DME/POS Billing Manual
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Review and Revision History

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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. Notification of the updated manual will be indicated in the “What’s Hot” section of the Web Portal. Outdated copies of material should be discarded.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 Section 3.0-Glossary.
- Addresses and telephone numbers referenced throughout this manual are included in Appendix A (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 new 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 Type Specific Forms
- Provider Type Specific Policies
- Provider Training Modules and Computer Based Training (CBT)
- Latest News/What's Hot
- Online Claim and Prior Authorization submission
- 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 Favorites the first time you visit the site so you can quickly return repeatedly.

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. The website includes a listing with the name and telephone number of the provider representative assigned to your specific area.

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
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 mail at the addresses listed in Appendix A. 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 A.

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 DC MEDICAID MANAGED CARE

DHCF implemented a Managed Care Program in the District to help provide quality care to DC Medicaid beneficiaries in a more economical manner. This section briefly explains this program. If you are interested in becoming a participant, contact DHCF at the address and number listed in Appendix A.

4.1 Program Overview

The DC Medicaid and Alliance Managed Care programs were developed to improve access to primary and preventive services while reducing the overall cost of care provided to DC Medicaid and Alliance enrollees. The reductions in cost result from changes in the behavior of patients who can develop stable and continuous relationships with primary care providers (PCP).

The services offered to all Medicaid managed care enrollees include:

- Access to consistent primary, preventive, and special care services
- 24-hour availability of nurse hotline to provide immediate access to health advice and/or access to urgent medical care.
- Freedom of choice to obtain Medicaid covered services from any in-network provider. Timely and appropriate access to services in accordance with professionally accepted standards of care
- Access to Care coordination and Case Management services that will strengthen and improve the overall health, educational, and social services; and
- Access to behavioral health, dental, vision, and transportation services (emergency and non-emergency)

The DC Medicaid and Alliance Managed Care programs seeks to optimize the investment in health care for managed care enrollees, which is particularly important in these times of fiscal austerity. Managed Care is one of the few ways of keeping costs under control and providing quality health care.

DHCF also implemented the Child and Adolescent Supplemental Security Income Program (CASSIP). CASSIP is a voluntary program for children and young adults, ages 0 thru 26 that have complex medical needs and eligible for Supplemental Security Income (SSI) or have SSI-related diagnoses that meet Social Security Administration's (SSA) medical disability criteria. Health Services for Children with Special Needs, Inc. (HSCSN) is currently the district's contractor that serves this population.

The services available to all CASSIP enrollees include, but not limited to:

- An assigned Care Manager
- Respite Care (168 hours every 6 months)
- Home Modifications (medically necessary)
- Adaptive equipment and supplies
- Orthodontic care
- Home Health/Personal Care Assistant services
- Feeding management programs
- Psychiatric Residential Treatment Facility (PRTF) and Psychiatric sub-acute care (for defined population)
- Long term medical care
- Intermediate Care Facility for Mental Retardation (ICF-MR)
- Behavioral Health rehabilitation services (day treatment programs)

Medicaid Managed Care Contacts:

AmeriHealth Caritas District of Columbia	(800) 408-7511
MedStar Family Choice DC	(888) 404-3549
Health Services for Children with Special Needs	(866) 937-4549
Wellpoint District of Columbia (formerly Amerigroup DC)	(202) 548-6700

Enrollment Broker:

DC Healthy Families and Alliance Program:	(800) 620-7802

4.2 Participants

The DC Medicaid Program serves an excess of 250,000 District of Columbia residents. Two-thirds of this population is enrolled in the Managed Care Program. The remaining third of the beneficiaries are enrolled in the Fee-for-Service Program. Members of eligible populations reside in all eight of the district's wards. Over half of the eligible population resides in Wards 4, 7 and 8 of the eastern part of the city. Eligible managed care enrollees shall be required to select a primary care provider within ten (10) days of becoming eligible for the program. If they do not select a primary care provider, they shall be assigned to one.

4.3 Providers

Eligible providers can be prepaid plans; public health clinics owned or operated by the district, hospital outpatient clinics, certain community health centers, and federally qualified health centers (FQHC) or physicians in private practice. To be eligible, a provider must agree to comply with certain federal and District requirements, must meet the district's requirements for the practice of medicine and/or for the operation of a prepaid plan or health care facility and must be enrolled as a DC Medicaid provider. Payment for services can be on a fee-for-service basis, a capitated basis for prepaid plans or alternative payment models.

4.4 Special Requirements for Managed Care Organizations

In addition to executing a provider application, an MCO or other pre-paid health plan must sign a contract, renewed annually, with the DC Medicaid Program to enroll Medicaid beneficiaries.

Individuals eligible to enroll in managed care fall under the following categories:

- Medicaid (TANF-TANF related),
- Children's Health Insurance Program (CHIP)
- Childless Adults
- Immigrant Children Program (ICP) and
- Alliance

4.5 Quality Assurance Program for DC Medicaid Managed Care

DHCF is responsible and accountable for all quality improvement activities as outlined in the department's Quality Strategy. Components of this Quality Strategy include at a minimum all requirements as outlined in The Centers for Medicare and Medicaid Services (CMS) Medicaid and CHIP Managed Care Final Rule (CMS 2390-F). DHCF is also responsible for tracking and monitoring provider utilization and quality of care standards. Providers are responsible for participating in quality improvement activities to promote improved quality of care, experience of care and decreased cost as outlined by the DHCF. DHCF is responsible for monitoring, analyzing, and distributing information related to quality improvement activities and providing support to implementation of continuous quality improvement activities.

5 PROVIDER PARTICIPATION INFORMATION

This section of the manual provides information regarding enrollment of providers to participate in the DC Medicaid Program.

5.1 Participating Provider

A participating provider is a person, institution, or organization who has an executed provider agreement with DHCF. To participate in the DC Medicaid Program, providers must adhere to the guidelines established by DHCF and outlined in the individual provider agreements.

5.2 Provider Types

The following types of providers qualify for Medicaid program enrollment consideration:

- Alcohol and Substance Abuse Clinic
- Ambulance Transportation
- Ambulatory Surgery Center
- Audiologist
- Birthing Center
- Clinic (Public/Private)
- Community Residential Facility
- DC Public Chartered Schools
- Dental Clinic
- Dentist
- Doula
- Durable Medical Equipment Supplier
- Federal Qualified Health Clinic
- Freestanding Radiology
- General Hospital
- Hearing Aid Dispenser
- Hemodialysis Center – Freestanding
- Home Health Agency
- Hospice
- Independent Lab/X-ray
- Licensed Independent Social Workers
- Nurse Practitioner Group
- Psychologists
- Telemedicine
- LTAC Hospital
- MCO (Managed Care Organization)
- Mental Health Clinic
- Mental Health Rehab Services (MHRS)
- Nurse Practitioner
- Nursing Facility
- Optician
- Optometrist
- Pediatric Palliative Care
- Pharmacy
- Licensed Marriage and Family Therapists
- Physician DO
- Physician MD
- Podiatrist
- Psychiatric Residential Treatment Facility
- Psychiatric Hospital Private
- Psychiatric Hospital Public
- Waiver (Elderly and Physically Disabled (EPD), Individual with Developmental Disabilities (IDD))
- Physician Group
- Personal Care Aide (PCA)
- Psychosocial Rehabilitation Services (Clubhouse)
- Physician Assistant
- Recovery Support Services

5.3 Provider Eligibility Requirements

Providers shall meet the following certification requirements to be considered for participation in the DC Medicaid Program. Requirements differ based on provider type and/or location as noted below:

5.3.1 District Providers

Providers licensed in the District of Columbia are eligible to request consideration for participation in the DC Medicaid program if the practice address is located within the geographic boundaries of the District of Columbia.

5.3.2 Out-of-District Providers

Providers whose practice address is located outside of the geographic boundaries of the District of Columbia are eligible to request consideration for participation in the DC Medicaid program if licensed in the state of the practice address.

5.3.3 Group Practice Providers

Licensed, registered, and/or certified businesses that have multiple members, who are registered to do business in the District of Columbia, are eligible to request consideration for participation in the DC Medicaid through a group practice.

When a group practice has been approved for participation, the group will be assigned a provider number. Payment for services rendered by all members of the group will be made under this number. Every member in the group must also be enrolled in DC Medicaid and have signed an individual Provider Agreement. A provider number will also be assigned to each member in the group to indicate which member is rendering the service.

For each new member the group wants to add, an enrollment package must be obtained, completed, and submitted to Maximus. Conduent will notify applicants in writing whether they have been approved for participation in the DC Medicaid Program.

5.3.4 Health Facilities

Licensed and certified health facilities are eligible to request consideration for participation in the DC Medicaid Program. In the case of new facilities or new services, acquisition of a certificate of need from the Health Reimbursement Arrangement (HRA) will also be required.

5.4 Application Procedures

To become a DC Medicaid provider, an applicant may submit an enrollment application online at www.dcpdms.com. Applicants also shall be subject to screening through any of the following:

- Ownership and Financial Disclosures
- Criminal Background Checks
- Fingerprinting; and/or
- Pre and Post Enrollment Site Visits

To access the online application, go to the “Provider” section of the Web Portal located in the left navigational pane and select the “Enroll Online” hyperlink.

DHCF shall revalidate all enrolled suppliers of DME/POS every three (3) years, and all other Medicaid providers every five (5) years, in accordance with 42C.F.R. § 455.414. The dates for revalidation of enrollment shall be calculated beginning on the date that the Director of DHCF, or a designee, signs the Provider Agreement.

DHCF shall review an Applicant's signed and finished Application within thirty (30) business days from the date it was received by DHCF. DHCF shall return the provider application package to the Applicant when DHCF determines the provider application package to be incomplete or to contain incorrect information. DHCF shall allow resubmission for incomplete or incorrect information a maximum of two (2) times within the same twelve (12) month period.

An Applicant shall be classified according to the following risk categories:

- High (subject to the screening requirements described in § 9404).
- Moderate (subject to the screening requirements described in § 9405); or
- Limited (subject to the screening requirements described in § 9406).

Providers or suppliers who are classified as "Moderate Risk" or "High Risk" shall be required to attend an orientation session before signing the Medicaid Provider Agreement.

5.4.1 How Track the Status of Your Enrollment Application

- Log into your account in the www.dcpdms.com Web Portal
- On your Provider Management Home page, you can view the “status” of your application in the “My Provider” section. See example below.

My Providers

Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	Location	Effective Date	Submit Date	Re-Enrollment Due Date
DC DDS	Approved	IDDD Waiver			Case Management	20007 - 3717		09/22/16	
Diet Ician	Approved	IDDD Waiver		111114028	Employment Readiness	20007 - 3717	09/22/16	09/22/16	09/22/19
Test DDS Deny	Denied	IDDD Waiver			Case Management	20007 - 3717		09/22/16	

5.4.2 Screening Providers or Suppliers Classified As "High Risk"

Pursuant to 42 C.F.R. § 455.450, the following provider and supplier types shall be classified within the "High Risk" category:

- Home Health Agencies ("HHAs") and
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") suppliers.

Screening for providers or suppliers classified as "High Risk" shall include the following:

- Verification that the provider or supplier meets requirements set forth in the D.C. Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 et seq.) and implementing rules, as well as all other applicable Federal and District laws and regulations.
- Verification of appropriate licensure, including licensure in states other than the district, in accordance with 42 C.F.R. § 455.412.
- Both pre- and post-enrollment database checks to ensure the provider or supplier continues to meet the enrollment criteria that corresponds to its provider or supplier type, in accordance with 42 C.F.R.§ 455.436.
- On-site visits were conducted in accordance with 42 C.F.R. § 455.432.
- Criminal background checks, pursuant to 42 C.F.R. § 455.434; and
- Submission of fingerprints, pursuant to 42 C.F.R. § 455.434, for all providers or individuals who maintain a five percent (5%) or greater ownership interest in the provider or supplier.

5.4.3 Screening Providers or Suppliers Classified As "Moderate Risk"

Pursuant to 42 C.F.R. § 455.450, the following provider and supplier types shall be classified within the "Moderate Risk" category:

- Community Mental Health Centers ("CMHCs").
- Hospices.
- Home and Community Based Services ("HCBS") Waiver providers.
- Intermediate Care Facilities for Individuals with Intellectual Disabilities ("ICFs/IID"); and
- Pharmacies.

Screening for providers or suppliers classified as "Moderate Risk" shall include the following:

- Verification that the provider or supplier meets requirements set forth in the D.C. Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 et seq.) and implementing rules, as well as all other applicable Federal and District laws and regulations.
- Verification of appropriate licensure, including licensure in states other than the district, in accordance with 42 C.P.R. § 455.412.

- Both pre- and post-enrollment database checks to ensure the provider or supplier continues to meet the enrollment criteria that corresponds to its provider or supplier type, in accordance with 42 C.P.R.§ 455.436; and
- On-site visits were conducted in accordance with 42 C.P.R. § 455.432.

5.4.4 Screening Providers or Suppliers Classified As "Limited Risk"

Pursuant to 42 C.P.R. § 455.450, any provider or supplier not designated as "Moderate Risk" or "High Risk" under §§ 9405 and 9404, shall be classified within the "Limited Risk" category. Screening for providers or suppliers classified as "Limited Risk" shall include the following:

- Verification that the provider or supplier meets requirements set forth in the D.C. Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 et seq.) and implementing rules, as well as all other applicable Federal and District laws and regulations.
- Verification of appropriate licensure, including licensure in states other than the district, in accordance with 42 C.P.R. § 455.412; and
- Both pre- and post-enrollment database checks to ensure the provider or supplier continues to meet the enrollment criteria that corresponds to its provider or supplier type, in accordance with 42 C.P.R.§ 455.436.

5.4.5 Crossover Only Providers

Providers who are interested in rendering QMB beneficiaries must enroll in the DC Medicaid program. The enrollment process involves completing a provider application and submitting all required documents, including all applicable licenses and/or certifications, a W-9 form, and the Medicaid provider agreement. Please note that participation in this program is limited to rendering services to QMB enrollees only.

5.4.6 Ordered or Prescribed Services

DC Medicaid will pay for compensable services or items prescribed or ordered by a practitioner only if they are ordered within the scope of DC Medicaid regulation and good medical practice. Items prescribed or ordered solely for the patient’s convenience or that exceed medical needs are not compensable. Payment may not be made for items or services prescribed or ordered by providers who have been terminated from the DC Medicaid Program.

5.5 Enrollment Application Approval

MAXIMUS will notify applicants by emailing a Welcome Letter when the provider is approved for participation in the DC Medicaid program. The Welcome Letter is issued to the provider’s primary contact email address (or correspondence address, if a paper application is submitted).

The Welcome Letter notifies the provider of the nine-digit Medicaid Provider ID that is used to submit claims. After the provider is approved, billing instructions and forms are available on the Medicaid Web Portal at www.dc-medicaid.com.

A provider who has been approved is eligible to be reimbursed only for services furnished on or after the effective date of the enrolled provider’s executed agreement with DHCF and only for eligible services. The effective date is determined by the date the application is approved except in extenuating circumstances.

6 REGULATIONS

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

An overview of the regulations governing provider activities follows.

6.1 Beneficiary Freedom of Choice of Providers

A beneficiary may obtain services from any institution, agency, or pharmacy, medical professional or medical organization that has an agreement with DHCF to provide those services. Therefore, there will be no direct or indirect referral arrangements between physicians and other providers of health care services, which might interfere with a beneficiary's freedom of choice. This is not intended to prohibit a physician from recommending the services of another provider, but does prohibit automatic referrals between providers, which could interfere with the beneficiary's freedom of choice.

6.2 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 regulations at 45 CFR Parts 80 and 84. DHCF ensures that no individual shall be subjected to discrimination under this plan on the grounds of race, color, national origin, or handicap.

6.3 Interrelationship of Providers

Providers are prohibited from referring or soliciting beneficiaries 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, recommending purchasing, 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, if the price is properly disclosed and appropriately reflected in the costs claimed or charges made by a practitioner.

6.4 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 beneficiaries. These records must meet all the criteria established by federal and District regulations. 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. If DHCF terminates an agreement with a provider, the records relating to services rendered up to the effective date of the termination remain subject to the requirements stated in this manual.

6.4.1 Medical Records

Providers who have examined, diagnosed, and treated a beneficiary, shall maintain individual beneficiary records that include, but are not limited to the following:

- Are legible throughout and written at the time services are rendered.
- Identify the beneficiary on every page.

