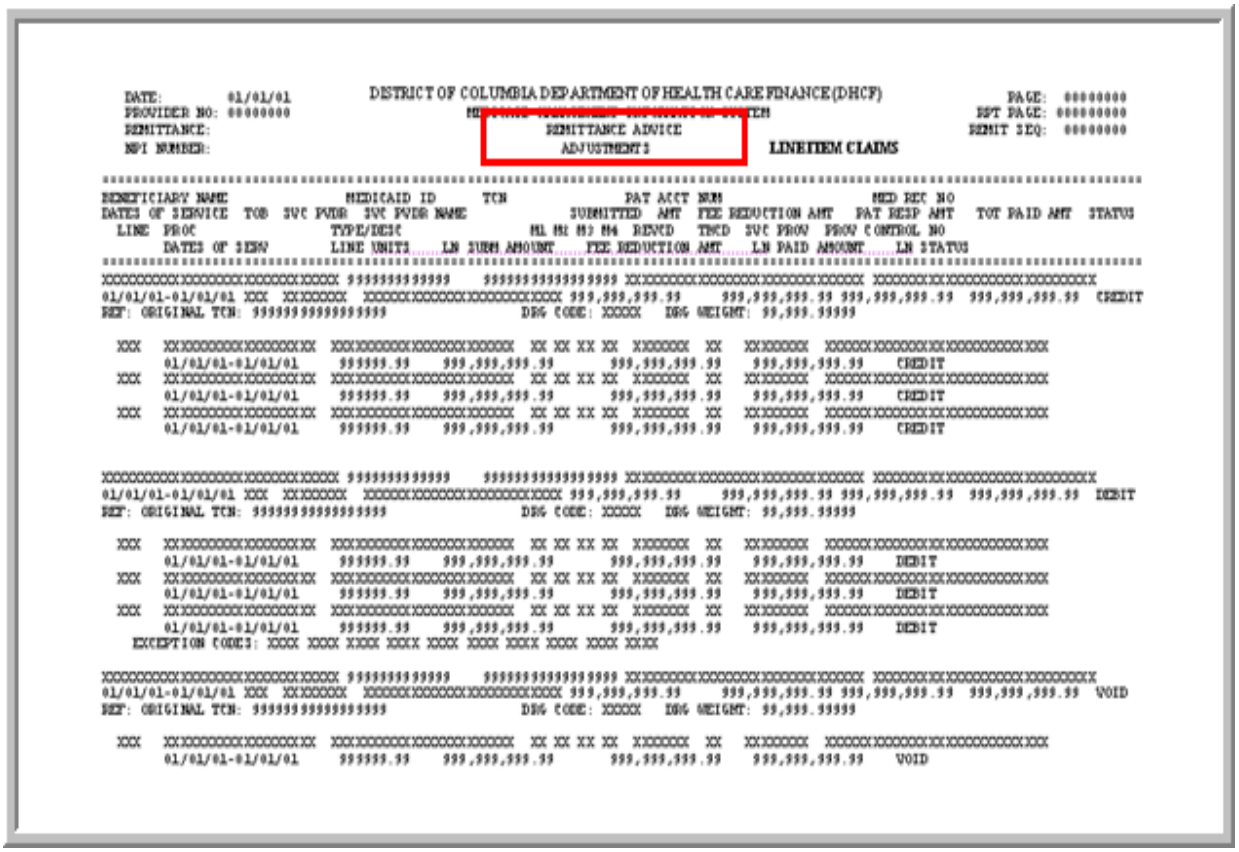


Table 12: Remittance Advice Adjustments Table

Field Name	Description
BENEFICIARY NAME	Patient name
MEDICAID ID	Medicaid's beneficiary ID for this patient
TCN	Transaction Control Number that uniquely identifies the claim
PAT ACCT NUM	Patient Account number
MED REC NO	The submitting provider's medical record number as referencing this claim
DATES OF SERV	First and last dates of service for this claim
TOB	Type of bill
SVC PVDR	Servicing provider ID
SVC PVDR NAME	Servicing provider name
SUBMITTED AMT	Total changes submitted for this TCN
FEE REDUCTION AMT	The difference between the submitted amount and the paid amount
PAT RESP AMT	Amount payable by patient
TOT PAID AMT	Total amount paid on this TCN. (For balancing, this should equal Submitted Charges minus Adjustments.)
STATUS	Claim Status (Paid – Denied – Suspended)
LINE	The line-item number on the claim
PROC	The line-item procedure code if applicable.
TYPE/DESC	The type of code listed in the PROC field.
M1, M2, M3, M4	The procedure code modifiers.
REVCD	The line-item revenue code if applicable.
THCD	The tooth code if applicable.
SVC PROV	The line-item Servicing provider ID
PROV CONTROL NO	The line-item control number submitted in the 837 which is utilized by the provider for tracking purposes. (REF02 qualifier 6R in 835)
DATES OF SERV	First and last dates of service for this line item
LINE UNITS	Number of units
LN SUBM AMOUNT	The line item submitted amount.
FEE REDUCTION AMT	The difference between the submitted amount and the paid amount
LN PAID AMOUNT	Amount paid for this line item
LN STATUS	The line-item status
REF : ORIGINAL TCN	The TCN that is being adjusted.
DRG CODE	DRG Code. (Not currently used).
DRG WEIGHT	DRG Weight. (Not currently used).
EXCEPTION CODES	The line-item exception codes
EXPLANATION OF BENEFITS CODES (EOB)	The line-item EOB codes

Figure 12: Remittance Advice Suspended Claims

```
*****************************************************************************************************************
 DATE:        09/07/09          DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)              PAGE:  00000004
 PROVIDER NO: 019999999                 MEDICAID MANAGEMENT INFORMATION SYSTEM                        RPT PAGE: 000001761
 REMITTANCE:  00441451                            REMITTANCE ADVICE                                    REMIT SEQ:  00000168
 NPI NUMBER: X1999999998                           SUSPENDED  CLAIMS          INPATIENT
=================================================================================================================
RECIPIENT NAME                MEDICAID ID      TCN              PAT ACCT NO                  MED REC NO
DATES OF SERV      STAT DT  TOB  SVC PVDR  SVC PRV NAME                 DRG CODE  DRG WEIGHT   TOTAL SUBMITTED  STATUS
 LN  DATES OF SERVICE  SVC PVDR  PROC               TYPE/DESC              M1 M2 M3 M4 REVCD   THCD      UNITS       SUBMITTED
=================================================================================================================
RECIPIENT SAMPLE                     709999999   09163800030000077
04/10/09-04/12/09  07/01/09 111  019999999  CAPITOL D.C. NURSING CENTER              0.00000          900.00  PEND
   EXCEPTION CODES: 0182 0303 0313 0381 1334 5209 5302
  1 04/10/09-04/12/09 019999999                    NU/NUBC UB92 CODE                  0121             2.00         500.00
  2 04/10/09-04/12/09 019999999 X0072              HC/HCPCS/CPT CODE                  0682             4.00         400.00
--- END OF PENDED CLAIMS FOR PROVIDER 019999999 ---
```

