

District of Columbia

Department of Health
Medical Assistance Administration



Provider Billing Manual
Long Term Care



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**DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH**

MEDICAL ASSISTANCE ADMINISTRATION

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DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

MEDICAL ASSISTANCE ADMINISTRATION

1.0 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

This manual's purpose is to document the policy and procedures for healthcare providers who participate in the District of Columbia (DC) Medicaid Program. The procedures 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

ACS will maintain this manual with information supplied by Medical Assistance Administration (MAA). When a revision occurs, replacement pages for the manual will be supplied to the providers by ACS. 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 will be distributed to providers who participate in the DC Medicaid Program, via the United States Postal Service. Each manual update will be transmitted with a numbered transmittal and an updated REVISION INDEX to track all updates to the manual.

1.5 Organization

This manual is organized into 13 sections. When a revision occurs to any part of this manual, a revised page will be issued to providers and should be inserted in the proper location. The outdated material should be discarded. Revised pages will carry a revision date in the lower right corner of the page. A Revision Index has been included in this manual following the Table of Contents. Each time a revision to the manual is issued, an updated Revision Index page(s) should replace the one(s) currently in your manual so that you have an accurate record of revisions made to the manual.

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

- “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.

2.0 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

Medicaid is authorized by Title XIX of the Social Security Act, 42 U.S.C. 1396, *et seq.* District participation is authorized by enabling legislation P.L. 90-227, 12/27/67.

2.3 Administration

The Department of Health (DOH) is the District of Columbia agency responsible for administering the DC Medicaid Program. MAA, is the bureau within DOH which administers the program.

2.4 Covered Services

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

- Dental (individuals under 21 years of age)
- Early and Periodic Screening, Diagnosis, and Treatment
- Home Health Care
- Emergency Services
- Inpatient Hospital

- Intermediate Care Nursing Facility (ICF)
- ICF/MR
- Laboratory and X-Ray
- MRDDA
- Managed Care
- Medical Equipment, Supplies, Prosthesis, Orthosis, and Appliances
- Medical Clinic (hospital and free-standing)
- Medical Transportation Service
- Medical Day Treatment
- Optometry
- Organ Transplant
- Out-of-District Services
- Osteopathy
- Personal Care
- Pharmacy
- Podiatry
- Physician
- Skilled Care Nursing Facility (SNF)

MAA pays for covered services rendered out-of-District to eligible District recipients, if any of the following circumstances exist:

- The services were rendered by an enrolled provider in the DC Medicaid Program.
- The recipient requires emergency medical care while temporarily away from his home.
- The recipient would be risking his health if he waited for the service until he returned home.
- Returning back to the District would endanger the recipient's health.
- Whenever it is general practice for recipients in an area of the District to use medical resources in a neighboring state.
- MAA decides, based on the attending physician's advice, that the recipient 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 MAA.

2.5 Non-Covered Services

Based on the policies established by MAA, 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

This list is only an example of the services not covered and should not be considered a complete list.

2.6 Inquiries

To receive information about the District of Columbia Medicaid Program, contact the DC Medicaid Fiscal Agent, ACS. Addresses and telephone numbers are included in Appendix A.

3.0 GLOSSARY

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

ACS	Affiliated Computer Services – Fiscal Agent for the DC Medicaid Program
ANSI	The American National Standards Institute
Approved	A term that describes a claim that will be or has been paid.
Automated Client Eligibility Determination System (ACEDES)	The combined eligibility determination system providing integrated automated support for several District of Columbia programs, including Medicaid.
BED	Bureau of Eligibility Determination
Buy-In	The process whereby MAA authorizes payments of the monthly premiums for Medicare coverage.

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMS	Centers for Medicaid and Medicare Services
CPT	Current Procedural Terminology code
Claim	A request for reimbursement of services that have been rendered.
Claim Type	A classification of claim origin or type of service provided to a recipient.
Claim Status	The determined status of a claim: approved, denied or pended.
Commission on Health Care Finance	The former name of the local District agency which administers the Medicaid Program and performs other necessary Medicaid functions. New designation within the Department of Health for this agency is <i>Medical Assistance Administration (MAA)</i> .
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 recipients.
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.
DCID	District of Columbia eight-digit recipient ID number

DCMMIS	District of Columbia Medicaid Management Information System
DHR	Department of Human Resources
DHS	Department of Human Services
DHHS	The U.S. Department of Health and Human Services
DOH	Department of Health
DX	Diagnosis Code
District	The District of Columbia
EOMB	Explanation of Medical Benefits
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment. A Medicaid initiative that provides preventative healthcare services for children.
EQRO	The External Quality Review Organization (see also PSRO) hired by the District to conduct independent reviews, audits and quality assurance functions for the Medicaid program.
EVS	Eligibility Verification System. A system to provide verification of recipient eligibility through telephone inquiry by the provider, using the DCID number.

Emergency	Emergency medical care shall mean the 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.
HCFA	Health Care Financing Administration
HCFA 1500	Claim form currently mandated by CMS, formerly known as HCFA, for submission of practitioner and supplier services
HIM	Health Insurance Manual
HMO	Health Maintenance Organization
ICD-CM	International Classification of Diseases – Clinical Modification
Involuntary Disenrollment	The involuntary termination of an enrollee from membership in the caseload of a managed care fee-for-service provider by the DC Medicaid program under conditions permitted by District and federal regulations.
MAC	Maximum Allowable Cost

Managed Care	Program to improve access to primary and preventive services where eligible recipients shall be required to select a primary care provider who will be responsible for coordinating the recipient's care. Payment for services shall be on a capitated basis for prepaid plans and a fee-for-services basis for primary care physicians in private practice.
Medicaid	The District of Columbia 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 recipients 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.
Medical Assistance Administration (MAA)	The local district agency that administers the Medicaid Program and performs other necessary Medicaid functions.
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.
NDC	National Drug Code

Non-Compensable Item	Any service a provider supplies for which there is no provision for payment under Medicaid regulations.
Open Enrollment Period	The 30-day period following the date the recipient is certified or re-certified for the District's Medicaid Program. During this period, a recipient 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.
PCA	Personal Care Aide. Provides health care services to homebound District of Columbia residents. Must meet certification requirements.
PSRO	Professional Standards Review Organization. An organization that operates review systems to determine whether services are medically necessary, provided appropriately, carried out on a timely basis, and meeting professional standards.
Parent	A child's natural parent or legal guardian.

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.
Primary Care Physician or Clinic	A Medicaid participating physician or clinic who/which practices as a general practitioner, family practitioner, internist, pediatrician, or obstetrician/gynecologist and who/which has entered into an agreement with the District of Columbia Medicaid Program to act as a managed care provider.
Prior Authorization	The approval of a service before it is provided.
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 medical services and has entered into an agreement with the District of Columbia's Medicaid program to provide such services.