- Are signed and dated by the licensed provider responsible. All care by ancillary personnel must be countersigned by the licensed provider responsible. Any alterations to the record must be signed and dated.
- Contains a preliminary working diagnosis as well as final diagnosis, including elements of history and physical examination upon which the diagnosis is based.
- Document in compliance with the service definitions and descriptions found in Physicians' Current Procedural Terminology (CPT), ICD-9/10, HCPS, CTD, Axis I
- Reflect treatments as well as the treatment plan.
- List quantities and dosages of drugs or supplies prescribed as part of the treatment and wellbeing of the patient.
- Indicate the progress of the beneficiary at every visit, the change of the diagnosis, the change of treatment, and the response to the treatment.
- Contain summaries of all referrals, hospitalizations, and reports of operative procedures
- Contains the results of all diagnostic tests and reports of all consultations.
- Reflect the disposition of the case.

6.4.2 Cost Reporting

Each participating facility shall submit an annual cost report to the Medicaid Program within ninety (90) days of the close of the provider's cost reporting period, which shall be concurrent with its fiscal year used for all other financial reporting purposes. The following provider types participating in the DC Medicaid program must submit annual cost reports.

- Intermediate Care Facilities
- DC Public Schools
- DC Chartered Schools
- Federally Qualified Health Centers
- Hospitals
- Long Term Care Facilities

A delinquency notice shall be issued if the provider does not submit the cost report on time and has not received an extension of the deadline for good cause. If the cost report is not submitted within thirty (30) days of the date of the notice of delinquency, twenty percent (20%) of the facility's regular monthly payment shall be withheld each month until the cost report is received.

Cost reports shall be properly completed in accordance with program instructions and forms and accompanied by supporting documentation required by the Medicaid Program. All cost reports shall cover a twelve (12) month cost reporting period, which shall be the same as the facility's fiscal year, unless the Medicaid Program has approved an exception.

Each facility shall maintain sufficient financial records and statistical data for proper determination of allowable costs.

Each facility's accounting and related records, including the general ledger and books of original entry, and all transaction documents and statistical data, are permanent records and shall be retained for a period of not less than five (5) years after the filing of a cost report or until the Notice of Final Program Reimbursement is received, whichever is later.

6.4.3 Fiscal Records

Providers shall retain for a minimum of 10 years all fiscal records relating to services rendered to and not limited to DC Medicaid beneficiaries. This may include, but is not limited to, purchase invoices, prescriptions, the pricing system used for services rendered to patients who are Medicaid eligible, and payments made by third-party payers.

6.4.4 Disclosure of Information

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 regulations of the Department of Health and Human Services and the DC Medicaid program.

6.4.5 Penalties for Non-Compliance

DHCF may terminate agreements with providers who fail to maintain and provide medical and fiscal records as described in the Provider Agreement. If a District or Federal review shows that DHCF paid for services that a provider failed to document as required by the provider's agreement, said provider can be subject to termination pursuant to DC Medicaid rules and regulations.

If DHCF finds, prior to paying a claim, that a service is not fully documented by the provider (cited in provider's medical records), payment shall not be made.

6.5 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 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 refers 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.

If 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).

An 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 ultimately 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.

6.6 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.

6.7 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.

6.8 Quality Assurance Program for DC Medicaid Managed Care

DHCF is responsible and accountable for all quality assurance activities implemented by the Department's Quality Assurance Program. Components of this Quality Assurance Program are as follows:

- DHCF's internal quality assurance plan will include the tracking and monitoring of provider utilization, the monitoring of program goals and objectives and fraud surveillance.
- Quality Improvement Organization (QIO) contracted with DHCF to perform retrospective claim audit, pre-authorization of specific services and review of DRG outliers.
- External Auditor contracted with DHCF to conduct quality review surveys of the DC Medicaid Program

The process of quality assurance is not complete without the documentation and dissemination of findings and results. All entities, both internal and external to the Department are charged with scrutinizing the quality of health care rendered to Medicaid beneficiaries. All providers participating in the DC Medicaid Program are required to comply with the reporting standards established by the Department. Participating providers shall receive periodic reports detailing quality assurance findings. Action shall be taken against providers that fall outside the norm and cannot provide adequate explanation of these deviations.

6.9 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.

6.10 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 contacts:

Department of Health Care Finance
Division of Program Integrity
441 Fourth Street, NW Washington, D.C. 20001
Telephone Number: 202 698-1718

Hotline Phone Number: 1-877-632-2873
https://www.dc-medicaid.com/dcwebportal/nonsecure/reportFraud

7 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 provide training on compliance requirements and cultural competencies. 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 work 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.

7.1 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.

7.2 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.

7.2.1 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 period, there is no guarantee that an interpreter will be available. However, urgent requests may be fulfilled depending on the subject on an interpreter's availability

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

- AmeriHealth Caritas DC Provider Services: 202-408-2237 or 1-888-656-2383
- Wellpoint District of Columbia (formerly 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

8 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.):

8.1 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 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.

8.2 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 are more than the beneficiary's needs or that fail to meet professionally recognized standards for health care.

8.2.1 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

8.2.2 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.

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

8.4 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 A.

8.4.1 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

9 BENEFICIARY ELIGIBILITY

This subsection provides an overview of beneficiary eligibility.

9.1 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 linked to the Interactive Voice Response (IVR), making it readily available to providers.

9.2 Individual Eligibility

Individuals may be eligible for DC Medicaid by either qualifying under a “categorically needy” program or by meeting the conditions to be considered “medically needy.” Categorically needy programs include Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), and refugee programs. Medically needy beneficiaries are those who do not qualify for cash benefits under a categorical program but meet the criteria to qualify as a medically indigent Medicaid beneficiary. The DC Medicaid Program does not cover medically indigent persons who are not eligible under a category that entitles receipt of federal financial participation. Following is a more specific list of groups eligible in the DC Medicaid Program:

1. Persons determined to be eligible for a grant through the TANF program.
2. Pregnant (medically determined) women who would be eligible for TANF if the child were born and living with the mother.
3. Pregnant women and infants up to one year of age with family incomes up to 185% of the federal poverty level
4. Persons who are age sixty-five or over, blind, or disabled, and who receive Supplemental Security Income (SSI) grants.
5. Person who are sixty-five or over or disabled and who meet more restrictive requirements than SSI.
6. Persons who would qualify for SSI except for certain Social Security cost-of-living increases.
7. Persons in medical facilities who, if they left such facilities, would qualify for SSI except for income.
8. Persons who have become ineligible for Medicaid who are enrolled in an HMO that is qualified under Title XIII of the Public Health Service Act
9. Persons who would be eligible for TANF if their work-related childcare costs were paid from earnings rather than by a government agency.
10. Children in licensed foster care homes or private childcare institutions for whom public agencies are assuming fiscal responsibility.
11. Children receiving subsidized adoption payments.
12. Persons who receive only a supplemental payment from the district
13. Certain disabled children aged eighteen (18) or under who live at home but would be eligible if they lived in a medical institution.
14. Pregnant women and children up to age five who are under 100% of the federal poverty level.

9.3 Eligibility Identification

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

9.3.1 Medical Assistance Card

When first determined eligible, each Medicaid beneficiary receives a paper Medical Assistance Card from the Economic Security Administration 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

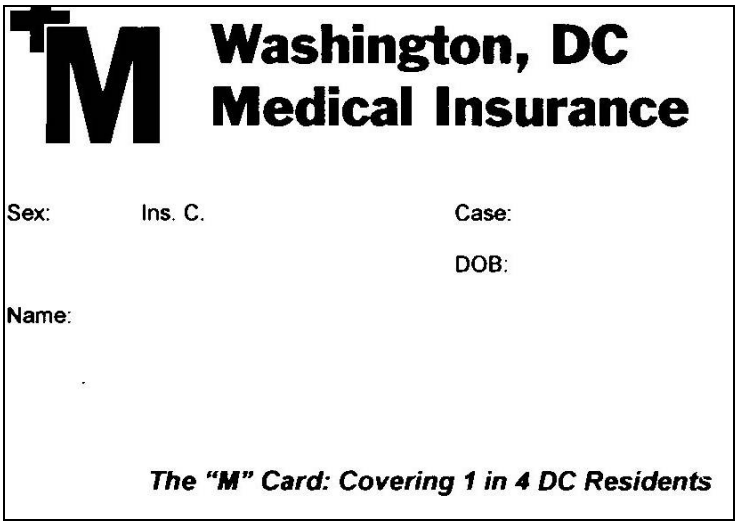
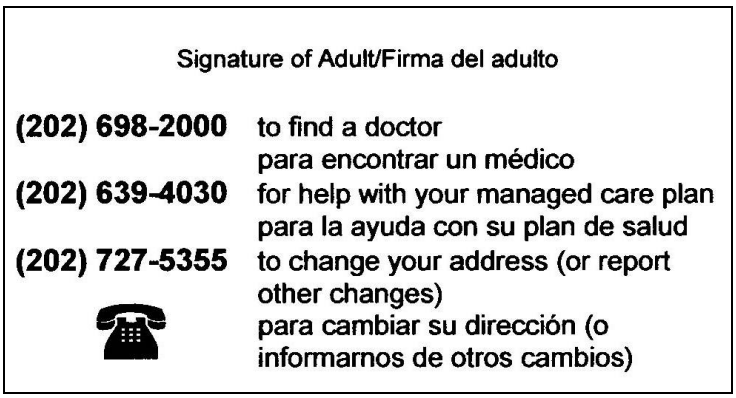


Figure 2: Medical Assistance Card – Back Image



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

9.3.2 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 DCAS determines her ongoing Medicaid eligibility. 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 ESA. The Interactive Voice Response (IVR) will then respond, "Medicaid Eligible," and claims may be submitted to Conduent. The address is listed in Appendix A. If you have questions concerning claim submission, please contact the Provider Relations Department at Conduent; questions regarding eligibility determinations should be directed to the Economic Security Administration. The addresses and telephone numbers are included in Appendix A.

9.3.3 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 to 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.

9.4 Provider Responsibility

The provider is responsible for the following eligibility verification activities.

9.4.1 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 A) 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 DCAS, which is operated by the Office of Information Systems.

9.4.2 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.

9.4.3 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.

9.4.4 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.

9.4.4.1 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

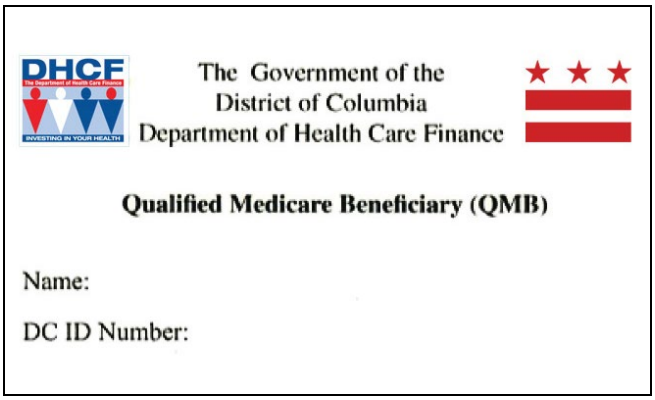
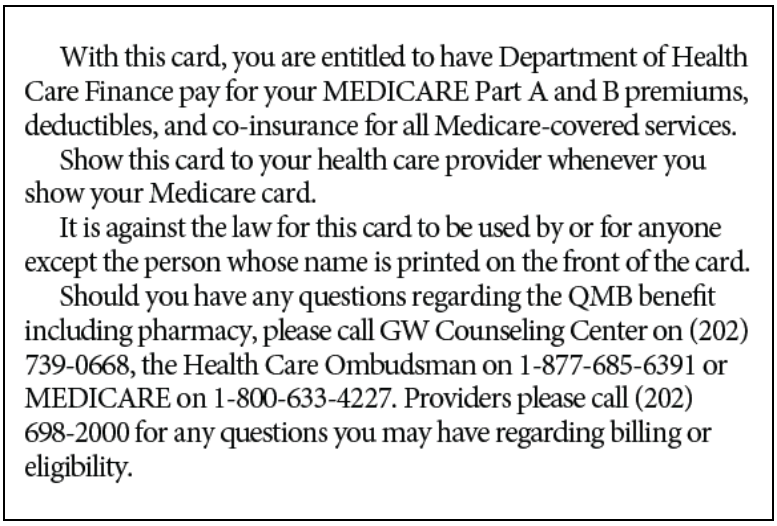


Figure 4: QMB Medical Assistance Card – Back Image


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.

9.4.4.2 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.

9.4.4.3 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.

10 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.

10.1 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, claim 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.

10.2 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:

- 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 (08/05), 2006 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.

10.3 Transaction Control Number

The transaction control number (TCN) is a unique tracking number assigned to each accepted claim. Rejected claims, submitted hard copy (Refer to the above Section 8.2 for list of reasons for claim rejection reasons) 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.

The TCN consists of 17 numeric digits. The TCN structure is as follows:

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)

10.4 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.

10.5 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.

10.5.1 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.

10.5.2 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.

10.5.3 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 be suspended 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 not give a reason.

10.6 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.

11 BILLING INFORMATION

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

11.1 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

11.1.1 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.

11.1.2 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 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 A for address and contact information.

11.2 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 pending 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 A.

11.3 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 A 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.

11.4 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.

11.5 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.

11.6 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 pending claim will result in claims denying for duplicate.

Telephone and/or written claim inquiries regarding non-payment of claims should be made 45 days after 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.
- 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 claim denied 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 A.

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).

11.7 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 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 A.

12 REIMBURSEMENT

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

12.1 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.

12.2 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 particular 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

12.3 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 A. Telephone inquiries will be directed to Conduent (the telephone number is included in Appendix A).

12.4 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.

12.4.1 Benefit Programs

Providers must make reasonable efforts to obtain sufficient 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.

12.4.2 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.

12.5 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.

12.6 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 items 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 2: 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.

12.7 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.

12.7.1 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.

12.7.2 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.

12.7.3 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.

13 Medical Review

The Office of the Medical Director's mission is to continuously improve safety, effectiveness, patient-centeredness, timeliness, efficiency, and equality of health care received by individuals served by DHCF programs. The Department of Health Care Finance conducts medical necessities, prior authorization reviews, and individual consideration determinations. The Medical Director's office is responsible for prior authorization procedures for organ transplantations which include:

- Liver transplantation
- Heart transplantation
- Kidney transplantation
- Allogeneic bone marrow transplantation
- Lung transplantation
- Autologous hematopoietic stem cell transplantation
- Left ventricular assist device (LVAD)

13.1 Consent for Sterilization

The Consent for Sterilization form is required of all providers involved in the sterilization procedure. The Consent for Sterilization form has four parts (listed below) that should be completed and submitted with the claim when billing for reimbursement.

- Consent to Sterilization
- Interpreter's Statement (if applicable)
- Statement of person Obtaining Consent
- Physician's Statement

Some general guidelines when filing sterilization claims:

- The beneficiary must be 21 years old when the consent form is signed.
- The consent form is valid for 180 days from the date it was signed by the patient.
- There must be at least a 30-day waiting period between the date the beneficiary signs the form and the date of surgery. If an emergency arises, the sterilization may be performed after 72 hours have elapsed from the time the beneficiary signed the form.

If information is incorrect or if the most current sterilization form is not completed the claim will be denied.

The most current consent form is available at CMS (https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf) or on the Web Portal at www.dc-medicaid.com under Provider Information and Forms.

14 PRIOR AUTHORIZATION

Procedures to follow for prior authorization are described in this section.

14.1 Written Request

DHCF requires written prior authorization for some medical services. If a service or item requires prior authorization, the provider must submit a Prior Authorization Request/Approval to DHCF. If DHCF approves the request, the provider will receive a prior authorization number. If DHCF denies the request, the service or item will not be considered for reimbursement.

Written prior authorization is required for the following:

- Services provided by an out-of-District non-participating DME vendor.
- Durable medical equipment is more than $500.00
- Medical supplies more than specific limitations
- Inpatient hospitalizations for medically necessary dental procedures (cosmetic procedures are not covered services)
- Prosthetic or orthotic appliances more than specific limitations

14.2 Verbal Request

DHCF will give verbal prior authorization for some medical services. If DHCF grants a verbal prior authorization, the provider will be given a prior authorization number. If DHCF denies verbal prior authorization, the service or item will not be considered for reimbursement. Non-emergency transportation services refer to the DHCF transportation broker. (Refer to Appendix A for-contact information.)

14.3 Authorization Waiver

All prior authorization requirements are temporarily waived in emergency situations. A situation is considered an emergency if an item or service is critical to the health, or required to sustain the life of the beneficiary. When the emergency ends, the provider must adhere to prior authorization requirements.

14.4 Authorization Procedures

After the Prior Authorization Request/Approval form has been completed, the form should be mailed to the address listed in Appendix A.

If DHCF has reviewed and approved the request, a prior authorization number will be assigned to the respective service or item. This number must be included in the appropriate block on the claim form. The completed claim form should be submitted through regular procedures to Conduent as listed in Appendix A.