Table 13: Remittance Advice Suspended Claims Table

FIELD NAME	DESCRIPTION
BENEFICIARY NAME	Patient name
MEDICAID ID	Medicaid's beneficiary ID for this patient
TCN	Transaction Control Number that uniquely identifies the claim
PAT ACCT NO	Patient account number as indicated on the claim by the provider
MED REC NO	The submitting provider's medical record number as referencing this claim
DATES OF SERV	First and last dates of service for this claim
STATUS DT	Date the claim was suspended (generally the cycle date)
TOB	Type of bill
SVC PVDR	Servicing provider ID
SVC PVDR NAME	Servicing provider name.
DRG CODE	DRG Code. (Not currently used).
DRG WEIGHT	DRG Weight. (Not currently used).
TOTAL SUBMITTED	Total charges submitted for this TCN
STATUS	The overall claim status.
LN	The line-item number on the claim
DATES OF SERVICE	First and last dates of service for this line item
SVC PVDR	The line-item servicing provider ID
PROC	The line-item procedure code if applicable
TYPE/DESC	The type of code listed in the procedure code (PROC) field
M1, M2, M3, M4	The procedure code modifiers.
REVCD	The line-item revenue code if applicable.
THCD	The tooth code if applicable.

FIELD NAME	DESCRIPTION
UNITS	Number of units
SUBMITTED	The line item submitted amount.
EXCEPTION CODES	The exception codes that are posted to the header level or the line item.

Figure 13: Remittance Advice Provider Totals/Legend

```
DATE:        09/07/09          DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)                PAGE:  00000005
PROVIDER NO: 02700000                MEDICAID MANAGEMENT INFORMATION SYSTEM                           RPT PAGE: 000000680
REMITTANCE:  00441326                              REMITTANCE ADVICE                                    REMIT SEQ:  00000077
NPI NUMBER: 18000797148                          PROVIDER TOTALS/LEGEND

CLAIM TOTALS           --------STATUS----------- ---COUNT---  --SUBMITTED AMT---  ------PAID AMT----
                                   ORIGINAL PAID           0              0.00               0.00
                              CREDIT ADJUSTMENTS           1             41.00-              5.00-
                               DEBIT ADJUSTMENTS           1             41.00               5.00
                                           VOIDS           0              0.00               0.00
                           ================== ==========  =================  =================
                              APPROVED SUBTOTAL                          0.00               0.00
                                       SUSPENDED           0              0.00
                                          DENIED           0              0.00
                           ================== ==========  =================  =================
                          CLAIM PROCESSED TOTAL                          0.00               0.00
                           PROVIDER FINANCIALS                                               0.00
                           ================== ==========  =================  =================
                                  PAYMENT TOTAL                                              0.00

                         OUTSTANDING CREDIT BALANCE AS OF 09/07/2009             0.00
                         TOTAL HISTORY ONLY FINANICAL TRANSACTIONS  COUNT:       0                      0.00
                         TOTAL HISTORY ONLY CLAIMS                  COUNT:       0                      0.00

                           ADJUSTMENT SUBTOTALS    -FIRST QUARTER---  -SECOND QUARTER--  --THIRD QUARTER--  -FOURTH QUARTER--
                           CREDIT ADJUSTMENTS 09              0.00               0.00               5.00-              0.00
                            DEBIT ADJUSTMENTS 09              0.00               0.00               5.00               0.00
ONOTE: FOR REMITTANCE ADVICES OVER 100 PAGES, ONLY THE FIRST PAGE AND THE PROVIDER TOTALS PAGE WILL BE MAILED. PLEASE CONTACT
 (202) 906-8319 OR (866) 752-9233 TO REQUEST A COPY OF THE ENTIRE REMITTANCE ADVICE IN A CD.
0--- END OF REMITTANCE FOR PROVIDER   027332900 ---
```

Table 14: Remittance Advice Provider Totals/Legend Table

FIELD NAME	DESCRIPTION
CLAIM TOTALS	Totals for all categories of the RA.
STATUS	The claim status header within claim totals
COUNT	The total claim count specific to the category
SUBMITTED AMT	The total amount submitted by the provider
PAID AMT	The total paid amount.
ORIGINAL PAID	New claims submitted for this cycle
CREDIT ADJUSTMENTS	The total amount of credit adjustments
DEBIT ADJUSTMENTS	The total amount of debit adjustments
VOIDS	Total number of voided claims
APPROVED SUBTOTAL	Subtotal of approved claims
SUSPENDED	Total number of suspended claims and charges
DENIED	Total number of denied claims and charges
CLAIM PROCESSED TOTAL	Total of submitted and paid amounts
PROVIDER FINANCIALS	
PAYMENT TOTAL	Total provider payment

FIELD NAME	DESCRIPTION
OUTSTANDING CREDIT BALANCE AS OF	The outstanding credit balances.
TOTAL HISTORY ONLY FINANCIAL TRANSACTIONS	
TOTAL HISTORY ONLY CLAIMS	
ADJUSTMENT SUBTOTALS	
CREDIT ADJUSTMENTS	
DEBIT ADJUSTMENTS	
FIRST QUARTER	The total amount of adjustments and/or voids for the first quarter (Jan – Mar) in the calendar year.
SECOND QUARTER	The total amount of adjustments and/or voids for the second quarter (Apr – June) in the calendar year.
THIRD QUARTER	The total amount of adjustments and/or voids for the third quarter (July – Sept) in the calendar year.
FOURTH QUARTER	The total amount of adjustments and/or voids for the fourth quarter (Oct – Dec) in the calendar year.
EXCEPTION LEGEND	Full description of any exception codes (denial reason codes) listed on this RA
EOB CODE LEGEND	Full description of any explanation of benefit codes listed on this RA

19.1 Instructions for Submitting Adjustments and Voids

An Adjustment/Void claim is submitted when the original paid claim was filed or adjudicated incorrectly. Denied claims cannot be adjusted. All adjustment claims must be filed within 365 days of the date of payment.

