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**Inpatient Hospital Billing Manual**  
**Date: 7/23/2025**  
**Version 8.01**

## 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 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](http://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](http://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](http://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 Outdated copies of material should be discarded.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](http://www.dhcf.dc.gov).

## 1.7 Web Portal

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

- Bi-monthly bulletins and transmittals

- Provider Type Specific Billing Tips
- Provider Type Specific FAQ (Frequently Asked Questions)
- Provider 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](http://www.dc-medicaid.com) in your browser Favorites the first time you visit the site so you can quickly return again and again.

## 1.8 Fiscal Agent

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

The fiscal agent consists of technical and program staff. Technical staff maintain 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

|   |   |
|---|---|
| <b>Conduent Provider Inquiry</b><br><b>PO Box 34734</b><br><b>Washington, DC 20043-4734</b> | (202) 906-8319 (inside DC metro area)<br>(866) 752-9233 (outside DC metro area)<br>(202) 906-8399 (Fax)<br><a href="mailto:providerinquiry@conduent.com">providerinquiry@conduent.com</a> |
| <b>Conduent EDI Gateway Services</b>  | (866) 407-2005<br><a href="http://edisolutionsmmis.portal.conduent.com/gcro/">http://edisolutionsmmis.portal.conduent.com/gcro/</a>   |

### 1.8.2 Mailing Contact Information

Providers may contact the fiscal agent via the 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 seq.) 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](http://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](http://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 seek 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 through 26 that have complex medical needs and are 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 are 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                                   | (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 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 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](http://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. [Note: All required documents as indicated by provider type must be received by Conduent' Provider Enrollment Department to complete the application package. Online applicants must indicate the correspondence and application tracking numbers on all documents submitted to Conduent.] Documents are to be mailed to Conduent at the address indicated in Appendix A.

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](http://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 |
| <a href="#">DC DDS</a>        | Approved | IDDD Waiver   |     |             | Case Management      | 20007 - 3717 |                | 09/22/16    |                        |
| <a href="#">Dietician</a>     | Approved | IDDD Waiver   |     | 111114028   | Employment Readiness | 20007 - 3717 | 09/22/16       | 09/22/16    | 09/22/19               |
| <a href="#">Test DDS Deny</a> | Denied   | IDDD Waiver   |     |             | Case Management      | 20007 - 3717 |                | 09/22/16    |                        |

- If you have any questions or concerns, please contact MAXIMUS Provider Customer Service at 844-218-9700 TTY 844-436- 8333 (Monday – Friday 8:00am- 5:00pm)

#### 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 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 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](http://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 seq.) 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, 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 responsible licensed provider. Stamped signatures will not be accepted. All care by ancillary personnel must be countersigned by the responsible licensed provider. Any alterations to the record must be signed and dated
- Contain a preliminary working diagnosis as well as final diagnosis, including elements of a 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
- Contain 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 the 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 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 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 an 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 the 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 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 which 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 an 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 competency. Staff additionally engage in issue-specific consultations and perform supplemental functions as necessary.
- **Community Engagement:** To ensure that LEP/NEP residents, workers, and visitors are aware of their language access rights, the Language Access Program conducts outreach in conjunction with community-based organizations that serve immigrant needs. In addition to tabling at events, Program staff regularly delivers "Know Your Rights" trainings. Staff also 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%20REGULATION%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 timeframe, there is no guarantee that an interpreter will be available. However, urgent requests may be fulfilled depending on an interpreter's availability.

For MCO Enrollees: Providers should follow the guidelines established by the enrollee's managed care organization (MCO) for receiving authorization for interpretive services. Please contact 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 billed and been paid for undocumented or unnecessary medical services, DHCF will review the claims and determine the amount of improper payment. The provider will be required to either submit payment or provide repayment through future claims. 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

#### 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
- 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 directly 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 financial responsibility
11. Children receiving subsidized adoption payments
12. Persons who receive only 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



Sex:                      Ins. C.    Case:

DOB:

Name:

***The "M" Card: Covering 1 in 4 DC Residents***

Figure 2: Medical Assistance Card – Back Image

### Signature of Adult/Firma del adulto

- (202) 698-2000** to find a doctor  
para encontrar un médico
- (202) 639-4030** for help with your managed care plan  
para la ayuda con su plan de salud
- (202) 727-5355** to change your address (or report  
other changes)  
para cambiar su dirección (o  
informarnos de otros cambios)



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 Inquiry 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 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](http://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 a 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

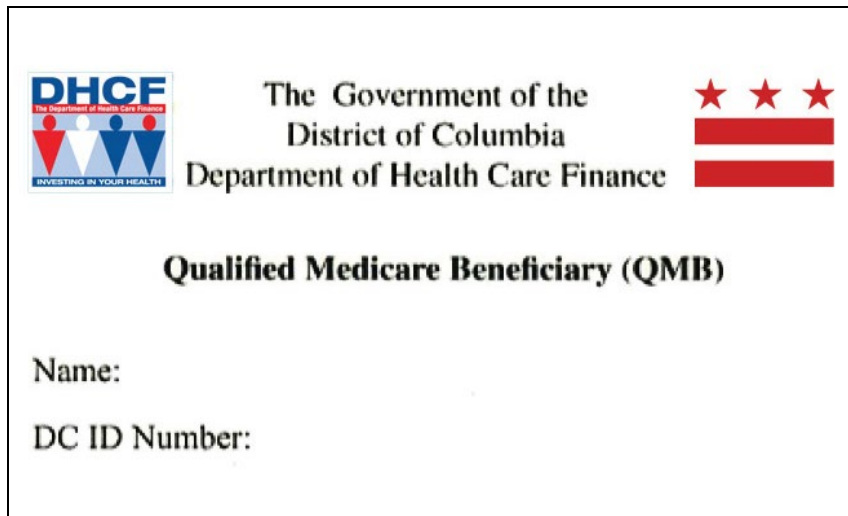


Figure 4: QMB Medical Assistance Card – Back Image

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 INPATIENT HOSPITAL SPECIFIC BILLING INSTRUCTIONS

### 10.1 All Patient Refined Diagnosis Related Groups (APR-DRG)

Effective October 1, 2014, the Department of Health Care Finance (DHCF) is implementing a new method of paying for hospital inpatient services in the fee-for-service Medicaid program. The new APR-DRG method will apply to general acute care hospitals currently paid by DRGs, including out-of-district hospitals except for Maryland hospitals. State of Maryland hospitals will continue to be paid by their current method as required by a federal waiver. The inpatient payment method for stand-alone mental health, long-term care, and rehabilitation facilities is outlined in Section 9.9 Payment to Specialty Hospitals for Inpatient Hospital Services.

The district currently uses a hospital-specific base price reimbursing each hospital at 98% of their costs. As of October 1, 2014, the department will implement a single district-wide base price for all acute care hospitals. The district-wide base rate will be set to be reimburse at 98% of costs for District hospitals as a group. Hospital-specific payment-to-cost ratios will vary dependent on each hospital's cost-efficiency. The hospital-specific base rate consists of the District-wide base rate plus each hospital's indirect medical education (IME) payment. This rate is used to calculate DRG base payments.

In addition, United Medical Center is the only hospital identified as being in an Economic Development Zone within the District. District government has a policy of providing a 2% favorable consideration to qualified businesses in Economic Development Zones. UMC will receive an increase to the District-wide base rate by 2%.

Under DRG payment, complete recording of all appropriate diagnoses and procedure codes is critical to appropriate DRG assignment.

For approximately 96% of stays, it is likely that payment will be made using a "straight DRG" calculation that is; payment will equal the DRG relative weight times the hospital's base rate. In special situations, payment may also include other adjustments, for example:

- **Transfer pricing adjustment:** Payment may be reduced when the patient is transferred to another acute care hospital.
- **Cost outlier adjustment:** Medicare and other DRG payers typically make additional "outlier" payments on stays that are exceptionally expensive for a hospital. Some payers also have a payment reduction if a stay is exceptionally profitable for a hospital. Nationally, outlier adjustments typically affect 1% to 2% of all stays and a higher percentage of all DRG payments. The Department will change from DRG-specific outlier thresholds to a single threshold for high side outliers and a single threshold for low-side outliers.
- **Policy Adjustors:** Policy adjustors can be used to explicitly increase or decrease DRG weights for certain care categories to meet policy goals. The Medicaid program may choose to focus its scarce funds in the clinical areas where Medicaid funding makes the most difference to beneficiary access focused on operating pay-to-cost ratios. Policy adjustors should be few, apply to entire Medicaid Care Categories (MCC), and be initiated for compelling policy reasons, e.g., to enable access for care where Medicaid payment levels can have substantial impact.

DHCF has evaluated the impact of various MCCs specific to pediatrics (less than 21 years old). The final rate setting occurred in May of 2014 and the Department has decided to implement three policy adjustors on October 1, 2014, to promote access for pediatric mental health, neonates: and for all other pediatric stays, excluding newborns.

The calculation formula is a case mix relative weight x policy adjustor = payment relative weight

- **Third Party Liability and patient cost-sharing:** DRG payment policies determine the allowed amount. From the allowed amount, payers typically deduct payments from other health coverage (e.g., workers' compensation) as well as the patient's share of cost. No changes are planned to current policies or procedures on third party liability or share of cost.

The Department will change from DRG-specific outlier thresholds to a single threshold for high-side outliers and a single threshold for low-side outliers.

The Department intends to implement V.31 of APR-DRGs, which was released October 1, 2013. Simulation modeling for the new payment method was performed using V.30 (released October 1, 2012). The final rate setting was completed using V.31.

### 10.1.1 Relative Weights

DC Medicaid will use Hospital-Specific Relative Value (HSRV) national relative weights as developed and maintained annually by 3M the Nationwide Inpatient Sample by 3M. The relative weight is multiplied by the hospital's base rate to determine the DRG base payment.

### 10.1.2 High cost/Low-cost Outlier Payments

High-cost outliers will be paid in a similar fashion to the current method; however, there are changes effective October 1, 2014. At that time, high-cost outliers will be paid using a standard high-cost outlier threshold that is no longer DRG-specific to determine whether a claim qualifies for high-cost outlier treatment. The change from DRG-specific thresholds to a single threshold necessitates a change in the outlier payment calculation. Currently, outliers are paid at 80% of excess costs. (Excess costs are costs that exceed the DRG cost outlier threshold.) The new method is as follows. First, it is determined whether a loss has occurred. If that loss reaches the outlier threshold, the stay qualifies for a high-cost outlier payment. The hospital CCR is multiplied by charges to calculate the estimated cost of the stay. The difference between the cost of stay and DRG payment determines the estimated loss on the stay. If the estimated loss exceeds the outlier threshold the stay qualifies for an outlier payment. The second step is to calculate the outlier payment as the estimated loss minus the threshold, times the marginal cost factor.

Low-cost outliers will be paid in a similar fashion to the current method using the transfer policy algorithm; however, there is one change that will be effective October 1, 2014. DRG-specific thresholds will no longer be used in favor of a single marginal cost threshold, to determine whether a claim qualifies for low-cost outlier treatment. The "gain" on these claims will be measured (charges times CCR minus the DRG payment) and if the gain exceeds the marginal cost threshold, then the transfer policy methodology to calculate the reduced payment will be used.

### 10.1.3 Payment for Transfers

DC Medicaid follows the Medicare model for transfers to another acute care hospital. For these stays, the transferring hospital would be paid the lesser of:

- The DRG base payment.
- A per diem amount times the actual length of stay plus one day (to recognize the up-front costs of admission). The per diem amount would be the DRG base payment divided by the DRG-specific average length of stay.
- The effect would be to reduce the DRG base payment if the actual length of stay at the transferring hospital is less than the overall average length of stay minus one day. The receiving hospital is paid the full DRG payment. Currently, claims with a patient discharge status of 02 or 05, indicating an acute care transfer, are paid using this transfer logic applied to the transferring hospital only. The Department will adjust transfer logic to include eight additional patient discharge status codes; see below for a listing of codes.

| <b>Changes in Discharge Status Codes that Affect Transfers</b>  |  |
|---|--|
| <b>Discharge Status Codes</b>   | <b>New Readmission Discharge Values that Parallel Current Discharge Status Codes</b>   |
| 02: Discharged/transferred to a short-term hospital for inpatient care                                    | 82: Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission  |
| 05: Discharged/transferred to a designated cancer center or children's hospital                           | 85: Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient             |
| 63: Discharged/transferred to a long-term care hospital   | 91: Discharged/transferred to a Medicare certified long-term care hospital (LTCH) with a planned acute care hospital inpatient           |
| 65: Discharged transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital      | 93: Discharged/transferred to Medicare certified long-term care hospital (LTCH) with a planned acute care hospital inpatient readmission |
| 66: Discharged/transferred to a critical access hospital  | 94: Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission                  |
| Notes:  |  |
| 1. Codes in black font will trigger a transfer adjustment for DRG claims effective 10/1/14.               |  |
| 2. Discharge status codes addressing readmission were announced in MLN Matters CR 8421 released 11/19/13. |  |

### 10.1.4 Interim Claims

District DRG hospitals, including out-of-District hospitals except Maryland hospitals. Maryland hospitals will continue to be paid by their current method as required by a federal waiver. The hospital can submit an interim claim (type of bill 112 or 113) and be paid an interim per diem (\$500) times the number of days. When the patient is discharged, the hospital voids the previous interim claims and submits one claim, admit through discharge showing all charges, diagnoses, and procedures for the full admit-through-discharge period. Bill types 114 (final interim claim) and 115 (late charges) will be denied from DRG hospitals.

### 10.1.5 Add-on Payments

DC Medicaid makes add-on payments to hospitals, e.g., for medical education and capital. Capital and direct medical education (DME) are currently paid as per-discharge add-ons while indirect medical education (IME) is added to each hospital's base rate. Some hospitals have requested that efficiency be rewarded in the reimbursement process by redirecting hospital-specific add-on payments toward the district-wide base price.

In January 2014, the District shared the plan to phase in the implementation of changes to add-on payments in the DRG reimbursement model for fee-for-service Medicaid beneficiaries. These are the final decisions regarding phased-in limits to Capital, DME, and IME payments for DRG hospitals which will be effective with the implementation of APR-DRGs on October 1, 2014:



- **IME:** IME limits will be phased in over two years. The District will limit IME to 75% of the amount calculated using the Medicare algorithm in FY15. In FY16 and thereafter, the limit will be 50% of the amount calculated using the Medicare algorithm.
- **DME:** In FY15, the District will limit DME to 200% of the District average DME payments per Medicaid patient day for teaching hospitals. That limit will move to 150% of the average for FY16 and thereafter.
- **Capital** - In FY15 and thereafter, capital add-ons will be limited to 100% of the District average capital payments per Medicaid patient day.

### 10.1.6 Newborn Birth Weight

For dates of discharge after April 1, 2010, providers were no longer required to record birth weight on newborn claims, but to code birth weight using the ICD-10 code. The capability still exists for hospitals to submit the birth weight in a separate field called the value code- amount field which is treated as a birth weight when the corresponding value code (code of 54) is entered indicating birth weight. As of 10/1/14, hospitals can submit birth weight on claims in either way- either within the diagnosis code or the value code field. DC Medicaid will adjust the APR-DRG grouper setting to allow the grouper to read birth weight in both ways. Hospitals are encouraged to submit the birth weight in the value-code field as this is more specific.

### 10.1.7 Hospital Outpatient Diagnostic Services

Hospital outpatient diagnostic services provided one to three days prior to an inpatient admission at the same hospital are not separately payable and should be billed as part of the inpatient stay. Diagnostic services are defined by the revenue code. Additionally, all hospital outpatient services that occur on the same day as an inpatient admission at the same hospital are considered part of the inpatient stay and are not separately payable. Please refer to section 15.1.8 - Observation Room Services of the Outpatient Billing Manual.

### 10.1.8 Resources for Inpatient Claim Billing and Pricing

Resources for Inpatient Claim Billing and Pricing include:

- **DRG Grouping Calculator:** 3M Health Information Systems has agreed to provide all District hospitals with access to an APR-DRG Grouping Calculator at no charge. The calculator is a webpage that enables the user to enter diagnoses, procedures and other claims data and then shows the step-by-step assignment of the APR-DRG to a single claim.
- **DRG Pricing Calculator:** Once decisions have been made about the structure of the APR-DRG payment method, DHCF plans to make an APR-DRG Pricing Calculator available. It will not assign the APR-DRG, but it will show how a given APR-DRG will be priced in different circumstances. The calculator will include a complete list of APR-DRGs and related information.

## 10.2 Same Day Discharges

Claims representing same-day discharges are denied with instructions to bill the services as outpatient services. Same-day discharges occur when the patient is admitted and discharged on the same date. Same-day discharges are not allowed unless the patient status indicates death.

## 10.3 One Day Stays

- A one-day stay occurs when the discharge date occurs on the day following the admission date. Under APR-DRG PPS, a claim reflecting a one-day stay is paid as a hospital stay but may be subject to post-payment review of the medical necessity of the admission.
- A one-day stay may qualify for a low-cost outlier adjustment pursuant to the low-cost outlier policy.

## 10.4 Payment to Specialty Hospitals for Inpatient Hospital Services

Effective October 1, 2014, the Department of Health Care Finance (DHCF) will implement a new payment method for hospital inpatient services at certain specialty hospitals in the fee-for-service Medicaid program. The new method will apply to specialty inpatient psychiatric, rehabilitation, adult long term care acute hospitals (LTCH) and pediatric LTCH hospitals. The District currently reimburses these types of hospital on a hospital-specific, flat-rate per diem method.

DHCF will use APR-DRGs to adjust payment to select specialty hospitals. Some hospitals will continue to be paid on a per diem basis and others on a per stay basis. In both cases the actual payment will be adjusted for the severity of the member, based on the APR-DRG assigned to their hospital stay. Specifically:

- Psychiatric hospitals: case mix adjusted per-diem
- Rehabilitation: case mix adjusted per-diem
- Pediatric LTCH: case mix adjusted per-diem
- Adult LTCH: DRG based per-stay

### 10.4.1 Per-diem Specialty Hospitals

Under the per diem method, each hospital will have their own per diem base rate. Each hospital stay will be assigned an APR-DRG. A relative weight is assigned to each APR-DRG. Payment is then a component of base rate x APR-DRG relative weight x number of authorized days.

There are no policy adjusters applied to the per-diem specialty hospitals.

The per diem hospitals will incorporate a new transfer payment rule. Historically, per diem reimbursement does not pay for the last day of a hospital stay (day of discharge). Under the new payment methodology, if a patient is transferred to another acute care facility, the per diem hospital will be paid for the last day of the stay, at the case mix adjusted per diem amount.

### 10.4.2 Per-stay Specialty Hospitals

Under the per stay method, the adult LTCH hospitals have a base rate. Each hospital stay will be assigned an APR-DRG. A relative weight is assigned to each APR-DRG. Payment is then a component of the base rate X APR-DRG relative weight + any applicable outlier adjustments.

Under the per stay method, there are low and high-cost outlier adjustments.

High-cost outliers will be paid in a similar fashion to other DRG hospitals. Currently, outliers are paid at 80% of excess costs. (Excess costs are costs that exceed the DRG cost outlier threshold.) The new method is as follows. First, it is determined whether a loss has occurred. If that loss reaches the outlier threshold, the stay qualifies for a high-cost outlier payment. The hospital CCR is multiplied by charges to calculate the estimated cost of the stay. The difference between the cost of the stay and DRG payment determines the estimated loss on the stay. If the estimated loss exceeds the outlier threshold the stay qualifies for an outlier payment. The second step is to calculate the outlier payment as the estimated loss minus the threshold, times the marginal cost factor.

Low-cost outliers will be paid in a similar fashion to the current method using the transfer policy algorithm. The "gain" on these claims will be measured (charges times CCR minus the DRG payment) and if the gain exceeds the marginal cost threshold, then the transfer policy methodology to calculate the reduced payment will be used.