15 DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND ORTHOTICS SPECIFIC BILLING INSTRUCTIONS

15.1 Clinic Eligibility Criteria

The Department of Health Care Finance (DHCF), the single state agency for the administration of medical assistance programs authorized under Titles XIX and XXI of the Social Security Act, shall ensure the provision of durable medical equipment, prosthetics, orthotics, and supplies (DME/POS) to qualified Medicaid beneficiaries in accordance with the requirements of this section and the D. C. Medicaid DME/POS Provider/Supplier Billing Manual. All providers/suppliers of DME/POS shall be enrolled as such by DHCF in accordance with Provider and Supplier Screening and Enrollment regulations and policies and § 996 of Title 29 District of Columbia Municipal Regulations (DCMR). Information regarding enrolled providers and suppliers may be obtained by contacting dhcf.providerenrollment@dc.gov.

To be eligible for Medicaid reimbursement, the delivery of DME shall be subject to the following requirements:

DME shall include equipment that:

- Can withstand repeated use.
- Is primarily and customarily used to serve medical purposes.
- Generally, not useful to a beneficiary in the absence of illness or injury; Is appropriate for use.
- in the beneficiary's home; and
- Is expected to have a useful life of at least three (3) years.

DHCF shall ensure that each Medicaid beneficiary retains his/her freedom of choice of DME/POS providers/suppliers, in accordance with 42 C.F.R. § 431.51.

For a beneficiary to receive DME/POS, the following requirements shall be met:

- The cost of the item shall be reasonable.
- The item shall be prescribed by a physician or other licensed practitioner of the healing arts operating within the scope of practice allowed under the District of Columbia Health
- Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 et seq.) and implementing rules, as well as all other applicable Federal and District laws.
- The prescribing clinician shall be enrolled as a provider in the District of Columbia Medicaid
- Program; and
- The prescribing clinician and DME/POS provider/supplier shall provide their National Provider Identification (NPI) numbers on the prescription, DME/POS Request and Prior Authorization Form (Form 7I9(A)), and claim.

The prescribing clinician shall ensure that Form 719(A) and any supporting documentation describe the beneficiary's condition and include, at minimum:

- The diagnosis related to the need for the DME/POS item.
- Any complicated medical conditions.

- A description of functional abilities and limitations, using assessments based on the standards described in § 997.8.
- The anticipated duration of the condition.
- Physical examination findings; and
- The potential for rehabilitation, if applicable.

For a beneficiary ages birth through twenty-one (21), who is entitled to the early and periodic screening, diagnosis, and treatment (EPSDT) benefit, covered items shall be limited to DME/POS that is included within the scope of the definition set forth in Section 1905(r) of the Social Security Act (42 U.S.C. §1396d(r)).

The information in this handbook is intended to assist providers with the billing of durable medical equipment covered by the DC Medicaid Program. To ensure accuracy of payment, providers are required to use the ICD-10 CM and HCPCS coding systems to indicate the appropriate diagnosis code associated with the supplies and/or equipment requested. In addition to the medical justification narrative provided in block 13 of the Prior Authorization Approval/Request 719(A) Form, a Certificate of Medical Necessity (CMN) letter is also required.

15.2 Covered Services

DHCF complies with CMS rules that govern the coverage of required services related to medical supplies and equipment. The major components of the rules are listed below:

- Reimbursement rates will be determined by DHCF annually. This method will only apply to those services that do not vary significantly in quality from one supplier to another.
- Reimbursement for items and services that are not covered by Medicare will be at the vendor's usual and customary charge, the prevailing charge, or the Medicaid fees schedule as determined by DHCF, whichever is less.
- Reimbursement for items or services that are covered by both Medicare and Medicaid but not subject to the lowest charge, will be reimbursed at not more than the reasonable charges established under Medicare Part B
- Reimbursement for the repair of equipment is only allowable for purchased equipment and shall not exceed 75% of the purchase price of the equipment listed in the DHCF fee schedule.
- Reimbursement for routine maintenance on rented equipment is not covered.
- Reimbursement for extensive repairs on purchased equipment which must be performed by an authorized technician is covered as a repair if billed by the supplier after receiving prior authorization.
- Reimbursement is allowed for rental or purchased equipment but must be prior authorized if indicated in the fee schedule.
- Reimbursement for construction as part of installation is not allowed.

15.3 Specific Coverage Criteria and Provider Procedures

15.3.1 Oxygen and Oxygen Equipment

Coverage of home oxygen and oxygen equipment will be considered reasonable and necessary only for patients with significant hypoxemia who meet medical documentation, laboratory evidence and health conditions. Prior authorization is required for the reimbursement of oxygen and oxygen equipment.

While there is no substitute for oxygen therapy, it is appropriate that each patient should receive optimum therapy before long-term home oxygen therapy is ordered. The physician must have examined the patient

recently (within 30 days of the start of therapy). Coverage is not allowed for oxygen order 'PRN' or "as needed". When oxygen is ordered 'PRN', there is no basis for determining if the amount of oxygen is reasonable and necessary for the patient.

Coverage is available for patients with significant hypoxemia in the chronic stable state if the following three conditions are met:

1. The attending authorized prescriber has determined that the patient has the following health condition:
    - A severe lung disease, such as chronic obstructive pulmonary disease (COPD), diffuse interstitual lung disease, whether of known or unknown etiology; cystic fibrosis bronchiectasis; widespread pulmonary neoplasm; or
    - Hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy. Examples of these symptoms and findings are pulmonary hypertension, recurring congestive heart failure (CHF) due to chronic corpulmonale, erythrocytosis, impairment of the cognitive process, nocturnal restlessness, and morning headache.

Conditions for which oxygen therapy is NOT covered:

- Angina pectoris I the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
- Breathlessness without corpulmonale or evidence of hypoxemia. Although intermittent oxygen use is sometimes prescribed to relieve this condition, it is potentially harmful and psychologically addicting.
- Severe peripheral vascular disease resulting in clinically evident denaturation in one or more extremities. There is no evidence that increased PO2 will improve the oxygenation of tissues with impaired circulation.
- Terminal illnesses that do not affect the lungs.
- Treatment of headache, including migraine
- Treatment of other health care conditions in which oxygen therapy is determined to be experimental or investigational.

2. The patient meets the blood gas evidence requirements in Group I-III:
    A) GROUP I: Coverage is provided for patients with significant hypoxemia evidenced by any of the following:
        - An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken at rest, breathing room air (an oxygen saturation at or below 94% is an acceptable level for children).
        - An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken during sleep from a patient who demonstrates an arterial PO2 at or above 56 m Hg or an arterial oxygen saturation at or above 89%, while awake; or a greater than normal fall in oxygen level during sleep (a decrease in arterials oxygen saturation more than 5%) associated with symptoms or signs attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia). In either of these cases, coverage is provided only for nocturnal use of oxygen. For children, the arterial oxygen saturation levels would be at or below 94%, taken during sleep from a patient who demonstrates arterial oxygen saturation at or above 95% while awake.
        - An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 8% taken during exercise for a patient who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, while at rest. In this case, supplemental oxygen is provided during exercise if there is evidence that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air. For children, the arterial oxygen

saturation levels would be at or below 94%, taken during exercise for a patient who demonstrates arterial oxygen saturation at or above 95%, while at rest.

B) GROUP II: Coverage is available for patients whose PO2 is 56-59 mm Hg or whose arterial blood oxygen saturation is 89%, if there is evidence of:

- Dependent edema suggesting corpulmonale.
- 'P' pulmonale on EKG (P wave greater than 33 mm in standard leads II, III, or AVF).

or

- Erythrocythemia with a hematocrit greater than 56%.

C) GROUP III: Coverage of home oxygen must be prior authorized by DC Medicaid for patients with arterial PO2 levels at or above 60 mm Hg or whose arterial blood oxygen saturation is at or above 90% (except for children whose saturation can be at or below 94%). The authorized prescriber must submit documentation, which specifies why oxygen is medically necessary documentation.

3. The patient has appropriately tried other alternative treatment measures without demonstrable success or other forms of treatment have not been tried but oxygen therapy is needed as part of the patient's initial treatment.

Any patient who does not meet the criteria specified above may be allowed coverage only if the oxygen request is prior authorized and the authorized prescriber is able to demonstrate that there is a medical risk that the patient's condition could be complicated by his or her withdrawal from oxygen, and if the attending authorized prescriber certifies that there is a continuing medical need for the patient to receive oxygen.

DC Medicaid will not provide reimbursement for respiratory/oxygen equipment and supplies, which do not meet existing clinical and medical standards of care. Further, DC Medicaid will not provide reimbursement for oxygen and equipment which is not being used by the beneficiary, regardless of the medical need. The DME/POS provider must monitor utilization and report, in writing, to the authorized prescriber when oxygen is not being used as prescribed. Additionally, the DME provider must provide written notification to DC Medicaid, which shows that either the patient has resumed compliance with medical orders or continues to be non-compliant. If non-compliance continues, DC Medicaid will notify the patient that coverage of the oxygen will cease and the effective date.

The attending authorized prescriber who requests the oxygen may specify the type of oxygen delivery system to be used (i.e., gas, liquid, or concentrator). If the type of system is not specified, the vendor must provide service `in the most cost-effective manner to carry out the authorized prescriber's order and meet the needs of the patient.

A complete assessment of the need for continuing oxygen therapy must be completed within six weeks of therapy if the patient's blood gas levels are initially above the levels specified under health conditions.

DC Medicaid reimburses for an oxygen set-up based upon the amount of oxygen used, prescribed liter flow rate and whether humidification is used. The rate does not vary according to the type of oxygen system: concentrator, liquid system, or gaseous system. The reimbursement is for monthly rental of the system (with or without humidification), which includes:

- Oxygen set-up
- Nasal Cannulas
- Extension Tubing
- Bubble bottle for humidification, if needed

15.3.2 Ventilators

Ventilators are covered items when ordered by an authorized prescriber and prior authorized by the DC Medicaid Program.

15.3.3 Suction Machines

Suction machines are covered by DC Medicaid for any individual who has a tracheotomy or who cannot swallow his or her own secretions. Suction machines will only be rented when the clinical documentation indicates that the expected length of use is three months or less. Otherwise, the machine will be purchased. If a back-up portable suction machine is required, it will include the cost of one set of tubing, two collection jars, a battery, and a charger. Supplies can be purchased as necessary according to the limits on the DHCF fee schedule. Rental includes the cost of the rental of the machine and a portable back up, tubing, collection jars, a battery, and a charger. Another code should be used for the back-up portable suction machines.

15.3.4 Humidification Systems

DC Medicaid will reimburse for an aerosol humidification system when the patient's upper airway is bypassed and for a vapor phase system when the patient is on a ventilator. The components of the aerosol system are:

- Reusable Dry Nebulizer
- Water Trap
- Compressor
- Swivel Adapter
- Corrugated Tubing

A disposable dry Nebulizer will only be allowed for patients for whom it is expected that the need for the humidification system will be short-term as it is expected that the tracheotomy will be closed.

A vapor phase humidification system will only be authorized for individuals who are on a ventilator when there is documented evidence that the use of the vapor phase is medically necessary rather than a matter of convenience to the caregiver.

A humidification system can only be purchased except in those instances where the individual is expected to require humidification for less than nine months.

15.3.5 Lymphedema Pumps

Lymphedema Pumps are covered only for patients with intractable Lymphedema (accumulation of excessive lymph fluid resulting from an occlusion of lymphatic vessels) of the extremities.

A non-segmental Lymphedema pump (E0650) is a device, which has a single outflow port on the compressor, which produces a level set of pressure. The fact that the air from the single tube may be transmitted to a sleeve/appliance with multiple compartments or segments does not affect the coding of the compressor.

A segmental Lymphedema Pump (E0651, E0652) is a device, which has multiple outflow ports on the compressor, which leads to distinct segments on the appliance, which inflates sequentially. A segmental pump that creates the same pressure (E0652) is further characterized by a regulator on each outflow port, which can deliver an individually determined pressure to each of several segments. The fact that the tubing and/or appliance can achieve a pressure gradient does not classify the compressor as E0652 because this is not a calibrated gradient pressure.

This condition is a relatively infrequent medical problem. Covered causes of Lymphedema include:

- Spread of malignant tumors with lymphatic obstruction

- Radical surgical procedures with removal of regional groups of lymph nodes (i.e., after radical mastectomy)
- Post radiation fibrosis
- Scaring of lymphatic channels
- Congenital anomalies
- Essential Lymphedema (Milroy's Disease).

A lymphedema pump is covered for a patient with intractable lymphedema of one or more extremities. The physician must have evaluated the patient's condition and determined the medical necessity of the device. The physician must specify the pressure to be used, the frequency and duration of use.

15.3.6 Blood Glucose Monitors

Home blood glucose monitors are covered for patients who are diagnosed with diabetics and will better control their blood glucose levels by frequently checking these levels and appropriately contacting their attending physician for advice and treatment. The medical justification should document the need for monitoring blood glucose.

A blood glucose monitor with special features is covered for patients who additionally have severe vision impairment (20/200). Coverage of home blood glucose monitors is limited to patients meeting the following conditions:

- The patient's physician states that the patient is capable of being trained to use the device in an appropriate manner. In some cases, the patient may not be able to perform this function, but a responsible family member can be trained to use the equipment and monitor the patient to ensure that the intended effect is achieved. This is permissible if the record is properly documented by the patient's physician.
- The device is designed for homes rather than clinical use.

15.3.7 Medical Alert Devices and Services

DHCF has established Medicaid coverage and reimbursement for medical alert services and devices under the home health benefit of the Medicaid State Plan. Medical alert devices and services will include coverage of personal emergency response system (PERS) devices and services, as well as medication management devices (MMD) and services. Addition of coverage of medical alert devices and services under the State Plan aligns with changes DHCF is proposing to the district's 1915(c) Home and Community Based-Services Waiver for the Elderly and Persons with Physical Disabilities effective October 1, 2020.

This policy change takes effect on October 1, 2020, the effective date established in the corresponding State Plan amendment, which was approved by the Centers for Medicare and Medicaid Services on September 30, 2020. The regulations governing the scope, coverage, and duration of DME services can be found in 29 DMCR 997. DHCF is also amending program rules by adding chapter 998 MEDICAL ALERT DEVICES AND SERVICES governing the scope, coverage, and duration of services.

Service Description	Procedure Code	Modifier	Notes	Rate Effective October 1, 2020
PERS – Installation	S5160	[None]	Single-unit installation at the outset of services (generally one-time across the life of services, unless there's a lapse)	$45.00
PERS – Services	S5161	[None]	Monthly rate for monitoring and services, including repairs or replacements of equipment	$35.00
MMD – Installation	T1505	U1	Single-unit installation at the outset of services (generally one-time	$40.00

			across the life of services, unless there's a lapse)	
MMD – Services	T1505	U2	Monthly rate for monitoring and services, including repairs or replacements of equipment	$50.00

Refer to Transmittal #20-35 for additional information.

15.4 Non-Covered DME/POS

Equipment that is NOT covered under the DC Medicaid DME/POS program may be covered under the District's EPSDT (Early and Periodic Screening, Diagnosis and Treatment) program for children under 21. Except for items deemed necessary under the EPSDT benefit, the following shall not be covered under the D.C. Medicaid DME/POS benefit:

- Replacement of an item while it is still under warranty or before the item meets the associated life expectancy unless prior authorization is obtained.
- Ventilators.
- Acquisition, maintenance, or repair of DME, prosthetic, and orthotic items that do not require prior authorization or are for general use in an institutional provider facility where a beneficiary resides.
- Consumable medical supplies for general or non-beneficiary specific use in intermediate care facilities for individuals with intellectual disabilities (ICF/IDD).
- Items solely for comfort and convenience of the beneficiary or his/her caregivers, such as air conditioners.
- Home or vehicle modifications that may be covered under waiver programs operating pursuant to Section 1915(c) of the Social Security Act.
- Rehabilitative equipment, for beneficiaries aged twenty-two (22) and up, is designed to bring a beneficiary into an upright position to stimulate vestibular function or balance.
- Items that are not suitable for, or are not primarily used in the home setting, including, but not limited to, car seats and non-rehabilitative strollers; and
- Supplies and other DME items used by personnel of a home health agency during a home visit.

15.5 Rental and Purchase Guidelines

Rental equipment is meant for short-term use when beneficiary needs are expected to change, or the beneficiary is expected to recover. When usage is anticipated to be long-term and the beneficiary's need is not expected to change, the items must be considered for purchase. Most items can be rented for a short time with authorization. An extension may be requested if the continued use is expected to be short-term. If it is determined through DHCF utilization review activities that a rented item should have been purchased, DC Medicaid will only provide reimbursement up to the established purchase price. DC Medicaid rental items are rented in thirty (30) day periods up to six (6) months.