Adjustments and voids can be submitted by paper or electronically using the Web Portal, WINSASAP or third-party software. Refer to the Web Portal Quick Reference Guide or the WINSASAP Guide for submitting adjustment and voids online or electronically.

To indicate an adjustment or voided claim, the following information must be recorded in the top right-hand corner of the claim form:

Code	Definition
A	Adjustment
-or-	
V	Void
-and-	
TCN	17-digit Transaction Control Number

Using the claim form, the provider must indicate whether the claim is being adjusted by writing the letter “A” in the top right-hand corner of the form. If the claim is being voided, the provider must indicate such by writing the letter “V” in the top right-hand corner of the form. The 17-digit TCN of the current paid claim is to be included at the top right-hand corner of both adjustments and voided claim forms in addition to the

appropriate 3-digit adjustment/void reason code. For example, A 23xxxxxxxxxxxxxxxx 014 or V23xxxxxxxxxxxxxxxx 014. Select the appropriate adjustment/void reason code from the list below.

Figure 14: Ajustment Example

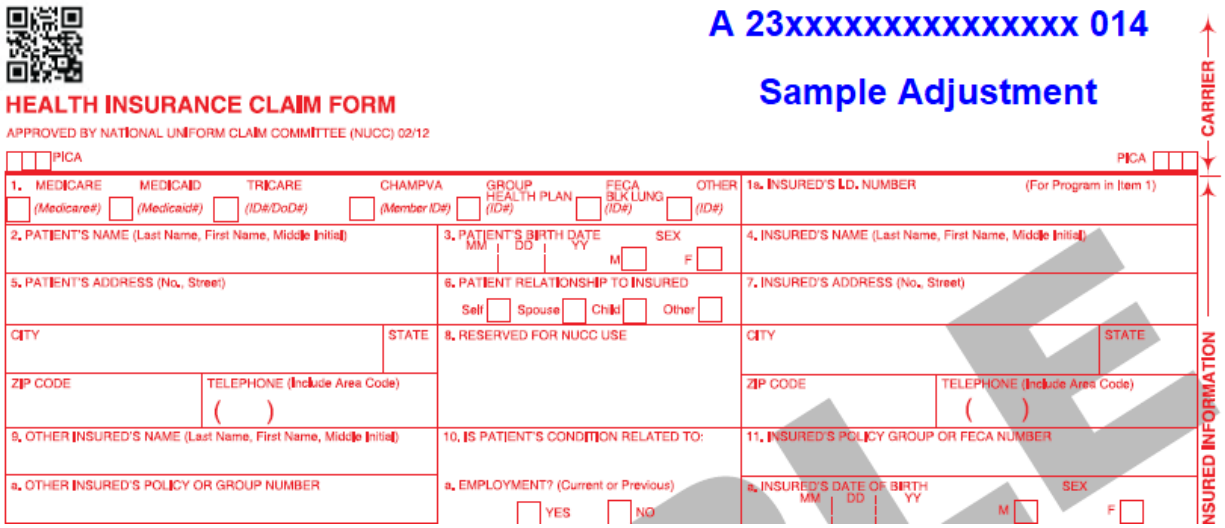


Figure 15: Void Example

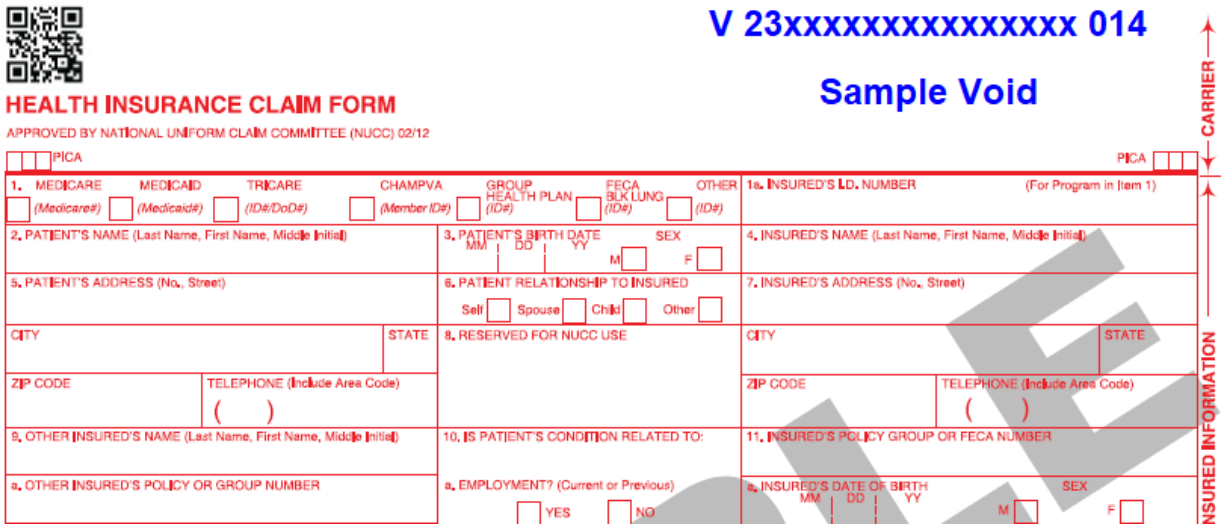


Table 15: Adjustment/Void Codes

011	RETRO RATE CHG / NO CUTBACK
014	PROV CLAIM FILING CORRECTION
019	POS PROV FILE CORR/LEGAL SETT
022	FISCAL AGENT CLM PROCESS ERROR
068	PROVIDER REFUND/CLM OVERPAYMNT
069	PROV RFND/OVERPAY FISC ERROR
070	PROV REFUND FOR HEALTH INSUR
071	PROV REFUND FOR CASUALTY INS
081	PROV CLAIM CORR/CLM FILED ERR

082	CLM VOID/FISC AGENT PROC ERROR
083	CLM VD/PD IN ERROR/RCP INCORRE
084	CLM VD/PD ERROR/PROV FIL INCOR
085	CLM VD/PD ERROR/INCORRECT PROV
086	CLAIM VOID MEDICARE RECOVERY
088	REFUND - PROVIDER ERROR
089	REFUND- FISCAL AGENT ERROR
090	PROV RTRN CHK/PD FOR INC BENE
099	PROV RETURN CHK/ INCORR PROV
101	VOID PAYMENT TO PIP HOSPITAL
102	ACCOMMODATION CHARGE CORRECT
103	PATIENT PAYMENT AMT CHANGED
104	PROCEDURE SERVICE DATES FIX
105	CORRECTING DIAGNOSIS CODE
106	CORRECTING CHARGES
107	UNIT VISIT STUDIES PRCD FIX
108	RECONSIDERATION OF ALLOWANCE
109	FIX ADMIT REFER PRESC PROVIDER
110	CORRECTING TOOTH CODE
111	CORRECTING SITE CODE
112	CORRECT TRANSPORTATION DATA
113	INPATIENT DRG
114	ADJUSTING PATIENT LEVEL CARE
115	RECOVERY BASED ON PRO REVIEW
116	ADJUSTED FOR RECP BEDHOLD DAYS
117	MANUAL CAPITATION VOID CLAIMS
118	REPROCESSED CLAIMS
119	AUTO RECOUPMENT SYSTEM ERROR
120	AUTO RECOUPMENT SYSTEM CHANG
121	PCG SERVICES
132	CLM VD/PROV SELF-IDENT FRAUD
300	BENEFICIARY DECEASED