For the per stay hospitals, transfer adjustments will be applied in the same manner that DRG-paid hospitals currently are. Specifically, DC Medicaid follows the Medicare model for transfers to another acute care hospital. For these stays, the transferring hospital would be paid the lesser of:

- The DRG base payment

- A per diem amount times the actual length of stay plus one day (to recognize the up-front costs of admission). The per diem amount is the DRG base payment divided by the DRG-specific average length of stay.

The effect of this calculation reduces the DRG base payment if the actual length of stay at the transferring hospital is less than overall average length of stay minus one day. The receiving hospital would receive the full DRG payment. Currently, claims with a patient discharge status of 02 or 05 indicating an acute care transfer are paid using special transfer logic applied to the transferring hospital only. The Department will adjust transfer logic to include eight additional patient status codes. Refer to the table below for a listing of codes.

| <b>Changes in Discharge Status Codes that Affect Transfers</b>                                       |  |
|--|--|
| <b>Discharge Status Codes</b>  | <b>New Readmission Discharge Values that Parallel Current Discharge Status Codes</b>   |
| 02: Discharged/transferred to a short-term hospital for inpatient care                               | 82: Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission    |
| 05: Discharged/transferred to a designated cancer center or children's hospital                      | 85: Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient               |
| 63: Discharged/transferred to a long-term care hospital  | 91: Discharged/transferred to a Medicare certified long-term care hospital (LTCH) with a planned acute care hospital inpatient             |
| 65: Discharged transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital | 93: Discharged/transferred to a Medicare certified long-term care hospital (LTCH) with a planned acute care hospital inpatient readmission |
| 66: Discharged/transferred to a critical access hospital   | 94: Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission                    |
| Notes:   |  |
| 1. Codes in black font will trigger a transfer adjustment for DRG claims effective 10/1/14.          |  |
| 2. Discharge status codes addressing readmission were announced in MLN Matters CR 8421               |  |

Interim claims will be accepted from specialty per-stay hospitals for stays that exceed a threshold of 30 days or \$500,000 in charges. The hospital can submit an interim claim (type of bill 112 or 113) and be paid an interim per diem amount (\$500) times the number of days. When the patient is discharged, the hospital voids the previous interim claims and submits one claim, admit through discharge showing all charges, diagnoses, and procedures for the full admit-thru-discharge period. Bill types 114 (final interim claim) and 115 (late charges) will be denied from DRG hospitals.

Specialty Hospital payments will be hospital specific. As such, no additional add-on payments are anticipated.

There are no changes to Medicare crossover claims. Medicaid will continue to pay the lesser of these two amounts on an inpatient crossover claim:

- The Medicaid allowed amount minus the Medicare paid amount
- The Medicare co-insurance amount plus Medicare deductible amount

## **10.5 Payment Adjustment for Provider - Preventable Conditions**

The District of Columbia Department of Health Care Finance (DHCF) is implementing a new policy required by federal law that prohibits Medicaid payment for services related to provider-preventable conditions (PPCs).

The federal requirements are part of the Patient Protection and Affordable Care Act (PPACA or the Affordable Care Act) which prohibited federal payments to states for Medicaid services related to health care-acquired conditions effective July 1, 2011 and required CMS to issue regulations.

On June 1, 2011, CMS published final regulations for Medicaid programs nationwide. CMS titled these provisions "Payment Adjustment for Provider-Preventable Conditions Including Health care-Acquired Conditions." The CMS rule was effective July 1, 2011; however, CMS delayed compliance enforcement until July 1, 2012, to allow Medicaid programs time to develop and complete implementation of PPC policies.

Medicaid providers will no longer be reimbursed for specific PPCs including both health care acquired conditions (HCACs) and erroneous surgical or other provider preventable conditions (OPPCs). Hence, payment will be adjusted for any portion of a provider's claim directly relating to the treatment of a specified list of HCACs that were not present upon admission to an inpatient hospital setting. This means that payments will only be adjusted if the patient did not have the condition upon admission to the hospital but acquired it during their hospital stay. In addition, no payment will be made for erroneous surgical or other invasive procedures, commonly known as OPPCs.

## 10.6 Hospital Acquired Conditions

HACs are any of the specified conditions which are present as a secondary diagnosis and acquired during the stay. For all claims submitted on or after July 1, 2012, each provider shall collect and record information related to HCACs in the present on admission (POA) indicator field and on the secondary diagnosis indicator field on all applicable claims, regardless of whether the claims are submitted in a hardcopy or electronic format.

The Medicaid HCACs are based on the list of Medicare HACs for FFY 2012 and are:

- 1) Foreign object retained after surgery
- 2) Air embolism
- 3) Blood incompatibility
- 4) Catheter associated with urinary tract infection
- 5) Pressure ulcers stage III and IV (decubitus ulcers)
- 6) Vascular catheter associated infection
- 7) Mediastinitis, after coronary artery bypass graft (CABG)
- 8) Falls and trauma, resulting in fractures, dislocations, intracranial injury, crushing injury, burns, and other unspecified effects of external causes
- 9) Manifestations of poor glycemic control
- 10) Surgical site infection after spine, neck, shoulder, or elbow orthopedic procedures
- 11) Surgical site infection after bariatric surgery for obesity
- 12) Deep vein thrombosis and pulmonary embolism after total knee replacement or hip replacement, except for pediatric (individuals under the age of 21) and obstetric populations.

The following provider types shall be denied reimbursement for the portion of a claim attributed to any HCAC:

- a) All Hospitals paid on a diagnosis-related group (DRG) basis; and
- b) All Hospitals paid on a non-DRG basis.

Claims paid by DRG will be adjusted using specific HCACs logic supplied with the 3M™ AP-DRG grouper software. This process functions in a similar way to the Medicare DRG grouper logic does for the Medicare HACs.

The DHCF claims processing system will identify HCACs from the diagnosis, procedure and POA information on the claim and disregard the HCAC in assigning the AP-DRG. Payment for the stay would therefore only be affected if the presence of HCAC would otherwise have pushed the stay into

a higher-paying AP-DRG. DRG claims will continue to be priced by DRG with payment reduced if removing the HCACs results in a DRG with a lower relative weight.

Non-DRG claims will price according to existing payment methodologies for the provider (e.g., per diem). However, these claims will go through the HAC logic of the AP-DRG grouper software to determine whether the HCAC affects payment and to calculate the proper payment adjustment, if applicable. DRG assignments will be used for the purpose of identifying the effect of a HCAC on the resources needed to care for a patient.

This process will function in the same manner as for DRG claims (see question 18). If removing the HCAC results in a DRG with a lower relative weight, then payment will be affected. Payment would be adjusted by a percentage based on the difference in the DRG weights. For example:

|  |  |
|--|--|
| DRG weight <u>before</u> removing the HCAC:  | 1.50   |
| DRG weight <u>after</u> removing the HCAC:   | 1.20   |
| Post-HCAC DRG weight as a percentage:        | 80%  |
| Facility per diem rate:                      | \$500  |
| Length of stay (LOS):                        | 4 days   |
| Claim price <u>before</u> removing the HCAC: | $\$500 \times 4 = \$2,000$   |
| Claim price <u>after</u> removing the HCAC:  | $(\$500 \times 4) \times (1.20 / 1.50) = (\$2,000 \times .80) = \$1,600$ |

## 10.7 Erroneous Surgical and OPPCs

These are surgical or other invasive procedures to treat a particular medical condition that result in an error. For all claims submitted on or after July 1, 2012, providers shall report OPPCs by using modifiers and E-codes on paper and electronic claim forms that refer to the prohibited procedures.

The Medicaid erroneous and OPPCs are:

- 1) Wrong surgical procedure.
- 2) Correct procedure performed on the wrong body part; and
- 3) Correct procedure performed on the wrong patient

The following provider types shall be denied compensation for claims associated with OPPCs:

- a) All Hospitals paid on a diagnosis-related group (DRG) basis.
- b) All Hospitals paid on a non-DRG basis; and
- c) Other providers, regardless of whether they are paid on a fee-for-service or capitated basis.

Hospital inpatient and outpatient providers should report wrong procedures using the following diagnosis codes in the fields provided for event codes:

- Y65.51 - Performance of wrong operation (procedure) on correct patient
- Y65.52 - Performance of operation (procedure) on patient not scheduled for surgery
- Y65.53 - Performance of correct operation (procedure) on wrong side/body part

In addition, facilities and practitioners should also report wrong procedures using the following CPT/HCPCS modifiers associated with the surgical procedure:

- PA - Surgical or other invasive procedure on wrong body part
- PB - Surgical or other invasive procedure on wrong patient
- PC - Wrong surgery or other invasive procedure on patient

## 10.8 Present on Admission (POA) Indicator

The present-on-admission indicator (POA) is the method that a hospital uses to identify which patient conditions were present on admission and which conditions developed while hospitalized. The POA indicator is assigned to each reported diagnosis code, for principal and secondary diagnoses. The POA must be reported for external cause of injury codes (E-codes) when the E-code is included in a secondary diagnosis code field locator (FL 67 A-Q).

For the official guidelines on how to apply the POA indicator as well as information on complete and accurate documentation, code assignment and reporting of diagnoses and procedures, please visit <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html> to see the *ICD-10-CM Official Guidelines for Coding and Reporting*.

## 10.9 Emergency Medicaid Policy

It is the policy of Department Healthcare Finance (DHCF) and Economic Security Administration (ESA) to provide Emergency Medicaid coverage to individuals who receive treatment for an emergency medical condition and who meet all eligibility requirements of the Medicaid program except for citizenship and immigration status.

Emergency Medicaid provides limited Medicaid coverage to individuals who meet financial, medical, and non-financial eligibility factors except for U.S. citizenship/eligible immigration status for the District of Columbia Medicaid program. Emergency Medicaid does not provide comprehensive health care coverage or continual health coverage. Emergency Medicaid only provides coverage and payment for the treatment of the emergency medical condition. If approved, Emergency Medicaid coverage is only for the duration of the emergency medical condition request. Emergency Medicaid only covers medical services associated with direct treatment of the emergency medical condition.

To be considered eligible for Emergency Medicaid, the applicant must meet the following non-financial and financial eligibility factors:

- Must meet the District's residency requirement for DC Medicaid.
- Must meet an emergency medical condition.
- Must not be a US citizen or have eligible immigration status for on-going Medicaid.
- Must meet the income standards for the specific eligibility category for which the individual qualifies for Emergency Medicaid.
  - For Aged, Blind, Disabled (ABD) category only, resources cannot exceed \$4,000 for an individual and \$6,000 for couple. The Aged, Blind, and Disabled category is the only eligibility category in which a resource test applies.

The income threshold for Emergency Medicaid shall be determined based on the eligibility category. Depending on the eligibility category, the prospective applicant will be determined using MAGI or non-MAGI rules. The MAGI methodology shall apply to the following eligibility groups:

- Childless Adults (21-64)
- Children (0-20)
- Parents/Caretaker Relatives
- Pregnant Women

Non-MAGI methodology shall apply to the Aged, Blind, or Disabled group. Applications for Emergency Medicaid may be submitted by the applicant, an adult in the applicant's household, an authorized representative, or, if the applicant is a minor or incapacitated, someone acting responsibly for the applicant. Pursuant to 42 C.F.R. §435.923, a provider cannot apply unless the applicant has designated the provider to be the authorized representative.

ESA has up to 45 days to process the application and determine eligibility for Emergency Medicaid. If an individual is approved for Emergency Medicaid, any services related to the emergency medical

condition that was treated within the three months before the date of application may be covered. If approved for retroactive Medicaid but the claim associated with the treatment of the emergency medical condition is prior to the maximum three months retroactive Medicaid eligibility effective date, the requested Emergency Medicaid service will not be covered.

### **10.9.1 Uninsured Individuals Who Receive Emergency Services**

An uninsured individual, who receives emergency services including labor and delivery, may apply for Emergency Medicaid coverage using the Combined Application for Medical Assistance, Emergency Medicaid Query form, and if MAGI, the supplemental question form.

To be eligible for Emergency Medicaid, an applicant must have an emergency medical condition and must meet financial and non-financial eligibility factors.

- Applications for Emergency Medicaid will be reviewed and processed by the Medicaid Branch at ESA.
- If eligibility factors could not be verified using electronic data hubs, the applicant may be required to provide additional documentation to verify any outstanding eligibility factors. The applicant must provide clinical documentation from a medical professional of the existence of an emergency medical condition.
  - a. Acceptable clinical documentation for labor and delivery includes:
    - Birth Certificate (if available)
    - Certificate of Birth
    - Hospital Discharge Summary
  - b. Acceptable clinical documentation for an emergency medical condition includes:
    - Medical examination report
    - Hospital Discharge Summary
    - Medical Records

Emergency medical conditions, excluding labor and delivery, must be verified by a DHCF licensed health care professional.

NOTE: The submission documents must include the date(s) of services for labor and delivery, or the emergency hospital stay.

- If the request for Emergency Medicaid is related to labor and delivery, ESA will verify all financial and non-financial eligibility factors and review the submission documents to either approve or deny Emergency Medicaid.
- If the request for Emergency Medicaid is not related to labor and delivery, ESA will determine if all financial and non-financial eligibility factors are met. The Emergency Medicaid medical documentation will be forwarded to DHCF's clinical review team to complete the clinical review.
- ESA will send the medical documentation to DHCF to initiate the clinical review process even if all other verification documents have not been received. Review of non-medical eligibility factors can occur prior to or while the clinical review is being conducted. If after review of the eligibility factors ESA determines that the individual does not meet any of the non-financial or financial eligibility factors, and then ESA must inform DHCF that further review is not needed due to ineligibility for Emergency Medicaid.

#### **10.9.1.1 DHCF Receipt of Emergency Medicaid Request**

- DHCF shall review the Emergency Medicaid request to ensure that the information is complete and contains appropriate clinical documentation to decide.
- The Health Care Operation Administration at DHCF has the responsibility of conducting the initial clinical review of all Emergency Medicaid clinical requests.
- If the request is incomplete, DHCF shall forward the request back to ESA to indicate that a clinical decision cannot be made, and additional documentation is needed.

- ESA will send out a notice informing the client that additional clinical information is needed. a. If additional clinical information is not received within 45 days of the application date, the application will be denied, and the applicant will be sent a legally sufficient and timely denial notice.
- If the clinical information is complete, the DHCF Clinical Reviewer shall determine whether the medical documentation meets the definition of an emergency medical condition.
- If the criteria for an emergency medical condition are met, the DHCF Clinical Reviewer will notify ESA of the emergency medical condition approval. If the applicant meets all other eligibility factors for Emergency Medicaid, then an approval notice will be sent to the applicant.
- If the request does not meet the criteria for Emergency Medicaid, the DHCF Clinical Reviewer shall deny the Emergency Medicaid request and forward the request to the DHCF Medical Director who is the second-level clinical reviewer of all denied requests. The first level Clinical Reviewer's denial decision shall be documented in the request package.
- The Medical Director shall confirm or disagree with the first reviewer's denial by reviewing documentation on whether the circumstances met the definition of an emergency medical condition.
- If the Medical Director agrees with the denial of the request, he or she shall confirm the decision.
- The request will be sent back to ESA indicating that DHCF has completed the clinical review. ESA will deny the Emergency Medicaid application.
- If the Medical Director disagrees with the denial, he or she shall document the evidence in support of an Emergency Medical Condition. The request will be sent back to ESA indicating that DHCF has completed the clinical review and approved the emergency medical condition.
- If the applicant wishes to dispute this decision, he or she may submit a formal request for an administration hearing with the Office of Administration Hearings (OAH).

### **10.9.2 Economic Security Administration's receipt of Request for Emergency Medicaid Determination**

- If the clinical review has been completed with an approval status and all financial and non-financial eligibility factors have been verified, the Medicaid Unit at ESA will approve eligibility for Emergency Medicaid.
- If the clinical review has been completed with a denied status or financial and other nonfinancial eligibility factors have not been verified within the 45 days application processing period, the Medical Unit at ESA shall deny the request for Emergency Medicaid application.

### **10.9.3 Alliance Beneficiaries and Medicaid-Reimbursable Emergency Services**

Medicaid reimbursable emergency services, including services related to labor and delivery, are not included in the Alliance benefit package, and will not be paid to network hospitals by managed care organizations participating in the Alliance program. These claims must be submitted directly to DHCF for payment. Providers must check for active Alliance eligibility prior to service delivery. Current Alliance beneficiaries will remain in program code 470.

Hospitals providing Medicaid reimbursable emergency medical services to Alliance beneficiaries should submit claims for these services directly to DHCF when the following conditions are met:

- Services were provided to an eligible and enrolled Alliance beneficiary.
- Services were provided to treat an emergency medical condition.
- Services are not related to an organ transplant procedure or dialysis; and
- The principal diagnosis code is an emergent diagnosis with a positive emergency room indicator value and any of the following qualifying values are present:
  - a. Hospital outpatients claim with revenue codes of 0450-0459.
  - b. Hospital inpatient claim with an emergency room admission based on the presence of revenue codes of 0450-0459



Effective August 1, 2017, claims for services related to labor and delivery must also be submitted to DHCF directly. This benefit change should have no impact on Alliance beneficiaries' access to emergency medical services. The Emergency Medicaid (780) request should only be submitted for individuals who are uninsured. Claims related to labor and delivery for Alliance beneficiaries will be paid as Fee for Service claims. The claims submitted for reimbursement shall include the initial inpatient hospital stay, as well as any claim related to complications that may occur during the stay or physician charges. This new policy also allows for the reimbursement of any claims related to the transfer of the beneficiary to another institution due to health complications. Hospitals must ensure that the diagnosis codes related to labor and delivery are on the initial inpatient claim. **Please reference Transmittals #12-27 and 17-20 for more information.**

#### **10.9.4 Alliance Beneficiaries and Dialysis Services**

The DC Healthcare Alliance program covers Dialysis services as a part of the managed care plans covered benefits. If an Alliance beneficiary needs to access dialysis services, an Emergency Medicaid application is not required. Providers should no longer apply for Emergency Medicaid; instead, providers may bill the managed care organizations directly for dialysis services. For more information, refer to Transmittal No. 13-15: Dialysis Coverage for DC Health Care Alliance issued on September 23, 2013.

#### **10.9.5 Options for Alliance Coverage for Individuals who received or Were Ineligible for Emergency Medicaid**

If a beneficiary wishes to continue health coverage beyond the Emergency Medicaid eligibility period or if Emergency Medicaid coverage has been denied and the individual wishes to be determined eligible for the Alliance program, the individual must contact ESA to conduct a face-to-face interview to determine eligibility. ESA will review the combined application. If needed, ESA will send a notification to the applicant requesting additional documentation. The beneficiary is not required to submit a separate application to be determined eligible for Alliance if the face-to-face interview is conducted within 45 days of the initial date of application. The process should be seamless for the applicant and reduce redundancies in processing multiple applications for the same individual.

For beneficiaries who request the face-to-face interview and supply ESA with all verification documents, eligibility for the Alliance will be determined. The eligibility start date will be the first day of the month of application. The eligibility for Alliance will override the eligibility span for Emergency Medicaid.

If an individual would like to purchase a plan through the DC Health Link marketplace, the applicant can visit <http://www.dchealthlink.com> to apply for medical coverage and to see how much cost sharing reductions (CSRs) or advanced premium tax credits (APTCs) they will be approved for. To be eligible for a qualified health plan, the beneficiary must have an eligible immigration status. For information regarding application submission and citizenship requirements, the beneficiary must contact the DC Health Link Customer Service number at (855) 532-5465.

#### **10.9.6 Retroactive Coverage Option for Alliance Beneficiaries**

Individuals applying for the Alliance program but who need coverage for an emergency service that occurred within the three months prior to the application submission date, can apply for Emergency Medicaid to have that claim paid. The applicant must complete the Emergency Medicaid Query Form.

#### **10.9.7 Emergency Medicaid Beneficiaries Receiving Dialysis Treatment**

For Emergency Medicaid beneficiaries assigned the 780-program code due to dialysis treatment:

Examples:

- a. Effective October 1, 2013, prior to the end date of the Emergency Medicaid eligibility period, individuals receiving Emergency Medicaid for dialysis services must apply for the DC Healthcare Alliance Program by submitting a combined application. The individual must be determined eligible for Alliance coverage to

continue to receive dialysis. On a temporary basis, ESA may waive the face-to-face requirement.