15.6 Repair and Replacement of Durable Medical Equipment

DME Medicaid policies governing the repair of DME vary by whether the DME is:

- For an individual residing in the community or in a facility
- Rented or purchased.
- Under warranty
- Customize or non-customized.

15.6.1 Repairs of Rentals

For rental DME, the DME rental fee covers the cost of maintenance and repair. Each DME provider must:

- maintain and repair directly any DME item(s) under rental to DC Medicaid fee-for-service (FFS) beneficiaries and
- Accept returns of substandard (less than full quality for a particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted/or sold) from beneficiaries.

In addition, all DME providers must immediately replace any broken, rented DME with DME in full working order.

15.6.2 DME under Warranty

When the repair of purchased equipment is needed, the DME provider must first look to receive repair by the manufacturer as specified in the manufacturer's warranty. When prior authorization for repairing equipment is requested, DHCF or its agent will always request a copy of the warranty on products received by the beneficiary 30 days or less prior to the submission date of the request for repair.

15.6.3 Customized versus Non-Customized DME

Customized DME is always purchased. Therefore, repair of customized DME is governed by the policies described for purchased DME. In addition, DHCF recognizes that repair of customized DME may require significant time, especially if it must be sent back to the manufacturer for repair. When customized DME must be sent back to the manufacturer, a DME provider must:

- Obtain from the manufacturer an estimate of the time it will take to repair and return to the DME.

This information should be provided to the Medicaid beneficiary and his/her parent or guardian as appropriate. This will help the beneficiary and any responsible parties to have expectations about when the DME will be returned to them.

- When the repair of customized DME requires that the DME be taken from the beneficiary (as opposed to repairing the item on the same day in the beneficiary's place of residence) the DME provider should replace the customized DME if needed or requested with DME that is as close as possible to the customized DME. In such instances, the DME provider should request, and DHCF or its prior authorization agent will give prior authorization for the rental of replacement DME until the repair of the customized DME is completed, in accordance with the policies governing rental equipment.

15.6.4 Repair and Replacement of DME When the Medicaid Fee-for-Service Beneficiary Resides in a Facility

In accordance with the rules governing nursing facility reimbursement (See Section 6512 of Chapter 65, Title 29 of the DCMR), and DC Medicaid Transmittal 01-31 issued on November 20, 2001, the acquisition, maintenance, and repair of non-customized DME is the responsibility of a nursing or intermediate care facility in which the Medicaid beneficiary resides. The repair and maintenance of customized, patient specific DME that has been purchased by the DC Medicaid FFS program for a beneficiary residing in a nursing or intermediate care facility is reimbursable by DC Medicaid. To receive reimbursement for repair of customized wheelchairs or other DME, facilities need to follow the instructions below related to the repair and replacement of DME for Medicaid beneficiaries residing in the community.

15.6.5 Repair and Replacement of DME When the Medicaid Fee-for-Service Beneficiary Resides in the Community

15.6.5.1 Purchased vs. Rental DME:

Reimbursement for the repair of equipment is only allowable for purchased equipment. Repairs of purchased DME must be prior authorized and billed using the following procedure code.

K0739: Repair or non-routine service for Durable Medical Equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes.

Prior authorization will be given if:

- The repair is not covered by the product's warranty. DHCF or its agent will request a copy of the warranty for repair requests on products received by the beneficiary 30 days or less prior to the submission date of the request for repair.
- Reimbursement for repairs shall not exceed 75% of the purchase price of the DME listed in the DHCF fee schedule.
- Replacement parts should be itemized separately with the appropriate descriptions, HCPCS code, and cost on the 719A Form used to request prior authorization.

DHCF will reimburse equipment rental when a beneficiary needs substitute DME while his/her DME is being repaired. Prior authorization requests for such rental will be approved in 6-month increments if: the rented device is medically necessary; the frequency of the rental is consistent with the HCPCS/CPT code definition; and the total cost to rent the product does not exceed the cost to purchase the product. Providers must cease billing for the replacement rental DME as soon as the repaired DME is returned to the Medicaid beneficiary.

15.7 Medical Necessity

Only supplies, equipment and appliances that are medically necessary are covered. "Medical Necessity" or "Medically Necessary Service" means medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of a health-related condition including services necessary to prevent a detrimental change in either medical or mental health status. Medically necessary services must be provided in the most cost effective and appropriate setting and should not be provided solely for the convenience of the member or service provider. ALL the following must be met for an item or service to be considered medically necessary. The supplies or equipment must be:
A reasonable and necessary part of the beneficiary's treatment plan

- Consistent with the symptoms, diagnosis or medical condition of the illness or injury under treatment
- Not furnished for the convenience of the beneficiary, family, attending practitioner or other practitioner or supplier
- Necessary and consistent with generally accepted professional medical standards (i.e., not experimental, or investigational)
- Established as safe and effective for the beneficiary's treatment protocol.
- Furnished at the most appropriate level that is suitable for use in the beneficiary's home environment.

15.8 Billing Issues

The DME provider may provide and be reimbursed for a supply item that the authorized prescriber has failed to order if this item is necessary to carry out the authorized prescriber's plan of treatment and is a component or auxiliary supply to another supply or piece of equipment for which there is a current authorized prescriber order. For instance, the authorized prescriber order or the plan of treatment states

"dressings" and includes gauze and sterile water, but not tape, on the 719(A) form. The DME provider may provide and be reimbursed for the tape used in the sterile dressings.

In another example, the authorized prescriber orders IV medications and includes an IV administration set with attachments and tubing on the 719(A) form. The DME provider will not be reimbursed for an infusion pump for the IV medication unless the authorized prescriber specifies the need for the pump on the 719(A) form. Any time the provider supplies items not listed on the 719(A) form, there is some risk that, upon utilization review, if the items are not clearly an integral medically necessary component of authorized prescriber-ordered treatments, the provider may be retroactively denied reimbursement. Either the 719 (A) form or the Prior Authorization form issued by DHCF are to be attached for billing with the CMS-1500 claim form.

Providers approved for participation in the Medicaid program must charge DC Medicaid for the provision of services and supplies to beneficiaries in amounts not to exceed the provider's usual and customary charges to the public. This means that even if the Medicaid established rates are higher than the provider's usual and customary charge, the provider must bill DC Medicaid no more than the usual and customary charge.

Supplies and equipment used during the home visit by personnel of the home health agency are not subject to separate reimbursement to the DME vendor by DC Medicaid. These kinds of expendable medical supplies (e.g., gauze, cotton, adhesive bandages, sphygmomanometer, scales, Foley catheter, etc.) are included in the Home Health Agency visit.

NOTE: The prescribing provider is still the authorizing official for requesting equipment, therapies and providing medical justification for requested durable medical equipment.

15.9 Individual Consideration (I/C)

15.9.1 Requests for Medical Equipment/Supply Not Specifically Covered:

In the DC Medicaid program, the stated coverage criteria represent the circumstances under which Medicaid will usually cover the item. The nature and extent of the documentation required would have to be individualized based on the item in question. The Prior Authorization Request/Approval Form 719(A) would require at least SOME of the following information: The diagnosis relating to the need for the item, complicating medical conditions, functional abilities and limitations (such as the ability to ambulate or transfer, the amount of time in a bed, chair or wheelchair, the type and frequency of activities outside the home), the duration of the condition, the overall course (improving or worsening), rehabilitation potential (including recent prior functional level), prognosis, description of and response to prior treatment, experience with similar items, physical examination findings, test results, etc. These cases need a letter forwarded to the Office of Quality Management located at 825 North Capitol Street NE, Suite 5135, Washington, DC 20002. Please include a signed form 719(A) (that has met all the other criteria for the completion of this form) with a narrative letter signed by the authorized prescriber documenting the aforementioned information.

15.9.2 Requests for Medical Equipment/Supply Not Specifically Covered Using Miscellaneous Codes

Miscellaneous codes (typically codes ending in 99, such as E1399 or L2999) are used to report procedures involving new technologies, or unique or rare services, and always require additional documentation. Supporting documentation includes:

- Literature describing the procedure or service provided.
- Letter of medical necessity signed by physician outlining the patient's diagnosis, overview of patient's condition and medical history, and clinical need for the procedure/service.

- Clinical studies demonstrating the efficacy and safety of the procedure/service may also be helpful, as well as the patient's functional capabilities and limitations, the overall course of therapy, prognosis, and treatment plan.

15.10 Diabetic Supplies

The District of Columbia Department of Health Care Finance has contracted with Magellan Health Services to manage a DC Medicaid diabetic supplies program. For this initiative, Magellan Medicaid Administration has retained two companies — Abbott Diabetes Care, Inc., and Roche Diagnostics Corporation — to be preferred providers of blood glucose monitors and strips effective July 1, 2011. This program applies to DC Medicaid Fee for service beneficiaries without other insurance or Medicare coverage. Beneficiaries who are not already using preferred Abbott and Roche products may switch to one of the preferred monitors and accompanying strips beginning July 1, 2011. Prescriptions for the preferred monitors and strips will be processed through the pharmacy's Point of Service electronic claims system. DC Medicaid will no longer cover test strips for non-preferred monitors after August 1, 2011, unless the beneficiary's physician has requested an override through the DC Medicaid Pharmacy Benefit Manager Prior Authorization request process.

Beginning July 1, 2011, DC Medicaid will cover only the following new blood glucose monitors:

Abbott Diabetes Care, Inc.	Roche Diagnostics Corporation
FREESTYLE LITE®	ACCU-CHEK COMPACT®
FREESTYLE FREEDOM® LITE	ACCU-CHEK AVIVA®
PRECISIONXTRA®	

Both Abbott Diabetes Care and Roche representatives are available to assist you with options to help beneficiaries obtain one of these preferred monitors. For additional product information, contact:

- Abbott 1-866-884-8892 www.myfreestyle.comlmeterprogram
- Roche 1-800-858-8072 www.accu-chek.com

15.11 Beneficiary Information

The beneficiary's eight-digit Medicaid number must be complete and valid for the dates of service being requested. There are eleven numbers not including the two zeroes for the new DCAS numbers. DCAS numbers are identified as beginning with the number 7. When the two zeroes preceded the number seven, drop the two zeroes, and use the eight digits beginning with 7. If you have three additional numbers, these indicate the program to which the beneficiary belongs. The provider is responsible for verifying the Medicaid eligibility of the patient every time a service is delivered. The provider must see the beneficiary's current Medicaid card each time a service is delivered. As an alternative, call the beneficiary Interactive Voice Response (IVR). The IVR is available 24 hours per day, seven days a week. The number is (202) 906-8319 (inside DC metro area) or (866) 752-9233 (outside DC metro area). Providers access the IVR by using their DC Medicaid provider number as identification. See Appendix A for specific instructions.

DC Medicaid beneficiaries that are enrolled in the Managed Care Plans are required to contact that specific Managed Care Organization for instructions on forwarding requests for DME services.

DC Medicaid beneficiaries that are enrolled in the Health Maintenance Organizations (HMOs) will need the vendor to check with that specific plan to find out the guidelines for what is required to request durable medical equipment.

For additional provider information, contact Conduent at (202) 906-8319 (inside DC metro area) or (866) 752-9233 (outside DC metro area).

Medicare or other insurance information must be provided on the 719(A) or claim whenever a provider becomes aware of other insurance coverage.

15.12 Program Category

Select the appropriate program from which the beneficiary is eligible to receive the requested services. This is addressed on the 719(A) in Block 4. Multiple selections will result in the request being rejected. The following information is required on the 719(A) if the vendor is a home health agency OR if the vendor is applying for services not covered in the DME program but may be covered through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

Select the appropriate program category by writing in Block 4, if you are a HOME HEALTH AGENCY, as well as checking Medical Supplies and Equipment

Select the appropriate program category by writing in Block 4, if you are requesting services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program as well as checking Medical Supplies and equipment.

15.13 Provider Signature

All 719(A) forms require the signature of the provider and date of the request. These two items MUST be on the 719(A) forms. DC Medicaid will not accept stamped or typed signatures in this section; original signatures are required. By signing and dating in the appropriate spaces, the provider certifies that he or she has reviewed the form for accuracy and is responsible for the contents submitted. Authorized prescriber signature dates are used as the initiation date for service. A service may occur after the authorized prescriber's signature, BUT a service cannot be authorized prior to the authorized prescriber's date of signature without his written documentation of the date of service within the six (6) month window allowed within the medical justification field.

15.14 Services Provided without the Signature of the Requesting Provider

The DME/POS provider may provide and be reimbursed for a supply item that the authorized prescriber has failed to order if this item is necessary to carry out the authorized prescriber's plan of treatment and is a component or auxiliary supply to another supply or piece of equipment for which there is a current authorized prescriber order. Any time the provider supplies items not listed on the 719(A) form, there is some risk that, upon utilization review, if the items are not clearly an integral medically necessary component of authorized prescriber-ordered treatments, the provider may be retroactively denied reimbursement.

For example, the authorized prescriber order or the plan of treatment states "dressings" and includes gauze and sterile water, but not tape, on the 719(A) form. The DME/POS provider may provide and be reimbursed for the tape used in the sterile dressings.

In another example, the authorized prescriber orders IV medications and includes an IV administration set with attachments and tubing on the 719(A) form. The DME/POS provider will not be reimbursed for an infusion pump for the IV medication unless the authorized prescriber specifies the need for the pump on the 719(A) form. Either the 719(A) form or the Prior Authorization form issued by DHCF is to be attached for billing with the CMS-1500 claim form.

15.15 Expectation of DME Vendors

If a provider accepts a Medicaid beneficiary as a client, the provider must provide all the DME services that are provided to the general population, not just the ones that the provider has chosen to provide. If any item or service is provided to the general population, it must also be provided to the Medicaid client,

regardless of the established reimbursement rate. Per the Provider Agreement, a Medicaid-enrolled provider must accept Medicaid payment as payment in full if the medical necessity is justified, and all other appropriate edits are correctly met. DME providers must know which items require authorization and the limitation on the provision of certain items as described in the DME listing. The Medicaid Program has established guidelines regarding which items require authorization, and the limitations that may be imposed on certain items, providers can reasonably be expected to know for which items Medicaid will pay.

The DME vendor must provide equipment and supplies as prescribed by the authorized prescriber on the 719(A) form. Orders must not be changed unless the vendor obtains a new 719(A) form prior to ordering or providing the equipment or supplies to the patient.

Medicaid will not reimburse the DME vendor for services provided prior to the date prescribed by the authorized prescriber, or prior to the delivery, or when services are not provided in accordance with published policies and procedures. If reimbursement is denied for one of these reasons, the DME vendor may not bill the Medicaid beneficiary for the service that was provided.

The DME provider must not provide items or extended quantities of items, which require authorization prior to obtaining the written authorization from DC Medicaid. Therefore, the liability for the charges for denied items or services, which the provider supplied prior to obtaining the required written authorization rests with the DME provider. A provider cannot bill a beneficiary for services if the services are covered by Medicaid and the provider is denied reimbursement due to his or her failure to obtain prior authorization or to perform other required administrative functions.

Per the Provider Agreement, a DME provider may only bill a Medicaid beneficiary for non-covered services. The DME provider is responsible for determining if an item is covered, whether it requires authorization, verifying Medicaid eligibility and verifying program eligibility. If the DME provider does not follow the established procedure for obtaining authorization for any item and the request is denied, the provider may not bill the beneficiary for that item.

The DME vendor must advise the Medicaid beneficiary in writing of any fiscal liability (potential or actual) for items delivered prior to the receipt of authorization by DC Medicaid. If all established guidelines are followed by the vendor and the request is denied, the DME vendor may seek reimbursement from the beneficiary. The vendor may not require the beneficiary to make a deposit or “pay in advance” for any item that is covered and requires prior authorization. If the vendor fails to follow established procedures for authorization or fails to notify the beneficiary of any fiscal liability and the item requested is determined not to be medically justified or does not meet criteria for reimbursement, the DME vendor may not bill the Medicaid beneficiary.

15.16 Medical Records

The authorized prescriber is responsible for assuring that the patient’s medical record contains sufficient documentation of the patient’s medical condition to substantiate the need for items ordered. The information would include the patient’s diagnosis and other pertinent information including, but not limited to, the duration of the patient's condition, clinical course, prognosis, nature and extent of functional limitations, other therapeutic interventions and results, experience with related items, etc. Prescribers are required to maintain the medical records for ten (10) years, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The patient’s medical record is not limited to the authorized prescriber’s office records. It may include hospital or nursing home records and records from other professionals, including, but not limited to, nurses, physical or occupational therapists, prosthetics, and orthotics. The documentation in the patient’s medical record would not routinely be sent to the Durable Medical Equipment (DME) provider; however, the DC Medicaid program may request this information in selected cases.