RA	Remittance Advice. A document sent to providers to report the status of submitted claims - paid, denied and pended from ACS.
RTP	Return to Provider
RTP Letter	A letter that accompanies a rejected claim that is sent to providers with an explanation.
Rejected	A term that describes a claim that has not met processing requirements.
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 who, 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 Health Care Financing Administration for coverage under the District of Columbia's Medicaid Program.

TANF	The categorical eligibility designation for individuals who are eligible for Medicaid by virtue of the fact that 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 recipient.
Urgent Care Services	Care necessary for an acute condition, not as serious as an emergency, yet one in which medical necessity dictates early treatment and/or a hospital environment
Vendor	A provider who usually sells an item such as durable medical equipment, medical supplies, or eyewear.
Void	A claim which has been paid and is later refunded because the original reimbursement was made for an erroneous provider or recipient identification number.
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 recipients not generally covered by Medicaid.

4.0 PROVIDER PARTICIPATION INFORMATION

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

4.1 Participating Provider

A participating provider is a person who has an executed provider agreement with MAA.

In order to participate in the DC Medicaid Program, providers must adhere to the guidelines established by MAA and outlined in their individual provider agreements. At a minimum, providers must adhere to the following requirements:

- All conditions specified in the provider agreement, signed by the provider and representative of MAA
- All policies and procedures established by MAA in regard to practice and procedures and in compliance with Title XIX
- Notification to MAA of any change in the information supplied to enroll in the program, i.e. address, group affiliations, additional licenses acquired, etc.
- Assurance of freedom of choice to all recipients of health care services.

4.2 Provider Types

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

• Adult Day Care	• Home Health Agency
• Alcohol and Substance Abuse Clinic	• Hospice
• Ambulance Transportation	• ICF/MR
• Ambulatory Surgery Center	• Independent Lab
• Assisted Living	• LTAC Hospital
• Audiologist	• Mental Health Clinic

4.0 PROVIDER PARTICIPATION INFORMATION

● Birthing Center	● Nurse Practitioner
● Case Manager	● Nursing Facility
● Community Residential Facility	● Optician
● Day Treatment	● Optometrist
● DC Schools	● Other Medical Transportation
● Dental Clinic	● Pharmacy
● Dentist	● Physician DO
● DHS Dental Clinics	● Physician MD
● DME Provider	● Podiatrist
● Emergency Access Hospital	● Private Clinic
● Family Planning Clinic	● Psychiatric Hospital Private
● Federal Quality Health Center	● Psychiatric Hospital Public
● Freestanding Radiology	● Public Health Center
● General Hospital	● Radiation Therapy Center
● Hearing Aid Dispenser	● Rehabilitation Centers
● Hemodialysis Center - Freestanding	● Residential Treatment Centers
● HMO	● Screening Clinics
● Home Community Based Waiver	● Speech/Hearing Clinic

4.3 Eligibility Requirements

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

4.3.1 District Providers

Licensed, registered, and/or certified providers in the District of Columbia and those residents in the Greater Washington Metropolitan Area (must use District of Columbia hospitals) are eligible to request consideration for participation in DC Medicaid.

4.3.2 Out-of-District Providers

Licensed, registered, and/or certified providers who are enrolled in their respective state Medicaid programs are eligible to request consideration for participation in the DC Medicaid Program. These providers are subject to the regulations of the DC Medicaid Program and must meet all requirements of MAA.

4.3.3 Group Practice Providers

Licensed, registered, and/or certified providers who have an occupancy permit (where applicable), are eligible to request consideration for participation in DC Medicaid through a group practice.

4.3.4 Health Facilities

Licensed and certified health facilities are eligible to request consideration for participation in DC Medicaid. In the case of new facilities or new services, acquisition of a certificate of need from the State Planning and Development Agency (SHPDA) may also be required.

4.4 Application Procedures

In order to become a DC Medicaid provider of service, a practitioner must request an enrollment form and a participation agreement from ACS. The address is included in Appendix A.

Telephone requests may be accepted by calling the ACS Provider Enrollment number listed in Appendix A.

Completed enrollment forms and signed provider agreements should be returned to the same address.

4.5 Approval

ACS will notify applicants in writing whether or not they have been approved for participation in the DC Medicaid Program. The notification will include the unique number assigned to the provider by ACS. After the provider has been approved, ACS will distribute billing instructions and forms as necessary to the provider.

4.0 PROVIDER PARTICIPATION INFORMATION

A provider who has been approved is eligible to be reimbursed only for services furnished on or after the effective date of the Provider Agreement and only for those services he is eligible to render subject to limitations in this section and in Section 12.0. The effective date determined by ACS will not be earlier than the first day of the second month, prior to the month in which the application was received. For example, a provider application received on April 15, 2002, could have an effective date of February 1, 2002. Each provider is assigned a nine-digit provider number to be used when communicating with the program and submitting claims.

4.6 Special Requirements for the 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 as well. A provider number will also be assigned to each member in the group to indicate which member is rendering the service.

To add a new member to the group, an enrollment package must be obtained, completed and submitted to ACS.

4.7 Special Requirements for Health Maintenance Organizations

In addition to executing a provider application, an HMO or other pre-paid health plan must sign an agreement, renewed annually, with the DC Medicaid Program in order to enroll Medicaid recipients.

5.0 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 is the District's agency responsible for administering the Medicaid Program. MAA is the bureau within the Department, which administers the program.

An overview of the regulations governing provider activities follows.

5.1 Recipient Freedom of Choice of Providers

A recipient may obtain services from any institution, agency, pharmacy, medical, professional, or medical organization that has an agreement with MAA 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 recipient'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 recipient's freedom of choice.

5.2 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. MAA ensures that no individual shall be subjected to discrimination under this plan on the grounds of race, color, national origin, or handicap.

5.3 Interrelationship of Providers

Providers are prohibited from referring or soliciting recipients 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, so long as the price is properly disclosed and appropriately reflected in the costs claimed or charges made by a practitioner.

5.4 Record Keeping

Providers shall retain for a minimum of six years (unless otherwise specified), medical and fiscal records that fully disclose the nature and extent of the services rendered to recipients. These records must meet all of the criteria established. Providers shall make such records readily available for review and copying by District and Federal officials or their duly authorized agents. The term "readily available" means that the records must be made available at the provider's place of business. If it is impractical to review records at the provider's place of business, upon written request, the provider must forward without charge, the original records or facsimiles. Records supporting those cost reports shall be retained until MAA advises the provider that his audit for that year is final. If MAA 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.