19.2 Submitting Claim Refunds

DHCF’s preferred method for a provider to refund the program for claims paid in error is for the provider to void the claims instead of submitting a check to DHCF. Overpayments will be deducted from the available claims’ payment balance. Voids may be submitted online, electronically or hardcopy. Note: Timely filing rules are not applicable for submitting voids.

APPENDIX A: MHRS Service Limitations

Listed below is a list of the MHRS billable services with the limitations on each.

MHRS Core Services	Limitations
Diagnostic/Assessment	**Limitations:** One (1) Diagnostic/Assessment is allowed every six (6) months (180 days). Additional units may be allowable if re-authorized by DBH for periodic assessment, pre- hospitalization screening, neuropsychological assessments and re-admission to Rehabilitation Day Services or IDT, or prior to second unit within 6 calendar months if re-authorized by DBH. Diagnostic/Assessment shall not be billed on the same day as Assertive Community Treatment. **Locations/Settings**: DBH certified Community Mental Health Rehabilitation Services Agency, Home or other Community Setting, Residential Facility of sixteen (16) beds or less.
Medication/Somatic Treatment	**Limitations:** No annual limits. Medication/Somatic Treatment shall not be billed on the same day as Assertive Community Treatment. **Locations/Settings**: DBH certified Community Mental Health Rehabilitation Services agency, Home or other Community Setting, Residential Facility of sixteen (16) beds or less.
Counseling	**Limitations**: Prior authorization is required after 160 units per year. Additional units allowable with reauthorization by DBH. Counseling shall not be billed on the same day as Rehabilitation Day Services, Intensive Day Treatment, Community-Based Intervention, or Assertive Community Treatment. **Locations/Settings**: DBH-certified Community Mental Health Rehabilitation Services agency, Home, or other Community Setting, Residential Facility of Sixteen (16) Beds or Less.
Community Support	**Limitations:** No annual limits. Community Support shall not be billed on the same day as Assertive Community Treatment or billed during a Rehab Day session. Community support shall not be billed on the same day as CBI unless community support services are provided 30 days prior to discharge from CBI. **Locations/Settings**: DBH certified Community Mental Health Rehabilitation Services agency, Home or other Community Setting, Residential Facility of sixteen (16) beds or less.
Crisis/Emergency	**Limitations:** No annual limits. No service combination exclusions. Retrospective authorization from DBH required when ACT provided on same day as Crisis/Emergency. **Locations/Settings**: DBH certified Community Mental Health Rehabilitation Services agency, Home, or other Community Setting.

MHRS Specialty Services	Limitations
Rehabilitation Day Services	Reauthorization after the first 90 units of Rehabilitation Day Services. Rehabilitation Day Services may not be billed on the same day as Counseling, Assertive Community Treatment, or CBI or same time as community support. **Location/Setting**: DBH Certified Community Mental Health Rehabilitation Services agency.
Intensive Day Treatment	**Limitations:** Prior authorization is required for the first seven (7) days per DBH and for reauthorization for the second and any additional episodes of care beyond 7 days up to a maximum of 14 days within a twelve (12) month period. Shall not be billed on the same day as any other service, except for Crisis/Emergency, Community Support or Community Based Intervention. Additional units of Diagnostic/Assessment may be billed for each additional episode of care, with prior authorization from DBH, when Diagnostic/Assessment pre-hospital screening occurs for purposes of determining re-admission to Intensive Day Treatment services. **Location/Setting**: DBH Certified Community Mental Health Rehabilitation Services agency.
Community-Based Intervention	**Limitations:** Prior authorization is required for enrollment. Re-authorization required for continued treatment. Shall not bill Community-Based Intervention, Assertive Community Treatment, Rehabilitation Day Services, Counseling, or Intensive Day Treatment on the same day. CBI shall not be billed on the same day as community support unless community support services are provided 30 days prior to discharge from CBI. **Location/Setting**: DBH certified Community Mental Health Rehabilitation Services agency, Home, or other Community Setting.
Assertive Community Treatment	**Limitations:** Prior authorization is required for enrollment. Re-authorization required for continued treatment. ACT shall not be billed on the same day as any other service, except for Crisis/Emergency for which retrospective authorization is required. **Locations/Settings:** DBH certified Community Mental Health Rehabilitation Services agency, Home, or other Community Setting.

Other Services	
Residential Crisis Stabilization	**Limitations:** prior authorization required after initial 2 days, for period up to 7 days, then re-authorization required for up to an additional 7 days (for maximum of 14 days total). **Locations/Settings**: DBH certified Community MH Rehab. Services agency.

APPENDIX B: REIMBURSEMENT RATE INCREASE FOR BEHAVIORAL HEALTH SERVICES

Transmittal #22-33notified all Medicaid behavioral health service providers that the District of Columbia Medicaid Fee Schedule will be updated. The rate changes outlined in this transmittal are the result of recently approved changes to the District of Columbia Medicaid State Plan and the District's implementation of Section 9817 of the American Rescue Plan Act (ARPA) of 2021.