Providers who have examined, diagnosed, and treated a patient, shall maintain individual beneficiary records that:

- Are legible throughout and written at the time services are rendered.
- Identify the beneficiary on every page.
- Are signed and dated by the licensed provider responsible. Stamped signatures will not be accepted. All care by ancillary personnel must be countersigned by the licensed provider responsible. Any alterations to the record must be signed and dated.
- Contains a preliminary working diagnosis as well as final diagnosis, including elements of history and physical examination upon which the diagnosis is based.
- Document in compliance with the service definitions and descriptions found in Physicians'.
- Current Procedural Terminology (CPT)
- Reflect treatments, as well as the treatment plan.
- List quantities and dosages of drugs or supplies prescribed as part of the treatment and wellbeing of the patient.
- Indicate the progress of the beneficiary at every visit, the change of the diagnosis, the change of treatment, and the response to the treatment.
- Contain summaries of all referrals, hospitalizations, and reports of operative procedures and excised tissues
- Contains the results of all diagnostic tests and reports of all consultations.
- Reflect the disposition of the case.

15.17 Supplier Documentation

As described in the section above, the supplier must have on file a copy of the authorized prescriber's order (719(A)), medically necessary documentation if required and additional medical necessity information (if provided by the authorized prescriber and/or required by DC Medicaid). The supplier must also have a detailed record of the items provided to the beneficiary, which would include brand name, model number, quantity, warranty, and the date of delivery. For durable medical equipment, the supplier should retain delivery and pick up slips. This information must be sent to DC Medicaid if requested or kept on site for audits/inspections.

15.18 Utilization Review

Periodically, an on-site medical and inspection of care review will be made for enrolled DME vendors. Visits may be unannounced. Medical records of beneficiaries currently receiving DME as well as a sample of closed records may be reviewed. DC Medicaid staff may visit beneficiaries and conduct a professional review with respect to the:

- Care being is not complying with duly promulgated regulations of DC Medicaid provided by the DME vendor.
- Necessity and desirability of the continued service to the beneficiary
- Feasibility of meeting the beneficiary's health needs in alternate care arrangements.
- Verification of the existence of all documentation required by Medicaid.

DC Medicaid may conduct utilization review activities, and providers will be held accountable for having fully completed 719(A) forms on all beneficiaries for all services provided. The 719(A) form must contain medical information to justify the DME items provided. DC Medicaid will deny or recoup payment for any DME services that cannot be justified by the 719(A) form or supporting medical documentation.

Items and services that are not documented as having been rendered will be considered not to have been rendered, and no reimbursement will be made.

Upon completion of the review, the utilization review analyst will meet with staff members as selected by the provider for an exit conference. This conference will provide an overview of the findings from the review. A report will be written detailing the findings of the analysts during the utilization review. Based on the review team's report and recommendations, DC Medicaid will take corrective action. Action taken and the level of management involved will be based on the severity of the cited deficiencies which adversely affect the health and safety of the beneficiaries, the quality of life of the residents, or utilization control regulations. If DC Medicaid requests corrective action plans, the DME vendor must submit the plan within thirty (30) days of the receipt of notice, to the utilization review analyst who conducted the review. Subsequent visits will be made to the provider for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance. Recoupment of monies will be made if there is no documentation to reflect that services were provided, or documentation does not support the provision of services for which the reimbursement was made.

16 Durable Medical Equipment Specific Billing Instructions

16.1 Durable Medical Equipment (DME) Provider Eligibility Criteria

DHCF requires that all providers of durable medical equipment and related services enter into a Medicaid provider agreement with DHCF. To have the agreement executed, the provider must at least meet the following requirements:

- Be legally authorized to do business in the jurisdiction where the proposed Medicaid transactions will occur.
- Be enrolled as an in-state or out-of-state provider based on location.
- Be financially responsible.
- Maintain the necessary equipment to operate the business and provide the services promptly to the Medicaid beneficiaries.
- Maintain sufficient staff to respond appropriately and timely to Medicaid beneficiaries.
- Maintain an occupancy permit and all required licenses appropriate to conduct business.

DHCF shall ensure that each Medicaid beneficiary retains his/her freedom of choice of DME/POS providers/suppliers, in accordance with 42 C.F.R. § 431.51.

16.1.1 Beneficiary Eligibility to receive DME/POS

For a beneficiary to receive DME/POS, the following requirements shall be met:

- The cost of the item shall be reasonable; `
- The item shall be prescribed by a physician or other licensed practitioner of the healing arts operating within the scope of practice allowed under the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 et seq.) and implementing rules, as well as all other applicable Federal and District laws.
- The prescribing clinician shall be enrolled as a provider in the District of Columbia Medicaid Program; and
- The prescribing clinician and DME/POS provider/supplier shall provide their National Provider Identification (NPI) numbers on the prescription, DME/POS Request and Prior Authorization Form (Form 719(A)), and claim.

The prescribing clinician shall ensure that Form 719(A) and any supporting documentation describe the beneficiary's condition and include, at minimum:

- The diagnosis related to the need for the DME/POS item.
- Any complicated medical conditions.
- A description of functional abilities and limitations, using assessments based on the standards described in § 997.8.
- The anticipated duration of the condition.
- Physical examination findings; and
- The potential for rehabilitation, if applicable.

16.2 Durable Medical Equipment Reimbursement

16.2.1 Covered Services

DHCF complies with CMS rules that govern the coverage of required services related to medical supplies and equipment. The major components of the rules are listed below:

- Reimbursement rates will be determined by DHCF annually. This method will only apply to those services that do not vary significantly in quality from one supplier to another.
- Reimbursement for items and services that are not covered by Medicare will be at the vendor's usual and customary or the prevailing charge as determined by DHCF, whichever is less.
- Reimbursement for items or services that are covered by both Medicare and Medicaid but not subject to the lowest charge, will be reimbursed at not more than the reasonable charges established under Medicare Part B
- Reimbursement for the repair of equipment is only allowable for purchased equipment and shall not exceed 75% of the actual purchase price of the equipment.
- Reimbursement for routine maintenance on rented equipment is not covered.
- Reimbursement for extensive repair purchased equipment which must be performed by an authorized technician is covered as a repair if billed by the supplier after receiving a prior authorization.
- Reimbursement is allowed for rental or purchased equipment but must be prior authorized if indicated in the fee schedule.
- Reimbursement for construction as part of installation is not allowed.

16.3 Fee Schedule

DME suppliers will accept the payments offered by DHCF as payment in full for the services provided by the DC Medicaid beneficiary. The fee schedule for professional services is annually updated and is subject to changes by DHCF. Providers will be notified in writing of any changes through provider manual and fee schedule updates.

16.4 Third-Party Reimbursement

In some cases, an individual may qualify for both DC Medicaid and Medicare, and sometimes for another health insurance plan. Medicare or any other such insurance plan must be billed first. Title XIX will pay the approved patient liability, which may remain after third-party payments. The DME supplier, in conjunction with the practitioner who orders the services, is responsible for determining other sources of coverage and may bill Title XIX only after all other sources have been exhausted.

16.5 Prior Authorizations for DME/POS

The District of Columbia Department of Health Care Finance's (DHCF) Medicaid program pays for durable medical equipment, prosthetics, orthotics, and supplies (DME/POS) that are required to aid or improve activities of daily living, when such DME/POS are prescribed by a physician or authorized prescriber (requesting provider) and are deemed medically necessary.

As stated in the DC Medicaid State Plan (Supplement 1 to Attachment 3.1.A, Page 20B) prior authorization is required for:

- DME/POS items that exceed specific criteria and/or require prior authorization, as set forth in the D.C. Medicaid Provider/Supplier Billing Manual and/or D.C. Medicaid Fee Schedule, available online at www.dc-medicaid.com.

- DME/POS items that are billed using miscellaneous codes or that require manual pricing.
- Items of durable medical equipment (DME) that exceed five hundred dollars ($500) in purchase price, unless exempted from the requirement as indicated on the fee schedule.
- Customized equipment; and
- DME, prosthetics, and orthotics, outside of the warranty period, which require repair or replacement.

Per Supplement to Attachment 3.1A, Page 20B, of the DC Medicaid State Plan, “Medical supplies and equipment in excess of specific limitation, i.e., cost, rental or lease equipment, or certain procedure codes must be prior authorized by the State Agency”., The purpose of prior authorization is to validate that the service or item being requested is medically necessary and that it meets DC Medicaid criteria for coverage. Pre-authorization does not automatically guarantee payment for the service; payment is contingent on passing all edits contained within the claim’s payment process; the beneficiary’s continued Medicaid eligibility; and the ongoing medical necessity for the service being provided. Authorizations are specific to a beneficiary, a provider, a service code, an established quantity, and for specific dates of service. If prior authorization is required, authorization shall be received prior to the delivery of the DME/POS service or item. DME/POS prior authorization is valid for six (6) months.

Enrollment in the DC Medicaid program is required for the physician or authorized person (i.e., requesting provider) that prescribes the DME/POS via the 719A form; and the provider that delivers and seeks reimbursement for the DME/POS item or service (i.e., billing provider) must be enrolled in the DC Medicaid program to receive reimbursement.

DME/POS providers must submit a 719A form for any portion of a DME/POS service that requires prior authorization. DME/POS that require prior authorization are identified in the DC Medicaid fee schedule. The 719A form must indicate the primary payer source and anticipated reimbursement. This does not apply for Medicare-crossover claims (where Medicare is the primary insurer and DC Medicaid is secondary).

For items that require prior authorization, in addition to providing the prescription described in § 997.3(b), the prescribing clinician shall also begin the prior authorization process by completing the clinical portion of Form 719(A) and providing the form to the DME/POS provider/supplier for completion. The DME/POS provider/supplier shall then present the completed Form 719(A), including the corresponding prescription, to DHCF or its designee, for approval. The DME/POS provider/supplier also shall be responsible for collecting and submitting supporting documentation and invoices to DHCF, or its designee, for review and approval.

If a DME/POS provider/supplier goes out-of-business, another enrolled DME/POS provider/supplier that can provide continuous DME/POS services/items to a beneficiary shall complete a new Form 719(A), include a reference to the original prior authorization number on Form 719(A), and submit the form to DHCF, or its designee. The new DME/POS provider/supplier shall not provide any new item to a beneficiary until DHCF, or its designee, has provided a new prior authorization number.

If a prescribing clinician or DME/POS provider/supplier receives a discount for an item ordered for use by a D.C. Medicaid beneficiary, the prescribing clinician and/or DME/POS provider/supplier shall subtract the amount of the discount from the amount for which reimbursement is sought prior to submitting the claim to DHCF. Failure to comply with the requirements of this paragraph may result in denied claims, temporary suspension of payments, or termination of the Medicaid Provider Agreement.

A DME/POS provider/supplier shall be required to provide original documentation reflecting all discounts that apply to the cost of any item provided to a Medicaid beneficiary.

A DME/POS provider/supplier shall be required to produce proof of delivery (POD) for all items that are provided to a Medicaid beneficiary. POD may include:

- Receipts that are signed by the beneficiary who requires DME/POS, or his or her legal representative; or
- Delivery confirmation.

DME/POS that does not require prior authorization per the DC Medicaid fee schedule may be provided and billed for using the CMS1500 form. Providers should forward the CMS1500 form directly to Conduent.

16.6 Administrative Prior Authorization Determination Criteria for DME/POS

In addition to a review of medical needs on every submitted prior authorization request, DHCF, or its designated agent, will use the following administrative criteria for prior authorization determinations:

- If the date of service precedes receiving prior authorization approval, the submitted request for prior authorization will be denied.
- Prior authorization approval is valid for six months from the date approved by DHCF, or DHCF's designated agent providing prior authorization.
- If there is no proposed date of service included on the submitted 719A form, Comagine Health Services will use the date of the requesting physician's signature [Box 15B] as the date of service. The physician's signature must precede the submission of the 719A form.
- Prior authorization requests will be denied if the requested dates of service are after 6 months from the physician's signature date.
- Prior authorization requests for repairs will be approved if the repair is medically justifiable for the beneficiary; and the repair is not covered by the product's warranty. DHCF, or its designated agent, will request a warranty for repair requests on products received by the beneficiary 30 days or less prior to the submission date.
- Prior authorization requests for rental will be approved in 6-month increments if:
  - the rented device is medically necessary.
  - the frequency of the rental is consistent with the HCPCS/CPT code definition; and
  - the total cost to rent the product does not exceed the cost to purchase the product.
- In addition to the clinical review of prior authorization requests, previous claims history and any other accessible historical information on a beneficiary shall be utilized in the prior authorization determination.
- Prior authorization requests containing HCPCS/CPT codes where the definition of the code includes language like 'miscellaneous' or 'non otherwise specified' will be processed only in the absence of a more precise or appropriate code or determination that a "miscellaneous" or "not otherwise specified" code is appropriate.

16.6.1 Policy and Procedure Regarding the 719A Form

Transmittal #23-37 clarified the process and requirements regarding the 719A prescription order form. The 719A form is the DC prescription order form that is a required document used to obtain medical, surgical, and dental services for the Fee-for-Service (FFS) Medicaid beneficiary. The 719A is required for any service that the Department of Health Care Finance (DHCF) has indicated on the fee schedule or in policy as needing prior authorization (PA). The purpose of prior authorization is to validate that the service or item being requested is medically necessary and that it meets DC Medicaid criteria for coverage. There are several details related to the 719A that require clarification:

- The 719A is an open prescription for 6 months.
- All the information in the patient, prescribing provider, and servicing provider sections must be completed in its entirety. None of the boxes should be left blank.
- The 719A should be completed accurately to prevent processing delays or the risk of having the form returned.
- All 719A forms require the signature of the provider and the date of the request. These two elements MUST be on the 719A form. DC Medicaid will not accept stamped or typed signatures in this section - original signatures are required. By signing and dating in the appropriate spaces, the provider certifies that he or she has reviewed the form for accuracy and is responsible for the contents submitted. Authorized prescriber signature dates are used as the initiation date for service.
- If a mistake is made on the 719A, the provider should draw a line through the incorrect information, initial and date any corrections made on the form. Whiteout should never be used to correct a mistake.

16.6.2 Required Attachments to the 719(A) Form for Certain DME/POS

All prior authorization requests for beneficiaries with both Medicare B and Medicaid (dual eligible) must include a denial response from Medicare or Medicare policy documentation of non-coverage. This documentation is also necessary for the processing of the claim.

Medical documentation and Certificates of Medical Necessity (CMN) provide DC Medicaid with a visual image of the patient's needs. The following Plan of Treatment (POT) is to MEDICALLY justify the necessity for all supplies and equipment under this program. Additionally, the vendor is required to attach the technical evaluation/ assessment to the 719(A) Form. When applicable, vendors are to also attach equipment warranty coverage. The DME/POS must be prescribed by an authorized prescriber, and the documentation must identify (where applicable):

- The diagnosis is related to the reason for the DME/POS request.
- The beneficiary's functional limitation and its relationship to the requested DME/POS
- How the DME/POS service will treat the beneficiary's medical condition
- The quantity needed and the reason the amount is needed.
- The frequency of use
- The estimated length of use of DME/POS
- How the needs were previously met; identify what changes have occurred
- How the service will be used in the beneficiary's environment
- The beneficiary or caregiver's ability, willingness, and motivation to use the DME/POS
- Identify any conjunctive treatment related to the use of the equipment.

There must be a diagnosis, which explains the need for the item(s) and supporting documentation for expendables, which are beyond the established guidelines for use. All services covered must be reasonable and medically necessary. Patient assessments may be required to evaluate when a particular treatment is reasonable and necessary. If the authorized prescriber orders items or quantities which are not the standard in medical or nursing practice, supporting documentation must be provided to justify the order.

Specialized DME/POS, such as specialized wheelchairs, adaptive equipment, etc., must be accompanied by a patient assessment which details the patient's functional abilities and/or disabilities, therapy goals, height and weight, rehabilitation potential and suitability of the home environment and the equipment for use in the patient's home from the physician.

For items (e.g., hospital beds) that may either be used for the convenience of the caregiver or to treat or manage medical condition, supporting documentation of the medical need and use of the equipment must be included. Medicaid does not cover convenience items for the beneficiary, the family, the attending practitioner, other practitioners, or the supplier.

Providers shall attach the specific medical justification and/or documentation noted below for the following types of requests:

Wheelchairs
Any mobility impairments, postural impairments, and cognitive ability related to specific wheelchair and/or wheelchair adaptations.

Hospital Beds
How the bed will be used to treat a medical condition, the functional limitations of the patient.

Patient Lifts
The patient's weight, identification of the caregiver and his or her ability to use the lift, functional limitations, how needs were previously met, and the home accessibility for the lift (identification or the caregiver is requested for purposes of documenting that the patient or identified caregiver is trained/oriented to operate the equipment).