5.4.1 Medical Records

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

- Are legible throughout and written at the time services are rendered
- Identify the recipient 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)
- Reflect treatments as well as the treatment plan
- List quantities and dosages of drugs or supplies prescribed as part of the treatment and well being of the patient
- Indicate the progress of the recipient at every visit, the change of the diagnosis, the change of treatment, and the response to the treatment
- Contain summaries of all referrals, hospitalizations, and reports of operative procedures and excised tissues
- Contain the results of all diagnostic tests and reports of all consultations
- Reflect the disposition of the case.

5.4.2 Fiscal Records

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

5.4.3 Disclosure of Information

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

A provider may disclose records or information acquired under the DC Medicaid Program only when the record or information is to be used in connection with a claim or to verify the

utilization of DC Medicaid benefits and the disclosure is necessary for the proper performance of the duties of any officer or employee of:

- (a) DOH
- (b) Any public, private agency or organization under an agreement with MAA in meeting requirements of the DC Medicaid Program
- (c) MAA
- (d) A representative of the Secretary of Health and Human Services

5.4.4 Penalties for Non-Compliance

MAA may terminate agreements with providers who fail to maintain and provide medical and fiscal records as described in the Provider Agreement. If District or Federal review shows that MAA paid for services that a provider failed to document as required by the provider's agreement, said provider is subject to termination pursuant to CHCF rules at DC Register 3870, August 3, 1984. The purpose of the rules is to establish administrative procedures for:

- 1) Restricting or terminating the participation of Medicaid providers who defraud or abuse the program, or fail to abide by the conditions of participation as set forth in pertinent laws and the provider agreement;
- 2) Suspending at the direction of the federal government those providers convicted of; "program-related" crimes;
- 3) Recovering overpayments to providers;
- 4) Determining program reimbursement based upon provider cost reports; and
- 5) Requesting reinstatement of a provider in the Medicaid program.

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

5.5 Authorized Signature

The provider entity who signed the Provider Agreement must enter an original signature on every claim. The provider may delegate signatory authority to an agent subsequent to written notice to MAA. The written notice must articulate an authorized name, the effective date of the delegation, and an original signature of the agent on the Delegation of Signatory Authority Form (see example on following page). The completed form must be submitted to ACS. The address is included in Appendix A. If MAA does not have a valid Delegation of Signatory Authority Form, reimbursement for services submitted through unauthorized signatures may be delayed or denied.

DELEGATION OF SIGNATORY AUTHORITY

PROVIDER NAME _____ **PROVIDER NUMBER** _____

TYPED NAME OF INDIVIDUAL(S) SIGNATURE OF INDIVIDUAL(S)	EFFECTIVE DATE	TERMINATION DATE

I/we authorize the individuals listed above to sign invoices on my/our behalf for presentation to the DC Medicaid Program certifying to the statements on the invoice and that the services claimed for reimbursement were rendered in accordance with the executed provider agreement and subsequent manuals and instructions.

As the enrolled entity, I/we understand that the delegation of signature authorization to the individuals listed above does not in any way diminish my/our responsibilities in accordance with the executed provider agreement.

Individual Provider’s Signature **Date**

Corporate name of the group, institute, medical facility, firm, or government, i.e., the provider entity.

Address **Phone Number**

Signature of Individuals Responsible to Enforce Compliance with these Conditions of Participation within the Corporation.

Chief Executive Officer **Date**

Chief Medical Officer **Date**

Principal Corporate Officer **Date**

Other Corporate Officers & Titles **Date**

5.6 Utilization Review

In accordance with Section 1902 (a) (30) of the Social Security Act, MAA has established procedures for reviewing the utilization of, and payment for, all Medicaid services. Accordingly, providers are required, upon request, to provide MAA, designated MAA 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 MAA 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 totaling more than \$25,000 during the twelve-month period ending on the date of the request. In addition, requests may be made about significant business transactions between the provider and any wholly owned supplier, or subcontractor, during the 5-year period on the date of the request. This information must be supplied within 35 days of request.

5.7 Consequences of Misutilization and Abuse

If routine utilization review procedures indicate that services have been billed for, that are unnecessary, inappropriate, contrary to customary standards of practice, or violate Medicaid regulations, the provider will be notified in writing. Claims that have not been approved will be delayed or suspended for a period not to exceed 120 days. The provider may need to explain billing practices and provide records for review. When appropriate, peer review may be convened. Subsequent to the investigation, termination may be warranted pursuant to rules DC Register 3870, August 3, 1984. 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.

5.8 Quality Assurance Program for DC Medicaid Managed Care

MAA 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:

- MAA'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
- Professional Standards Review Organization (PSRO) contracted with MAA to perform retrospective claim audit, pre-authorization of specific services and review of DRG outliers
- External Auditor contracted with MAA 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 recipients. All providers participating in the DC Medicaid Program are required to comply with the reporting standards established by the Department. Participating providers shall receive periodic reports detailing quality assurance findings. Action shall be taken against providers that fall outside the norm and cannot provide adequate explanation of these deviations.

5.9 Consequences of Fraud

If an investigation by DOH shows that a provider submitted false claims for services not rendered or provided assistance to another in submitting false claims for services not rendered, DOH will initiate termination proceedings pursuant to rules at DC Register 3870, August 3, 1984. In addition to administrative action, the case record will be referred to the Medicaid Fraud Unit, Office of the Corporation Counsel, for further review and criminal prosecution under District and Federal law. Sanctions for criminal violations will be imposed pursuant to District and Federal law.

6.0 ADMINISTRATIVE ACTIONS

The following administrative actions can be taken in response to provider misutilization or fraud and abuse.

6.1 Restitution

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

6.2 Termination

A Provider Agreement can be terminated for cause prior to term completion (where applicable) if evidence indicates that the provider:

- Is not complying with duly promulgated regulations of DC Medicaid
- Is not complying with the terms of the Provider Agreement
- Has not been licensed, registered, and/or certified under state or District law while providing services
- Has been suspended or terminated from Medicare
- Has been convicted of a Medicaid-related criminal offense
- Has had a disciplinary action against him 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 recipients who have borrowed or stolen Medicaid identification cards

Termination proceedings will be invoked pursuant to rules at DC Register 3870, August 3, 1984.

6.2.1 Notification

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

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

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

6.2.2 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.

6.3 Appeal Process

A provider may request a formal review if he disagrees with a decision made by MAA. Rules governing appeals filed by providers are cited in the Provisions for Fair Hearings, DC Code Title 3-210.1 - 3-210.18 and the DC Register page 3870 - 3885, August 3, 1984. 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 MAA at the address in Appendix A.

6.4 Reinstatement

The provider must send a written request to MAA 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.

6.4.1 Criteria for Reinstatement

MAA 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

6.4.2 Notification of Action

MAA will notify the provider in writing within 45 days of the request for reinstatement. The notification will indicate the disposition of the request.

7.0 RECIPIENT ELIGIBILITY

This subsection provides an overview of recipient eligibility.