Rehabilitative Services Effective October 1, 2022

Mental Health Rehabilitative Services (MHRS)

Service Description	Procedure Code	Modifier	Rate Effective 10/01/22
Screening, Diagnostic Assessment (at least 3hrs)	T1023	HE	$275.34
Screening, Diagnostic Assessment (at least 3hrs)	T1023	GT, HE	$275.34
Screening, Brief Diagnostic Assessment (40-50mins)	H0002		$91.78
Screening, Brief Diagnostic Assessment (40-50mins)	H0002	GT	$91.78
Med Training/Support Group	H0034	HQ	$13.36
Med Training/Support Group	H0034	HQ, GT	$13.36
Med Training/Support Individual	H0034		$53.37
Med Training/Support Individual	H0034	GT	$53.37
Community Support Group	H0036	HQ	$6.45
Community Support Group	H0036	GT, HQ	$6.45
Community Support Individual	H0036		$25.77
Community Support Individual	H0036	GT	$25.77
Community Support Collateral	H0036	UK	$25.77
Community Support Family without consumer	H0036	GT, UK	$25.77
Community Support Family without consumer	H0036	HS	$25.77
Community Support Family with consumer	H0036	GT, HS	$25.77
Community Support Family with consumer	H0036	HR	$25.77
Community Support Family with consumer	H0036	GT, HR	$25.77
Community Support CRF	H0036	U1	$25.77
Community Support Physician Team Mbr	H0036	AM	$25.77
Community Support Physician Team Mbr	H0036	GT, AM	$25.77
Self-help/Peer Support	H0038		$25.77
Self-help/Peer Support Group	H0038	HQ	$6.45
Self-help/Peer Support Family Service	H0038	HS	$23.33
Self-help/Peer Support Family Group Service	H0038	HQ, HS	$7.06

Mental Health Clubhouse Services	H2031		$100.88
Crisis Intervention Service	H2011		$62.84
Day Services (1 day at least 3 hours)	H0025		$124.14
Day Services (1 day at least 3 hours)	H0025	GT	$124.14
Intensive Day Treatment (1 day at least 5 hours)	H2012		$174.80
Community-Based Intervention - CBI (Level II) IHCBS	H2022		$55.18
Community-Based Intervention - CBI (Level II) IHCBS	H2022	GT	$55.18
Community-Based Intervention - CBI (Level III) IHCBS- short term	H2022		$55.18
Community-Based Intervention - CBI (Level I) MST	H2033		$55.18
Community-Based Intervention - CBI (Level I) MST	H2033	GT	$55.18
Functional Family Therapy	H2033	HU	$55.18
Assertive Community Treatment – ACT Individual	H0039		$39.45
Assertive Community Treatment - ACT Individual	H0039	GT	$39.45
Assertive Community Treatment – ACT Group	H0039	HQ	$9.88
Assertive Community Treatment – ACT Group	H0039	GT, HQ	$9.88
Counseling Group	H0004	HQ	$7.66
Counseling Group	H0004	GT, HQ	$7.66
Counseling On-site Individual	H0004		$30.59
Counseling On-site Individual	H0004	GT	$30.59
Counseling On-site Family without Consumer	H0004	HS	$30.59
Counseling On-site Family without Consumer	H0004	GT, HS	$30.59
Counseling On-site Family with Consumer	H0004	HR	$30.59
Counseling Off-site Individual	H0004	HE, TN	$38.42
Child/Parent Psychotherapy	H0004	HT	$38.42
Trauma-Focused Cognitive Behavioral Therapy	H0004	ST	$38.42
Cognitive Behavioral Therapy Trauma-focused	H0004	GT, ST	$38.42
Cognitive Behavioral Therapy Trauma-focused - TREM	H0004	ST, UB	$10.62
Trauma Systems Therapy - TST	H0004	ST, UA	$38.42
Case Management	H0006		$23.33
Clinical Care Coordination	T1017		$28.06

Adult Substance Use Rehabilitative Services (ASURS) – *Temporarily enhanced an additional 20% through the end of the federal COVID-19 PHE*

Service Description	Procedure Code	Temporary Enhanced Rate Modifier	Temporary Enhanced Rate Effective 10/01/22
Urinalysis Collection	H0048	LR	$11.21
Clinical Care Coordination	T1017	HF	$33.67
Clinical Care Coordination	T1017	HF, GT	$33.67
Counseling, Group	H0005		$9.19
Counseling Group	H0005	GT	$9.19
Counseling, Group, Psycho-educational	H2027	HQ	$7.74
Counseling, Group, Psycho-educational	H2027	GT, HQ	$7.74
Counseling, Group, Psycho-educational (HIV)	H2027	HF, HQ	$7.74
Counseling, Individual, On-site, Behavioral Health Therapy	H0004	HF	$36.71
Counseling, Individual, Off-site	H0004	HF, TN	$37.50
Counseling, Family with Client	H0004	HF, HR	$36.71
Counseling, Family without Client	H0004	HF, HS	$36.71
Crisis Intervention	H0007	HF	$47.06
Short Term MMIWM - (Medically Monitored Inpatient Withdrawal Management)	H0010	U1	$633.31
Behavioral Health Assessment, On-going, Risk Rating	H0002	TG	$192.13
Diagnostic Assessment, Comprehensive Adult	H0001		$330.40
Medication Assisted Treatment, Methadone, Clinic or Take Home	H0020		$10.93
Medication Assisted Therapy, Administration	H0020	HF	$10.93
Medication Management, Adult	H0016		$64.05

Medication Management, Youth	H0016	HA, HF	$64.05
Multi-Systemic Therapy for Juveniles (ACRA) (ages 12 - 20)	H2033	HA, HF	$80.42
Multi-Systemic Therapy for Juveniles (ACRA) (ages 21-24)	H2033	HF	$80.42
Case Management	H0006		$28.00
Case Management (HIV)	H0006	HF, HK	$28.00
Recovery Support Service (RSS), Individual	H2014	UK, GT	$30.93
RSS Group	H2014	HQ	$7.74
Trauma Recovery and Empowerment Services (TREM)	H0004		$12.74

Behavioral Health Stabilization

Service Description	Procedure Code	Modifier	Rate Effective 10/01/22
Brief Psych Emergency	S9484		$251.38
Extended Psychiatric Emergency	S9485		$1,162.81
Mobile Crisis Intervention	S9484	U1	$251.38
Mobile Outreach	H0023		$216.11
Short-term Psychiatric Stabilization	S9485	U1	$408.78

Transition Planning Services

Service Description	Procedure Code	Modifier	Rate Effective 10/01/22
Transitional Planning Service	G9012		$1,084.57

Rehabilitation Services for Deaf and Hard of Hearing Effective October 1, 2022

Mental Health Rehabilitative Services (MHRS) for Deaf and Hard of Hearing

Service Description	Procedure Code	Modifier	Rate Effective 10/01/22
Screening, Diagnostic Assessment (at least 3hrs)	T1023	HE, HK	$367.04
Brief Diagnostic Assessment (40-50 mins)	H0002	HK	$122.34
Med Training/Support Group	H0034	HK, HQ	$19.38
Med Training/Support Individual	H0034	HK	$64.01
Community Support Group	H0036	HK, HQ	$9.54
Community Support Individual	H0036	HK	$31.50