Tens-Like Units
The physical and functional limitations, the success/failure of alternative treatment modalities, the patient/caregiver's ability to manage application of the device, and the demonstrated benefit for on-going use.

Apnea Monitor
Include a comprehensive history and physical related to the respiratory condition; identify the final primary and secondary diagnoses related to apnea; include confirmation that the patient has apnea; knowledge of the outcome of any previous study and the medical justification of the sleep study is needed.

Oxygen and Oxygen Equipment
The flow rate, frequency, and duration of use. For portable systems, provide a description of the activities the patient participates in on a regular basis that requires a portable system in the home and the therapeutic purpose served by that portable system that cannot be met by a stationary system. Specifically, the supporting documentation must include:

- A recent PO2 or saturation level (at least 20 days prior to discharge).
- A diagnosis of the disease requiring home use of oxygen
- The oxygen flow rate (any request for oxygen with a flow rate more than 4 liters per minute must be prior authorized by DC Medicaid
- An estimate of the frequency, duration of use (e.g., 2 liters per minute, 12-hours a day), and duration of need (e.g., six months or lifetime)

The patient's attending authorized prescriber must submit new supporting medical necessity documentation whenever there is a revision to the oxygen requirements based on a change in condition and the need for oxygen therapy. Without any revision, the medical necessity documentation is valid for a twelve-month period for adults and six-months for children. The authorized prescriber may only certify the need for oxygen therapy if the authorized prescriber has seen the patient.

The medical necessity documentation must also include the results of a blood gas study ordered and evaluated by the attending authorized prescriber. This will usually be in the form of a measurement of the partial pressure of oxygen (PO2) in arterial blood. A measurement of arterial oxygen saturation obtained by ear or pulse oximetry, however, will also be acceptable when ordered and conducted by a qualified provider or supplier of laboratory services and evaluated by the attending authorized prescriber. The

conditions under which the laboratory tests are performed must be specified in writing and submitted with medical necessity documentation (i.e., at rest, while sleeping, while exercising, in the room air, or if while on oxygen, the amount, body position during testing and similar information necessary for interpreting the evidence).

In situations when arterial blood gas and oximetry studies are both used to document the need for home oxygen therapy and the results are conflicting, the arterial blood gas study is the preferred source of documenting the medical need. A DME/POS supplier is not considered a qualified provider or supplier of laboratory services for the purposes of these guidelines. This prohibition does not extend to the results of an arterial blood gas test conducted by a hospital certified to do such tests. The preferred sources of laboratory evidence are existing authorized prescribers and/or hospital records that reflect the patient's medical condition. If more than one arterial blood gas test is performed during the patient's hospital stay, the test result closest to the hospital discharge date must be submitted. The attending authorized prescriber's statement of recent hospital test results is acceptable instead of copies of the hospital records. Repeat arterial blood gas or oximetry will normally be necessary only where evidence indicates that an oxygen beneficiary has undergone a major change event relevant to the home use of oxygen. For example, if there has been a significant increase in the amount of oxygen required (e.g., an increase of more than 4 liters per minute) another blood gas or oximetry study may be necessary.

Ventilators
The medical documentation from the authorized prescriber must indicate the prognosis for weaning from the ventilator along with the expected length of use of the ventilator, the stability of the patient on the ventilator at the time of discharge from the hospital. Sleep studies are not mandated (i.e., family members with documented history, etc.), and will continue to be used. However, medical justification still needs to document the need for the equipment.

Wound Care Supplies
The location of the wound; the size, depth, drainage, and color; and the authorized prescriber's orders for care are needed from the prescriber. Where applicable, the Home Health Agency involved may provide a Plan of Treatment meeting the documentation requirements (i.e., size, depth, drainage color, etc.) to the DME/POS vendor for submission with the 719(A).

Nutritional Supplements (Enteral Feedings Only)
The Home Health Agency must identify the complete diet order, to include any intake other than the prescribed supplement and the patient's response to the diet. Medical justification for a specific formula is necessary to prevent therapeutic substitution to another brand.

The Medicare Certificates of Medical Necessity can be used as medical justification attached to the 719(A) forms in place of the narrative letters.

16.7 DME Medical Assistive Devices and Services (DME MADS) Referrals

The referral form for DME Medical Assistive Devices and Services is to be used in conjunction with the Beneficiary, their family, or Authorized Representative and may be used to request either Personal Emergency Response System (PERS) services or a Medication Management Device (MMD) service (or both services simultaneously).

Figure 6: Sample referral form for DME Medical Assistive Devices and Services

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

REFERRAL FORM FOR DME MEDICAL ASSISTIVE DEVICES AND SERVICES (DME MADS)

Instructions: This form is to be used in conjunction with the Beneficiary, their family, or Authorized Representative and may be used to request either Personal Emergency Response System (PERS) services or a Medication Management Device (MMD) services (or both services simultaneously).

□ New Referral □ Reauthorization of Existing Services □ Transfer Request

Beneficiary Information

Beneficiary Name: _____ Medicaid ID: _____ Program Code: _____

Address: _____ Telephone Number: _____

_____ Date of Birth: _____

Beneficiary's Physician: _____ Physician telephone: _____

Physician NPI, if known: _____ Physician fax number: _____

Special Notes for Installation: _____

Provider Selection (select 1): □ Guardian – 068565892 □ Best Buy Health – 037965419 □ Lifeline Systems – 027850295

Service Selection: □ Landline PERS □ Wireless PERS □ Mobile PERS □ Medication Management Device
(select all that apply)

If Medication Management Device, please list a contact who can assist with installation and loading:

Referral Information

Referrer's Name: _____ Referrer's Telephone Number: _____

Relationship to Beneficiary: _____ Referrer's Fax Number: _____

Has this person been assessed with the interRAI HC in the last 90 days? Yes No
If no, is clinical documentation to justify the referral attached? Yes No

Does the Beneficiary work with a Home Health Agency? Yes No

If so, please include the name of the Home Health Agency: _____

Provider Acceptance

Date 719A form submitted: _____ Authorization Number: _____

Service Start Date: _____

Please submit this form to an approved DME MADS provider via secure email to the following:

- Guardian Medical Monitoring: gf-hc@guardianmedicalmonitoring.com
- Best Buy Health: Referrals-CST@bestbuy.com or Secure Fax: 1-800-325-5145
- Lifeline Systems: governmentservices@lifeline.com

Rev. 10/2022

17 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 3: CMS1500 Claim Form Instructions

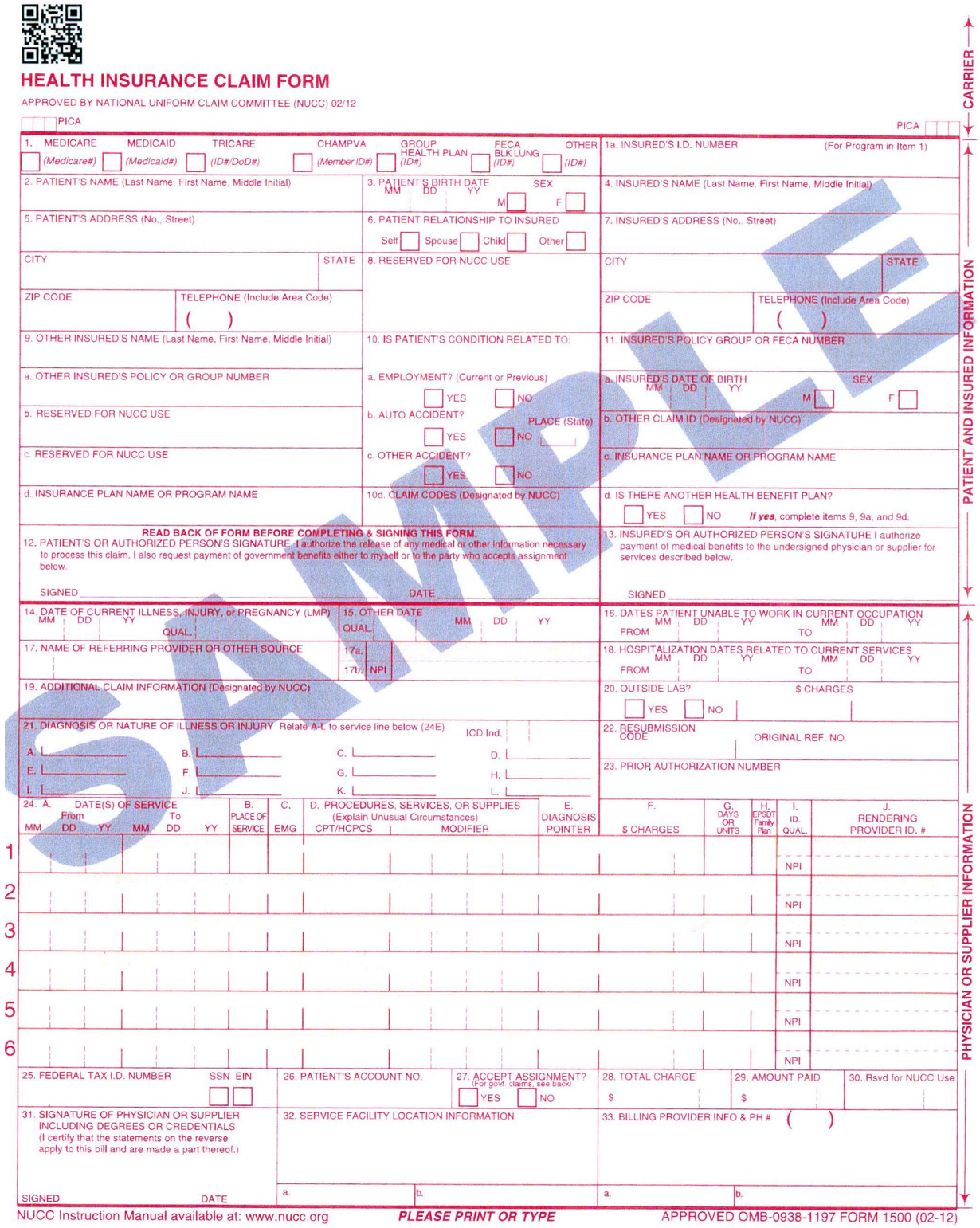
Field #	Field Description	Guideline
1	**Health Insurance Box**	Select Medicaid
1a	**Insured's ID Number**	Enter the patients' eight-digit DC Medicaid identification number excluding the leading zeroes. Verify the beneficiary's Medical Assistance Card to make certain that you have the beneficiary's correct 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**	

Field #	Field Description	Guideline
10a	**Employment (Current or Previous)**	Select the appropriate box to indicate if the patient's condition is an employment related injury
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

Field #	Field Description	Guideline
		05 HIS Free-Standing Facility 06 HIS Provider-Based Facility 07 Tribal 638 Free-Standing Facility 08 Tribal 638 Provider-Based Facility 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

Field #	Field Description	Guideline
		or multiple letters are applicable. ICD codes must be entered in Item Number 21 only. Do not enter them in 24E. 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 7: 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? PLACE (State) YES NO

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

17.1 Instructions for Billing for Medicare Deductible and Coinsurance

In accordance with the District's State Plan, Medicare Part B deductibles and co-payments are limited to the State Plan rates and payment methodologies. For clinic services, DC Medicaid pays the deductible and co-insurance as calculated by Medicare.

Medicare must be billed first when billing for a Medicaid patient who is also covered by Medicare. After Medicare processes the claim, submit a Medicare Crossover claim to Medicaid using the CMS-1500 claim form.

NOTE: When billing for Medicare Part B deductible and/or coinsurance, you must submit a CMS-1500 claim form **with all required fields completed or the claim will be returned**. The Medicare EOMB must be attached, reflecting the amount of deductible/coinsurance. The procedure code information will allow Conduent to determine Medicaid's payment obligation in accordance with the district's state plan.

18 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 8: Remittance Advice Mailer Page

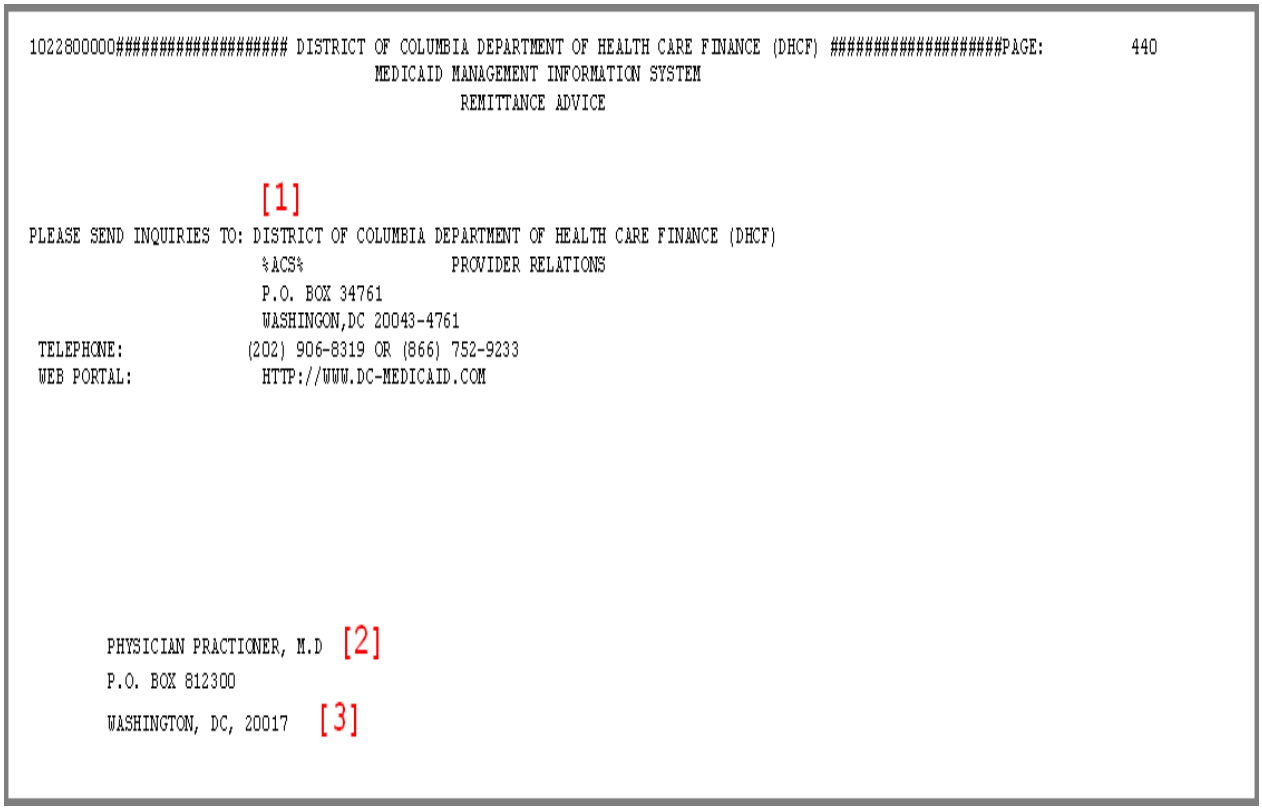


Table 4: Remittance Advice Mailer Page Table

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 9: Remittance Advice Header Page

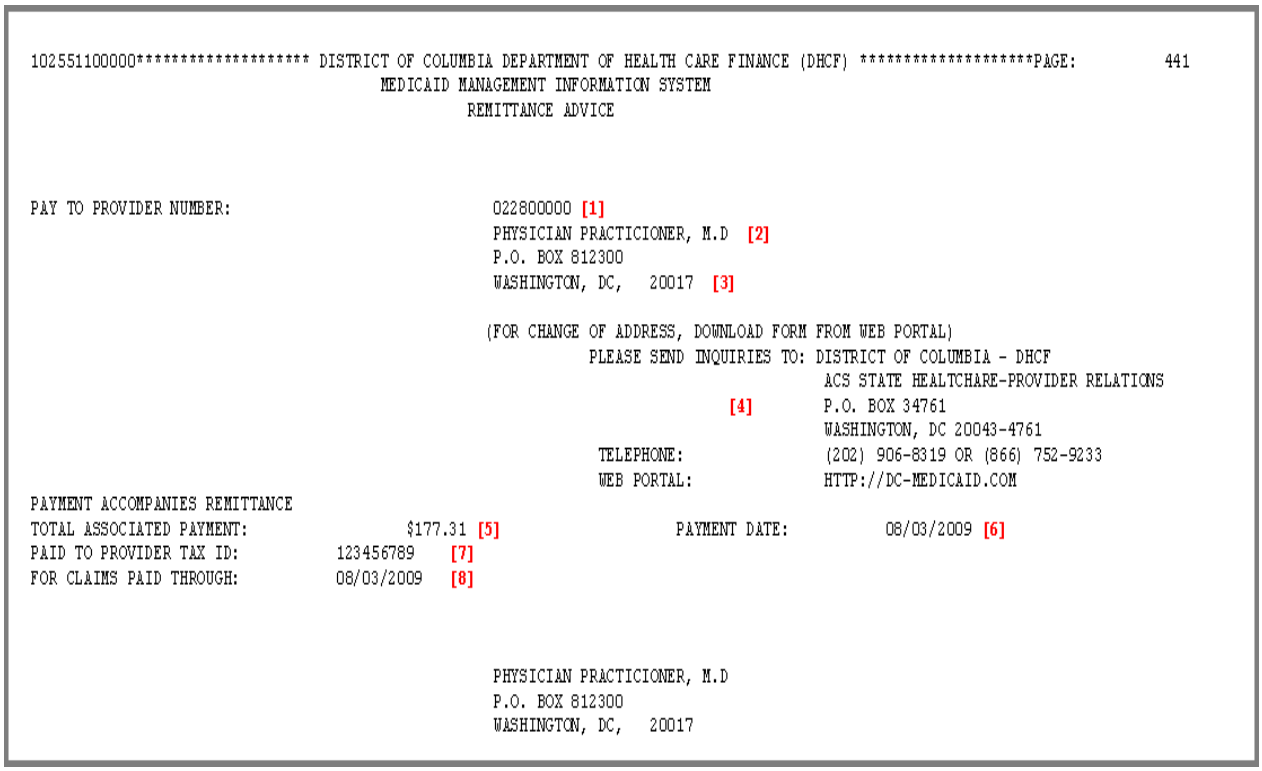


Table 5: Remittance Advice Header Page Table

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 providing 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 10: Remittance Advice Provider Messages