7.1 Eligibility Determination

The Bureau of Eligibility Determination, Income Maintenance Administration (IMA), determines recipient eligibility for the DC Medicaid Program.

The Office of Information Systems operates the Automated Client Eligibility Determination System (ACEDS), which determines and tracks eligibility, providing integrated automated support for several District of Columbia programs, including Medicaid. The ACEDS eligibility information is directly linked to EVS, making it readily available to providers.

7.2 Eligibility of Persons

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 recipients 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 133% 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 child care costs were paid from earnings rather than by a government agency
10. Children in licensed foster care homes or private child care institutions for whom public agencies are assuming financial responsibility
11. Children receiving subsidized adoption payments
12. Persons who receive only a supplemental payment from the District
13. Certain disabled children age 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

7.3 Eligibility Identification

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

7.3.1 Medical Assistance Card

When first determined eligible, each Medicaid recipient receives a plastic Medical Assistance Card from the Income Maintenance 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 recipient has provided this information to the eligibility-determining agency, a provider should ask the recipient 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.

<p>MEDICAL ASSISTANCE CARD DISTRICT OF COLUMBIA GOVERNMENT (READ INSTRUCTIONS ON BACK)</p>		
<p>SEX: SSN: NAME:</p>	<p>INS.C. RRN: DOB:</p>	<div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <p>SIGNATURE OF NAMED INDIVIDUAL (Head of Family if person named cannot write)</p>
<p>DC IDENTIFICATION NO.</p>		
<p>telephone</p>		

INFORMATION

1. It is against the law for this card to be used by or for anyone but the person whose name is printed on the front. You will be prosecuted under applicable Federal law if misused.
2. Carry this card with you at all times. Parent or guardian should hold cards for young children.
3. You must show this card to your doctor, hospital, or clinic before obtaining health services and to the druggist if you are obtaining prescription medicine.
4. If you have any questions on services covered by this card, (202) 724-5506.
5. If there is any change in your income, resources, family size or address, you must notify your case worker within two weeks. For general medical assistance information, call (202) 724-5506.

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

7.3.2 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 IMA determines her ongoing Medicaid eligibility. The temporary eligibility will allow immediate receipt of all Medicaid-covered ambulatory services that are related to pregnancy, and the patient will be issued a dated Notice of Presumptive Eligibility, a copy of which follows.

A District of Columbia Identification Number (DC ID#) will be established/issued no later than fourteen days from the date of the Notice by IMA. The Eligibility Verification System (EVS)

7.0 Recipient Eligibility

will then respond “Medicaid Eligible,” and claims may be submitted routinely to ACS. The address is listed in Appendix A.

In the meantime, it is expected that most services will be furnished by the DHS clinic or the FQHC; however, should a patient require your services, the Notice of Presumptive Eligibility will certify her as temporarily Medicaid eligible. Claims for services provided within the fourteen day period should be submitted to the address listed in Appendix A.

If you have questions concerning claim submission, please contact the Provider Relations Department at ACS; questions regarding eligibility determinations should be directed to the Income Maintenance Administration. The addresses and telephone numbers are included in Appendix A.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

NOTICE OF PRESUMPTIVE DETERMINATION

PROVIDER NAME _____

PATIENT NAME _____

DATE DETERMINED PRESUMPTIVELY
ELIGIBLE _____

[] You have been found temporarily eligible for Medicaid. You must go to the IMA Service Center to apply for Medicaid. If you **do not** apply for Medicaid, your eligibility will terminate by the last day of the month after the month you were determined eligible. Temporary Medicaid will cover services related to your pregnancy. Delivery costs will not be covered unless you apply at a DHS Service Center and are eligible. Call 202/724-5506 for the DHS Service Center in your area.

If you **do** apply for Medicaid at the DHS Service Center, you **may** be eligible to receive Medicaid coverage for all pregnancy-related services (including delivery) up to and for 60 days after the end of your pregnancy. Please go to the DHS Service Center as soon as possible so that you can receive Medicaid throughout your pregnancy.

[] You have been found **ineligible** for presumptive eligibility. However, you may be eligible for Medical Assistance. Call the Medicaid Information Unit on 202/724-5506 for the Service Center in your area.

DHS _____ A

Original to:

645 H St., N.E.
Washington, DC 20002

Copy to Applicant

Copy for Provider File

7.4 Provider Responsibility

The provider is responsible for the following eligibility verification activities.

7.4.1 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 recipient, the provider cannot collect payment from DC Medicaid. The provider should verify:

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

The provider must verify the recipient's eligibility by calling the Eligibility Verification System (EVS) using a touch-tone telephone (telephone number included in Appendix A) and supplying the recipient identification number found on the recipient's ID card. EVS receives eligibility information from ACEDS which is operated by the Office of Information Systems.

7.4.2 Third-Party Liability

Third-party liability (TPL) identifies primary payor resources outside of DC Medicaid who should be billed for the services, i.e., Workmen's Compensation, CHAMPUS, Medicare, private insurance carriers, etc. Since DC Medicaid is a payor of last resort, the provider must bill other resources first. 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 recipient 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, MAA should be notified. All recoveries should be turned over to MAA immediately to offset payments already made by MAA on behalf of the recipient.

7.4.3 Medicaid Recipient Restriction Program

MAA may restrict a DC Medicaid recipient 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 Recipient Restriction is a corrective process by which a recipient 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 recipient's total health care. This restriction will not apply when there is need for a second opinion or when there is a medical emergency.

8.0 CLAIMS PROCESSING PROCEDURES

Claims go through many stages before they are finally processed; they are received, reviewed, coded, input, and edited.

In order 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.

8.1 Receive and Record

Claims are received by ACS in one of two media: hard copy or electronic. Hard copy 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 cartridge, diskette or EDI (Electronic Data Interchange). WINASAP 2000 has been developed by ACS to give DC Medicaid providers the capability for accelerated submission of Medicaid claims. 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.

8.2 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
- Recipient Medicaid identification number is missing
- Date(s) of service is missing
- Attachments (if required) are missing
- Claim is unable to image (too light)
- Billing amount is missing

Any claim that is RTP will be accompanied by an RTP letter. 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 the claim can be transferred to hard copy for resubmission.

8.3 Transaction Control Number

Claims that are not rejected receive a tracking control number (TCN). This is a unique tracking number assigned to each claim. The TCN consists of 17 numeric digits. The first position designates the document input medium indicator. The next five digits indicate the year and Julian date. The next two digits designate the image machine number followed by the next three digits, which designate the batch number. The following three digits designate the type of document (i.e., new document, credit or adjustment), followed by the document number. The last 2 digits designate the line number.

8.4 Input

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

8.5 Edits

When the claims data has been loaded into the computer, it is edited to ensure compliance with the following DC Medicaid requirements:

- Provider eligibility
- Recipient 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 either paid, denied, or pended.