- b. Individuals who had active Alliance coverage prior to transitioning to Emergency Medicaid program code 780 can automatically be converted back to program code 470. No new application is required.

## 10.10 Medical Abortions

The District of Columbia Medicaid Program complies with the requirements of the Hyde Amendment<sup>1</sup> regarding Medicaid coverage of medical abortions. There are only three (3) instances for which the District will reimburse Medicaid providers to provide abortions to Medicaid beneficiaries. Those three instances are: (1) when the pregnancy will endanger the woman's life; (2) when the pregnancy results from rape; or (3) when the pregnancy results from incest.

Effective immediately, the following HCPCS codes are now covered on the DC Medicaid fee schedule:

- S0190-Mefepristone 200mg
- S0191-Misoprostol 20mcg
- S0199-Medically induced abortion by oral ingestion of medication

Including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, and ultrasound to confirm completion of pregnancy), except the drug. The above-referenced HCPCS codes require a Prior Authorization (PA).

To obtain a P A for a medical abortion, the request shall be submitted to the Department of Health Care Finance (DHCF) contracted Quality Improvement Organization (QIO) via the provider portal <https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin>. The current QIO is Comagine Health. The following documents shall be submitted to constitute a request for a Medicaid-reimbursable therapeutic, elective, or medical abortion:

1. Completed 719A form
2. Verification of pregnancy
3. Verification of length of gestational period
4. Clinical justification to terminate the pregnancy in cases where the pregnancy would endanger the life the mother; and
5. Police report for cases of rape/incest.

## 10.11 Coverage for Noninvasive Prenatal Testing (NIPT)

The Department of Health Care Finance (DHCF) is committed to ensure pregnant women in the District have access to state-of-the-art prenatal screening as recommended by the American College of Obstetricians and Gynecologists (ACOG) in the professional setting. Transmittal #22-19 provided notice of coverage and reimbursement of cell-free DNA-based non-invasive prenatal laboratory testing that looks for genetic abnormalities during pregnancy.

These tests are collectively referred to as non-invasive prenatal testing (NIPT) and are commonly billed with codes such as 81420 (fetal chromosomal aneuploidy) and/or 81507 (fetal aneuploidy trisomy risk) in the professional fee schedule. For other billing codes associated with NIPT, see the professional fee schedule. The reimbursement rates for these laboratory tests are based on the published guidance by CMS and in accordance with District of Columbia payment policy established at 29 DCMR §§ 988 (Medicaid Fee Schedule) and 991 (Other Laboratory and X-Ray Services). This is applicable for fee-for-service providers that bill procedure codes on CMS-1500 claim forms and for providers enrolled in Medicaid Managed Care Organization (MCO) networks.

### 10.11.1 Background

In accordance with ACOG recommendations, NIPT has been approved effective March 1, 2022. NIPT is an advanced screening technology that uses fetal DNA from a pregnant woman's blood sample to identify a range of fetal chromosomal abnormalities with greater predictability as compared to traditional screening tests. ACOG recommends this screening for all pregnant women, regardless of maternal age or risk of chromosomal abnormality. NIPT is the most sensitive and specific screen for common fetal abnormalities, supported by both diagnostic testing and genetic counseling.

Providers should discern medical necessity for ordering NIPT for each pregnant woman on an individual basis and follow the ACOG recommendations for when the pregnancy is a single, twin, or multiple gestation. Providers should also conduct proper counseling about the screening and diagnostic testing options when the decision is made to order the test and follow through with a treatment plan for when genetic counseling is necessary including the outcome of a positive, negative, or inclusive result. DHCF believes that access to comprehensive perinatal services, including NIPT, enables all pregnant women to engage in their care and prepare for various outcomes identified by NIPT in coordination with their providers.

### 10.11.2 Non-invasive Prenatal Testing Procedure Codes

Providers may bill for NIPT using the below procedure codes. The NIPT codes do not require prior authorization.

|              |  |
|--------------|--|
| <b>81329</b> | SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; dosage/deletion analysis (e.g., carrier testing), includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed |
| <b>81336</b> | SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; full gene sequence   |
| <b>81337</b> | SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; known familial sequence variant(s)   |
| <b>81420</b> | Fetal chromosomal aneuploidy (e.g., trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21                          |
| <b>81422</b> | Fetal chromosomal microdeletion(s) genomic sequence analysis (e.g., DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood  |
| <b>81479</b> | Unlisted molecular pathology procedure   |
| <b>81507</b> | Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy   |

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

## 10.12 Lactation Services

Lactation services are covered under Medicaid to promote breastfeeding of infants, including lactation consultation education and support, breast pumps and lactation supplies, and banked donor milk. These lactation services are included in "pregnancy-related services" under 42 CFR § 440.210, durable medical equipment under Section 2110(a)(12) of the Social Security Act, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services pursuant to Section 1905(a)(4)(B) of the Social Security Act, respectively. Extensive research studies have documented many short-term and long-term benefits of breastfeeding for both the nursing infant and mother, and the Centers for Medicare and Medicaid Services (CMS) encourage States to increase access to lactation services. The U.S. Preventive Services Task Force (USPSTF) specifically recommends coordinated interventions throughout pregnancy, birth, and infancy to increase breastfeeding initiation, duration, and exclusivity. This rule supports breastfeeding

as the optimal way to feed infants. Additionally, this rule sets standards for Medicaid participation and identifies health care practitioners eligible for reimbursement of lactation services.

### **10.12.1 Lactation Consultation, Education and Support**

Lactation consultation, education, and support shall mean evaluation of the mother and infant's overall breastfeeding readiness, education on proper breastfeeding techniques, education on the proper use of a breast pump, and delivery of other necessary information and assistance to enhance breastfeeding.

Lactation consultation, education, and support shall be reimbursed by the Department of Health Care Finance (DHCF) under the "pregnancy-related services" benefit, subject to any requirements set forth in the State Plan, implementing rules, and any subsequent amendments thereto.

Lactation consultation, education, and support shall be covered for Medicaid eligible women as follows:

- One (1) prenatal visit; and Up to six (6) visits during the sixty (60) day postpartum period. The sixty (60) day postpartum period shall be defined as beginning on the last day of pregnancy and extending through the end of the calendar month in which the sixtieth (60th) day after the end of the pregnancy falls.

Reimbursable lactation consultation, education, and support may be provided in a clinic, physician's office, freestanding birth center, or in the home, by the following practitioners:

- A certified nurse mid-wife, licensed pursuant to the District of Columbia Health Occupations Revision Act of 1985 (HORA), effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 et seq. (2012 Repl. & 2015 Supp.)), Chapter 58 (Nurse-Midwives) of Title 17 of the District of Columbia Municipal Regulations (DCMR), and who demonstrates current certification by the International Board of Lactation Consultant Examiners (IBLCE) to deliver lactation consultation, education, and support; or
- A registered lactation consultant, who demonstrates current certification by the IBLCE to deliver lactation consultation, education, and support.

For a provider to receive Medicaid reimbursement, each provider shall comply with all provider screening and enrollment requirements set forth under Chapter 94 (Medicaid Provider and Supplier Screening, Enrollment, and Termination) of Title 29 DCMR. Additionally, a registered lactation consultant shall meet the following requirements:

- Deliver lactation consultation, education, and support only when the services are ordered and/or prescribed by a physician, nurse practitioner, or certified nurse midwife who is licensed pursuant to HORA and corresponding rules and is screened and enrolled in accordance with Chapter 94 of Title 29 DCMR.
- Submit a copy of the order or prescription for lactation consultation, education and support with each claim that is submitted for Medicaid reimbursement; and
- Complete an orientation session on billing provided by DHCF or its agent.

If a registered lactation consultant who meets the qualifications is employed by or has a contract with a Federally Qualified Health Center (FQHC) to deliver lactation consultation, education, and support, and the FQHC submits claims for reimbursement to DHCF for those services in accordance with Chapter 45 (Medicaid Reimbursement for Federally Qualified Health Centers) of Title 29 DCMR, the registered lactation consultants shall not bill DHCF separately for those services.

### **10.12.2 Breast Pumps and Lactation Supplies**

Breast pumps and lactation supplies described under Subsection 10002.4 are reimbursable for mothers with infants under "durable medical equipment," subject to any requirements set forth in the District of Columbia State Plan for Medical Assistance (State Plan), § 996 of Title 29 DCMR, and any subsequent amendments thereto.

Breast pumps and lactation supplies shall be reimbursable if:

- The above criteria set forth is met.
- Prescribed by one of the following providers that has been screened and enrolled pursuant to Chapter 94 (Medicaid Provider and Supplier Screening, Enrollment, and Termination) of Title 29 DCMR and has a treatment relationship with the beneficiary or infant:
  - A physician licensed pursuant to HORA and corresponding rules.
  - A nurse practitioner licensed as an advanced practice registered nurse pursuant to HORA and corresponding rules; or
  - A certified nurse mid-wife licensed as an advanced practice registered nurse pursuant to HORA and corresponding rules; and
- The infant is between the age of zero (0) and twelve (12) months, unless DHCF or its agent grants prior authorization when an infant is older than twelve (12) months.

The following breast pumps are available to beneficiaries in accordance subject to the following additional requirements:

- Hospital grade, or multi-user, electric pump only available for rental through prior authorization under the following circumstances:
  - A mother and infant are separated due to illness.
  - A mother is unable to feed directly from the breast due to congenital anomalies.
  - A mother is unable to feed directly from the breast due to the prematurity of the baby.
  - A mother requires induced lactation.
  - A mother requires re-lactation.
  - An infant is adopted; or
  - A mother or infant has other medical or psychological conditions that preclude effective feeding at the breast.
- Individual electric breast pump for a mother who needs to maintain lactation because of separation from the infant on a regular basis, such as being employed.
- Manual breast pump for a mother who needs to occasionally express milk.

The following lactation supplies shall be reimbursed by DHCF:

- A maximum of two (2) breast pump kits, including tubing, valves, flanges, and collection bottles.
- Nipple shields; and
- Supplemental feeding tubes/devices and syringes.

### 10.12.3 Banked Donor Milk

Medicaid-reimbursable banked donor milk shall be provided on an outpatient basis for Medicaid-eligible mothers with infants, and shall be provided in accordance with the following requirements:

- The infant is between the age of zero (0) and twelve (12) months, unless DHCF or its agent grants prior authorization when an infant is older than twelve (12) months.
- The infant requires banked donor milk due to the following reasons:
  - Banked donor milk is necessary for the infant to thrive because the infant is fragile, preterm, or is medically compromised, such as having a diagnosis of formula intolerance, metabolic conditions, or genetic conditions requiring human milk; and
  - The mother cannot breastfeed due to illness, death, surgery, chronic condition, or drug or medication use that is contraindicated for breastfeeding.
- The requesting physician is the infant's treating physician and has documented medical
- The requesting physician has discussed with the parent or guardian the benefits and risks of using banked donor milk, including infectious disease, freshness, effects of pasteurization, nutrients, and growth factors.
- The requesting physician has addressed the donated human milk bank donor screening, pasteurization, milk storage, and transport of the donated milk.

- The requesting physician has provided an informed consent form that the parent or guardian has signed and dated, and indicates that the risks and benefits of using banked donor milk have been discussed with them; and
- The banked donor milk is pasteurized, donated by a screened donor, and supplied by a donated human milk bank that meets the following requirements:
  - Is screened and enrolled in Medicaid pursuant to the requirements set forth in Chapter 94 (Medicaid Provider and Supplier Screening, Enrollment, and Termination) of Title 29 DCMR.
  - Is approved by the Human Milk Bank Association of North America (HMBANA) and meets other standards as may be adopted by DHCF.
  - Adheres to guidelines set forth by HMBANA and meets other standards as may be adopted by DHCF; and
  - Transports banked donor milk in a manner that protects the milk from contamination, thawing, and refreezing.

The following documentation shall be submitted to DHCF for review and approval to determine the medical necessity of banked donor milk:

- A Donated Human Milk Request Form that is:
  - Completed and signed by the treating physician on an initial or continuing request for authorization, and specifies the quantity and time frame; and
  - Completed by the donated human milk bank and specifies the quantity and time frame.
- The following written documentation from the treating physician to support a finding that banked donor milk is medically necessary for the beneficiary:
  - A detailed explanation of why the infant cannot survive and grow as expected on any other formula (e.g., elemental, special, or routine formulas or food) or any enteral nutritional product other than donor human milk.
  - A detailed explanation of why donated human milk must be used to correct or ameliorate a documented condition or defect; and
  - Documentation that the infant participated in a clinical feeding trial of an appropriate nutritional product every one hundred eighty (180) days. If the infant is too fragile for a feeding trial, documentation must support the illness that makes the infant too fragile to test; and
- The informed consent identifies the risks and benefits for the parent or guardian of using banked donor milk.

A request for authorization for banked donor milk shall be completed, signed, and submitted to DHCF by the treating physician every ninety (90) days, and shall expire upon the infant's first birthday.

#### **10.12.4 Records**

Each provider shall maintain complete and accurate records reflecting the specific lactation services ordered and provided to each beneficiary. Additionally, the ordering physician of donated human milk and the donated human milk bank shall each maintain copies of the Donated Human Milk Request form.

Each provider shall permit reviews and on-site inspections to be conducted by CMS, its agents, DHCF and its agents to determine provider compliance with all applicable laws.

Each provider shall maintain and make available upon request by authorized federal and local Medicaid personnel, complete financial records covering its operations.

All financial and treatment records and information shall be maintained for a period of at least ten (10) years following the date of treatment for which a claim for reimbursement was made or when all audits or investigations have been completed, whichever is longer.

Each provider shall comply with the terms of its Medicaid Provider Agreement with respect to the maintenance of all beneficiary and financial records.

All medical records shall be maintained in accordance with the Health Insurance Protection and Affordability Act of 1996 (HIPAA), effective August 21, 1996 (Pub. L. 104-191, 110 Stat. 1936) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), enacted under Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L. 111-5).

### 10.12.5 Reimbursement

Each provider shall comply with the requirements set forth in Chapter 14 (HealthCare Assistance Reimbursement) of Title 29 DCMR.

DHCF shall establish fees and reimbursement for only those services outlined in the above subsections. Reimbursement for lactation services shall be made according to the District of Columbia Medicaid fee schedule available online at <http://www.dc-medicaid.com>.

### 10.12.6 Audits and Reviews

DHCF shall perform audits to ensure that Medicaid payments are consistent with efficiency, economy, and quality of care and made in accordance with federal and District rules governing Medicaid.

Each Provider shall allow access to relevant records and program documentation upon request and during an on-site audit or review by DHCF, other District of Columbia government officials and representatives of the United States Department of Health and Human Services (HHS).

### 10.12.7 Definitions

- **Breast pump** - A device used to extract breast milk from a lactating mother. The following are breast pumps for the purposes of this section:
  - **Hospital grade electric breast pump** - A breast pump with high levels of suction and pressure that are typically larger and heavier than other breast pumps.
  - **Individual electric breast pump** - A breast pump that typically runs on batteries or household current and is typically lightweight and compact.
  - **Manual breast pump** - A breast pump that does not run on electricity and allows the user to produce suction and control Induced lactation - The process of making milk without going through pregnancy and birth.
- **Nipple shields** - A cover which a mother places over her nipple prior to breastfeeding.
- **Pregnancy-related services** - Services that are necessary for the health of the pregnant woman and fetus, or that have become necessary because of the woman having been pregnant.
- **Re-lactation** - The process of rebuilding milk supply when it has reduced significantly or is not of sufficient quantity to sustain the baby, after weeks or months of not breastfeeding.
- **Supplemental lactation aides** - a device that allows a breastfeeding mother to supplement the infant with expressed breast milk.

## 10.13 Long-Acting Reversible Contraception

LARCs are long-acting, reversible contraceptives, such as intrauterine devices (IUD) and implant. Studies have shown that LARCs are safe and effective for most women and have the highest rates of continuation and satisfaction. In 2012, the American Congress of Obstetricians and Gynecologists (ACOG) published practice guidelines recommending that LARCs be offered as first-line contraceptive methods and encouraged as options for most women. The major advantage of LARCs compared with other reversible contraceptive methods is that they do not require ongoing effort on the part of the user for long-term and effective use.

The District's Medicaid Program provides coverage for several different types of Intrauterine Devices (IUDs): Paraguard® (Copper IUD); Mirena® and Skyla® (Levonorgestrel releasing IUD); and etonogestrel hormonal implant, Nexplanon. Refer to Transmittal #14-24 for additional information.

### **10.13.1 Fee-for-Service**

When a provider performs LARC services in an office setting for a beneficiary in the fee-for-service Medicaid program, Medicaid pays the provider for the procedure based upon DHCF's published fee schedule. If the provider has supplied the IUD or implant, the provider can also bill Medicaid and be paid for the covered supplies or devices. When a provider performs LARC services in an in-patient hospital setting for a fee-for-service Medicaid beneficiary, the provider bills DC Medicaid separately for his/her professional services but will receive a discounted or "facility" rate to account for the fact that the doctor is not responsible for overhead and other administrative expenses in a hospital setting. The provider must bill his/her services on a Professional Claim form (CMS1500).

If the procedure is done in a hospital on an in-patient basis, DHCF also provides the hospital payment through our fee-for-service reimbursement methodology known as Diagnosis Related Groups (DRG). The DRG system is a per-case reimbursement mechanism under which inpatient admission cases are divided into distinct patient categories called diagnosis-related groups based on diagnosis, procedures, age, sex, and discharge status along with complex clinical algorithms to identify the reason for admission and the presence of complications and comorbidities. Thus, in a situation where a woman has delivered a baby in the hospital and receives a LARC method immediately post-partum, the provider would submit his or her bill to include separate claims for the labor and delivery and for the insertion of the device on a CMS 1500. The hospital's bill would also include codes for all the procedures performed, any ancillary services provided such as laboratory and x-ray and all supplies, drugs and devices administered, including the LARC method. The hospital's claims for the patient's stay are fed into the DRG system and the claim is paid upon the assigned DRG. The District's in-patient hospital payment methodology has been designed to provide hospital payment rates that cover - on average - 98 percent of their costs. Therefore, the cost of supplying LARC methods on an inpatient basis is factored into the rates paid to District hospitals.

### **10.13.2 Managed Care**

When a provider provides LARC services in an office setting for a beneficiary enrolled in a Medicaid Managed Care Organization (MCO), the provider is paid based upon his/her provider agreement with the MCO. Similarly, if these services are provided in a hospital setting, both the provider and the hospital must submit their claims to the MCO for payment. Rates are established by the MCO. IL requires all our Medicaid health plans to cover the same services our regular Medicaid covers.

DHCF pays each plan a set amount per member per month. These rates are established, in part, on analysis of claims data and are designed to be actuarially sound. For labor and deliveries, DHCF also pays an additional "kick" payment in the month of the mother's delivery.

This is an additional, lump-sum payment to the MCO to cover all labor and delivery costs, including all hospital and physician charges, as well as any pre-natal or postpartum care in the month of delivery. The value of the kick payment is \$8,933.00. All DC Medicaid MCOs report that they provide coverage for LARCs in office and in hospital in-patient settings.

### **10.13.3 New Policies**

To ensure that DHCF's coverage and reimbursement policies do not act as a disincentive to LARC services, DHCF has taken the following actions:

1. DHCF has eliminated the differential payment for fee-for-service physician services in office based and in-patient settings for Procedure Codes 11 981 and 58300. Effective October 1, 2014, providers will receive the higher office rates associated with these procedure codes for fee-for-service beneficiaries.



2. For fee-for-service beneficiaries, DHCF will allow providers to supply and bill for the LARC device/supply in an inpatient setting. Effective October 1, 2014, a provider billing for the insertion of the device/supply may also procure the device/supply and then bill for it on the same CMS 1500 claim form as the delivery procedure indicating the place of service as 21 (inpatient hospital setting). The provider may only bill for the device/supply if he or she has procured it. Further, DHCF will only make one payment for reimbursement for the supply/device to the provider or the hospital whichever has provided the LARC. If the hospital has not procured and supplied the LARC, it cannot be included in the hospital I claims submission.
3. DHCF encourages hospitals and Medicaid MCO's to examine coverage and reimbursement policies for LARC's to ensure there are no impediments or barriers to access.
4. DHCF annually reviews its fee schedule including reimbursement for LARCs.