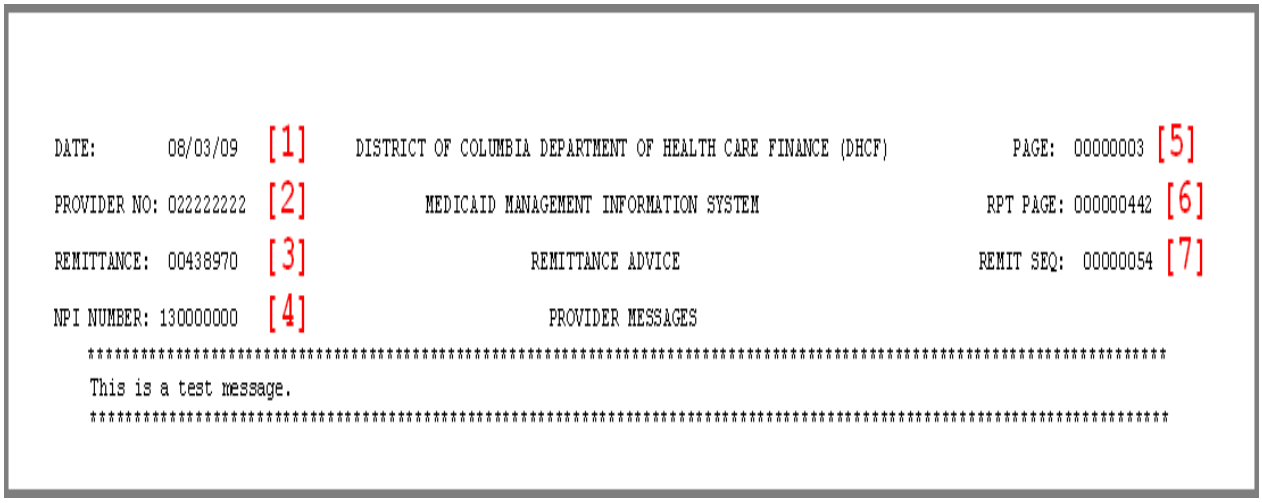


Table 6: Remittance Advice Provider Messages Table

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 11: Remittance Advice Paid Claims

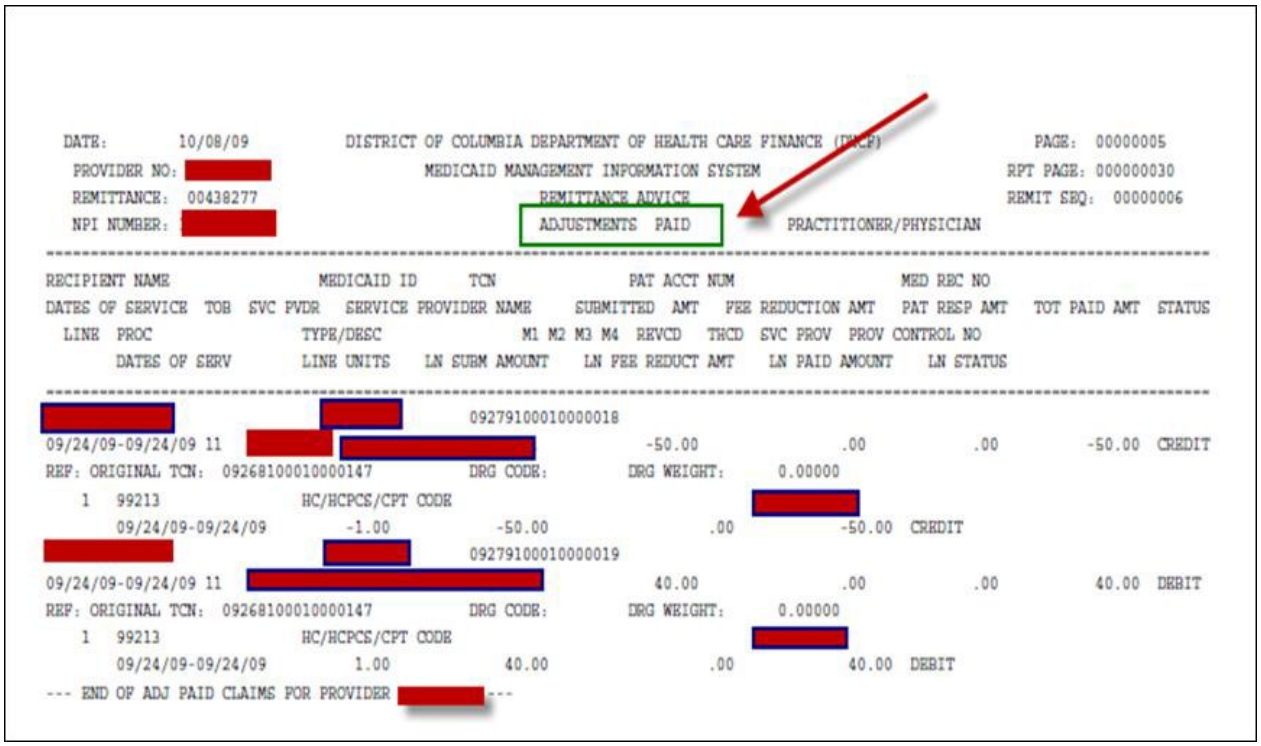


Table 7: Remittance Advice Paid Claims Table

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.)
STATUS	14	Claim Status (Paid – Denied – Suspended)
LINE	15	The line-item number on the claim

FIELD NAME	Field #	DESCRIPTION
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 12: Remittance Advice Adjustments

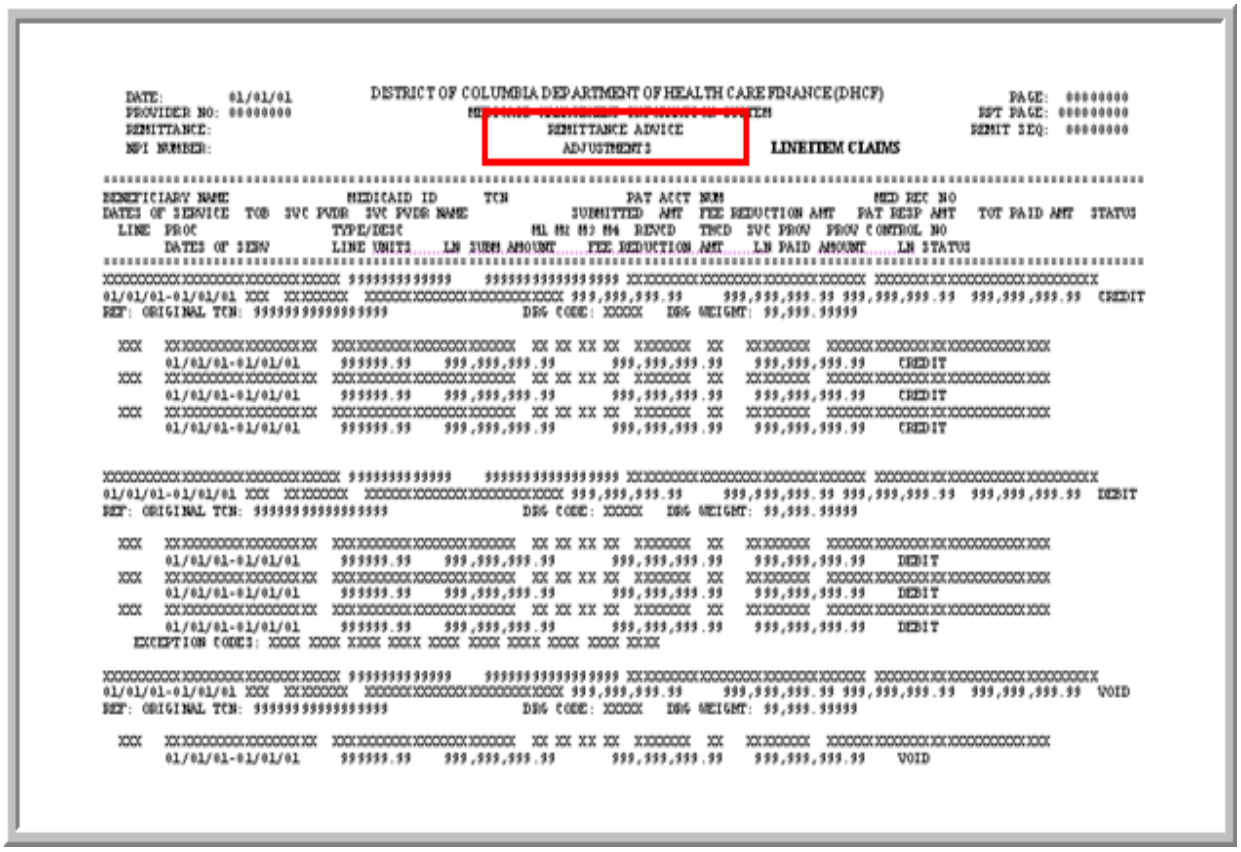
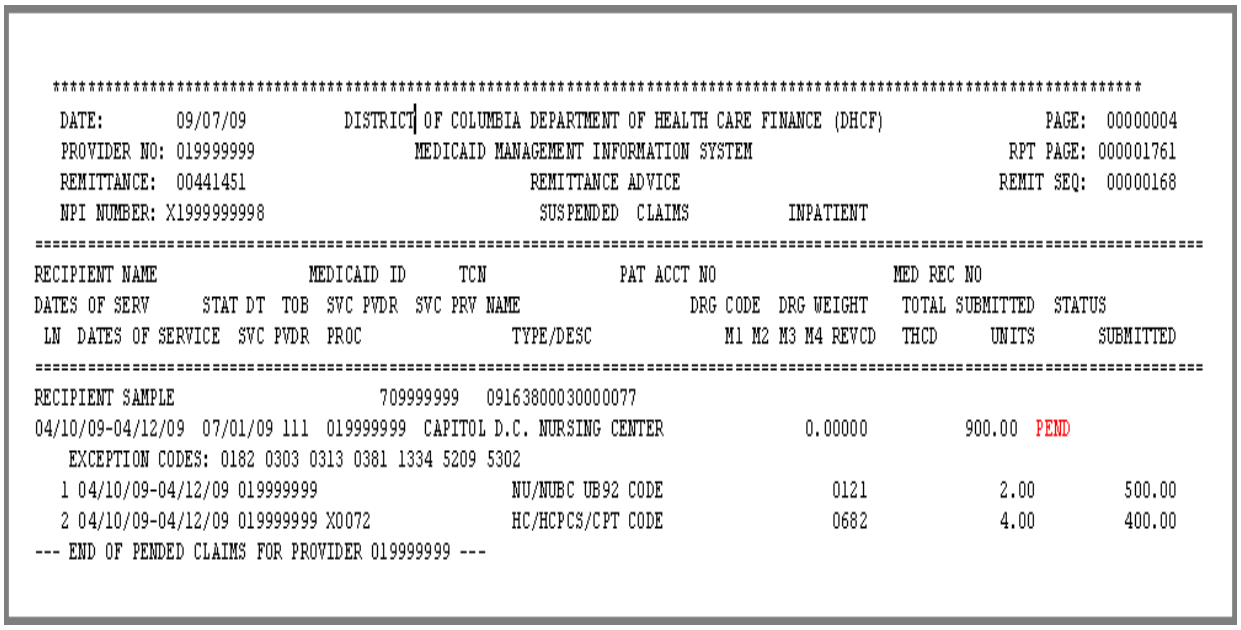


Table 8: Remittance Advice Adjustments Table

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 13: Remittance Advice Suspended Claims



