DHCF The Department of Health Care Finance
INVESTING IN YOUR HEALTH

District of Columbia Medicaid Bulletin

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CHANGES IN PCA SERVICES

Effective January 1, 2011, PCA services will be capped at 520 hours per beneficiary per calendar year (Jan. 1 – Dec. 31).

- The State Plan PCA services benefit is intended to be short-term and rehabilitative in nature. Beneficiaries are eligible to receive up to eight (8) hours of PCA services per day based upon functional need.
- **PCA services rendered on and after January 1, 2011, under the State Plan do not require prior authorization.**
- PA requests must be submitted online through the Web Portal at www.dc-medicaid.com. The following documents must be uploaded with the request:
  - New patients - Request for State Plan Personal Car Aide (PCA) Services, Plan of Care (CMS Form 485), and State Plan 2011-1 Guidelines Worksheet.
  - Transfer patients - Request for State Plan Personal Care Aide (PCA) Services, Plan of Care (CMS Form 485), State Plan 2011-1 Guidelines Worksheet, Inter-Agency Transfer Form, Discharge Summary, a copy of the telephone/verbal order (if Plan of Care has not been signed by the attending physician)
- The Request for State Plan Personal Care Aide (PCA) Services, Plan of Care (CMS485), and State Plan 2011-1 Guidelines Worksheet is on the Web Portal at www.dc-medicaid.com under "Provider Information/Forms".
- Recipients requiring more than 520 hours of PCA services, must be enrolled in the EPD Waiver to continue receiving services. Recipients desiring placement must contact an EPD Waiver (case management) provider agency of choice to begin the enrollment process.
- Please refer to Transmittals # 10-20, 10-21, 10-22, 10-23, and 10-24 for additional information. These Transmittals are posted on the Web Portal under Provider Bulletins/Transmittals.

Questions regarding this **policy change** should be directed to Dena Hassan, Management Analyst, DHCF Office on Chronic and Long Term Care at 202-724-4178.

CRITERIA UPDATED FOR RECIPIENTS TREATED FOR ADHD

The DC Medicaid fee-for-service (FFS) program updated the criteria for recipients to receive medications in the treatment of Attention Deficient Hyperactivity Disorder (ADHD) or narcolepsy. Effective June 7, 2010**,** all recipients under 21 years old on preferred ADHD drugs will no longer require a prior authorization. All non-preferred drugs will deny at point of sale and require a non-preferred prior authorization form be completed by the prescribing doctor and may be approved for a maximum of six months.

For all recipients 21 years and older, prior authorization by the prescriber is required to continue on any therapy for Anti-Hyperkinesis/ADHD drugs. This requirement is for preferred and non-preferred agents. To see the current DC Preferred Drug List (PDL), visit www.dcpbm.com under "Provider Documents" section. Below are the approved **Anti-Hyperkinesis/ADHD** drugs for recipients 21 years and older:

Approved ADHD Drugs (21 years old or older)

Preferred	Non-Preferred
Amphetamine Salts ER	Adderall XR
Concerta	Vyvanse
Focalin XR	
Strattera	

Approved Narcolepsy (21 years old or greater)

Preferred	Non-Preferred
Amphetamine Salts IR	Adderall
Dexedrine	Provigil
Dexmethyphenidate ER	Ritalin
Dextroamphetaminie ER/IR	Ritalin SR
Metadate ER	
Methylin ER	
Methylphenidate	
Methylphenidate ER/SR/SA	
Ritalin LA	

NEW PRIOR AUTHORIZATION REQUEST FORMS FOR XELODA AND SUBOXONE

Beginning **Dec. 1, 2010 all** requests for **Suboxone/Subutex (Buprenorphine)** must be submitted by fax. Additional documentation is required for approval of Suboxone therapy. There is a separate request form for initial therapy and continuation (renewal) of therapy. The forms can be downloaded from the website, www.dcpbm.com under 'Forms and Documents".

Xeloda

Beginning **Dec. 1, 2010**, **Xeloda (Capecitabine**) medications will require a faxed PA for the diagnosis of breast cancer. Additional information and documentation is required for approval. The fax form can be downloaded rom the website, www.dcpbm.com under 'Forms and Documents". These forms and all other prior authorizations forms **MUST** be submitted by fax to 1-866-535-7622.

REMINDER - UPDATE YOUR PROVIDER LICENSE

Providers with licenses that expired on 12/31/2010, should fax a copy of the renewed license to Provider Enrollment at (800) 335-8465. Licenses must be updated to prevent claims from suspending and termination of your DC Medicaid provider ID.

If you have questions, contact Provider Enrollment at (202) 906-8318 (inside DC metro area) or (866) 752-9231 (outside DC metro area).