Refer to Transmittal #14-24 for additional information.

### 10.13.4 Reimbursement for LARC Devices and Supplies

Table 2: Fee-for-Service Reimbursement Rates for LARCs

| Procedure Code | LARC Service  | Prior Authorization Needed | Physician supplied – Office or In-Patient Setting                           | Hospital Supplied In-Patient Setting |
|----------------|---|----------------------------|---|--------------------------------------|
|                |   |                            | Reimbursement Per Fee Schedule  | Reimbursement Per DRG Assignment     |
| J7300          | Paraguard copper IUD  | No                         | \$600.00  | DRG Assignment                       |
| J7302          | Mirena, Levonorgestrel-releasing intrauterine device system 52 mg               | No                         | \$759.29  | DRG Assignment                       |
| J7307          | Nexplanon Etonogestral implant 68 mg radiopaque                                 | Yes*                       | \$675.04  | DRG Assignment                       |
| J7301          | Skyla<br><br>Levonorgestrel releasing Intrauterine contraceptive system 13.5 mg | Yes                        | Currently requires manual pricing but fee schedule will be updated 1/1/2015 | DRG Assignment                       |

Table 3: Fee-for-Service Reimbursement for Physician Services Associated with LARC Services

| Physician Services** |   |                |                          |                          |
|----------------------|---|----------------|--------------------------|--------------------------|
| Procedure Code       | Procedure Description                             | Office Setting | In-Patient Setting (Old) | In-Patient Setting (New) |
| 11981                | Insertion non-biodegradable drug delivery implant | \$126.88       | \$73.83                  | \$126.88                 |
| 58300                | Insertion IUD                                     | \$63.81        | \$46.24                  | \$63.81                  |

\*NOTE: Procedure code J7307 requires Prior Authorization for office-based service. The Prior Authorization is obtained by submitting a completed Form 719A (Prior Authorization Request/Approval) signed and dated by the requesting physician. Form 719A should be faxed to DHCF at 202.610.3209 to obtain approval before services are provided.

## 10.14 Doula Benefit, Provider Qualifications and Enrollment, Rates and Reimbursement Standards

Effective October 1, 2022, the Department of Health Care Finance (DHCF) will reimburse for doula services and enroll doulas as providers in health programs (Medicaid, Alliance, and the Immigrant Children's Program). **Transmittal #22-34** outlines the scope of services, enrollment information, billing standards, and reimbursement rates for doulas.

### 10.14.1 Scope of Services

Doulas will provide services and supports to birthing parents enrolled in DHCF health programs. Specifically, doula services include up to twelve (12) visits for a person who is pregnant or in the six (6) months after their pregnancy ends. Doula services are separated into two (2) periods: the perinatal period (before, during, and up to six (6) weeks after delivery) and the doula postpartum period (beginning on the last day of pregnancy and extending through the end of the calendar month in which one hundred eighty (180) days after the end of the pregnancy falls). Doulas will be expected to use the initial visit with a beneficiary to develop a Care Plan for both the perinatal and postpartum periods.

- During the perinatal period, services include:
  - 1) Perinatal counseling and education, including infant care, to prevent adverse outcomes.
  - 2) Labor support and attendance at delivery, including the development of a birth plan; and
  - 3) Coordination with community-based services, to improve beneficiary outcomes.
- During the postpartum period, services include:
  - 1) Visits with the beneficiary to provide basic infant care.
  - 2) Accompanying the beneficiary to a clinician visit.
  - 3) Lactation support; and
  - 4) Emotional and physical support.

*Limits:* Doula services are limited to a total of twelve (12) visits per beneficiary across the perinatal and the postpartum period. Doula services are provided as preventive services in DHCF health programs and must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law to prevent perinatal complications and/or promote the physical and mental health of the beneficiary.

### 10.14.2 Doula Provider Qualifications

Qualified doula providers must be at least 18 years of age, possess a high school diploma or equivalent, and possess a current certification by a doula training program or organization, approved by DHCF. For more information on eligible certifications and information that doulas will have to provide to successfully enroll in the program, refer to **Transmittal #22-34**.

### 10.14.3 Doula Enrollment

To provide doula services, doulas are required to enroll as DHCF provider. This initial enrollment makes doulas eligible to serve fee-for-service Medicaid beneficiaries and allows doulas to enroll in Medicaid managed care organizations that serve Medicaid, Alliance, and ICP clients. Refer to **Transmittal #22-34** for specific enrollment information and instructions.

DHCF MCOs must establish provider agreements with and enroll doulas, as doula services are now a covered benefit for health coverage programs administered by DHCF. The addition of doula services as a covered benefit does not invalidate existing contracts between doula service providers and MCOs nor prohibit future contracts between doula service providers and MCOs.

### 10.14.4 Doula Services Rates and Billing

Once enrolled, doulas will be able to bill DHCF for services delivered to fee-for-service Medicaid clients. The following codes and rates are being added to the DHCF Fee Schedule and are intended to be used by doulas to treat their clients.

| CPT Code Description   | CPT Code | Modifier | Rate     |
|--|----------|----------|----------|
| Perinatal Doula Support Visit  | 99600    | HD       | \$97.04  |
| Doula Support at Delivery HD -Vaginal Delivery   | 59400    | HD       | \$686.23 |
| Doula Support at Delivery HD -c-section  | 59514    | HD       | \$686.23 |
| Doula Support at Delivery HD -V-BAC  | 59612    | HD       | \$686.23 |
| Postpartum Doula Support-15 Minute Increment   | 99199    | HD       | \$12.13  |
| Doula Incentive Payment for Obstetric Postpartum Visit 7 to 84 Days After Labor and Delivery | 99199    | HD U8    | \$100.00 |

#### 10.14.4.1 Managed Care Rates and Utilization Management

As with other provider types, DHCF will be directing managed care organization (MCO) payment of doula services by establishing minimum reimbursement rates using the rates outlined above. Doulas enrolled with MCOs will be expected to collaborate with a beneficiary's managed care case manager and the MCO's utilization management team to coordinate doula services.

### 10.14.5 Billing Medicaid for Doula Services

#### 10.14.5.1 Fee for Service

Once enrolled in the Fee for Service Medicaid program (through DHCF), doulas can bill the DHCF after logging in through the Provider Portal at <https://www.dc-medicaid.com/dcwebportal/home>. After logging in, doulas will need to select "Claims Entry", and then "CMS 1500/Medicare Part B" with the Medicaid ID of the client and the NPI of the doula. After accessing the Claims Entry form, doulas will then need to enter the appropriate billing code and modifier. Doulas may also submit claims through software provided by their employing entity or billing specialists.

#### 10.14.5.2 Managed Care

Providers should follow instructions provided by the enrollee's MCO for billing for doula services, which will be provided during the enrollment process. MCOs are required to reimburse providers at the rates published in this transmittal. Contact the appropriate MCO for more information.

## 11 Telemedicine Services

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

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

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

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

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

### 11.1 Telemedicine Service Model

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

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

### 11.2 Participant Eligibility

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

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

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

### 11.3 Provider Site Eligibility

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

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

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

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

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

### 11.4 Provider Reimbursement

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

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

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

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

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

- In the event the beneficiary's home is the originating site, the distant site provider must specify the place of service "10" which is defined as "telehealth provided in patient's home".
- In the event a DCPS or a DCPCS is the originating site, the distant site provider must specify the place of service "03" which is defined as "school".
- In the event the beneficiary is at any other eligible originating site (see section IV above), the distant site provider must specify the place of service "02" which is defined as "telehealth

provided other than in patient's home". When utilizing place of service "02", the distant site provider must also report the National Provider Identifier (NPI) of the originating site provider in the "referring provider" portion of the claim.

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

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

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

## 11.5 Federally Qualified Health Center (FQHC) Reimbursement

In accordance with the District's Prospective Payment System (PPS) or alternative payment methodology (APM) for FQHCs, the following reimbursement parameters will be established for the purposes of telemedicine in the District:

- **Originating Site:** An FQHC provider must deliver an FQHC-eligible service to be reimbursed the appropriate PPS, APM, or fee-for-service (FFS) rate at the originating site.
- **Distant Site:** An FQHC provider must deliver an FQHC-eligible service to be reimbursed the appropriate PPS, APM, or FFS rate; and
- **Originating and Distant Site:** If both the originating and the distant site are FQHCs, for both to receive reimbursement, each site must deliver a different PPS or APM service (e.g., medical or behavioral). If both sites submit a claim for the same PPS or APM service (e.g., medical), then only the distance site will be eligible to receive reimbursement.

## 11.6 Education-Related Services Reimbursement

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

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

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

## 11.7 Covered Services

Services that can be delivered via telemedicine include:

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

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

## 11.8 Excluded Services

The Program will not reimburse telemedicine providers for the following:

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

## 11.9 Technical Requirements

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

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

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

## 11.10 Medical Records

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

## 11.11 Confidentiality

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

## 12 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.

### 12.1 Receive and Record

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

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

Hard copy claims are received in the mailroom where they will undergo a review process.

### 12.2 Review

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

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

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

### 12.3 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

|                        |  |  |                    |  |
|------------------------|--|--|--------------------|--|
| 19021                  | 1  | 0123   | 000001             | 7  |
| Julian Date<br>(YYDDD) | Media Type<br>(By Value)   | Batch Number<br>(By Position)                | Document<br>Number | TCN Type<br>(By Value)   |
|                        | 1 = Web<br>2 = Electronic Crossover<br>3 = Electronic Submitted Claim<br>4 = System Generated<br>5 = Web w/attachment<br>6 = Special Batch<br>7 = Retro-rate<br>8 = Paper<br>9 = Paper w/attachment<br>0 = Encounter | 1 = Machine number<br>2 - 4 = Assigned batch |                    | 0 – 4 = PBM<br>5 - 6 = Available<br>7 = Original<br>8 = Credit (void)<br>9 = Debit<br>(adjustment) |

## 12.4 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.

## 12.5 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
- Pended claims (in process)
- Paid claims MTD
- Denied claims MTD
- Adjusted claims MTD
- Paid claims YTD
- Denied claims YTD

### 12.5.1 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.

### 12.5.2 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

### 12.5.3 Suspended

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

Conduent and DHCF resolve all pending claims. The RA will only state that the claim is suspended and will not give a reason.

## 12.6 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.

## 13 BILLING INFORMATION

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

### 13.1 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 for goods or services provided to Medicaid beneficiaries:

- CMS1500
- ADA 2012 Dental Form
- UB-04

#### 13.1.1 Form Availability

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.

#### 13.1.2 Procedure and Diagnosis Code Sources

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

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

### 13.2 Electronic Billing

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

- Web Portal
- EDI
- WINASAP

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. 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.

### 13.3 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](http://www.cms.gov/Medicare/Medicare.html) or call Medicare at 800.633.4227.

### **13.4 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.

### **13.5 Medicaid Claims with Third Party Payments**

When billing a Medicaid patient who is also 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.

### **13.6 Resubmission of Denied Claims**

If a claim has been denied due to reasons other than violations of good medical practice or Medicaid regulations, the claim may be resubmitted. An original claim must be submitted; copies will not be accepted. Only claims, which have appeared on your remittance advice as, denied, can be resubmitted.

Claims that are still in a Pend status cannot be resubmitted until they have been denied. Resubmission of a pended claim will result in claims denying for duplicate.

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

Instructions for resubmitting a denied claim are as follows:

- Claims must be received within 365 days after the date of service or in the case of inpatient hospital services, 365 days after the date of discharge. Claims must be resubmitted within 365 days of the RA date on which the claim denied for any reason(s) other than timely filing.
- Complete a new red claim form. A copy of the original claim form will be accepted if it is clear, legible and has been resigned (a copied or stamped signature will not be accepted).
- Correct any errors that caused the original claim to be denied.
- Do not write anything on the claim except what is requested. Any additional information should be submitted in writing and attached to the claim.

- Attach a copy of the Remittance Advice without staples, paper clips or colored highlighting on which the denied claim appears and any other documentation necessary to have the claim paid (e.g., consent form, isolation form). If more than one resubmitted claim appears on a page of the remittance, a copy of that page should be attached to each claim being submitted.
- Forward all resubmitted claims to the appropriate P.O. Box listed in Appendix 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).

## **13.7 Claim Appeals**

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

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

## 14 REIMBURSEMENT

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

### 14.1 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.

### 14.2 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

### 14.3 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).

### 14.4 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. Instructions for billing DC Medicaid after the other source has made payment are contained in this manual in Section 9.4.

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.

#### 14.4.1 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.

#### 14.4.2 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 MMIS 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.

## 14.5 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.

## 14.6 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 item if the beneficiary has been notified by the provider prior to dispensing the service or item that it will not be covered by DC Medicaid.

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

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

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



Table 4: Crossover Pricing Logic

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

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

### 14.7 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.

### **14.7.1 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.

### **14.7.2 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.

### **14.7.3 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.

## 15 Medical Review

The Office of the Medical Director's mission is to continuously improve the 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 necessity, 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)

### 15.1 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](http://www.dc-medicaid.com) under Provider Information and Forms.

## 16 PRIOR AUTHORIZATION

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

### 16.1 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 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

### 16.2 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 a verbal prior authorization, the service or item will not be considered for reimbursement. Non-emergency transportation services are referred to the DHCF transportation broker. (Refer to Appendix A for contact information.)

### 16.3 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.

### 16.4 Prior Authorization Procedures

Prior authorization is required for all non-emergency, inpatient admissions. Based on policy and procedures, certain dental procedures require prior authorization. Providers should submit a 719A Prior Authorization form, as well as the dentists' pre-treatment estimate for prior authorization.

The 719A form is the physician's or authorized prescriber's written prescription for services and/or supplies. You will receive this form from the physician, authorized prescriber, or the beneficiary. All fields must be completed accurately to prevent processing delays or having the form returned to you. Upon receipt of the form, the following information should have been completed by the physician or authorized prescriber:

1. Patient information
2. Prescribing provider information
3. Diagnosis code
4. Justification which should include the how the service will be used in the beneficiary's environment, including the beneficiary's or caregiver's ability, willingness, and motivation to use the product and the requested date of service for the service/product.
5. Must be signed and dated by the physician or authorized prescriber

If the above information is not on the form and correct when it is received, it is the billing provider's responsibility to contact the physician and/or authorized prescriber to obtain the necessary information.

#### **16.4.1.1 Pre-Admission Review**

Providers will be notified of incomplete 719A forms or incomplete clinical information and be given up to two or three business days as appropriate to submit additional information to complete the review. Notification of an incomplete review submission will occur via the web portal for web submission (preferred), and via fax for fax submission. If the 719A form remains incomplete after 2 business days a technical denial will be issued. If clinical information remains incomplete after 2 days, a non-certification or technical denial may result when referred to the physician reviewer. Comagine Health has 5 days to complete the review, once all the information has been received to complete the review process.

#### **16.4.1.2 Timeframes for Submission of Pre-Admission Reviews**

Requests for Pre-Admission require a minimum of 5 days' advanced notice prior to the anticipated date of the service delivery. If additional information is required, the review timeline may take longer than 5 days when Comagine Health is awaiting additional information from the provider.

#### **16.4.1.3 Medical Necessity Review Process**

During the Pre-Admission review, Comagine Health's clinical reviewer will review the medical information submitted and evaluate the medical necessity for admission at the requested level of care. Medical Necessity Criteria and review protocols are met, the Comagine Health clinical reviewer will issue a Prior Authorization number and the review will be authorized.

#### **16.4.1.4 Transfer (Admission) Reviews**

Transfers between hospitals require a separate admission review to be completed from the receiving provider and a discharge from the referring facility. This includes inter-facility transfers, such as discharge from one level of care to another as well as discharges to different facilities. Thus, each facility will have a unique Prior Authorization number to use on their claim form. The following considerations apply:

- All transfers from one inpatient setting to another require a prior authorization admission review with the receiving facility. Transfers will be evaluated to ensure that the recipient continues to meet severity of illness and intensity of service criteria for that level of care.
- All transfers require the receiving facility to submit a request for authorization prior to the transfer.

## **16.5 Determining Medical Necessity**

**Providers should consult the fee schedule to determine if the procedure code requires prior authorization.**

Medical necessity or a medically necessary service is defined as medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of a health-related illness, condition or disability including services necessary to prevent a detrimental change in either medical, behavioral, mental, or dental health status. Only supplies, equipment, appliances, and services that are determined as medically necessary by the Department of Health Care Finance or its contracted representative are covered.

Services determined as medically necessary must be:

1. Appropriate to the individual's physical, mental, developmental, psychological, and functional health
2. Clinically appropriate in terms of type, frequency, extent, setting and duration
3. Reasonable and necessary part of the beneficiary's treatment plan

4. Not furnished for the convenience of the beneficiary's family, attending practitioner or other practitioner or supplier
5. Be necessary and consistent with accepted professional medical standards (i.e., not experimental, or investigational)
6. Be established as safe and effective for the beneficiary's treatment protocol
7. Be furnished at the most appropriate level that is suitable for use in the beneficiary's home environment

For general information about what is covered under the District's Medicaid Fee-for-Service program, as well as what is covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children.

## 16.6 Required Documentation

In addition to confirming medical necessity, the following documents are required.

1. **Prior Authorization Form (PA 719A form):** This form is used by physicians and authorized prescribers to order durable medical equipment, supplies, services (i.e., home care, dental, optical) that are necessary to treat a health care condition. This serves as the beneficiary's prescription.
2. The **Letter of Medical Necessity** provides DC Medicaid with a visual image of the patient's needs. This letter is issued by the physician or authorized prescriber.
3. **Evaluation/Assessment** is submitted if necessary.
4. **Plan of Treatment** medically justifies the necessity for all supplies, equipment, and/or service under this program and must be attached to the 719A form.

## 17 Completing the UB04 Claim Form

The Uniform Bill, UB-04 claim form must be completed by hospital providers billing for dialysis services. These instructions have been coordinated and compared to the instructions provided in the District of Columbia UB-04 Billing Providers Manual issued by the Uniform Billing Task Force. Provider billing claims electronically, please refer to the UB04 EDI manual.