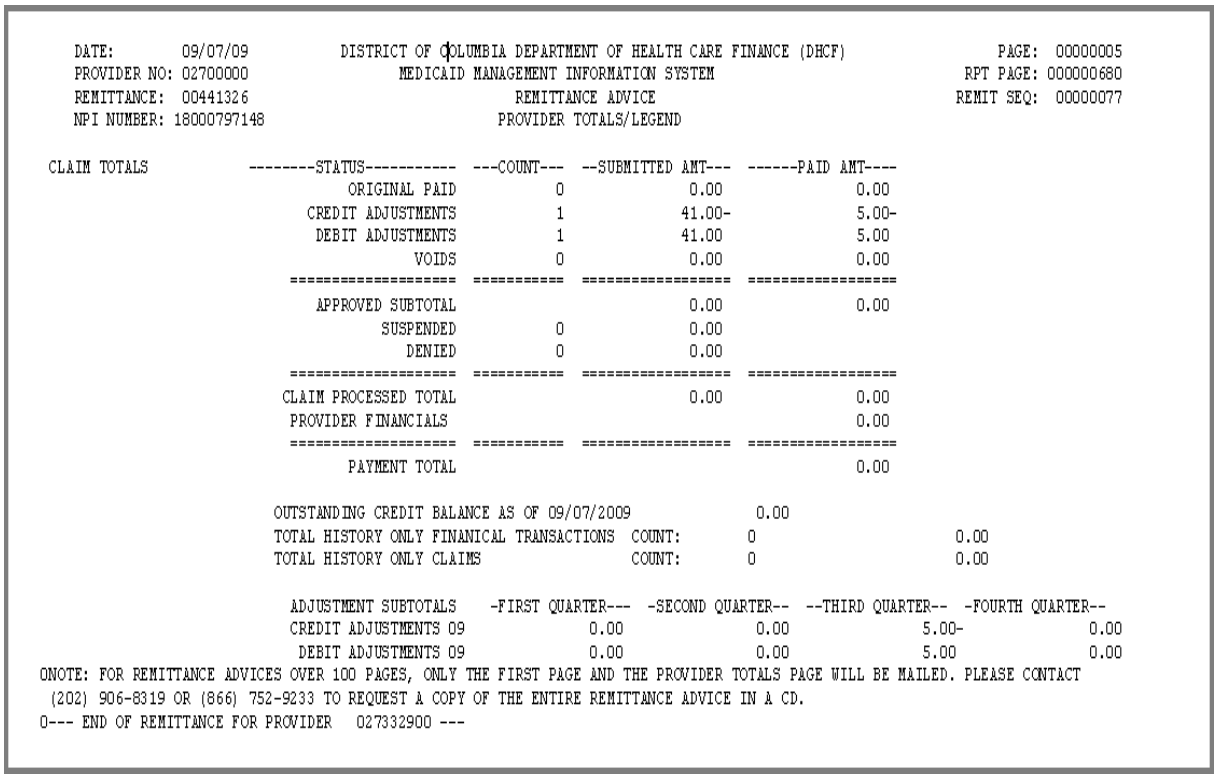
```
**********************************************************************************************************************************
 DATE:       09/07/09          DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)                PAGE:  00000004
 PROVIDER NO: 019999999              MEDICAID 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 9: 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.
UNITS	Number of units

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

Figure 14: 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 10: 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

18.1 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. There is no timely filing limit on submitting voids. Voids may be submitted at any time.

Adjustments and voids can be submitted on 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 15: Ajustment Example

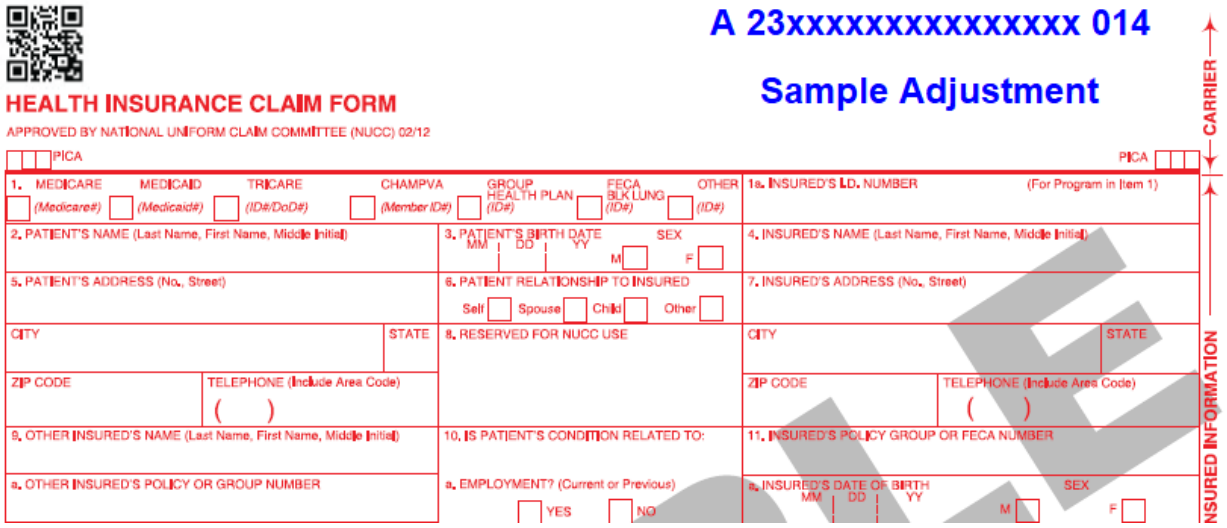
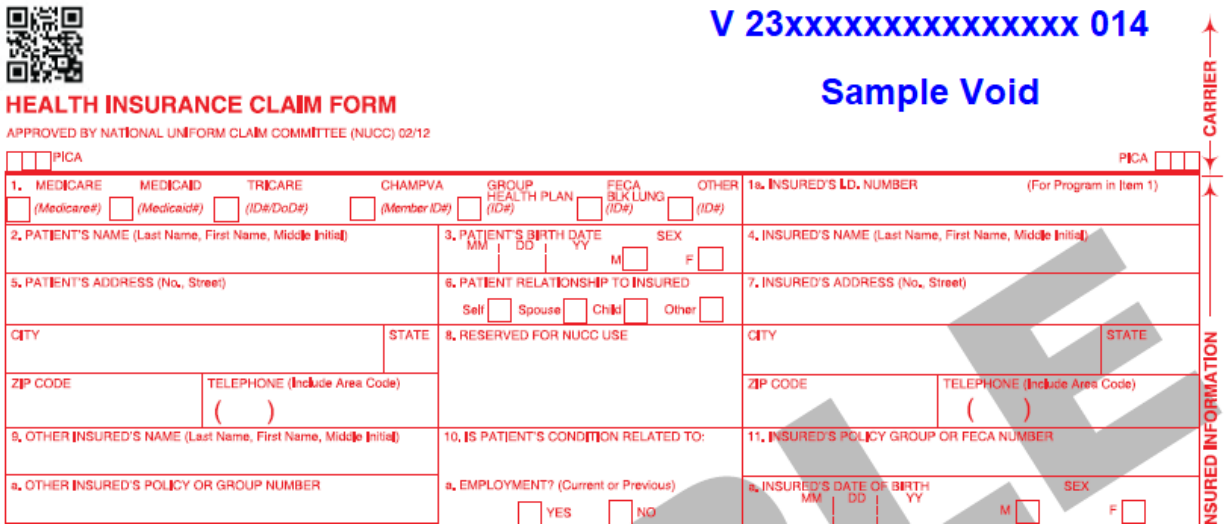


Figure 16: Void Example



.

Table 11: 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

18.2 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: 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 B: 719A COMPLETION INSTRUCTIONS

Patient

a. Enter the beneficiary's name as it appears on the Medical Assistance Card.
b. Enter the beneficiary's 8-digit Medicaid number (DCID) as it appears on the Medical Assistance Card.
c. Enter the beneficiary's address including street, city, state, and zip code.
d. Enter the beneficiary's telephone number.
e. Enter the beneficiary's date of birth.
f. Enter the beneficiary's sex.

Prescribing Provider

a. Enter the prescribing provider's provider number (Medicaid number) and NPI.
b. Enter the prescribing provider's address including street, city, state, and zip code.
c. Enter the telephone number of the prescribing provider.

Servicing Provider

a. Enter the servicing provider's (billing provider) provider number (Medicaid number) and NPI.
b. Enter the servicing provider's address including street, city, state, and zip code.
c. Enter the telephone number of the servicing provider.

Other health insurance coverage

a. Enter the name of the policy holder, plan name, address, and policy of any third party reported by the beneficiary or known by the provider to cover the services being requested.
b. If not applicable, enter "N/A" or "None".

Discharge Date:

a. Enter the discharge date if the patient is still in a facility.

Requested service.

a. Select the appropriate block for the requested equipment or service.

Beneficiary location

a. Select the block that appropriately describes the beneficiary's location.

Note: If the beneficiary is in an ICF/MR, nursing home or hospital, the date of discharge is required.

Diagnosis

a. Enter the appropriate diagnosis code from the ICD-10 CM that best reflects the beneficiary's condition and describes the need for the service or equipment requested.

Procedure code

a. Enter the HCPCS/CPT (procedure) code with the appropriate modifier (if applicable) of the equipment or service requested.

Description of services, durable medical equipment, or supplies

a. Enter the description of the requested equipment or service listed in the HCPCS/CPT Coding Manual.

Time required

a. Enter the best estimate of the timeframe and the beneficiary will have the requested equipment or service.

Frequency or units

a. Enter the number of services required or the number of items required to provide for the beneficiary's needs.
b. The time the service is needed may exceed limits and require adjustments by the Department of Health Care Finance for the balance of time needed for the service.

Estimated charges

a. Enter the estimated customary and usual charge for the service or equipment.

Justification

a. Enter medical justification for the equipment or supplies to be provided.
b. Enter the date of service for the requested product or service.

Note:

a. Do not enter the ICD-10 CM code here.
b. When requesting additional equipment accessories (i.e., a standard wheelchair) include height and weight, if the equipment is extra heavy, extra tall, etc.

For Dental Use Only

a. Select the appropriate tooth number, quadrant(s), and surface area.

For DME, Home Health, Private Duty Use Only

a. This section must be signed by the physician or authorized prescriber attesting to a face-to-face encounter.
b. Select the appropriate provider type.
c. Enter the name and title of the allowed prescriber.
d. Enter the date the form was signed.

Durable Medical Equipment Face to Face Regulations

a. Select the equipment that the face-to-face attestation is for.

Signature of Requesting Provider & Date:

a. This form must be signed by the physician or authorized prescriber requesting the services to be prior authorized.
b. Enter the title of the person signing the form.
c. Enter the date the form was signed.

Tips:

When completing the form, please be mindful of the following

- Copies of the 719A form are acceptable for original prior authorization requests.
- All 719A forms must be typed or printed legibly.
- Use miscellaneous codes **ONLY** when a more precise and appropriate HCPCS code is not available.
- When using a miscellaneous code, include the manufacturer's quote, invoice, or paid receipt with the 719A form, in addition to the required documentation.
- Prior authorization (PA) does not guarantee payment. A PA only authorizes those services and/or equipment may be provided.
- Payment for services and supplies is rendered in accordance with the fee schedule.

- Do not submit claims for a procedure requiring prior authorization without first obtaining the PA number. If you submit a claim for a procedure code that requires a PA, your claims will deny. Please consult the fee schedule to verify if the procedure code requires prior authorization. Once the PA request has been approved, you will receive a Prior Authorization letter containing the prior authorization number to enter your claim.

- Resubmissions must include a new 719A form with all required documentation including the letter received identifying the reason for the return.

Note:

- Payment is contingent on passing all edits contained within the claim's payment process, the beneficiary's continued Medicaid eligibility, and the ongoing medical necessity for the service being provided. Authorizations are specific to a beneficiary, a provider, a service code, an established quantity, and for specific dates of service. If prior authorization is required, authorization shall be received prior to the delivery of the DME/POS service or item. DME/POS prior authorizations are valid for six (6) months, except for capped rental items.
- Do not submit claims for a procedure requiring prior authorization without first obtaining the PA number. If you submit a claim for a procedure code that requires a PA, your claim will be denied if the PA number is not provided. Please consult the fee schedule at www.dc-medicaid.com, to verify if the procedure code requires prior authorization. Once the PA request has been approved, you will receive a PA letter containing the prior authorization number to enter your claim.
- If granted, a prior authorization is valid for six (6) months from the date of the physician or authorized provider's (requesting provider) signature or proposed delivery date.
- A service may occur after the authorized prescriber's signature, BUT a service cannot be authorized prior to the authorized prescriber's date of signature without his written documentation of the date of service within the six (6) month window allowed within the medical justification field.
- Use miscellaneous codes ONLY when a more precise and appropriate Healthcare Common Procedure Coding System (HCPCS) code is not available. When using a miscellaneous code, include the manufacturer's quote, invoice, or paid receipt with the 719A form, in addition to the required clinical documentation.
- If a prescribing clinician or DME/POS provider/supplier receives a discount for an item ordered for use by a D.C. Medicaid beneficiary, the prescribing clinician and/or DME/POS provider/supplier shall subtract the amount of the discount from the amount for which reimbursement is sought prior to submitting the claim to DHCF. Failure to comply with the requirements of this paragraph may result in denied claims, recoupment of any overpayments, temporary suspension of payments, or termination of the Medicaid Provider Agreement.
- A DME/POS provider/supplier shall be required to provide original documentation reflecting all discounts that apply to the cost of any item provided to a Medicaid beneficiary.
- In the case where a beneficiary walks into a DME provider office pharmacy for a product that does not require prior authorization (e.g., a pack of protective underwear, a blood pressure cuff, or compression stockings), a written prescription from a prescribing provider is sufficient.
- If a DMEPOS provider/supplier goes out-of-business, another enrolled DMEPOS provider/supplier that can provide continuous DMEPOS services/items to a beneficiary shall complete a new Form 719A, include a reference to the original prior authorization number on Form 719A, and submit the form to DHCF, or its designee. The new DMEPOS provider/supplier shall not provide any new item to a beneficiary until DHCF, or its designee, has provided a new prior authorization number.
- A DME/POS provider/supplier shall be required to produce proof of delivery (POD) for all items that are provided to a Medicaid beneficiary. POD may include:
    - Receipts that are signed by the beneficiary who requires DME/POS, or his or her legal representative; or
    - Delivery confirmation.

Prior to or at the delivery of DME, the DMEPOS provider/supplier shall perform an onsite evaluation of the beneficiary's home, if applicable, to verify that the beneficiary can adequately maneuver the item that is

provided considering the physical layout, doorway widths and thresholds, and surfaces. There shall be a written report on this evaluation, and the provider/supplier shall make it available upon DHCF's request. Documentation required under this section shall also be subject to the record keeping requirements of 29 DCMR § 996.9.

Figure 17: Sample 719A Prior Authorization Form

Government of the District of Columbia
Department of Health Care Finance
Fee-For-Service Medicaid Program

719A Prior Authorization Request

Patient			Prescribing Provider		Servicing Provider	
Beneficiary Name			Provider Name		Provider Name	
DCID Number			Provider Numbe	NPI	Provider Numbe	NPI
Address City, State, Zip			Address City, State, Zip		Address City, State, Zip	
Telephone Number	DOB	SEX	Telephone Number		Telephone Number	
Other Health Insurance Coverage			Requested Service		Beneficiary Location	
			Surgery ☐ DME ☐		Home ☐	
			Medical ☐ Pharmacy ☐		ICF/MR ☐	
			Dental ☐ Eyewear ☐		Nursing Hom ☐	
			Hospice ☐ Other ☐		Hospital ☐	
Discharge Date:			Home Health: ☐ Skilled Nurse ☐PT ☐OT ☐SLP ☐HHA ☐Private Dut		Office ☐	

Requested Service Data

Diagnosis Code	Procedure Code	Description of Services, DME and Supplies	Time Required	Frequency or Units	Estimated Charges

Justification

For Dental Use only

DENOTE THE TEETH ALREADY MISSING BY "X", TO BE EXTRACTED BY"?", X-RAYS TAKEN BY "V"

Q1				FACIAL								FACIAL				Q2
01	02	03	PRIMARY TEETH	04	05	06	07	08	09	10	11	12	13	PRIMARY TEETH	14	15	16
R																	L
I				A	B	C	D	E	F	G	H	I	J				E
G				LINGUAL								LINGUAL					F
H				T	S	R	Q	P	O	N	M	L	K				T
T																	
32	31	30		29	28	27	26	25	24	23	22	21	20		19	18	17
Q4				FACIAL								FACIAL					Q3

For DME, Home Health, Private Duty Use Only

Requesting Physician Certification: I certify that I have documented that a Face-to-Face encounter, related to the primary reason the beneficiary requires Home Health or DME services, occurred on _____ between the beneficiary and the allowed prescriber (listed below).

☐Primary Physician ☐ Nurse Practitioner ☐ Certified Nurse Mid-Wife ☐ Physician Assistant ☐ Acute or Post-Acute Physician

Name of allowed prescriber:_____ Title:_____ Date:_____

Durable Medical Equipment Face to Face Regulations

☐ **Any HCPCS code for the following types of DME:** ++Transcutaneous Electrical Nerve Stimulation (TENS) unit ++Rollabout Chair ++Traction-cervical ++Oxygen and Respiratory equipment ++Hospital beds and accessories

☐ Any item of DME that appears on the DMEPOS Fee Schedule with a price ceiling at or greater than $1,000.

☐ Any other item of DME that CMS adds to the list of Specified Covered Items

Signature of the Requesting Provider: I Certify that the services requested are medically indicated and necessary for the health of this patient and that the foregoing information is true, accurate, and complete.

Signature:_____ Title:_____ DATE

APPENDIX C: SUBMITTING 719A FORM

Failure to send the form and all required documentation to the correct office will delay processing of the request.

Service	Who to contact for Prior Authorizations	Comagine	DHCF Medicaid	Other
Botox	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Cosmetic, Plastic, reconstructive surgery (limited coverage)	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Dental Services	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Durable Medical Equipment	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Hearing Aids and Artificial Larynxes (for adults)	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Home Infusion	Department of Health Care Finance (DHCF) Office of Pharmacy Management: 202.442.5952 Fax-202-722-5685		X	
Home and Community Based Waiver Services for Persons with Intellectual Disabilities/Developmental Disabilities	DC Department on Disability Services Developmental Disabilities Administration Medicaid Waiver Office 202.730.1566 Fax number: 202.730.1804			X
Home and Community Based Waiver Services for Elderly Persons with Disabilities – CASE MANAGEMENT PROVIDERS	DHCF Office of Chronic & Long-Term Care 202.442.9533 (Comagine provides EPD waiver CM PAs only)		X	
Home and Community Based Waiver Services for Elderly Persons with Disabilities— NON-CASE MANAGEMENT PROVIDERS	DHCF Office of Chronic & Long-Term Care 202.442.9533		X	
Home Health Services (non-waiver)	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Injections Administered in a Physician's office ("J codes")	DHCF Office of Pharmacy Management: Phone: 202.442.5952 Fax: 202.722.5685		X	

Inpatient Hospital Admissions	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Medications dispensed by a pharmacy	Magellan Help Desk-800.273.4962			X
Nutritional Supplements (tube feedings) for in-home care	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Orthotics and Prosthetics	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Optical Services	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Organs Transplants (when covered, e.g., heart, kidney, liver, allogeneic bone marrow	DHCF / Medicaid Medical Director: 202.442.9077 Fax number: 202.535.1216		X	
Outpatient Procedures Surgeries	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Pain Management Procedures (Inpatient)	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Pediatric Specialty Hospital Admissions (i.e., Cumberland and Kennedy Krieger Hospitals)	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Personal Care Aide Services (non-waiver)	DHCF Office of Chronic & Long-Term Care 202.442.9533		X	
Pet Scans	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Sleep Studies	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		
Surgical procedures (Some types require prior authorization, including gastric bypass surgery, mammoplasty	Comagine Health Prior Authorization Unit: 800.251.8890 Email: dcmedicaid@qualishealth.org	X		

APPENDIX D: IVR INSTRUCTIONS

The Department of Health Care Finance Medicaid Branch 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 unlimited number 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 claim 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.

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 an item 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 generally 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.