UPDATE: ANESTHESIA BILLING INSTRUCTIONS

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 Modifier AA is to be used by anesthesiologists only. Modifier AA should **not** be used for medical direction of CRNAs
AD	Medical supervision by a 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 percent of the calculated rate for services performed personally by an anesthesiologist
AD	Reimbursed at 35 percent of the calculated rate
QK	Reimbursed at 65 percent of the calculated rate
QX	Reimbursed at 50 percent of the calculated rate to the CRNA
QY	Reimbursed at 50 percent of the calculated rate
QZ	Reimbursed at 90 percent of the calculated rate to the CRNA for services without medical direction by an anesthesiologist

Anesthesiologists and CRNAs must bill the appropriate number of units in 15 minute increments. **One fifteen (15) minute increment of anesthesia time equals one (1) unit.**

CROSSOVER PRICING LOGIC CHANGE

Effective October 4, 2010, the pricing methodology of crossover claims has changed. Crossover claims pay at the lesser amount based upon the formulas listed below by claim type:

Claim Type	Pricing Logic	Example
Medicare Part-B (CMS1500)	**Reimbursement amount will equal the lesser of** (MEDICARE COINSRURANCE + MEDICARE DEDUCTIBLE) **OR** (MEDICAID ALLOWED AMOUNT – MEDICARE PAID)	Coinsurance: $29.60 Medicare Deductible: $0.00 Medicaid allowed charges: $138.98 Medicare Paid: $118.38 Difference: $20.60 **Provider payment = $20.60**
Medicare Part-B (CMS1500) Other	**Reimbursement amount will equal the lesser of** (MEDICARE COINSRURANCE + MEDICARE DEDUCTIBLE) **OR** (MEDICAID ALLOWED AMOUNT – MEDICARE-PAID)	Coinsurance: $22.10 Medicare Deductible: $0.00 Medicaid allowed charges: $22.00 Medicare Paid: $27.90 Difference: -$5.90 **Claim denies for 5318 - calculated ALLOWED AMOUNT is zero or the calculated ALLOWED AMOUNT less TPL is zero**
Outpatient Crossover Non-Lab	**Reimbursement-amount will equal the lesser of** (MEDICARE COINSRURANCE + MEDICARE DEDUCTIBLE) **OR** (MEDICAID ALLOWED AMOUNT – MEDICARE PAID)	Coinsurance: $18.57 Medicare Deductible: $0.00 Medicaid allowed charges: $137.01 Medicare Paid: $74.25 Difference: $62.76 **Provider payment = $62.76**
Outpatient Crossover Lab	**Reimbursement amount will equal the lesser of** (MEDICARE COINSRURANCE + MEDICARE DEDUCTIBLE) **OR** (MEDICAID ALLOWED AMOUNT – MEDICARE PAID)	Coinsurance: $8.73 Medicare Deductible: $0.00 Medicaid allowed charges: $2.46 Medicare Paid: $32.28 Difference: $29.82 **Provider payment = $8.73**

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CROSSOVER PRICING LOGIC CHANGE

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Claim Type	Pricing Logic	Example
Inpatient Crossover	**Reimbursement amount will equal the lesser of** (MEDICARE COINSRURANCE + MEDICARE DEDUCTIBLE) **OR** (MEDICAID ALLOWED AMOUNT – MEDICARE PAID)	Coinsurance: $470.00 Medicare Deductible: $0.00 Medicaid allowed charges: $450.00 Medicare Paid: $449.20 Difference: $.80 **Provider payment = $0.80**
LTC	**Reimbursement amount will equal the lesser of** (MEDICARE COINSRURANCE + MEDICARE DEDUCTIBLE) **OR** ((MEDICAID ALLOWED AMOUNT – PATIENT RESP) - MEDICARE PAID))	Coinsurance: $300.00 Medicare Deductible: $0.00 Medicaid allowed charges: $21.27 Patient Liability: $321.27 Medicare Paid: $111.80 Difference: $230.74 **Provider payment = $230.74**

DENTAL PRIOR AUTHORIZATION REMINDER

Dental PA requests cannot be submitted online. Mail the 719A Prior Authorization Request Form and all required supporting documentation (i.e., x-rays, models etc.) to:

Delmarva Foundation
2175 K Street, NW
Suite 250
Washington, DC 20037-1845

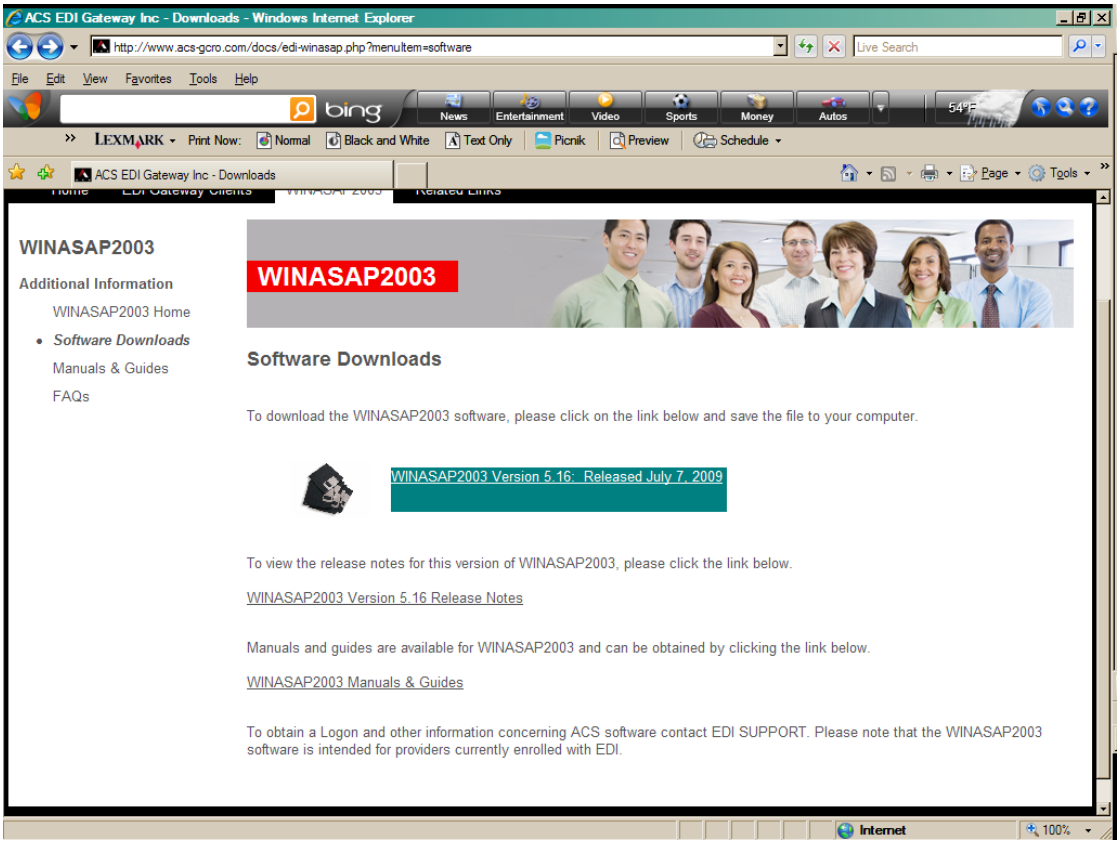
NEWBORN BIRTH WEIGHT ON UB04

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 AP-DRG grouper (v26) DRG assignment is determined by the diagnosis and procedure codes, not the condition code.

If you have questions, contact Provider Inquiry at (202) 906-8319 (inside DC metro area) or (866) 752-9231 (outside DC metro area).

HAVE YOU UPDATED YOUR WINASAP2003 VERSION LATELY?

Periodically ACS EDI will release a new version of its proprietary billing software, WINASAP2003. Providers are usually notified of new version updates either by a banner message or on the www.dc-medicaid.com Web site under "What's Hot?" The provider or submitter should check periodically with ACS EDI by logging on to the following Web site: www.acs-gcro.com. Click on the heading labeled "WINASAP2003" and choose the link labeled "WINASAP2003 Software Download." This will give providers the most current version and release date for the WINASAP2003 Software. Providers can also review or download a copy of the WINASAP2003 Manuals & Guides for reference.



IMPORTANT NUMBERS & ADDRESSES

Provider Inquiry **PO Box 34734** **Washington, DC 20043-4734**	(202) 906-8319 (inside DC metro area) (866) 752-9233 (outside DC metro area) (202) 906-8399 (Fax)	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
Provider Enrollment **PO Box 34761** **Washington, DC 20043-4761**	(202) 906-8318 (inside DC metro area) (866) 752-9231 (outside DC metro area) (888) 335-8465 (Fax) **www.dc-medicaid.com**	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
Pharmacy Benefits Management	ACS Technical Call Center: (800) 272-9679 ACS Clinical Call Center (Prior Authorizations): (800) 273-4962 ACS PBM Fax Number: (866) 535-7622 **http://www.dcpbm.com**	Hours of Operation 24/7/365
ACS EDI Gateway Services	(866) 407-2005 **http://www.acs-gcro.com**	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
Transportation Broker **Medical Transportation Management, Inc. (MTM)**	(888) 561-8747 (866) 796-0601 (to schedule appointment) **http://www.mtm-inc.net/index.asp**	
Dental Help Line	(866) 758-6807	
Fraud Hotline	(877) 632-2873	
Health Care Ombudsman	(877) 685-6391	

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

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