The Remittance Advice (RA) document sent to providers shows the status of each claim submitted by the provider and entered into 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

8.5.1 Approval Notification

Claims that meet all requirements are paid during the next payment cycle. Twice a month, the provider will receive a Remittance Advice (RA) listing all paid, denied and pended claims in the system, sorted in the following sequence:

- RA number
- Claim input form indicator
- Claim status

8.0 CLAIMS PROCESSING PROCEDURES

- Recipient last name
- Recipient first name
- TCN
- Provider zip code
- Pay to provider number

The provider will also receive a reimbursement check. 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 need to be initiated by the provider since. Errors can only be corrected by the provider **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 Recipient 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 an accommodation. The provider will need to **adjust** (correct) the claim in order 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 for all paid claims in accordance with current guidelines. Payments to providers may be increased or decreased by MAA to accommodate previous overpayments, underpayments or an audit.

8.5.2 Denied

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

- Recipient not eligible on date of service
- Provider not eligible on date of service
- Duplicate claim
- Claims submitted more than six months from date of service (timely filing)

8.5.3 Pended

Claims that do not meet the edit requirements cannot be paid until discrepancies have been resolved. In order to verify that the claim is in error, the MMIS assigns a status of “Pend” which will outline the problem to resolve the issue.

ACS and MAA resolve all pended claims. The RA will only state that the claim is suspended and will not give a reason.

8.6 Timely Filing

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

To avoid denial, claims must be received within 6 months after the date of service or in the case of inpatient hospital services, 6 months after the date of discharge.

Exceptions may be considered if proof of any of the following conditions exists:

8.0 CLAIMS PROCESSING PROCEDURES

- A retroactive adjustment must be paid to providers who are reimbursed under a retrospective payment plan
- A claim for payment from Medicare has been filed in a timely manner; the agency may pay a DC Medicaid claim or residual relating to the same services within 6 months after the agency or provider receives notice of the disposition of the Medicare claim
- Claims have been delayed due to provider investigation
- The agency has to make payments in accordance with a court order, to carry out hearing decisions or agency corrective actions to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court orders to others in the same situation as those directly affected by it
- Claims have been delayed due to third-party billing
- Medicaid eligibility spend-down has been exhausted, disability determined, or eligibility is retroactive
- Health maintenance or prepaid capitation grants are involved
- Claims have been delayed due to out-of-District billing; out-of-District providers have twelve months from the date of services to submit claims
- A claim has been previously submitted but has not been paid
- A claim has been delayed due to authorization requirements of MAA.

The processing of a new provider's enrollment application may cause some of the provider's claims to exceed the six-month filing limit. To prevent automatic denial of claims that fall within the effective date of the Provider Agreement but exceed 6 months from the date of service, mail claims directly to the ACS claims P.O. Box listed in Appendix A. In addition, a hard copy claim must be received for any exceptions authorized for reimbursement. Authorized exceptions cannot be accepted electronically.

8.7 Remittance Advice

RA's are the vehicle used by MAA to communicate with the providers on the status of claims. ACS is responsible for creating RAs twice a month. The RA provides pertinent information relevant to the claim, the errors that have been detected, and the payment amount. Listed below is a description of each field on the RA. This information will help you to better understand the information on the RA.

REMITTANCE ADVICE EXPLANATION

FIELD NO.	FIELD NAME	EXPLANATION
1	TO	The name of the Medicaid provider number of the payee provider who is getting the remittance advice
2	RA NO	The remittance advice number associated with the check
3	DATE PAID	Date Paid
4	PROVIDER NO	The Medicaid provider number of the pay-to-provider
5	PAGE	The page number of the report (leading zeros are suppressed for a specific provider's remittance being printed.
6	PATIENT NAME	Patient name
7	RECIPIENT ID NO	The recipient identification number under which the claim was filed
8	TRANS-CONTROL-NO	The transaction control number of the claim
9	FIRST SVC DATE	The first date of service in the claim record

8.0 CLAIMS PROCESSING PROCEDURES

10	LAST SVC DATE	The last date of service in the claim record
11	COVD DAYS	The covered days are the number of days the provider is paid for
12	DAILY RATE	The daily rate is the calculated rate the provider is paid per day
13	LC	The level of care of the recipient
14	PAID BY MCAID	The Medicaid reimbursement amount of the claim
15	EOB	Two explanations of benefits codes appear for each claim header and for each claim line (if lines are contained in the claim for the claim type). These codes are printed for suspended and denied claims. For paid claims, an alpha value in the EOB code indicates the claim has been cutback and the code is the reason for the cut-back. An explanation of all the EOB codes and the cutback codes on the provider's RA is printed at the end of the provider's RA.
16	EOB CONTINUATION	The claim carries only two EOB fields. If exception codes are posted to the claim that could have caused the claim to be denied and the EOB codes related to these exception codes are not the same as the EOB codes on the claim record, then the EOB codes are printed on this line.
17	CLAIM TYPE	The claim input form indicator description
18	CLAIM STATUS	The claim status description

8.0 CLAIMS PROCESSING PROCEDURES

19	REMITTANCE TOTALS	This section name is used to denote the total of all the claims for this provider's remittance advice
20	PAID ORIGINAL CLAIMS	The number of claims and associated dollars for original claims paid on this provider's remittance advice
21	PAID ADJUSTMENT CLAIMS	The number of claims and associated dollars for credits and adjustments paid on this provider's remittance advice. Gross adjustments are tallied as adjustment claims
22	DENIED ORIGINAL CLAIMS	The number of claims and associated dollars for original denied claims on this provider's remittance advice
23	DENIED ADJUSTMENT CLAIMS	The number of claims and associated dollars for adjustments denied on the provider's remittance advice
24	PENDED CLAIMS (IN PROCESS)	The number of claims and associated dollars for original claims and adjustments that are currently on the suspended claims file
25	AMOUNT OF CHECK	The sum of reimbursements equals the amount that the provider will receive in the form of this check.
26	THE FOLLOWING IS A DESCRIPTION OF THE EOB CODES THAT APPEAR ABOVE	This paragraph prints if any suspense or denial EOB codes appear for any header claims or any claim line-item for the claim type being printed for the

8.0 CLAIMS PROCESSING PROCEDURES

provider. The EOB code itself prints down the page followed by the actual text for the EOB code from the EOB text file from online MMIS. Any cutback codes that appear on the RA are also listed and explained here (only applies to claims paid). Any adjustment reasons that appear on the RA are also listed and explained here.

27

COUNT

This is the occurrence counter for each of the EOB codes that print in the EOB code explanation section at the end of the RA for each provider. The count is simply a tally of all occurrences of the EOB code. The same is true for cutback codes and adjustment reasons.

8.8 Inquiries

When making written and telephone inquiries related to RA status, providers must provide ACS 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.