**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) with a request to resubmit on the proper claim form.**

Table 5: Completing the UB04 Claim Form

| Form Locator | Requirement            | Field Description                             | Guideline  |
|--------------|------------------------|---|--|
| 1            | Required               | Provider Name, Address, and Telephone Number  | Billing Provider Name, Address and Telephone Number: Enter the agency name, street, city, state, zip code, and telephone number.<br><br>Line 1 – Provider Name<br>Line 2 – Provider Street Address<br>Line 3 – Provider City, State, Zip +4<br>Line 4 – Provider Telephone   |
| 2            | Not Required           | Pay-to Name, Address, and Secondary ID Fields | Enter the address information of the pay-to provider if it is different than the billing provider identified in field locator 1.   |
| 3A           | Optional               | Patient Control Number (PCN)                  | Enter the patient's account number assigned by the provider to facilitate retrieval of the individual's account of services. If the patient's account number is listed on the claim, it will appear on the remittance advice.  |
| 3B           | Required if applicable | Medical/Health Record Number                  | Enter the patient's medical record number (limited to ten digits) assigned by the home health agency.  |
| 4            | Required               | Type of Bill                                  | Enter the three-digit type of bill code. This field has been expanded from three to four characters with zero being the first digit. Claims will be processed based on the last three digits.<br><br>The type of bill code requires one digit each in the following sequence:<br>1st: zero (0)<br>2nd: type of facility<br>3rd: bill classification<br>4th: frequency<br><br>Type of facility – 2nd digit<br>1: Hospital<br>8: Special Facility (Ambulatory Surgery Center)<br><br>Bill Classification – 3rd digit<br>1: Inpatient (including Medicare Part A)<br>2: Inpatient (for hospital referenced diagnostic |

| Form Locator | Requirement            | Field Description       | Guideline  |
|--------------|------------------------|-------------------------|--|
|              |                        |                         | services)<br>3: Outpatient<br>4: Non-patient laboratory specimen<br><br>Frequency – 4th digit<br>0: Non-payment/Zero charges claim<br>1: Admit through discharge claim<br>2: Interim – first claim<br>3: Interim – continuing claim<br>4: Interim – last claim<br>5: Late charge(s) only claim<br>7: Adjustment<br>8: Void<br><br>Note: If the type of bill ends with '1' (i.e., 111, 331, etc.) or '4' (i.e., 114, 334, etc.), the patient status <u>cannot</u> be 30 (still a patient) or 09 (admit to hospital). If the type of bill ends with '2' (i.e., 112, 332, etc.) or '3' (i.e., 113, 333, etc.) the patient status <u>must be</u> 30 (still a patient) or 09 (admit to hospital). |
| 5            | Not Required           | Federal Tax Number      | Enter the TIN or EIN   |
| 6            | Required               | Statement Covers Period | Enter the beginning and ending dates of service billed in MMDDYY format.   |
| 7            | Not Required           | Unlabeled               | Leave this field blank   |
| 8b           | Required               | Patient Name/Identifier | Enter the patient's name as it appears on the Medical Assistance Card in last name, first name, middle initial format.   |
| 9a           | Not Required           | Patient Address         | Enter the patient's street address   |
| 9b           | Not Required           | Patient Address         | Enter the patient's city   |
| 9c           | Not Required           | Patient Address         | Enter the patient's state  |
| 9d           | Not Required           | Patient Address         | Enter the patient's zip code   |
| 9e           | Not Required           | Patient Address         | Enter the patient's country code   |
| 10           | Required               | Patient Birth date      | Enter patient's date of birth in MMDDYYYY format   |
| 11           | Required               | Patient Sex             | Indicate the patient's gender<br><br>M: Male<br>F: Female<br>U: Unknown  |
| 12           | Not Required           | Admission Date          | Enter the date the patient was admitted for care in MMDDYY format.   |
| 13           | Required if applicable | Admission HR (hour)     | Enter the appropriate code identifying the hour the patient was admitted for care.<br>00 12:00-12:59<br>01 01:00-01:59<br>02 02:00-02:59<br>03 03:00-03:59<br>04 04:00-04:59<br>05 05:00-05:59<br>06 06:00-06:59<br>12 12:00-12:59 (Noon)<br>13 01:00-01:59 (Midnight)<br>14 02:00-02:59<br>15 03:00-03:59<br>16 04:00-04:59<br>17 05:00-05:59<br>18 06:00-06:59<br>19 07:00-07:59   |



| Form Locator | Requirement            | Field Description  | Guideline   |
|--------------|------------------------|--------------------|---|
|              |                        |                    | 07 07:00-07:59<br>08 08:00-08:59<br>09 09:00-09:59<br>10 10:00-10:59<br>11 11:00-11:59<br>20 08:00-08:59<br>21 09:00-09:59<br>22 10:00-10:59<br>23 11:00-11:59  |
| 14           | Required if applicable | Type of Admission  | Enter the appropriate type of admission code for inpatient claims.<br><br>1: Emergency<br>2: Urgent<br>3: Elective<br>4: Newborn<br>9: Information not available  |
| 15           | Required if applicable | Source of Referral | Enter the appropriate source of admission code for inpatient claims.<br><br>For emergency, elective, or other type of admission<br>1: Physician referral/Normal delivery<br>2: Clinic referral/Premature delivery<br>3: HMO referral/Sick baby<br>4: Transfer from a hospital/Extramural birth<br>5: Transfer from a skilled nursing facility<br>6: Transfer from another health care facility<br>7: Emergency room<br>8: Court/law enforcement<br>9: Information not available<br>A: Transfer From Rural Primary Hospital<br>B: Transfer from another home health<br>C: Readmit to same home health<br>D: Transfer from same hospital inpatient<br>E: Transfer from ambulatory surgical center<br>F: Transfer from hospice   |
| 16           | Not Required           | Discharge Hour     | Enter the appropriate code identifying the hour the patient was discharged.   |
| 17           | Required               | Patient Status     | Enter the code that identifies the patient's status as of the statement covers through date.<br><br>01: Discharge to home or self-care (routine discharge)<br>02: Discharged/transferred to another short-term general hospital for inpatient care<br>03: Discharged/transferred to skilled nursing facility<br>04: Discharged/transferred to an intermediate care facility<br>05: Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution<br>06: Discharged/transferred to home under care of organized home health service organization<br>07: Left against medical advice or discontinued care<br>08: Discharged/transferred to home under care of a Home IV provider<br>09: Admitted as an inpatient to this hospital |

| Form Locator | Requirement            | Field Description          | Guideline  |
|--------------|------------------------|----------------------------|--|
|              |                        |                            | 20: Expired<br>21: Discharge/Transfer to Court/Law Enforcement<br>30: Still a patient<br>31: Still a patient – defined by State<br>40: Expired at home (Medicare hospice claim only)<br>41: Expired in a medical facility (e.g., hospital, SNF, ICF, or freestanding hospice) (Medicare hospice claims only)<br>42: Expired – place unknown<br>50: Discharged to Hospice – Home<br>51: Discharged to Hospice – Medical Facility (certified) providing hospice level of care<br>61: Discharged/transferred within the institution to a hospital-based, Medicare-approved swing bed<br>62: Discharged/transferred to inpatient rehabilitation facility, including rehabilitation distinct part units of a hospital<br>63: Discharged/transferred to a Medicare –certified long-term care hospital<br>64: Discharged/transferred to a nursing facility certified under Medicaid, but not under Medicare<br>65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital<br>70: Discharged/transferred to another type of health care institution not defined in code list |
| 18 - 28      | Required if applicable | Condition Codes            | Enter the code(s) used to identify conditions relating to the bill.<br><br>02: Condition is employment related<br>03: Patient covered by insurance reflected here<br>05: Lien has been filed<br>08: Beneficiary would not provide information concerning other insurance charges<br>09: Neither patient nor spouse is employed<br>10: Patient and/or spouse is employed but no EGHP exists<br>11: Disability and Beneficiary but no LGHP<br>12: General Care Patient in a special unit<br>13: CORF services provided offsite<br>A1: EPSDT/CHAP<br>A2: Physically Handicapped Children’s Program<br>A3: Special federal funding<br>A4: Family planning<br>A5: Disability<br>A7: Induced abortion danger to life<br>A8: Induced abortion victim rape/incest<br><br>Refer to the Uniform Billing Manual for a complete listing of codes.  |
| 29           | Not Required           | ACDT State                 | Enter 2-digit state abbreviation where the accident occurred.  |
| 31 - 34      | Required if applicable | Occurrence Codes and Dates | Enter the appropriate code(s) and date(s).   |

| Form Locator | Requirement            | Field Description                                  | Guideline  |
|--------------|------------------------|--|--|
|              |                        |  | 01: Auto accident<br>02: No-fault insurance involved<br>03: Accident/tort liability<br>04: Accident/employment related<br>05: Other accident<br>06: Crime victim<br>09: Start of Infertility Treatment Cycle<br>24: Date insurance denied<br>25: Date benefits terminated by Primary Payer<br>27: Date Home Health Plan established<br>35: Date Treatment Started from P.T.<br>36: Date of Inpatient Hospital Discharge for Covered Transplant Patient<br>42: Date of discharge<br>43: Scheduled Date of Consulted Surgery<br>44: Date Treatment Started for O.T.<br>45: Date Treatment Started for S.T.   |
| 35 - 36      | Not Required           | Occurrence Span Codes and Dates                    | Enter the code and related dates that identify an event that relates to the payment of the claim.<br><br>17: Prior Stay Dates<br>27: Date Home Health Plan established<br>MO: PRO/UR approved stay dates<br>M2: Inpatient respite dates  |
| 38           | Not required           | Responsible Party Name and Address (Claim Address) | Enter the name and address of the party to whom the claim is being submitted   |
| 39 - 41      | Required if applicable | Value Codes  | Enter the appropriate value code and amount.<br><br>14: No Fault including auto/other<br>21: Catastrophic<br>22: Surplus<br>23: Recurring monthly income<br>24: Medicaid rate code<br>37: Pints of blood furnished<br>38: Blood deductible pints<br>39: Pints of blood replaced<br>45: Accident Hour (Enter the hour code from the table shown for LOCATOR 13)<br>80: Covered days<br>82: No Other Coverage<br>83: Billed and Paid<br>84: Billed and Not Paid<br>A1: Deductible Medicare Payer A<br>B1: Deductible Medicare Payer B<br>C1: Deductible Medicare Payer C<br>A2: Coinsurance Medicare Payer A<br>B2: Coinsurance Medicare Payer B<br>C2: Coinsurance Medicare Payer C |
| 42           | Required               | Rev. Code  | Enter the revenue code that identifies the specific accommodation, ancillary service, or billing calculation. <b>On the last line, enter 0001 for the total.</b>   |

| Form Locator    | Requirement            | Field Description            | Guideline  |
|-----------------|------------------------|------------------------------|--|
|                 |                        |                              | Refer to the Uniform Billing Manual for listing of revenue codes.  |
| 43              | Required if applicable | Description                  | Enter the 11-digit National Drug Code (NDC) when billing for physician administered drugs in an outpatient setting.  |
| 44              | Required               | HCPCS/Rates/HIPPS Code       | Enter the appropriate CPT or HCPCS code relevant to the accommodation revenue code entered for the services being billed (see field 42 for more info).                                   |
| 45              | Required               | Serv. Date                   | Enter the dates of service if billing for hospital outpatient services   |
| 45<br>(line 23) |                        | Page _ of _<br>Creation Date | Enter the appropriate page number and total number of pages associated with the claim. For example, Page 2 of 4.<br><br>Enter the date the claim was created or prepared for submission. |
| 46              | Required               | Serv. Units                  | Enter the total number of covered accommodation days or ancillary units of service for each revenue code billed as appropriate   |
| 47              | Required               | Total Charges                | Enter the total charges for each related revenue/procedure code.<br><br>Enter the grand total charges at the bottom of this field to be associated with revenue code 001.                |
| 48              | Required if applicable | Non-covered charges          | Enter the charges for any non-covered services   |
| 50              | Required               | Payer Name                   | As applicable, enter the name of the beneficiary's primary, secondary, and tertiary insurance on lines A, B, and C.<br><br>For claims with no TPL, DC Medicaid is entered on line A.     |
| 51A-C           | Not Required           | Health Plan ID               | Enter the nine-digit Medicaid provider number  |
| 52A-C           | Not Required           | Rel. Info                    | Enter the appropriate code indicating if a signed statement from the patient or the patient's legal representative permitting the provider to release data to another organization.      |
| 53A-C           | Not Required           | ASG. BEN.                    | Enter the appropriate code indicating that a signed form authorizing the third-party payer to remit payment directly to the provider.<br><br>N: No<br>W: Not applicable<br>Y: Yes        |
| 54A-C           | Required if applicable | Prior Payments               | Enter payment received from any other insurance carrier.   |
| 55A-C           | Not Required           | Est. Amount Due              | Enter the amount estimated by the provider to be due from the indicated payer  |
| 56              | Required               | Billing Provider NPI         | Enter the National Provider Identifier for the billing provider  |

| Form Locator | Requirement            | Field Description            | Guideline  |
|--------------|------------------------|------------------------------|--|
| 58A-C        | Required               | Insured's Name               | As applicable, enter the insured's name for the primary, secondary, and tertiary insurance on lines A, B, and C according to proper billing order.<br><br>On the line that shows payer, Medicaid, enter the beneficiary's name exactly as it appears on the Medical Assistance card. |
| 59A-C        | Required               | P. Rel                       | Enter the appropriate code indicating the relationship of the patient to the identified insured.<br><br>01: Spouse<br>18: Self<br>19: Child<br>20: Employee<br>21: Unknown<br>39: Organ Donor<br>40: Cadaver Donor<br>53: Life Partner<br>G8: Other Relative                         |
| 60A-C        | Required               | Insured's Unique ID          | Enter the insured's ID for the plans listed in 50 A, B, and C that relates to the insured's name in 58 A, B, and C.<br><br>Enter the patient's Medicaid ID as it appears on their Medical Assistance Card omitting the leading zeroes in the field that corresponds with DC Medicaid |
| 61A-C        | Required if applicable | Insured Group Name           | As applicable, enter the group name of the recipient's primary, secondary, and tertiary insurance on lines A, B, and C, according to the proper billing order.<br><br>Do not enter a group name on the line that shows payer "Medicaid".   |
| 62A-C        | Required if applicable | Insurance Group Number       | As applicable, enter the group number of the recipient's primary, secondary, and tertiary insurance on lines A, B, and C, according to the proper billing order.<br><br>Do not enter a group number on the line that shows payer "Medicaid".   |
| 63A-C        | Required if applicable | Treatment Authorization Code | Enter the 10-digit prior authorization number  |
| 64A-C        | Required if applicable | Document Control Number      | Enter the transaction control number (TCN) of the original claim for proof of timely filing on a resubmission of a claim.  |
| 65A-C        | Required if applicable | Employer Name                | Enter the name of the employer that could provide a source of third-party insurance payment  |
| 66           | Required               | DX Version                   | Enter the qualifier that denotes the version of the International Classification of Diseases (ICD) reported. A value of 9 indicates ICD-9; a value of 0 indicates ICD-10.  |
| 67           | Required               | Principal Diagnosis Code     | Enter the principal diagnosis code(s) provided at the time of admission as stated by the physician   |

| Form Locator | Requirement            | Field Description                 | Guideline   |
|--------------|------------------------|-----------------------------------|---|
|              |                        |                                   | <p>The POA indicator is reported on the eighth digit of Field Locator (FL) 67, principal diagnosis, and on the eighth digit of each of the secondary diagnosis fields, FL 67 A-Q.</p> <p>The valid POA indicator codes are:</p> <p>Y = Diagnosis was present at time of inpatient admission</p> <p>N = Diagnosis was not present at time of inpatient admission</p> <p>U = Documentation insufficient to determine if condition was present at the time of inpatient admission</p> <p>W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission</p> <p><i>Blank</i> - Unreported/not used. Diagnosis is exempt from POA reporting</p> <p>Note: For ASC X12N 837 Institutional (837I). The POA indicator is reported in segment HI in the 2300 loop, data element C022-09.</p> |
| 67A -Q       | Required if applicable | Other DX codes and POA indicator  | Enter the additional diagnosis code(s) provided at the time of admission as stated by the physician   |
| 69           | Required               | Admit DX code                     | Enter the diagnosis code provided at the time of admission as stated by the physician   |
| 70A - C      | Not Required           | Patient's reason DX               | Enter the diagnosis code indicating the patient's reason for visit at the time of outpatient registration   |
| 71           | Not Required           | PPS Code                          | Enter the Prospective Payment System (PPS) code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer  |
| 72A -C       | Not Required           | ECI                               | Enter the ICD-10-CM diagnosis code pertaining to external cause of injuries, poisoning, or adverse effect.  |
| 74           | Required if applicable | Principal Procedure Code and Date | Enter the appropriate surgical procedure code if the operating room was used. Record the date in MMDDYY format.   |
| 74a-e        | Required if applicable | Other procedure codes and dates   | Enter the appropriate ICD-10-CM surgical procedure code if the operating room was used. Record the date in MMDDYY format.   |
| 76           | Required if applicable | Attending NPI/Qual Last/First     | Enter the NPI of the attending provider.<br><br>If the attending provider is atypical, leave this field blank. Instead enter the Medicaid provider number to  |

| Form Locator | Requirement            | Field Description       | Guideline  |
|--------------|------------------------|-------------------------|--|
|              |                        |                         | the right-hand side of the “qualifier” box. Enter “G2” in the qualifier box.   |
| 77           | Not Required           | Operating provider      | <p>Enter the NPI of the provider performing surgery, as well as the last name/first name</p> <p>If the operating provider is atypical, leave this field blank. Instead enter the Medicaid provider number to the right-hand side of the “qualifier” box. Enter “G2” in the qualifier box.</p>  |
| 78 - 79      | Not Required           | Other (A or B) provider | <p>Enter the NPI of the other provider (e.g., referring, ordering, assisting provider, etc.), as well as the last name/first name.</p> <p>If Referring enter DN as qualifier code for Other in field 79, then the Referring Provider's NPI and Last, First name</p> <p>If the other provider (e.g., referring, ordering, assisting provider, etc.) is atypical, leave this field blank. Instead enter the Medicaid provider number to the right-hand side of the “qualifier” box. Enter “G2” in the qualifier box.</p>   |
| 80           | Required if applicable | Remarks                 | <p>If submitting an adjustment or void of a previously paid claim, enter the 17-digit transaction control number of the paid claim to be adjusted or voided along with the appropriate adjustment/void reason code in this field.</p> <p>011 RETRO RATE CHG / NO CUTBACK<br/>                     014 PROV CLAIM FILING CORRECTION<br/>                     019 POS PROV FILE CORR/LEGAL SETT<br/>                     022 FISCAL AGENT CLM PROCESS ERROR<br/>                     068 PROVIDER REFUND/CLM OVERPAYMNT<br/>                     069 PROV RFND/OVERPAY FISC ERROR<br/>                     070 PROV REFUND FOR HEALTH INSUR<br/>                     071 PROV REFUND FOR CASUALTY INS<br/>                     081 PROV CLAIM CORR/CLM FILED ERR<br/>                     082 CLM VOID/FISC AGENT PROC ERROR<br/>                     083 CLM VD/PD IN ERROR/RCP INCORRE<br/>                     084 CLM VD/PD ERROR/PROV FIL INCOR<br/>                     085 CLM VD/PD ERROR/INCORRECT PROV<br/>                     086 CLAIM VOID MEDICARE RECOVERY<br/>                     088 REFUND - PROVIDER ERROR<br/>                     089 REFUND- FISCAL AGENT ERROR<br/>                     090 PROV RTRN CHK/PD FOR INC BENE<br/>                     099 PROV RETURN CHK/ INCORR PROV<br/>                     101 VOID PAYMENT TO PIP HOSPITAL<br/>                     102 ACCOMMODATION CHARGE CORRECT<br/>                     103 PATIENT PAYMENT AMT CHANGED<br/>                     104 PROCEDURE SERVICE DATES FIX<br/>                     105 CORRECTING DIAGNOSIS CODE<br/>                     106 CORRECTING CHARGES<br/>                     107 UNIT VISIT STUDIES PRCD FIX<br/>                     108 RECONSIDERATION OF ALLOWANCE<br/>                     109 FIX ADMIT REFER PRESC PROVIDER</p> |

| Form Locator | Requirement | Field Description | Guideline  |
|--------------|-------------|-------------------|--|
|              |             |                   | 110 CORRECTING TOOTH CODE<br>111 CORRECTING SITE CODE<br>112 CORRECT TRANSPORTATION DATA<br>113 INPATIENT DRG<br>114 ADJUSTING PATIENT LEVEL CARE<br>115 RECOVERY BASED ON PRO REVIEW<br>116 ADJUSTED FOR RECP BEDHOLD DAYS<br>117 MANUAL CAPITATION VOID CLAIMS<br>118 REPROCESSED CLAIMS<br>119 AUTO RECOUPMENT SYSTEM ERROR<br>120 AUTO RECOUPMENT SYSTEM CHANG<br>121 PCG SERVICES<br>300 BENEFICIARY DECEASED - New |
| 81A - D      |             | CC                | Enter the taxonomy code of the billing/pay-to-provider preceded by the B3 qualifier.   |

## 17.1 Electronic Billing

Medicaid will accept UB-04 claims on cartridge, diskette or transmitted electronically. Providers who are interested in receiving instructions on electronic transmission should indicate this interest on the enrollment application. If the provider is already enrolled, please notify the Conduent EMC Coordinator listed in Appendix A.

## 17.2 Private Room

Medicaid will reimburse private room charges if certification of medical necessity is attached to the claim (i.e., isolation statement), or if facility only has private room accommodations. In this case, a confirmation letter is required.