Community Support Collateral	H0036	HK, UK	$31.50
Community Support Family without Consumer	H0036	HK, HS	$31.50
Community Support Family with Consumer	H0036	HK, HR	$31.50
Community Support CRF	H0036	HK, U1	$31.50
Community Support, Physician Team Member	H0036	AM, HK	$31.50
Community Support, Self-help/Peer Support	H0038	HK	$31.50
Community Support, Self-help/Peer Support Group	H0038	HK, HQ	$9.54
Community Support, Family/Couple Peer Support Family Service	H0038	HK, HS	$31.50
Crisis Emergency	H2011	HK	$84.74
Day Services (1 day at least 3 hours)	H0025	HK	$176.41
Intensive Day Treatment (1 day at least 5 hours)	H2012	HK	$235.98
Community-Based Intervention – CBI (Level II and III) IHCBS	H2022	HK	$51.24
Community-Based Intervention – CBI (Level I) MST	H2033	HK	$82.32
Functional Family Therapy	H2033	HK, HU	$82.32
Assertive Community Treatment - ACT Individual	H0039	HK	$54.53
Assertive Community Treatment - ACT Group	H0039	HK, HQ	$16.50
Counseling Group	H0004	HK, HQ	$11.47
Counseling on-site Individual	H0004	HK	$37.88
Counseling on-site Family without Consumer	H0004	HK, HS	$37.88
Counseling on-site Family with Consumer	H0004	HK, HR	$37.88
Psychotherapy for Family Violence Child/Parent	H0004	HK, HT	$51.24
Cognitive Behavioral Therapy Trauma-focused	H0004	HK, ST	$51.24
Cognitive Behavioral Therapy Trauma-focused – TREM	H0004	ST, UB, HK	$14.34
Trauma Systems Therapy - TST	H0004	ST, UA, HK	$51.86
Mental Health Clubhouse Services	H2031	HK	$136.19
Clinical Care Coordination	T1017	HK	$31.50

Adult Substance Use Rehabilitation Services (ASURS) for Deaf and Hard of Hearing –
Temporarily enhanced an additional 20% through the end of the federal COVID-19 PHE

Service Description	Procedure Code	Temporary Enhanced Rate Modifier	Temporary Enhanced Rate Effective 10/01/22
Breathalyzer Collection	H0048	HK	$15.14
Urinalysis Collection	H0048	HK, LR	$15.14
Clinical Care Coordination	T1017	HF, HK	$37.79
Counseling, Group	H0005	HK	$13.76
Counseling, Group, Psycho-educational	H2027	HK, HQ	$11.43
Counseling, Individual, On-site, Behavioral Health Therapy	H0004	HF, HK	$45.47
Counseling, Individual, Off-site	H0004	HF, HK, TN	$47.22
Counseling, Family with Client	H0004	HF, HK, HR	$45.47
Counseling, Family without Client	H0004	HF, HK, HS	$45.47
Crisis Intervention	H0007	HF, HK	$63.52
Short Term MMIWM - (Medically Monitored Inpatient Withdrawal Management)	H0010	U1, HK	$915.38
Behavioral Health Assessment, On-going, Risk Rating	H0002	HK, TG	$240.84
Diagnostic Assessment, Comprehensive Adult	H0001	HK	$440.44
Medication Assisted Treatment, Methadone, Clinic or Take Home	H0020	HK	$10.94
Medication Assisted Therapy, Administration	H0020	HF, HK	$14.76
Medication Management, Adult	H0016	HK	$76.82
Multi-Systemic Therapy for TAY - Transitional Aged Youth (ACRA) (Ages 21-24)	H2033	HF, HK	$98.78
Case Management	H0006	HK	$37.80
Case Management (HIV)	H0006	HK, HF, HV	$37.80
Recovery Support Service, Group	H2014	HK, HQ	$11.44
Recovery Support Service (RSS), Individual	H2014	UK, HK	**
Trauma Recovery and Empowerment Services (TREM)	H0004	ST, UB, HK	$14.34

Transition Planning Services for Deaf and Hard of Hearing

Service Description	Procedure Code	Modifier	Rate Effective 10/01/22
Transitional Planning Service	G9012	HK	$1,464.18

Refer to **Transmittal #22-33** for additional information.

APPENDIX C: ADDRESS AND TELEPHONE NUMBER DIRECTORY

Appeal Notification
Conduent State Healthcare
District Medicaid Claims Processing Fiscal Agent
PO Box 34734
Washington, DC 20043
Attention: Claims Appeal

Claims Appeal – Claims past Timely Filing
Conduent
District Medicaid Claims Processing Fiscal Agent
P.O. Box 34734
Washington, DC 20043
Attention: Timely Filing Claims Appeal

Conduent Provider Inquiry Unit
(866) 752-9233 (outside DC metro area)
(202) 906-8319 (inside DC metro area)

Claim Status Information/Claims Payment Information
Conduent State Healthcare
District Medicaid Claims Processing Fiscal Agent
P.O. Box 34734
Washington, DC 20043
Attention: Provider Inquiry Unit
Telephone Numbers:
(866) 752-9233 (outside DC metro area)
(202) 906-8319 (inside DC metro area)

Claim Submission Information - Mail
For CMS-1500s:
Conduent
District Medicaid Claims Processing
P. O. Box 34768
Washington, DC 20043

For UB04s:
Conduent
District Medicaid Claims Processing
P. O. Box 34693
Washington, DC 20043

For Dental and Pharmacy Claims
Conduent
District Medicaid Claims Processing
P. O. Box 34714
Washington, DC 20043

For Adjustments and Voids:
Conduent
District Medicaid Claims Processing
P. O. Box 34706
Washington, DC 20043

For Medicare Crossover Claims
Conduent
District Medicaid Claims Processing
P. O. Box 34770
Washington, DC 20043

Telephone Inquiries
AmeriHealth DC
(800) 408-7511

CPT-4 Coding Information
American Medical Association
100 Enterprise Place
P.O. Box 7046
Dover, Delaware 19903-7046
Attention: Order Department
Telephone: (800) 621-8335

Dental Helpline
(866) 758-6807

District of Columbia Managed Care Enrollment Broker
Maximus
(800) 620-7802

Durable Medical Equipment (DME)
Comagine Health
Prior Authorization Unit: (800) 251-8890
Pharmacy Consultant Office – (202) 422-5988

General Program Information
Department of Health Care Finance
441 4th St NW
Suite 900
Washington, DC
Telephone: (202) 442-5988
www.dhcf.dc.gov

ICD-10-CM Orders
MEDICODE
5225 Post Way
Suite 500
Salt Lake City, Utah 84116
Telephone – (800) 999-4600