REMITTANCE ADVICE
 DCMC8000-R001 (CP-O-12)
 AS OF 01/31/02

DISTRICT OF COLUMBIA MEDICAL ASSISTANCE ADMINISTRATION
 MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 03/15/02

R E M I T T A N C E A D V I C E

[1] TO: PRESIDENTIAL WOODS HEALTH CAR [2] R.A. NO.: 0000042 [3] DATE PAID: 01/31/02 [4] PROVIDER NUMBER: 109779700 [5] PAGE: 1

[6] * PATIENT NAME *	[7] * RECIPIENT *	[8]	[9] FIRST	[10] LAST	[11] COVD	[12] DAILY	[13] L BILLED	OTHER	PATIENT	[14] PAID BY	[15]

[16] LAST	FI IDENT NUM	TRANS-CONTROL-NUMBER	SVC DATE	SVC DATE	DAYS	RATE	C	AMT.	INS. RESPON.	MCAID PLAN	EOB EOB

[17] * * * CLAIM TYPE: LONG TERM CARE						[18] * * * CLAIM STATUS: IN PROCESS					

ORIGINAL CLAIMS:

JONES A 70313227 0-02003-11-002-0001-01 12/01/01 12/15/01 0 0.00 100.00 0.00 0.00 0.00 900

[19]REMITTANCE TOTALS	NUMBER OF CLAIMS	AMOUNT
[20]PAID ORIGINAL CLAIMS:	0	0.00
[21]PAID ADJUSTMENT CLAIMS:	0	0.00
[22]DENIED ORIGINAL CLAIMS:	0	0.00
[23]DENIED ADJUSTMENT CLAIMS:	0	0.00
[24]PENDED CLAIMS (IN PROCESS):	1	0.00
PAID CLAIMS MTD:	0	0.00
DENIED CLAIMS MTD:	0	0.00
ADJUSTED CLAIMS MTD:	0	0.00
PAID CLAIMS YTD:	0	0.00
DENIED CLAIMS YTD:	0	0.00
ADJUSTED CLAIMS YTD:	0	0.00
[25]AMOUNT OF CHECK:		0.00

---- [26]THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT:

900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM. [27]COUNT:
 1

9.0 BILLING INFORMATION

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

9.1 Billing Procedures

Each provider must supply their own standard claim form for the services provided. ACS only distributes Prior Authorization (719A) and Medicaid Laboratory Invoice for Ophthalmic Dispensing forms.

9.2 Electronic Billing

DC Medicaid will accept transmission of claims electronically. Currently DC Medicaid receives claims in the following media:

- Cartridge
- Diskette
- WINASAP 2000

ACS/EDI supports this function. Electronic claim submission provides for timely submission and processing of claims. It also reduces the rate of pended and denied claims.

Providers who are interested in receiving cartridge billing instructions should indicate this interest on their enrollment application. Permission from the DC Medicaid Program is required prior to submitting cartridge claims. Procedures specific to cartridge 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 the ACS at the number and address listed in Appendix A.

REQUEST FOR FORMS

Place indicate the “Type of Form” you are requesting. Enter the quantity of forms you are requesting in the “Number of Forms” column.

SUBMITTED BY

SUBMIT TO

PROVIDER NAME: _____
PROVIDER I.D. NO.: _____
ADDRESS: _____
DATE: _____

DISTRICT MEDICAID
CLAIMS PROCESSING
ACS
P.O. BOX 34734
WASHINGTON, DC 20043

TYPE OF FORMS

QUANTITY

MEDICAID LABORATORY INVOICE FOR OPHTHALMIC
DISPENSING

PRIOR AUTHORIZATION (719A)

9.3 Medicare/Medicaid Crossover Billing

When a recipient has been determined as dually-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 ACS for processing electronically.

If Medicare is billed for services to a recipient 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 ACS for processing. Refer to Appendix A for the address to submit these claims.

9.4 Medicaid Claims with Third Party Payments

Medicaid is always the payor of last resort. When a recipient has insurance from another source, employer or private policy, the provider must bill this source first. When the third party payor has made payment for the services, the provider should bill Medicaid for the residual amount.

To bill Medicaid, an original copy of the claim with a copy of the third party payor's EOMB attached, should be submitted to ACS for processing. When interviewing the patient the provider should always question the patient about third party resources available to the patient, regardless of the information supplied through EVS.

9.5 Resubmission

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.

Resubmitted copies of claims which lack an original signature or which are illegible will not be processed.

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.** Inquiries on claims that have pended on your remittance advice should be made **after** six months from the date the claim initially appeared as pending.

Instructions for resubmitting a denied claim are as follows:

- Claims must be received within 180 days after the date of service or in the case of inpatient hospital services, 180 days after the date of discharge. Claims must be resubmitted within one year of the RA date on which the claim denied for any reason(s) other than timely filing.
- Complete a new claim form. A copy of the original claim form will be accepted provided that 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 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 ACS Provider Inquiry at 1-866-752-9233.

10.0 REIMBURSEMENT

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

10.1 Maximum Fees or Rates

The maximum fees or rates shall be the lower of either the provider's charge to the general public, the upper limits set by Medicare, or the fees or rates established by MAA and listed in each individual provider manual.

10.2 Changes in Fees or Rates

DC Medicaid must provide the public with a 60-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. This is a federal regulation that is stated in 42 CFR 47.205. The public notice will be published in the District of Columbia Register.

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

10.3 Payment Inquiries

Providers may inquire regarding payment of claims. Inquiries must include the TCN, the RA payment date, and the provider's DC Medicaid identification number (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 ACS (the telephone number is included in Appendix A).

10.4 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 recipient, or any other person will be required to return the supplementary payment. The provider may, however, seek supplemental payment from recipients who are required to pay part of the cost (co-payment). For example, recipients must pay 50 cents for each prescription (original and refills) for patients who are 21 years of age or older. However, a provider may bill a Medicaid recipient for non-compensable service or item if the recipient has been notified by the provider prior to dispensing the service or item that it will not be covered by DC Medicaid. Examples of these services are transportation services that are not required based on DC Medicaid policy, experimental medical procedures, etc.

10.5 Coordination of Benefits

The DC Medicaid Program is a "last-pay" 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 recipient 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.

10.5.1 Benefit Programs

Providers must make reasonable efforts to obtain sufficient information from the recipient regarding primary coverage. Medical resources which 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.

10.5.2 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 recipient 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.

10.6 Prescribed or Ordered 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.

10.7 Method of Payment

The DC Medicaid Program makes direct payments to eligible providers for compensable medical care and related items dispensed to eligible recipients. In order 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 recipient 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 through a factor either directly, or by power of attorney.

10.7.1 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.

10.7.2 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.

10.7.3 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.