## 17.3 Newborn Care

All mother and newborn hospital stays must be billed on a separate UB04 claim form. The following modifications are required when billing for affected newborn/infant services and procedures:

- Claims must be submitted on paper; not electronic.
- Claims must be billed using the newborn's DC Medicaid identification number. Claims should not be billed using the mother's identification number.

All newborn services should be bundled into the newborn DRG, unless the baby becomes ill post-delivery.

### 17.3.1 Newborn Birth Weight

When billing newborn inpatient stays where the birth weight influences the DRG assignment, the birth weight must be indicated by using the appropriate diagnosis code to the fifth digit, such as 765.19 – preterm NEC 2500+g. With the new APR-DRG grouper (v35) DRG assignment is determined by the diagnosis and procedure codes, not the condition code.

Note: The grouper version will change to v37 in October 2020.



## 17.4 Ambulatory Surgical Centers (ASC) Billing

All related services performed by an ambulatory surgery center must be billed on the UB04 claim form following the instructions listed below.

- Claims for ASC covered services must use type of bill (TOB) 0831.
- Must have the same from and through dates indicated in form locator (FL) 6
- Revenue codes 0490 or 0360 should be used for procedures that have been assigned to ASC payment groups.
- The CPT-4 code that best describes the procedure is required and must be entered in FL 44.
- When billing for chemotherapy related services, must include the national drug code (NDC)

### 17.4.1 Instructions for Completing the UB04 for ASC Billing

Table 6: Completing the UB04 Claim Form for ASC Billing

| Form Locator | Requirement | Field Description                            | Guideline  |
|--------------|-------------|--|--|
| 1            | Required    | Provider Name, Address, and Telephone Number | Billing Provider Name, Address and Telephone Number: Enter the agency name, street, city, state, zip code, and telephone number.<br>Line 1 – Provider Name<br>Line 2 – Provider Street Address<br>Line 3 – Provider City, State, Zip +4<br>Line 4 – Provider Telephone   |
| 4            | Required    | Type of Bill                                 | Enter the three-digit type of bill code. This field has been expanded from three to four characters with zero being the first digit. Claims will be processed based on the last three digits.<br><br>0831 (Special Facility – Ambulatory Surgery Center)<br><br>Note: If the type of bill ends with '1' (i.e., 111, 331, etc.) or '4' (i.e., 114, 334, etc.), the patient status <u>cannot</u> be 30 (still a patient) or 09 (admit to hospital). If the type of bill ends with '2' (i.e., 112, 332, etc.) or '3' (i.e., 113, 333, etc.) the patient status <u>must be</u> 30 (still a patient) or 09 (admit to hospital). |
| 6            | Required    | Statement Covers Period                      | Enter the beginning and ending dates of service billed in MMDDYY format.   |
| 8b           | Required    | Patient Name/Identifier                      | Enter the patient's name as it appears on the Medical Assistance Card in last name, first name, middle initial format.   |
| 10           | Required    | Patient Birth date                           | Enter patient's date of birth in MMDDYYYY format   |
| 11           | Required    | Patient Sex                                  | Indicate the patient's gender<br>M: Male<br>F: Female<br>U: Unknown  |
| 12           | Required    | Admission Date                               | Enter the date the patient was admitted for care in MMDDYY format.   |
| 17           | Required    | Patient Status                               | Enter the code that identifies the patient's status as of the statement covers through date.<br>01: Discharge to home or self-care (routine discharge)<br>02: Discharged/transferred to another short-term   |

| Form Locator | Requirement | Field Description | Guideline   |
|--------------|-------------|-------------------|---|
|              |             |                   | <p>general hospital for inpatient care<br/>                     03: Discharged/transferred to skilled nursing facility<br/>                     04: Discharged/transferred to an intermediate care facility<br/>                     05: Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution<br/>                     06: Discharged/transferred to home under care of organized home health service organization<br/>                     07: Left against medical advice or discontinued care<br/>                     08: Discharged/transferred to home under care of a Home IV provider<br/>                     09: Admitted as an inpatient to this hospital<br/>                     20: Expired<br/>                     30: Still a patient<br/>                     40: Expired at home (Medicare hospice claim only)<br/>                     41: Expired in a medical facility (e.g., hospital, SNF, ICF, or freestanding hospice) (Medicare hospice claims only)<br/>                     43: Discharged/transferred to federal healthcare facility<br/>                     50: Discharged to Hospice – Home<br/>                     51: Discharged to Hospice – Medical Facility (certified) providing hospice level of care<br/>                     61: Discharged/transferred within the institution to a hospital-based, Medicare-approved swing bed<br/>                     62: Discharged/transferred to inpatient rehabilitation facility, including rehabilitation distinct part units of a hospital<br/>                     63: Discharged/transferred to a Medicare – certified long-term care hospital<br/>                     64: Discharged/transferred to a nursing facility certified under Medicaid, but not under Medicare<br/>                     65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital<br/>                     66: Discharged/transferred to a critical access hospital<br/>                     70: Discharged/transferred to another type of health care institution not defined in code list</p> |
| 39 - 41      | Required    | Value Codes       | <p>Enter the appropriate value code and amount.<br/>                     80: Covered days<br/>                     81: Non-covered days<br/>                     82: Co-insurance days (required only for Medicare crossover claims)<br/>                     83: Lifetime reserve days (required only for Medicare crossover claims)</p> <p>Enter the appropriate Value Code in the code portion of the field and the Number of Days in the Dollar portion of the Amount section of the field. Enter 00 in the Cents portion of the Amount section of the field</p>  |

| Form Locator | Requirement            | Field Description      | Guideline  |
|--------------|------------------------|------------------------|--|
| 42           | Required               | Rev. Code              | Enter the revenue code that identifies the specific accommodation, ancillary service, or billing calculation.<br>0360 – Operating Services General Classification<br>0361 – Minor Surgery<br>0362 - Organ Transplant – other than kidney<br>0367 – Kidney Transplant<br>0369 – Other OR Services<br>0490 – Ambulatory Surgical Care General Classification<br>0499 – Other Ambulatory Surgical<br>On the last line, enter 0001 for the total.  |
| 43           | Required if applicable | Description            | Enter the 11-digit National Drug Code (NDC) when billing for physician administered drugs in an outpatient setting.  |
| 44           | Required               | HCPCS/Rates/HIPPS Code | Enter the appropriate CPT or HCPCS code relevant to the accommodation revenue code entered for the services being billed (see field 42 for more info).<br><br>When billing DHCF for services, the provider is also required to report the usual and customary charge (UCR) that the provider normally charges his non-Medicaid patients. By reporting the UCR, the provider's profile will accurately reflect the reimbursement rates of Medicaid and how they compare to private healthcare reimbursement. This reporting also provides DHCF with the information necessary to request and propose increases in reimbursement.              |
| 46           | Required               | Serv. Units            | Enter the total number of covered accommodation days or ancillary units of service for each revenue code billed as appropriate   |
| 47           | Required               | Total Charges          | Enter the total charges for each related revenue/procedure code. Enter the grand total charges at the bottom of this field to be associated with revenue code 0001.<br><br>When billing DHCF for services, the provider is also required to report the usual and customary charge (UCR) that the provider normally charges his non-Medicaid patients. By reporting the UCR, the provider's profile will accurately reflect the reimbursement rates of Medicaid and how they compare to private healthcare reimbursement. This reporting also provides DHCF with the information necessary to request and propose increases in reimbursement. |
| 50           | Required               | Payer Name             | As applicable, enter the name of the beneficiary's primary, secondary, and tertiary insurance on lines A, B, and C. For claims with no TPL, DC Medicaid is entered on line A.  |
| 56           | Required               | Billing Provider NPI   | Enter the National Provider Identifier for the billing provider  |

| Form Locator | Requirement | Field Description        | Guideline   |
|--------------|-------------|--------------------------|---|
| 58A-C        | Required    | Insured's Name           | <p>As applicable, enter the insured's name for the primary, secondary, and tertiary insurance on lines A, B, and C according to proper billing order.</p> <p>On the line that shows payer, Medicaid, enter the beneficiary's name exactly as it appears on the Medical Assistance card.</p>   |
| 59A-C        | Required    | P. Rel                   | <p>Enter the appropriate code indicating the relationship of the patient to the identified insured.</p> <p>01: Spouse<br/> 18: Self<br/> 19: Child<br/> 20: Employee<br/> 21: Unknown<br/> 39: Organ Donor<br/> 40: Cadaver Donor<br/> 53: Life Partner<br/> G8: Other Relative</p>   |
| 60A-C        | Required    | Insured's Unique ID      | <p>Enter the insured's ID for the plans listed in 50 A, B, and C that relates to the insured's name in 58 A, B, and C. Enter the patient's Medicaid ID as it appears on their Medical Assistance Card omitting the leading zeroes in the field that corresponds with DC Medicaid</p>  |
| 67           | Required    | Principal Diagnosis Code | <p>Enter the principal diagnosis code(s) provided at the time of admission as stated by the physician</p> <p>The POA indicator is reported on the eighth digit of Field Locator (FL) 67, principal diagnosis, and on the eighth digit of each of the secondary diagnosis fields, FL 67 A-Q.</p> <p>The valid POA indicator codes are:</p> <p><i>Y</i> = Diagnosis was present at time of inpatient admission</p> <p><i>N</i> = Diagnosis was not present at time of inpatient admission</p> <p><i>U</i> = Documentation insufficient to determine if condition was present at the time of inpatient admission</p> <p><i>W</i> = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission</p> <p><i>Blank</i> - Unreported/not used. Diagnosis is exempt from POA reporting</p> |

| Form Locator | Requirement            | Field Description       | Guideline   |
|--------------|------------------------|-------------------------|---|
|              |                        |                         | Note: For ASC X12N 837 Institutional (837I). The POA indicator is reported in segment HI in the 2300 loop, data element C022-09.  |
| 69           | Required               | Admit DX code           | Enter the diagnosis code provided at the time of admission as stated by the physician   |
| 77           | Required if applicable | Operating provider      | Enter the NPI of the provider performing surgery, as well as the last name/first name. If the operating provider is atypical, leave this field blank. Instead enter the Medicaid provider number to the right-hand side of the "qualifier" box. Enter "G2" in the qualifier box.  |
| 78 - 79      | Required if applicable | Other (A or B) provider | <p>Enter the NPI of the other provider (e.g., referring, ordering, assisting provider, etc.), as well as the last name/first name.</p> <p>If Referring enter DN as qualifier code for Other in field 79, then the Referring Provider's NPI and Last, First name</p> <p>If the other provider (e.g., referring, ordering, assisting provider, etc.) is atypical, leave this field blank. Instead enter the Medicaid provider number to the right-hand side of the "qualifier" box. Enter "G2" in the qualifier box.</p>  |
| 80           | Required if applicable | Remarks                 | <p>If submitting an adjustment or void of a previously paid claim, enter the 17-digit transaction control number of the paid claim to be adjusted or voided along with the appropriate adjustment/void reason code in this field.</p> <p>011 RETRO RATE CHG / NO CUTBACK<br/>                     014 PROV CLAIM FILING CORRECTION<br/>                     019 POS PROV FILE CORR/LEGAL SETT<br/>                     022 FISCAL AGENT CLM PROCESS ERROR<br/>                     068 PROVIDER REFUND/CLM OVERPAYMNT<br/>                     069 PROV RFND/OVERPAY FISC ERROR<br/>                     070 PROV REFUND FOR HEALTH INSUR<br/>                     071 PROV REFUND FOR CASUALTY INS<br/>                     081 PROV CLAIM CORR/CLM FILED ERR<br/>                     082 CLM VOID/FISC AGENT PROC ERROR<br/>                     083 CLM VD/PD IN ERROR/RCP INCORRE<br/>                     084 CLM VD/PD ERROR/PROV FIL INCOR<br/>                     085 CLM VD/PD ERROR/INCORRECT PROV<br/>                     086 CLAIM VOID MEDICARE RECOVERY<br/>                     088 REFUND - PROVIDER ERROR<br/>                     089 REFUND- FISCAL AGENT ERROR<br/>                     090 PROV RTRN CHK/PD FOR INC BENE<br/>                     099 PROV RETURN CHK/ INCORR PROV<br/>                     101 VOID PAYMENT TO PIP HOSPITAL<br/>                     102 ACCOMMODATION CHARGE CORRECT<br/>                     103 PATIENT PAYMENT AMT CHANGED<br/>                     104 PROCEDURE SERVICE DATES FIX<br/>                     105 CORRECTING DIAGNOSIS CODE<br/>                     106 CORRECTING CHARGES</p> |

| Form Locator | Requirement | Field Description | Guideline   |
|--------------|-------------|-------------------|---|
|              |             |                   | 107 UNIT VISIT STUDIES PRCD FIX<br>108 RECONSIDERATION OF ALLOWANCE<br>109 FIX ADMIT REFER PRESC PROVIDER<br>110 CORRECTING TOOTH CODE<br>111 CORRECTING SITE CODE<br>112 CORRECT TRANSPORTATION DATA<br>113 INPATIENT DRG<br>114 ADJUSTING PATIENT LEVEL CARE<br>115 RECOVERY BASED ON PRO REVIEW<br>116 ADJUSTED FOR RECP BEDHOLD DAYS<br>117 MANUAL CAPITATION VOID CLAIMS<br>118 REPROCESSED CLAIMS<br>119 AUTO RECOUPMENT SYSTEM ERROR<br>120 AUTO RECOUPMENT SYSTEM CHANG<br>121 PCG SERVICES<br>300 BENEFICIARY DECEASED - New |
| 81A - D      | Required    | CC                | Enter the taxonomy code of the billing/pay-to-provider preceded by the B3 qualifier.  |

#### 17.4.2 Reimbursement for ASC

- A maximum of five (5) surgeries may be performed per day per claim
- The reimbursement for multiple surgeries performed is as follows:
- First surgery performed will be reimbursed at 100% of the allowed amount
- Second surgery performed will be reimbursed at 50% of the allowed amount
- Three to five surgeries performed per day will be reimbursed at 25% of the allowed amount

### 17.5 Anesthesia Billing

The Department of Health Care Finance (DHCF) requires that **all** anesthesia providers assign one of the following modifiers to each CPT anesthesia code submitted on the CMS1500 claim form.

Modifiers:

| Modifier | Description  |
|----------|--|
| AA       | Anesthesia service performed personally by an anesthesiologist<br>Modifier AA is to be used by anesthesiologists only.<br>Modifier AA should <b>not</b> be used for medical direction of CRNAs |
| AD       | Medical supervision by an anesthesiologist   |
| QK       | Used by medical direction of two, three or four concurrent anesthesia procedures involving CRNAs or anesthesiologists  |
| QX       | CRNA service with medical direction by a physician   |
| QY       | Anesthesiologist medically directs one CRNA  |
| QZ       | CRNA service without medical direction by a physician  |

Reimbursement Methodology:

| Modifier | Reimbursement   |
|----------|---|
| AA       | Reimbursed at 100% of the calculated rate for services performed personally by an |

|    |   |
|----|---|
|    | anesthesiologist  |
| AD | Reimbursed at 35% of the calculated rate  |
| QK | Reimbursed at 50% of the calculated rate  |
| QX | Reimbursed at 50% of the calculated rate to the CRNA  |
| QY | Reimbursed at 50% of the calculated rate  |
| QZ | Reimbursed at 100% of the calculated rate to the CRNA for services without medical direction by an anesthesiologist |

Anesthesiologists and CRNAs must bill anesthesia in time increments. The conversion factor for anesthesia is \$17.66 for dates of services January 1 – December 31, 2025.

Anesthesiologists and CRNAs must bill anesthesia in time increments. The conversion factor for anesthesia is \$17.75 for dates of services January 1 – December 31, 2024.

Anesthesiologists and CRNAs must bill anesthesia in time increments. The conversion factor for anesthesia is \$18.02 for dates of services January 1 – December 31, 2023.

Anesthesiologists and CRNAs must bill anesthesia in time increments. The conversion factor for anesthesia is \$18.94 for dates of services January 1 – December 31, 2022.

## 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 6: Remittance Advice Mailer Page

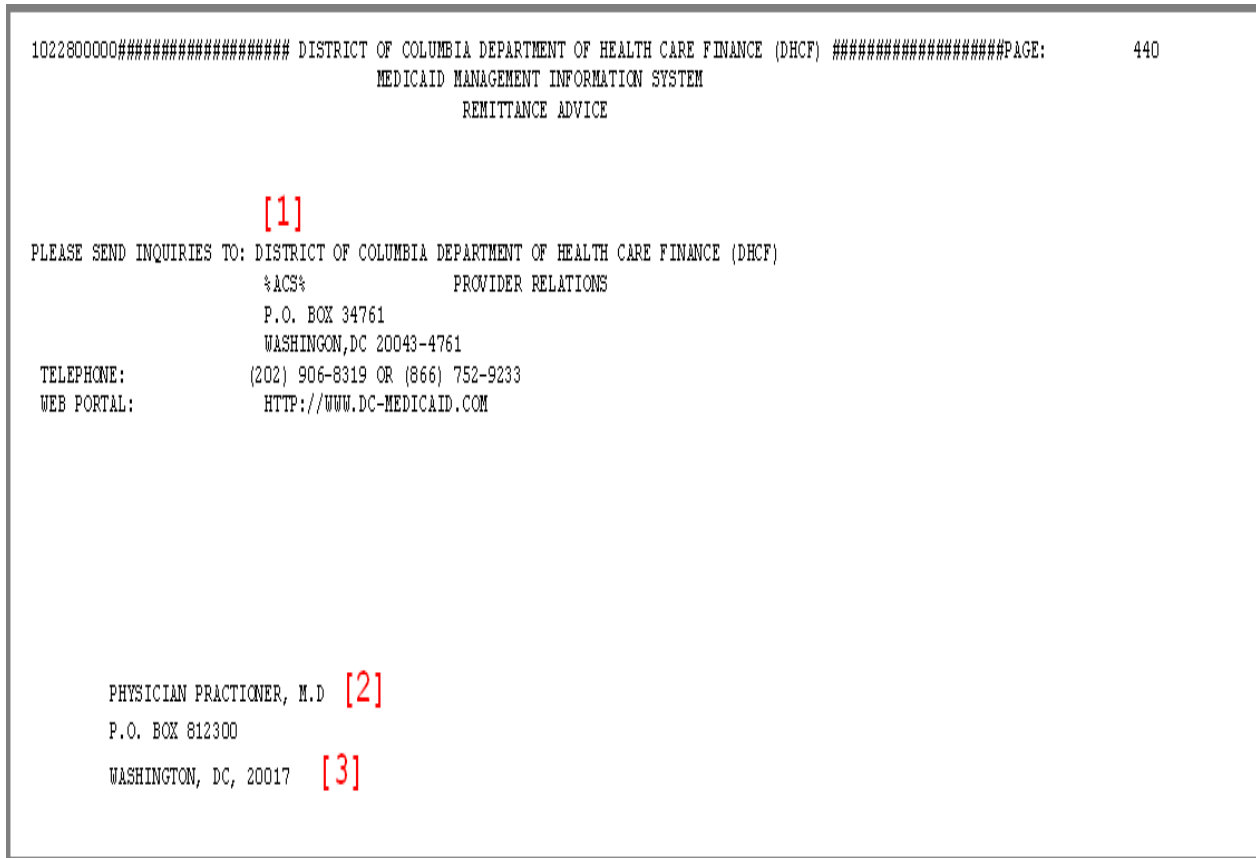


Table 7: Remittance Advice Mailer Page Table

| 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  |



|                           |   |  |
|---------------------------|---|--|
| <b>PROVIDER ADDRESS 1</b> | 3 | Provider remit mailing address first address line  |
| <b>PROVIDER ADDRESS 2</b> | 3 | Provider remit mailing address second address line |
| <b>PROVIDER CITY</b>      | 3 | Provider Remit Mailing address city                |
| <b>PROVIDER STATE</b>     | 3 | Provider Remit Mailing address state               |
| <b>PROVIDER ZIP</b>       | 3 | Provider Remit Mailing address zip code            |