Electronic Claims Submission/Electronic RA Information
EDI (Electronic Data Interchange) – (866) 775-8563

Eligibility Determination Information
Economic Security Administration - (202) 724-5506
Inquiry Recertification - (202) 727-5355
Fax Request - (202) 724-2041

Eligibility Verification
Interactive Voice Response System (IVR)
(202) 906-8319

Health Services for Children with Special Needs HSCSN
(202) 467-2737

Medicare Customer Service
(800) 633.4227
www.cms.gov/Medicare/Medicare.html

Medicaid Payment Schedule Information
Conduent
Provider Inquiry Unit
P.O. Box 34743
Washington, DC 200043
Telephone Numbers
(866) 752-9233 (outside the District of Columbia)
(202) 906-8319 (inside the District of Columbia)

Medicaid Fraud Hotline
(877) 632-2873

Pharmacy Consultant
Department of Health Care Finance
441 4th St NW
Suite 900
Washington, DC 20001
Telephone Numbers
(202) 442-9078 or (202) 442-9076

Prior Authorization Form Submission
Comagine Health
Prior Authorization Unit: (800) 251-8890

Provider Enrollment Information
MAXIMUS
Provider Enrollment Unit
P.O. Box 34086
Washington, DC 20043-9997
Telephone Numbers
(844) 218-9700
www.dcpdms.com

Transportation Broker
Medicaid Transportation Management, Inc. (MTM)
Telephone Number - (888) 561-8747
www.mtm-inc.net

Third Party Liability
Department of Health Care Finance
441 4th St NW, Suite 1000S
Washington, DC 20001
Attention: Third Party Liability
Telephone: (202) 698-2000

APPENDIX D: IVR INSTRUCTIONS

The Department of Health Care Finance Medicaid Branch (DHCF) determines eligibility for the DC Medicaid Program.

Providers should verify the beneficiary's name and identification number, effective dates of eligibility, services restricted to specified providers, and whether other insurance is on file (commonly referred to as third party liability) before rendering services.

Beneficiary eligibility may be verified by calling the Interactive Voice Response System (IVR) using a touch-tone telephone and entering the beneficiary identification number found on the beneficiary's Medical Assistance ID card. The IVR is available 24 hours a day, seven days a week with an unlimited number of inquiries being performed per call. The IVR may be used up to 30 minutes per call. Providers should also have their DC Medicaid provider number or NPI number ready.

To access the District of Columbia Government Medicaid IVR, dial (202) 906-8319 (inside DC Metro area) or (866) 752-9233 (outside DC Metro area) from your touch-tone phone. Select one of the following options listed below and follow the prompts. The system will prompt you to enter your nine-digit Medicaid provider number or 10-digit National Provider Identifier (NPI) followed by the pound (#) key.

- Press 1 - To verify beneficiary eligibility and claims status.
- Press 2 - If you are a new provider and would like to enroll or if you are changing your provider number, contact MAXIMUS at 844.218.9700.
- Press 3 - For EDI Technical Support Services
- Press 4 - For all other questions

Once you have concluded your inquiries, record the confirmation number provided at the end of the call.

APPENDIX E: GLOSSARY

The following terms are used throughout this manual. The definition relates to the term used in the DC Medicaid Program:

ACA – Affordable Care Act was signed into law by President Obama on March 23, 2010, it aims to bring comprehensive and equitable health insurance coverage to many Americans. The ACA guarantees

ADA – American Dental Association

Adjustment – A transaction that changes any information on a claim that has been paid. A successful adjustment transaction creates a credit record, which reverses the original claim payment, and a debit record that replaces the original payment with a corrected amount; a change submitted because of a billing or processing error.

ANSI - American National Standards Institute

Approved - A term that describes a claim that will be or has been paid.

ASC - Ambulatory Surgery Code

Buy-In - The process whereby DHCF authorizes payments of the monthly premiums for Medicare coverage.

CFR – Code of Federal Regulations

CHAMPUS - Civilian Health and Medical Program of the Uniformed Services

CHIP – Children's Health Insurance Program is a program administrated by the US Department of Health and Human Services that provides matching funds to states for health insurance to families with children. CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.

Claim - A request for reimbursement of services that have been rendered.

Claim Status - The determined status of a claim: approved, denied or suspended.

Claim Type - A classification of claim origin or type of service provided to a beneficiary.

CLIA – Clinical Laboratory Improvement Amendments

CMS - Centers for Medicaid and Medicare Services

CMS1500 - Claim form currently mandated by CMS, formerly known as HCFA-1500, for submission of practitioner and supplier services

Conduent – is the fiscal agent for the DC Medicaid Program (formerly known as Affiliated Computer Services)

Cost Settlement – Refers to a reimbursement method in which the reimbursement is made on actual cost information

Covered Services - All services which providers enrolled in the DC Medicaid program are either required to provide or are required to arrange to have provided to eligible beneficiaries.

CPT - Current Procedural Terminology code

Crossover - The process by which the Medicare intermediaries and Medicare carriers supply Medicaid with the deductible and co-insurance amounts to be paid by Medicaid.

DCAS – District of Columbia Access System

DCID - District of Columbia's eight-digit beneficiary ID number

DCMMIS - District of Columbia Medicaid Management Information System

Denied – A term that describes a claim that results in nonpayment.

DHCF - Department of Health Care Finance (formerly known as Medical Assistance Administration (MAA). The name of the local District agency administering the Medicaid program and performs other necessary Medicaid functions.

DHHS - Department of Health and Human Services

DHR - Department of Human Resources

DHS - Department of Human Services

District - The District of Columbia

DME – Durable Medical Equipment

DMERC - Durable Medical Equipment Regional Carrier

DOH - Department of Health

DRG - Diagnosis Related Grouper

Dual-eligible - individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

DX - Diagnosis Code

EDI – Electronic Data Interchange

Emergency - Sudden unexpected onset of a condition requiring medical or surgical care that may result in permanent physical injury or a threat to life if care is not secured immediately after the onset of the condition or as soon thereafter.

Enrollment - The initial process by which new enrollees apply for managed care or provider enrollment.

EOMB - Explanation of Medical Benefits

EPSDT – The Early and Periodic Screening, Diagnosis, and Treatment is a Medicaid initiative that provides preventative healthcare services for children.

ESA – Economic Security Administration (formerly known as Income Maintenance Administration), through an MOU with the Medicaid agency, has the responsibility to determine eligibility for all medical assistance programs. They also determine eligibility for SNAP, TANF, childcare subsidy, burial assistance and many more.