11.0 PRIOR AUTHORIZATION

Procedures to follow for prior authorization are described in this section. Section 12 will provide additional information prior authorization, as appropriate, for specific types of services.

11.1 Written Request

DC Medicaid 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 DC Medicaid. If DC Medicaid approves the request, the provider will receive a prior authorization number. If DC Medicaid denies the request, the service or item will not be considered for reimbursement.

Following is a list of medical services that require written prior authorization:

- Out-of-District non-emergency service/non-participating provider
- Van, wheelchair and non-emergency ambulance transportation to and from medical services
- Durable medical equipment in excess of \$250.00
- Plastic and reconstructive surgery for cosmetic purposes
- Medical supplies in excess of specific limitations
- Selected drug items
- Inpatient hospitalizations for dental procedures and for procedures that are cosmetic and/or medically necessary
- Prosthetic or orthotic appliances in excess of specific limitations

- Transplant Surgeries
- Co-surgeons
- Assistant Surgeons
- Certain vision care services

More complete information regarding services which require prior authorization are included in Section 12.0 of this manual.

11.2 Verbal Request

DC Medicaid will give verbal prior authorization for some medical services. If a verbal prior authorization is granted by DC Medicaid, the provider will be given a prior authorization number. If a verbal prior authorization is denied by DC Medicaid, the service or item will not be considered for reimbursement. ACS will be the authorizing agent for non-emergency medical transportation services.

11.3 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 recipient. When the emergency ends, the provider must adhere to prior authorization requirements.

11.4 Authorization Procedures

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

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

12.0 DC MEDICAID MANAGED CARE

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

12.1 Background

In early 1992, Mayor Kelly instructed the District's MAA to design and implement a managed care program for certain Medicaid recipients. Over the course of 1993, the staff of MAA designed the program now known as "DC Medicaid Managed Care". In addition, a waiver application based on that design was sent to the federal Health Care Financing Administration and was approved in April, 1993. MAA's staff worked with a group of Medicaid providers and a group of Medicaid recipients in identifying implementation issues that needed to be resolved so that the program could be implemented with as few difficulties as possible. In preparation, MAA developed provider requirements and capitation rates, program regulations; necessary systems modifications; and developed a horizontal linkage with governmental agencies to ensure a cooperative relationship.

12.2 Participants

The DC Medicaid program serves approximately 120,000 recipients, of whom approximately 80,000 shall be required to participate in the DC Medicaid Managed Care program. Members of the eligible population reside in all eight of the District's wards, although over half reside in wards VI, VII and VIII in the Eastern part of the city. Eligible recipients 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.

12.3 Providers

Eligible providers can be prepaid plans, public health clinics owned or operated by the District, hospital outpatient clinics, certain community health centers, 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 shall be on a capitated basis for prepaid plans and fee-for-service for primary care physicians in private practice.

12.4 Program Overview

The DC Medicaid Managed Care program was developed to improve access to primary and preventive services while reducing the overall cost of care provided to DC Medicaid recipients. The reductions in cost result from changes in the behavior of patients who have the opportunity to develop stable and continuous relationships with primary care providers (PCP). The program will result in reduction in the inappropriate use of the emergency room for non-emergencies, avoidance of unnecessary inpatient admissions though more consistent primary and preventive care, and the elimination of "doctor-shopping."

The advantages for the recipients include:

- Access to consistent primary and preventive care
- 24 hour availability of a physician in case the recipient needs medical care
- The choice of a doctor or clinic
- An opportunity to develop a long-term relationship with a physician who will come to know the recipient's complete health history and will be responsible for coordinating his/her care
- Knowledge that his/her physician is responsible for coordinating his/her specialty and inpatient care needs
- "**HELPLINE**", a recipient hotline for information and complaints.

The DC Medicaid Managed Care program seeks to optimize the investment in health care for DC Medicaid recipients which is particularly important in these times of fiscal austerity. Throughout the 1980's the number of DC Medicaid recipients remained constant but the cost of the program tripled. With increasing enrollment in the 1990's DC Medicaid Managed Care is one of the few ways of keeping costs under control without reducing services.

13.0 LONG TERM CARE SPECIFIC BILLING INSTRUCTIONS

13.1 Billing Instructions for Long Term Care Claims (UB-92)

The Uniform Bill, UB-92, must be completed by Long Term Care Providers billing for long term care services. A sample UB-92 follows the section for completing the form. These instructions have been coordinated and compared to the instructions provided in the District of Columbia UB-92 Billing Providers Manual issued by the Uniform Billing Task Force.

If you are billing claims electronically, please refer to the UB-92 EMC manual.

13.2 Billing Procedures

INSTRUCTIONS FOR COMPLETING THE LONG TERM CARE INVOICE (UB-92 CLAIM FORM)

These instructions are to be used for billing hardcopy long-term care services.

13.0 Long Term Care Specific Billing Instructions

FIELD 1 PROVIDER NAME, ADDRESS AND TELEPHONE NUMBER

REQUIRED: Enter the provider name, address, telephone number, and fax number, if available.

FIELD 3 PATIENT CONTROL NO.

OPTIONAL: Enter the patient number assigned by the provider to facilitate cross-referencing of records and payments.

FIELD 4 TYPE OF BILL:

Electronic Claims:

212 - Admission (requires an admission date **Claim Data Tab /Admissions**)

213 - Continuous Bill

214 - Discharge (requires patient status in **Block 22**)

Electronic claims, a discharge date must be entered along with the last date of service.

Paper Claims:

LTA - Admission (requires an admission date in **Block 17**)

LTC - Continuous Bill

LTD - Discharge (requires patient status in **Block 22**)

Paper claims, the last date of service in **Block 6** will be keyed as the discharge date.

13.0 Long Term Care Specific Billing Instructions

FIELD 6 STATEMENT COVERS PERIOD (FROM THRU)

REQUIRED: Enter the month and year from the first date of service to the last date of service (MM/DD/YY).

FIELD 7 COV'D (COVERED DAYS)

OPTIONAL: Enter the total number of covered accommodations days/units.

FIELD 8 NON COVERED DAYS

REQUIRED, IF APPLICABLE: Combine the number of bed hold days that are not covered by Medicaid.

FIELD 12 PATIENT NAME

REQUIRED: Enter the patient's last name, first name, and middle initial.

FIELD 17 ADMISSION DATE (Only if being billed as an LTA type of bill)

REQUIRED: Enter the date the patient was admitted to your facility.

FIELD 22 STAT (PATIENT STATUS)

REQUIRED: Enter the code that identifies the patient's status as of the statement covers through date. Patient status codes are defined as follows:

<u>Code</u>	<u>Definition</u>
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care

13.0 Long Term Care Specific Billing Instructions

03	Discharged/transferred to skilled nursing facility
04	Discharged/transferred to an intermediate care facility
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a Home IV provider
20	Expired
30	Still a patient

FIELD 23 MEDICAL RECORD NO.