Figure 7: Remittance Advice Header Page

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

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

(FOR CHANGE OF ADDRESS, DOWNLOAD FORM FROM WEB PORTAL)
PLEASE SEND INQUIRIES TO: DISTRICT OF COLUMBIA - DHCF
ACS STATE HEALTHCARE-PROVIDER RELATIONS
[4] P.O. BOX 34761
WASHINGTON, DC 20043-4761
(202) 906-8319 OR (866) 752-9233
TELEPHONE:
WEB PORTAL: HTTP://DC-MEDICAID.COM

PAYMENT ACCOMPANIES REMITTANCE
TOTAL ASSOCIATED PAYMENT: $177.31 [5] PAYMENT DATE: 08/03/2009 [6]
PAID TO PROVIDER TAX ID: 123456789 [7]
FOR CLAIMS PAID THROUGH: 08/03/2009 [8]

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

Table 8: Remittance Advice Header Page Table

| FIELD NAME                     | Field # | DESCRIPTION  |
|--------------------------------|---------|--|
| <b>PAY TO PROVIDER NUMBER</b>  | 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. |
| <b>PROVIDER NAME</b>           | 2       | The name of the provider receiving the remittance advice   |
| <b>PROVIDER ADDRESS 1</b>      | 3       | Provider remit mailing address first address line  |
| <b>PROVIDER ADDRESS 2</b>      | 3       | Provider remit mailing address second address line   |
| <b>PROVIDER CITY</b>           | 3       | Provider Remit Mailing address city  |
| <b>PROVIDER STATE</b>          | 3       | Provider Remit Mailing address state   |
| <b>PROVIDER ZIP</b>            | 3       | Provider Remit Mailing address zip code  |
| <b>PLEASE SEND INQUIRES TO</b> | 4       | Fiscal Agent Services Name/Address/City/State/Zip, contact phone number and the Web Portal address.  |

| FIELD NAME               | Field # | DESCRIPTION  |
|--------------------------|---------|--|
| TOTAL ASSOCIATED PAYMENT | 5       | Total amount of the cycle check/EFT                                    |
| PAYMENT DATE             | 6       | This is the payment date of the check /EFT                             |
| PAID TO PROVIDER TAX ID  | 7       | The federal tax ID of the provider or group who is to receive payment. |
| FOR CLAIMS PAID THROUGH  | 8       | CYCLE RUN DATE   |

**Provider Messages**

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

*Page Header Information*

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

Figure 8: Remittance Advice Provider Messages

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

Table 9: 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. |

|                   |   |  |
|-------------------|---|--|
| <b>REMITTANCE</b> | 3 | The remittance advice number uniquely identifies the remittance Advice prepared for this provider for a given payment cycle. |
| <b>NPI NUMBER</b> | 4 | The pay to provider's National Provider Identifier (NPI)   |
| <b>PAGE</b>       | 5 | Page number within each provider's report  |
| <b>RPT PAGE</b>   | 6 | Page number across all provider's reports  |
| <b>REMIT SEQ</b>  | 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 9: Remittance Advice Paid Claims

DATE: 10/08/09      DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)      PAGE: 00000005  
 PROVIDER NO: [REDACTED]      MEDICAID MANAGEMENT INFORMATION SYSTEM      RPT PAGE: 000000030  
 REMITTANCE: 00438277      REMITTANCE ADVICE      REMIT SEQ: 000000006  
 NPI NUMBER: [REDACTED]      ADJUSTMENTS PAID      PRACTITIONER/PHYSICIAN

| RECIPIENT NAME   | MEDICAID ID | TCN               | PAT ACCT NUM      | MED REC NO | DATES OF SERVICE   | TOB | SVC        | PVDR       | SERVICE PROVIDER NAME | SUBMITTED AMT | PEE             | REDUCTION AMT | PAT RESP AMT | TOT PAID AMT   | STATUS            |                |           |
|--|-------------|-------------------|-------------------|------------|--|-----|------------|------------|-----------------------|---------------|-----------------|---------------|--------------|----------------|-------------------|----------------|-----------|
| LINE   | PROC        | TYPE/DESC         | M1                | M2         | M3   | M4  | REVCD      | TRCD       | SVC                   | PROV          | PROV CONTROL NO | DATES OF SERV | LINE UNITS   | LN SUBM AMOUNT | LN PEE REDUCT AMT | LN PAID AMOUNT | LN STATUS |
| [REDACTED]   | [REDACTED]  | [REDACTED]        | 09279100010000018 |            | 09/24/09-09/24/09  | 11  | [REDACTED] | [REDACTED] | [REDACTED]            | -50.00        | .00             | .00           | .00          | -50.00         | CREDIT            |                |           |
|  |             |                   |                   |            | REF: ORIGINAL TCN: 09268100010000147      DRG CODE:      DRG WEIGHT: 0.00000 |     |            |            |                       |               |                 |               |              |                |                   |                |           |
| 1  | 99213       | HC/HCPCS/CPT CODE |                   |            | 09/24/09-09/24/09  |     |            |            |                       | .00           |                 | -50.00        |              |                | CREDIT            |                |           |
| [REDACTED]   | [REDACTED]  | [REDACTED]        | 09279100010000019 |            | 09/24/09-09/24/09  | 11  | [REDACTED] | [REDACTED] | [REDACTED]            | 40.00         | .00             | .00           | .00          | 40.00          | DEBIT             |                |           |
|  |             |                   |                   |            | REF: ORIGINAL TCN: 09268100010000147      DRG CODE:      DRG WEIGHT: 0.00000 |     |            |            |                       |               |                 |               |              |                |                   |                |           |
| 1  | 99213       | HC/HCPCS/CPT CODE |                   |            | 09/24/09-09/24/09  |     |            |            |                       | .00           |                 | 40.00         |              |                | DEBIT             |                |           |
| --- END OF ADJ PAID CLAIMS FOR PROVIDER [REDACTED] --- |             |                   |                   |            |  |     |            |            |                       |               |                 |               |              |                |                   |                |           |

Table 10: Remittance Advice Paid Claims Table

| <b>FIELD NAME</b>        | <b>Field #</b> | <b>DESCRIPTION</b>  |
|--------------------------|----------------|---|
| <b>BENEFICIARY NAME</b>  | 1              | Patient name  |
| <b>MEDICAID ID</b>       | 2              | Medicaid's beneficiary ID for this patient  |
| <b>TCN</b>               | 3              | Transaction control number uniquely identifies the claim  |
| <b>PAT ACCT NUM</b>      | 4              | Patient account number as indicated on the claim by the provider  |
| <b>MED REC NO</b>        | 5              | The submitting provider's medical record number as referencing this claim. This number is printed on the RA to assist providers in identifying the patient for whom the service was rendered. |
| <b>DATES OF SERV</b>     | 6              | First and last dates of service for this claim  |
| <b>TOB</b>               | 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.  |
| <b>SVC PVDR</b>          | 8              | Servicing provider ID   |
| <b>SVC PVDR NAME</b>     | 9              | Servicing provider name   |
| <b>SUBMITTED AMT</b>     | 10             | Total charges submitted for this TCN  |
| <b>FEE REDUCTION AMT</b> | 11             | The difference between the submitted amount and the paid amount   |
| <b>PAT RESP AMT</b>      | 12             | Amount payable by patient   |
| <b>TOT PAID AMT</b>      | 13             | Total amount paid on this TCN. (For balancing, this should equal Submitted Charges minus Adjustments.)  |
| <b>STATUS</b>            | 14             | Claim Status (Paid – Denied – Suspended)  |
| <b>LINE</b>              | 15             | The line-item number on the claim   |
| <b>PROC</b>              | 16             | The line-item procedure code if applicable.   |
| <b>TYPE/DESC</b>         | 17             | The type of code listed in the procedure code (PROC) field.   |
| <b>M1, M2, M3, M4</b>    | 18             | The procedure code modifiers.   |
| <b>REVCD</b>             | 19             | The line-item revenue code if applicable.   |
| <b>THCD</b>              | 20             | The tooth code if applicable.   |
| <b>SVC PROV</b>          | 21             | The line-item servicing provider ID   |
| <b>PROV CONTROL NO</b>   | 22             | The line-item control number submitted in the 837 which is utilized by the provider for tracking purposes. (REF02 qualifier 6R in 835)  |
| <b>DATES OF SERV</b>     | 23             | First and last dates of service for this line item  |
| <b>LINE UNITS</b>        | 24             | Number of units   |
| <b>LN SUBM AMOUNT</b>    | 25             | The line item submitted amount.   |
| <b>FEE REDUCTION AMT</b> | 26             | The difference between the submitted amount and the paid amount   |
| <b>LN PAID AMOUNT</b>    | 27             | Amount paid for this line item  |

| FIELD NAME | Field # | DESCRIPTION          |
|------------|---------|----------------------|
| LN STATUS  | 28      | The line-item status |

Figure 10: Remittance Advice Adjustments

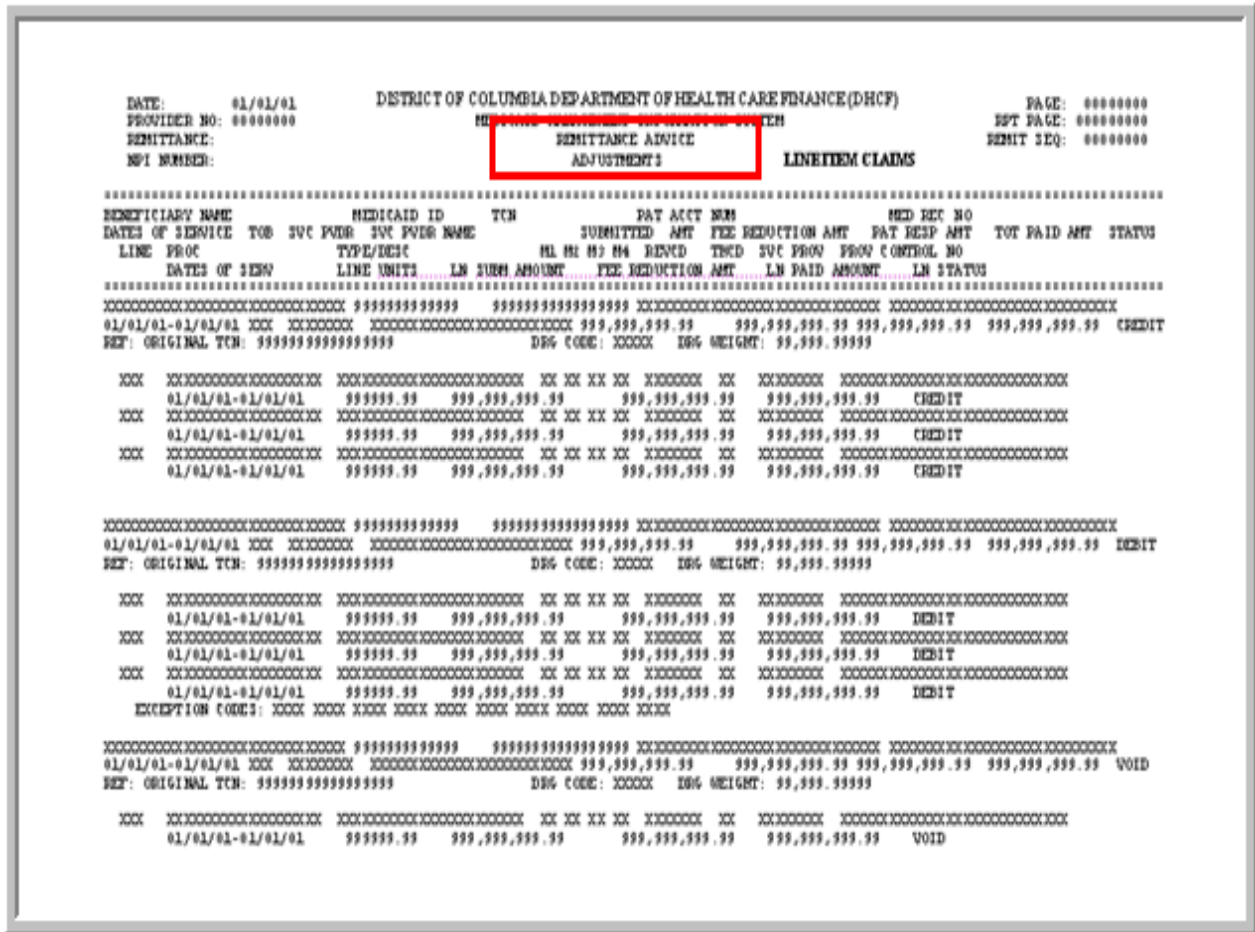


Figure 11: Remittance Advice Adjustments Table

| 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   |

| <b>Field Name</b>                          | <b>Description</b>   |
|--|--|
| <b>SUBMITTED AMT</b>                       | Total charges submitted for this TCN   |
| <b>FEE REDUCTION AMT</b>                   | The difference between the submitted amount and the paid amount  |
| <b>PAT RESP AMT</b>                        | Amount payable by patient  |
| <b>TOT PAID AMT</b>                        | Total amount paid on this TCN. (For balancing, this should equal Submitted Charges minus Adjustments.)                                 |
| <b>STATUS</b>                              | Claim Status (Paid – Denied – Suspended)   |
| <b>LINE</b>                                | The line-item number on the claim  |
| <b>PROC</b>                                | The line-item procedure code if applicable.  |
| <b>TYPE/DESC</b>                           | The type of code listed in the PROC field.   |
| <b>M1, M2, M3, M4</b>                      | The procedure code modifiers.  |
| <b>REVCD</b>                               | The line-item revenue code if applicable.  |
| <b>THCD</b>                                | The tooth code if applicable.  |
| <b>SVC PROV</b>                            | The line-item Servicing provider ID  |
| <b>PROV CONTROL NO</b>                     | The line-item control number submitted in the 837 which is utilized by the provider for tracking purposes. (REF02 qualifier 6R in 835) |
| <b>DATES OF SERV</b>                       | First and last dates of service for this line item   |
| <b>LINE UNITS</b>                          | Number of units  |
| <b>LN SUBM AMOUNT</b>                      | The line item submitted amount.  |
| <b>FEE REDUCTION AMT</b>                   | The difference between the submitted amount and the paid amount  |
| <b>LN PAID AMOUNT</b>                      | Amount paid for this line item   |
| <b>LN STATUS</b>                           | The line-item status   |
| <b>REF : ORIGINAL TCN</b>                  | The TCN that is being adjusted.  |
| <b>DRG CODE</b>                            | DRG Code. (Not currently used).  |
| <b>DRG WEIGHT</b>                          | DRG Weight. (Not currently used).  |
| <b>EXCEPTION CODES</b>                     | The line-item exception codes  |
| <b>EXPLANATION OF BENEFITS CODES (EOB)</b> | The line-item EOB codes  |