FFP – Federal Financial Participation: the Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures.

FQHC – Federally Qualified Health Center

HBX – Health Benefits Exchange: the entity that administers and oversees the online marketplace for District residents and small businesses to enroll in private or public health insurance options. The District's Health Benefit Exchange will allow individuals and small businesses to compare health plans, to learn if they are eligible for tax credits for private insurance or health programs like DC Healthy Families/Medicaid, and to enroll in a health plan that meets their needs.

HCFA - Health Care Finance Administration

HCPCS- Healthcare Common Procedure Coding System

ICD-CM - International Classification of Diseases Clinical Modification

ICP – Immigrant Children's Program is a health program designed as a safety net for children under the age of 21 who do not meet the citizenship/immigration status requirements for Medicaid.

IMD – Intermediate Mental Disorder

IVR – The Interactive Voice Response Verification system is a system to provide verification of beneficiary eligibility, checking claim status through telephone inquiry by the provider, using the DCID number or Social Security Number (SSN)

LTAC - Long Term Acute Care

MAGI – Modified Adjusted Gross Income is a methodology for how income is counted and how household composition and family size are determined

Managed Care Organization - Program to improve access to primary and preventive services where eligible beneficiaries shall be required to select a primary care provider who will be responsible for coordinating the beneficiary's care. Payment for services shall be on a capitated basis for prepaid plans.

Medicaid - The District of Columbia's medical assistance program, provided under a state plan which has been approved by the U.S. Department of Health and Human Services under Title XIX of the Social Security Act.

Medicaid Benefits Package - All health services to which beneficiaries are entitled under the District of Columbia Medicaid program, except service in a skilled nursing facility, an institution for mental diseases, and other services specifically excluded in the contract.

Medically Necessary - Description of a medical service or supply for the prevention, diagnosis, or treatment which is (1) consistent with illness, injury, or condition of the enrollee; (2) in accordance with the approved and generally accepted medical or surgical practice prevailing in the geographical locality where, and at the time when, the service or supply is ordered.

Medicare – A federal program (Title XVIII of the Social Security Act) providing health insurance for individuals 65 and older or disabled. Medicare Part A covers hospitalization and is automatically provided to any qualified beneficiary. Medicare Part B covers outpatient services and is voluntary (requires a premium contribution).

NCCI – National Correct Coding Initiative

NDC - National Drug Code

Non-Compensable Item - Any service a provider supplies for which there is no provision for payment under Medicaid regulations.

NPI - National Provider Identifier is a 10-digit number that uniquely identifies a healthcare provider. Providers must apply for an NPI through NPPES.

NPPES – National Plan and Provider Enumeration System

OIS – Office of Information Systems

Open Enrollment Period - The 30-day period following the date the beneficiary is certified or re-certified for the District's Medicaid Program. During this period, a beneficiary eligible to be covered under the managed care program may select a provider without restriction.

Ophthalmic Dispensing Services - The design, verification, and delivery to the intended wearer of lenses, frames, and other specifically fabricated optical devices as prescribed by an optometrist or ophthalmologist.

Out-of-District – Any zip code outside of the District of Columbia.

Parent - A child's natural parent or legal guardian.

PBM – Pharmacy Benefits Management

PID – District of Columbia nine-digit provider ID number

Prepayment Review - Determination of the medical necessity of a service or item before payment is made to the provider. Prepayment review is performed after the service or item is provided and involves an examination of an invoice and related material, when appropriate. This should not be confused with prior authorization.

Prescription (Vision) - The written direction from a licensed ophthalmologist or optometrist for therapeutic or corrective lenses and consists of the refractive power and, when necessary, the vertex distance, the cylinder axis, and prism.

Prior Authorization (PA) - The approval of a service before it is provided, but it does not necessarily guarantee payment.

Provider - A person, business, or facility currently licensed under the law of any state and enrolled in Medicaid to practice medicine, osteopathy, dentistry, podiatry, optometry, or to provide other Medicaid approved services and has entered into an agreement with the District of Columbia's Medicaid program to provide such services.

QHP – Qualified Health Plan is a major medical health insurance plan that covers all the mandatory benefits of the ACA and is eligible to be purchased with a subsidy, also known as a premium tax credit.

QIO - Quality Improvement Organization

QMB – Qualified Medicare Beneficiary

RA – The Remittance Advice is a document sent to providers to report the status of submitted claims - paid, denied, and pended from Conduent.

Rejected - A term that describes an electronically submitted claim that has not met processing requirements

RTP - Return to Provider

RTP Letter - A letter that accompanies a rejected claim that is sent to providers with an explanation identifying the reason for the return

Service Area - The area within the city limits of the District of Columbia

Specialist - An enrolled Medicaid physician whose practice is limited to a particular area of medicine including one whom, by virtue of advance training, is certified by a specialty board.

Spend-Down - Occurs when an individual or family is ineligible for Medicaid benefits due to excess income but can receive Medicaid benefits by incurring medical expenses in the amount of the excess income.

State Plan - The State Plan of Medical Assistance, which describes the eligibility criteria, services covered payment methodology and/or rates and any limitations approved by the Centers for Medicaid and Medicare Services for coverage under the District of Columbia's Medicaid Program.

TANF - The categorical eligibility designation for individuals who are eligible for Medicaid by they are eligible for cash assistance from the Temporary Assistance for Needy Families (TANF) program.

TCN - The unique transaction control number that is assigned to each claim for identification.

Third-Party Liability - Medical insurance, other coverage, or sources, which have primary responsibility for payment of health, care services on behalf of a Medicaid- eligible beneficiary.

Timely Filing – A period in which a claim must be filed to be considered eligible for payment.

UB04 – A revised version of the Universal Billing Form UB92 used by institutional providers

Urgent Care Services - Care necessary for an acute condition, not as serious as an emergency, yet one in which medical necessity dictates early treatment and/or a hospital environment.

Vendor - A provider who usually sells items such as durable medical equipment, medical supplies, or eyewear.

VFC- Vaccine for Children is a Centers for Disease Control (CDC) federally funded program that supplies providers with vaccines at no charge for eligible children up to age 18.

Void - A claim, which has been paid and is later refunded because the original reimbursement was made for an erroneous provider or beneficiary identification number; or payment was made in error.

Waiver - A situation where CMS allows the District to provide services that are outside the scope of the approved State Plan services, in non-traditional settings, and/or to beneficiaries not covered by Medicaid.

Web Portal – An internet gateway that provides tools and resources to help healthcare providers conduct their business electronically.

WINSASAP – Free software provided by Conduent that can be used to create claims in X12N format.