Figure 12: Remittance Advice Suspended Claims

```

*****
DATE:          09/07/09          DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)          PAGE: 00000004
PROVIDER NO: 019999999          MEDICAID MANAGEMENT INFORMATION SYSTEM          RPT PAGE: 000001761
REMITTANCE: 00441451          REMITTANCE ADVICE          REMIT SEQ: 00000168
NPI NUMBER: X1999999998          SUSPENDED CLAIMS          INPATIENT
*****
RECIPIENT NAME          MEDICAID ID          TCN          PAT ACCT NO          MED REC NO
DATES OF SERV          STAT DT          TOB          SVC PVDR          SVC PRV NAME          DRG CODE          DRG WEIGHT          TOTAL SUBMITTED          STATUS
LN          DATES OF SERVICE          SVC PVDR          PROC          TYPE/DESC          M1          M2          M3          M4          REVC          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 11: 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                                |

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

Figure 13: Remittance Advice Provider Totals/Legend

| FIELD NAME  | DESCRIPTION  |
|---|--|
| DATE: 09/07/09  | DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)                                |
| PROVIDER NO: 02700000   | MEDICAID MANAGEMENT INFORMATION SYSTEM   |
| REMITTANCE: 00441326  | REMITTANCE ADVICE  |
| NPI NUMBER: 18000797148   | PROVIDER TOTALS/LEGEND   |
| PAGE: 00000005  |  |
| RPT PAGE: 000000680   |  |
| REMIT SEQ: 00000077   |  |
| 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 FINANCIAL 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<br>(202) 906-8319 OR (866) 752-9233 TO REQUEST A COPY OF THE ENTIRE REMITTANCE ADVICE IN A CD.<br>0--- END OF REMITTANCE FOR PROVIDER 027332900 --- |  |

Table 12: 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.                         |



| <b>FIELD NAME</b>                                | <b>DESCRIPTION</b>   |
|--|--|
| <b>ORIGINAL PAID</b>                             | New claims submitted for this cycle  |
| <b>CREDIT ADJUSTMENTS</b>                        | The total amount of credit adjustments   |
| <b>DEBIT ADJUSTMENTS</b>                         | The total amount of debit adjustments  |
| <b>VOIDS</b>                                     | Total number of voided claims  |
| <b>APPROVED SUBTOTAL</b>                         | Subtotal of approved claims  |
| <b>SUSPENDED</b>                                 | Total number of suspended claims and charges   |
| <b>DENIED</b>                                    | Total number of denied claims and charges  |
| <b>CLAIM PROCESSED TOTAL</b>                     | Total of submitted and paid amounts  |
| <b>PROVIDER FINANCIALS</b>                       |  |
| <b>PAYMENT TOTAL</b>                             | Total provider payment   |
| <b>OUTSTANDING CREDIT BALANCE AS OF</b>          | The outstanding credit balance.  |
| <b>TOTAL HISTORY ONLY FINANCIAL TRANSACTIONS</b> |  |
| <b>TOTAL HISTORY ONLY CLAIMS</b>                 |  |
| <b>ADJUSTMENT SUBTOTALS</b>                      |  |
| <b>CREDIT ADJUSTMENTS</b>                        |  |
| <b>DEBIT ADJUSTMENTS</b>                         |  |
| <b>FIRST QUARTER</b>                             | The total amount of adjustments and/or voids for the first quarter (Jan – Mar) in the calendar year.   |
| <b>SECOND QUARTER</b>                            | The total amount of adjustments and/or voids for the second quarter (Apr – June) in the calendar year. |
| <b>THIRD QUARTER</b>                             | The total amount of adjustments and/or voids for the third quarter (July – Sept) in the calendar year. |
| <b>FOURTH QUARTER</b>                            | The total amount of adjustments and/or voids for the fourth quarter (Oct – Dec) in the calendar year.  |
| <b>EXCEPTION LEGEND</b>                          | Full description of any exception codes (denial reason codes) listed on this RA                        |
| <b>EOB CODE LEGEND</b>                           | Full description of any explanation of benefit codes listed on this RA                                 |

## 18.1 Inquiries

When making written and telephone inquiries related to RA status, providers must provide Conduent with the date of the RA and the TCN for the claim in question. All written inquiries should be mailed to the Provider Inquiry P.O. Box listed in Appendix A.

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

To indicate an adjustment or voided claim, the following information must be recorded in field locator 80.

|       |   |
|-------|---|
| Code  | Definition  |
| A     | Adjustment  |
| -or-  |   |
| V     | Void  |
| -and- |   |
| TCN   | 17-digit Transaction Control Number and 3-digit reason code from the list below |

When submitting an **adjustment** for a previously paid claim that processed under your NPI, you must submit your adjusted claim in the same manner.

- Use the UB04 claim form.
- Indicate the letter “A” for adjustment, the Transaction Control Number of the current paid claim followed by the appropriate adjustment reason code in the Remarks field locator 80.
- If completing the UB04, enter the billing address including the +4-zip code of the pay-to-provider in Field Locator 1, enter the billing (pay-to) provider’s NPI in field locator 56, and the taxonomy code in field locator 81CC preceded by the B3 qualifier.

When submitting a **void** for a previously paid claim that processed under your NPI number, you must submit your adjusted claim in the same manner.

- Indicate the letter “V” for void, the Transaction Control Number of the current paid claim followed by the appropriate adjustment reason code in the Remarks field locator 80.
- If completing the UB04, enter the billing address including the +4-zip code of the pay-to-provider in Field Locator 1, enter the billing (pay-to) provider’s NPI in field locator 56, and the taxonomy code in field locator 81CC preceded by the B3 qualifier.

Figure 14: Adjustment Example

|  |                                   |                                   |    |                     |                |          |       |   |    |    |
|--|-----------------------------------|-----------------------------------|----|---------------------|----------------|----------|-------|---|----|----|
| 68<br>DX                               | 67<br>A                           | B                                 | C  | D                   | E              | F        | G     | H | 68 |    |
| 69 ADMIT<br>DX                         | 70 PATIENT<br>REASON DX           | a                                 | b  | c                   | 71 PPS<br>CODE | 72<br>ED | a     | b | c  | 73 |
| 74<br>PRINCIPAL PROCEDURE<br>CODE DATE | a<br>OTHER PROCEDURE<br>CODE DATE | b<br>OTHER PROCEDURE<br>CODE DATE | 75 | 76 ATTENDING<br>NPI | QUAL           | LAST     | FIRST |   |    |    |
| c<br>OTHER PROCEDURE<br>CODE DATE      | d<br>OTHER PROCEDURE<br>CODE DATE | a<br>OTHER PROCEDURE<br>CODE DATE |    | 77 OPERATING<br>NPI | QUAL           | LAST     | FIRST |   |    |    |
| 80 REMARKS                             | 81CC<br>a                         | b                                 |    | 78 OTHER<br>NPI     | QUAL           | LAST     | FIRST |   |    |    |
| A 23XXXXXXXXXXXXXXXXX 014              | c                                 |                                   |    | 79 OTHER<br>NPI     | QUAL           | LAST     | FIRST |   |    |    |
| SAMPLE AJUSTMENT                       | d                                 |                                   |    |                     |                |          |       |   |    |    |

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC<sup>®</sup> National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 15: Void Example

Table 13: 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         |

### **18.3 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 4<sup>th</sup> St NW  
Suite 900  
Washington, DC  
Telephone: (202) 442-5988  
[www.dhcf.dc.gov](http://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](http://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 4<sup>th</sup> 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](http://www.dcpdms.com)

Transportation Broker  
Medicaid Transportation Management, Inc. (MTM)  
Telephone Number - (888) 561-8747  
[www.mtm-inc.net](http://www.mtm-inc.net)

Third Party Liability  
Department of Health Care Finance  
441 4<sup>th</sup> St NW, Suite 1000S  
Washington, DC 20001  
Attention: Third Party Liability  
Telephone: (202) 698-2000

## APPENDIX B: COMPLETING 719A PRIOR AUTHORIZATION FORM

### 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 as listed in the HCPCS/CPT Coding Manual.

### Time required

- a. Enter best estimate of the timeframe 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 for extra heavy, extra tall, etc.

**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.

**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

**Quick Tips**

Please be mindful of the following when completing a 719A form:

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

Figure 16: 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 Number   | NPI                               |                                       | Provider Number                 | 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 <input type="checkbox"/>  | DME <input type="checkbox"/>      | Home <input type="checkbox"/>         |                                 |                    |                   |    |    |    |    |    |    |
|  |                |   | Medical <input type="checkbox"/>  | Pharmacy <input type="checkbox"/> | ICF/MR <input type="checkbox"/>       |                                 |                    |                   |    |    |    |    |    |    |
|  |                |   | Dental <input type="checkbox"/>   | Eyewear <input type="checkbox"/>  | Nursing Home <input type="checkbox"/> |                                 |                    |                   |    |    |    |    |    |    |
|  |                |   | Hospice <input type="checkbox"/>  | Other <input type="checkbox"/>    | Hospital <input type="checkbox"/>     |                                 |                    |                   |    |    |    |    |    |    |
| Discharge Date:  |                |   | Home Health: <input type="checkbox"/> Skilled Nurse <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> HHA <input type="checkbox"/> Private Duty |                                   |                                       | Office <input type="checkbox"/> |                    |                   |    |    |    |    |    |    |
| 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   | 02             | 03  | FACIAL  |                                   |                                       |                                 |                    | 12                | 13 | Q2 |    |    |    |    |
| 01   |                |   | 04  | 05                                | 06                                    | 07                              | 08                 | 09                | 10 | 11 | 14 | 15 | 16 | Q3 |
| R  |                |   |   |                                   |                                       |                                 |                    |                   |    |    |    |    |    |    |
| I  |                |   | A   | B                                 | C                                     | D                               | E                  | F                 | G  | H  | I  | J  |    |    |
| G  |                |   | LINGUAL   |                                   |                                       |                                 |                    | LINGUAL           |    |    |    |    |    |    |
| H  |                |   | T   | S                                 | R                                     | Q                               | P                  | Q                 | N  | M  | L  | K  |    |    |
| T  |                |   |   |                                   |                                       |                                 |                    |                   |    |    |    |    |    |    |
| 32   | 31             | 30  | 29  | 28                                | 27                                    | 26                              | 25                 | 24                | 23 | 22 | 21 | 20 | 19 | 18 |
| Q4   |                |   | FACIAL  |                                   |                                       |                                 |                    | FACIAL            |    |    |    |    | 17 | 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). |                |   |   |                                   |                                       |                                 |                    |                   |    |    |    |    |    |    |
| <input type="checkbox"/> Primary Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Certified Nurse Mid-Wife <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Acute or Post-Acute Physician                                 |                |   |   |                                   |                                       |                                 |                    |                   |    |    |    |    |    |    |
| Name of allowed prescriber: _____  |                |   | Title: _____  |                                   |                                       | Date: _____                     |                    |                   |    |    |    |    |    |    |
| Durable Medical Equipment Face to Face Regulations   |                |   |   |                                   |                                       |                                 |                    |                   |    |    |    |    |    |    |
| <input type="checkbox"/> 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  |                |   |   |                                   |                                       |                                 |                    |                   |    |    |    |    |    |    |
| <input type="checkbox"/> Any item of DME that appears on the DMEPOS Fee Schedule with a price ceiling at or greater than \$1,000.  |                |   |   |                                   |                                       |                                 |                    |                   |    |    |    |    |    |    |
| <input type="checkbox"/> 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.   |                |   |   |                                   |                                       |                                 | DATE               |                   |    |    |    |    |    |    |
| Signature: _____   |                |   |   |                                   |                                       | Title: _____                    |                    |                   |    |    |    |    |    |    |

719A June 2018

**APPENDIX C: SUBMITTING 719A PRIOR AUTHORIZATION 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 |
|---|---|----------|---------------|-------|
| <b>Botox</b>  | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a>    | X        |               |       |
| <b>Cosmetic, Plastic, reconstructive surgery (limited coverage)</b>   | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a>    | X        |               |       |
| <b>Dental Services</b>  | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a>    | X        |               |       |
| <b>Durable Medical Equipment</b>  | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a>    | X        |               |       |
| <b>Hearing Aids and Artificial Larynxes (for Adults)</b>  | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a>    | X        |               |       |
| <b>Home Infusion</b>  | Department of Health Care Finance (DHCF)<br>Office of Pharmacy Management:<br>202.442.5952 Fax-202-722-5685   |          | X             |       |
| <b>Home and Community Based Waiver Services for Persons with Intellectual Disabilities/Developmental Disabilities</b> | DC Department on Disability Services<br>Developmental Disabilities Administration<br>Medicaid Waiver Office<br>202.730.1566<br>Fax number: 202.730.1804 |          |               | X     |
| <b>Home and Community Based Waiver Services for Elderly Persons with Disabilities – CASE MANAGEMENT PROVIDERS</b>     | DHCF Office of Chronic & Long-Term Care<br>202.442.9533<br><br>(Comagine provides EPD waiver CM PAs only)   |          | X             |       |
| <b>Home and Community Based Waiver Services for Elderly Persons with Disabilities—NON-CASE MANAGEMENT PROVIDERS</b>   | DHCF Office of Chronic & Long-Term Care<br>202.442.9533   |          | X             |       |
| <b>Home Health Services (non-waiver)</b>  | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a>    | X        |               |       |
| <b>Injections Administered in a Physician’s office (“J codes”)</b>  | DHCF Office of Pharmacy Management:<br>Phone: 202.442.5952<br>Fax: 202.722.5685   |          | X             |       |

|  |  |   |   |   |
|--|--|---|---|---|
| <b>Inpatient Hospital Admissions</b>   | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a> | X |   |   |
| <b>Medications dispensed by a pharmacy</b>   | Magellan Help Desk-800.273.4962  |   |   | X |
| <b>Nutritional Supplements (tube feedings) for in-home care</b>  | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a> | X |   |   |
| <b>Orthotics and Prosthetics</b>   | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a> | X |   |   |
| <b>Optical Services</b>  | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a> | X |   |   |
| <b>Organs Transplants (when covered, e.g., heart, kidney, liver, allogeneic bone marrow)</b>                       | DHCF / Medicaid Medical Director:<br>202.442.9077<br>Fax number: 202.535.1216  |   | X |   |
| <b>Outpatient Procedures Surgeries</b>   | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a> | X |   |   |
| <b>Pain Management Procedures (Inpatient)</b>  | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a> | X |   |   |
| <b>Pediatric Specialty Hospital Admissions (i.e., Cumberland and Kennedy Krieger Hospitals)</b>                    | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a> | X |   |   |
| <b>Personal Care Aide Services (non-waiver)</b>  | DHCF Office of Chronic & Long-Term Care<br>202.442.9533  |   | X |   |
| <b>Pet Scans</b>   | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a> | X |   |   |
| <b>Sleep Studies</b>   | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a> | X |   |   |
| <b>Surgical procedures (Some types require prior authorization, including gastric bypass surgery, mammoplasty)</b> | Comagine Health<br>Prior Authorization Unit: 800.251.8890<br>Email: <a href="mailto:dcmedicaid@Comaginehealth.org">dcmedicaid@Comaginehealth.org</a> | 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 claims status.
- Press 2 - If you are a new provider and would like to enroll or if you are changing your provider number, contact MAXIMUS at 844.218.9700.
- Press 3 - For EDI Technical Support Services
- Press 4 - For all other questions

Once you have concluded your inquiries, record the confirmation number provided at the end of the call.

## APPENDIX E: GLOSSARY

The following terms are used throughout this manual. The definition relates to the term used in the DC Medicaid Program:

**ACA** – Affordable Care Act was signed into law by President Obama on March 23, 2010, it aims to bring comprehensive and equitable health insurance coverage to many Americans. The ACA guarantees

**ADA** – American Dental Association

**Adjustment** – A transaction that changes any information on a claim that has been paid. A successful adjustment transaction creates a credit record, which reverses the original claim payment, and a debit record that replaces the original payment with a corrected amount; a change submitted because of a billing or processing error.

**ANSI** - American National Standards Institute

**Approved** - A term that describes a claim that will be or has been paid.

**ASC** - Ambulatory Surgery Code

**Buy-In** - The process whereby DHCF authorizes payments of the monthly premiums for Medicare coverage.

**CFR** – Code of Federal Regulations

**CHAMPUS** - Civilian Health and Medical Program of the Uniformed Services

**CHIP** – Children's Health Insurance Program is a program administrated by the US Department of Health and Human Services that provides matching funds to states for health insurance to families with children. CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.

**Claim** - A request for reimbursement of services that have been rendered.

**Claim Status** - The determined status of a claim: approved, denied or suspended.

**Claim Type** - A classification of claim origin or type of service provided to a beneficiary.

**CLIA** – Clinical Laboratory Improvement Amendments

**CMS** - Centers for Medicaid and Medicare Services

**CMS1500** - Claim form currently mandated by CMS, formerly known as HCFA-1500, for submission of practitioner and supplier services

**Conduent** – is the fiscal agent for the DC Medicaid Program (formerly known as Affiliated Computer Services)

**Cost Settlement** – Refers to a reimbursement method in which the reimbursement is made on actual cost information

**Covered Services** - All services which providers enrolled in the DC Medicaid program are either required to provide or are required to arrange to have provided to eligible beneficiaries.

**CPT** - Current Procedural Terminology code

**Crossover** - The process by which the Medicare intermediaries and Medicare carriers supply Medicaid with the deductible and co-insurance amounts to be paid by Medicaid.

**DCAS** – District of Columbia Access System

**DCID** - District of Columbia's eight-digit beneficiary ID number

**DCMMIS** - District of Columbia Medicaid Management Information System

**Denied** – A term that describes a claim that results in nonpayment.

**DHCF** - Department of Health Care Finance (formerly known as Medical Assistance Administration (MAA)). The name of the local District agency administering the Medicaid program and performs other necessary Medicaid functions.

**DHHS** - Department of Health and Human Services

**DHR** - Department of Human Resources

**DHS** - Department of Human Services

**District** - The District of Columbia

**DME** – Durable Medical Equipment

**DMERC** - Durable Medical Equipment Regional Carrier

**DOH** - Department of Health

**DRG** - Diagnosis Related Grouper

**Dual-eligible** - individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

**DX** - Diagnosis Code

**EDI** – Electronic Data Interchange

**Emergency** - Sudden unexpected onset of a condition requiring medical or surgical care that may result in permanent physical injury or a threat to life if care is not secured immediately after the onset of the condition or as soon thereafter.

**Enrollment** - The initial process by which new enrollees apply for managed care or provider enrollment.

**EOMB** - Explanation of Medical Benefits

**EPSDT** – The Early and Periodic Screening, Diagnosis, and Treatment is a Medicaid initiative that provides preventative healthcare services for children.

**ESA** – Economic Security Administration (formerly known as Income Maintenance Administration), through an MOU with the Medicaid agency, has the responsibility to determine eligibility for all medical assistance programs. They also determine eligibility for SNAP, TANF, childcare subsidy, burial assistance and many more.



**FFP** – Federal Financial Participation: the Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures.

**FQHC** – Federally Qualified Health Center

**HBX** – Health Benefits Exchange: the entity that administers and oversees the online marketplace for District residents and small businesses to enroll in private or public health insurance options. The District's Health Benefit Exchange will allow individuals and small businesses to compare health plans, to learn if they are eligible for tax credits for private insurance or health programs like DC Healthy Families/Medicaid, and to enroll in a health plan that meets their needs.

**HCFA** - Health Care Finance Administration

**HCPCS** - Healthcare Common Procedure Coding System

**ICD-CM** - International Classification of Diseases Clinical Modification

**ICP** – Immigrant Children's Program is a health program designed as a safety net for children under the age of 21 who do not meet the citizenship/immigration status requirements for Medicaid.

**IMD** – Intermediate Mental Disorder

**IVR** – The Interactive Voice Response Verification system is a system to provide verification of beneficiary eligibility, checking claim status through telephone inquiry by the provider, using the DCID number or Social Security Number (SSN)

**LTAC** - Long Term Acute Care

**MAGI** – Modified Adjusted Gross Income is a methodology for how income is counted and how household composition and family size are determined

**Managed Care Organization** - Program to improve access to primary and preventive services where eligible beneficiaries shall be required to select a primary care provider who will be responsible for coordinating the beneficiary's care. Payment for services shall be on a capitated basis for prepaid plans.

**Medicaid** - The District of Columbia's medical assistance program, provided under a state plan which has been approved by the U.S. Department of Health and Human Services under Title XIX of the Social Security Act.

**Medicaid Benefits Package** - All health services to which beneficiaries are entitled under the District of Columbia Medicaid program, except service in a skilled nursing facility, an institution for mental diseases, and other services specifically excluded in the contract.

**Medically Necessary** - Description of a medical service or supply for the prevention, diagnosis, or treatment which is (1) consistent with illness, injury, or condition of the enrollee; (2) in accordance with the approved and generally accepted medical or surgical practice prevailing in the geographical locality where, and at the time when, the service or supply is ordered.

**Medicare** – A federal program (Title XVIII of the Social Security Act) providing health insurance for individuals 65 and older or disabled. Medicare Part A covers hospitalization and is automatically provided to any qualified beneficiary. Medicare Part B covers outpatient services and is voluntary (requires a premium contribution).

**NCCI** – National Correct Coding Initiative

**NDC** - National Drug Code

**Non-Compensable Item** - Any service a provider supplies for which there is no provision for payment under Medicaid regulations.

**NPI** - National Provider Identifier is a 10-digit number that uniquely identifies a healthcare provider. Providers must apply for an NPI through NPPES.

**NPPES** – National Plan and Provider Enumeration System

**OIS** – Office of Information Systems

**Open Enrollment Period** - The 30-day period following the date the beneficiary is certified or re-certified for the District's Medicaid Program. During this period, a beneficiary eligible to be covered under the managed care program may select a provider without restriction.

**Ophthalmic Dispensing Services** - The design, verification, and delivery to the intended wearer of lenses, frames, and other specifically fabricated optical devices as prescribed by an optometrist or ophthalmologist.

**Out-of-District** – Any zip code outside of the District of Columbia.

**Parent** - A child's natural parent or legal guardian.

**PBM** – Pharmacy Benefits Management

**PID** – District of Columbia nine-digit provider ID number

**Prepayment Review** - Determination of the medical necessity of a service or item before payment is made to the provider. Prepayment review is performed after the service or item is provided and involves an examination of an invoice and related material, when appropriate. This should not be confused with prior authorization.

**Prescription (Vision)** - The written direction from a licensed ophthalmologist or optometrist for therapeutic or corrective lenses and consists of the refractive power and, when necessary, the vertex distance, the cylinder axis, and prism.

**Prior Authorization (PA)** - The approval of a service before it is provided, but it does not necessarily guarantee payment.

**Provider** - A person, business, or facility currently licensed under the law of any state and enrolled in Medicaid to practice medicine, osteopathy, dentistry, podiatry, optometry, or to provide other Medicaid approved services and has entered into an agreement with the District of Columbia's Medicaid program to provide such services.

**QHP** – Qualified Health Plan is a major medical health insurance plan that covers all the mandatory benefits of the ACA and is eligible to be purchased with a subsidy, also known as a premium tax credit.

**QIO** - Quality Improvement Organization

**QMB** – Qualified Medicare Beneficiary

**RA** – The Remittance Advice is a document sent to providers to report the status of submitted claims - paid, denied, and pending from Conduent.

**Rejected** - A term that describes an electronically submitted claim that has not met processing requirements

**RTP** - Return to Provider

**RTP Letter** - A letter that accompanies a rejected claim that is sent to providers with an explanation identifying the reason for the return

**Service Area** - The area within the city limits of the District of Columbia

**Specialist** - An enrolled Medicaid physician whose practice is limited to a particular area of medicine including one whom, by virtue of advance training, is certified by a specialty board.

**Spend-Down** - Occurs when an individual or family is ineligible for Medicaid benefits due to excess income but can receive Medicaid benefits by incurring medical expenses in the amount of the excess income.

**State Plan** - The State Plan of Medical Assistance, which describes the eligibility criteria, services covered payment methodology and/or rates and any limitations approved by the Centers for Medicaid and Medicare Services for coverage under the District of Columbia's Medicaid Program.

**TANF** - The categorical eligibility designation for individuals who are eligible for Medicaid by they are eligible for cash assistance from the Temporary Assistance for Needy Families (TANF) program.

**TCN** - The unique transaction control number that is assigned to each claim for identification.

**Third-Party Liability** - Medical insurance, other coverage, or sources, which have primary responsibility for payment of health, care services on behalf of a Medicaid- eligible beneficiary.

**Timely Filing** – A period in which a claim must be filed to be considered eligible for payment.

**UB04** – A revised version of the Universal Billing Form UB92 used by institutional providers

**Urgent Care Services** - Care necessary for an acute condition, not as serious as an emergency, yet one in which medical necessity dictates early treatment and/or a hospital environment.

**Vendor** - A provider who usually sells items such as durable medical equipment, medical supplies, or eyewear.

**VFC**- Vaccine for Children is a Centers for Disease Control (CDC) federally funded program that supplies providers with vaccines at no charge for eligible children up to age 18.

**Void** - A claim, which has been paid and is later refunded because the original reimbursement was made for an erroneous provider or beneficiary identification number; or payment was made in error.

**Waiver** - A situation where CMS allows the District to provide services that are outside the scope of the approved State Plan services, in non-traditional settings, and/or to beneficiaries not 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.