REQUIRED: Enter the number assigned to the patient's medical record.

FIELD 42 REV CD (REVENUE CODES)

REQUIRED: On Line 1 enter 150 for room and board. On line 2 enter 001 for the total.

FIELD 43 DESCRIPTION (REVENUE CODES)

REQUIRED: Revenue Code 150 for Room and Board.

13.0 Long Term Care Specific Billing Instructions

Revenue Code 001 for total charges.

FIELD 44 HCPCS/RATES

REQUIRED: Facility per diem rate

FIELD 47 TOTAL CHARGES

REQUIRED: Enter the total charges.

FIELD 50 PAYER

REQUIRED: Enter separate lines for Medicaid and Medicare as appropriate. Use field 50A for Medicaid and field 50B for Medicare.

13.0 Long Term Care Specific Billing Instructions

FIELD 51 PROVIDER NO.

REQUIRED: Enter assigned nine-digit Medicaid provider number and Medicare number as appropriate. Use field 51A for Medicaid and field 51B for Medicare.

FIELD 54 PRIOR PAYMENTS

REQUIRED, IF APPLICABLE: Enter third party payor amount.

FIELD 58 INSURED'S NAME

REQUIRED: Enter the insured's last name, first name, and middle initial. The name must match the name on the Medical Assistance Card.

FIELD 60 CERT. - SSN - HIC. - ID NO.

REQUIRED: Enter the patient's 8-digit Medicaid identification number from the Medical Assistance Card.

FIELD 61 INSURED GROUP NAME

REQUIRED, IF APPLICABLE: If a third party has been identified, enter the name of the insurance company.

FIELD 62 INSURANCE GROUP NUMBER

REQUIRED, IF APPLICABLE: If a third party has been identified, enter the group number of the insurance company.

FIELD 67 PRINCIPAL DIAGNOSIS CODE

REQUIRED: Enter the full IDC-9-CM code for the condition that has been established to be chiefly responsible for the patient's admission (799.9 Only).

13.0 Long Term Care Specific Billing Instructions

FIELD 84 REMARKS

REQUIRED, IF APPLICABLE: For a claim adjustment/void
(see Section 13.2.2)

FIELD 85 PROVIDER REPRESENTATIVE

REQUIRED: An authorized provider representative must sign the claim. This must be an authorized signature indicating that the information entered on the face of the bill is in conformance with the certification on the back of the bill.

FIELD 86 DATE

REQUIRED: Enter the date on which the bill was signed, or sent to ACS for payment.

13.0 Long Term Care Specific Billing Instructions

Insert Sample UB-92 here.

13.0 Long Term Care Specific Billing Instructions

13.2.1 Electronic Billing

Medicaid will accept UB-92 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 ACS EMC Coordinator listed in Appendix A.

13.2.2 Adjustment and Void Procedures

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 six months of the original date of payment.

Adjustment/void claims for long-term care services are filed using the UB-92 Claim Form. To indicate an adjustment or voided claim, the following information must be indicated in Field 84 (Remarks) of the UB-92 Claim Form. The provider must indicate whether the claim is being adjusted/voided by writing the letter “A” for an adjustment or “V” for a void in Field 84 (Remarks) followed by the 17-digit transaction control number (TCN) of the paid claim to be adjusted or voided. An appropriate adjustment/void reason code should be indicated following the TCN. The following is a list of these codes. For your reference a sample claim adjustment follows the instructions.

13.0 Long Term Care Specific Billing Instructions

ADJUSTMENT/VOID REASON CODES

<u>Code</u>	<u>Description</u>
A5	ACCOMODATION CHARGE CORRECTION
A6	PATIENT PAYMENT AMOUNT CHANGED
A7	PROCEDURE OR SERVICE DATE CORRECTION
A8	CORRECTED DIAGNOIS CODE
A9	CORRECTED CHARGE AMOUNT
B0	UNIT, VISIT OR PROCEDURE CODE CORRECTION
B1	RECONSIDERATION OF ALLOWABLE AMOUNT
B2	CORRECTED ADMITTING, REFERRING OR PRESCRIBING PROVIDER NAME
B6	SERVICE NOT COVERED BY MEDICARE
B7	CORRECTED TRANSPORTATION DATA
C0	CORRECTED PAYMENT AMOUNT
C3	BILLING CLERK USED WRONG PROVIDER
C4	BILLING CLERK USED WRONG RECIPIENT ID
C9	SERVICE NOT COVERED BY PRIMARY CARRIER
D3	PARTIAL PAYMENT FROM LIABILITY INSURANCE
D4	PAYMENT CHANGE FOR RELATED CLAIM

13.0 Long Term Care Specific Billing Instructions

13.2.3 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. Only claims that have appeared on the Remittance Advice as a denial can be resubmitted. Instructions for resubmitting a denied claim are as follows:

- Claims must be received within 180 days after the date of service or in the case of inpatient hospital services, 180 days after the date of discharge. Claims must be resubmitted within one year of the RA date on which the claim denied for any reason(s) other than timely filing.
- Complete a new claim form. A copy of the original claim form will be accepted provided that 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 deny.
- 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 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 address listed in Appendix A.

13.2.4 Medicare Coinsurance and Deductibles

When billing for 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 appropriate claim form. Attach the Medicare Explanation of Medical Benefits (EOMB) to the Medicare Residuals claim as proof of payment or denial of payment by Medicare.

When billing for Part A coinsurance, you must submit: A UB-92 claim form.

When billing for Part B coinsurance, you must submit: A HCFA-1500 claim form.

All required fields on the form must be completed.

When billing for Part A or Part B, you must submit: The Medicare EOMB or the claim will be returned. This will allow us to utilize all diagnosis and procedure code information to determine Medicaid's payment obligation in accordance with the District's State Plan.

**APPENDIX A: ADDRESS AND TELEPHONE
NUMBER DIRECTORY**

Appeal Notification – MAA copy

Department of Health
Medical Assistance Administration
2100 Martin Luther King, Jr. Avenue, SE
Suite 302
Washington, DC 20020
Attention: Appeal Unit

Claims Appeal – Claims Over 6 Months Old Submission Information

ACS
District Medicaid Claims Processing Fiscal Agent
P.O. Box 34734
Washington, DC 20043
Attention: Timely Filing Claims Appeal

Claim Status Information/Claims payment Information

ACS
District Medicaid Claims Processing Fiscal Agent
P.O. Box 34734
Washington, DC 20043
Attention: Provider Inquiry Unit
Telephone Number = 1-866-752-9233

Claim Submission Information

Mail

For HCFA 1500s:

ACS
District Medicaid Claims Processing
P.O. Box 34768
Washington, DC 20043

For UB92s:

ACS
District Medicaid Claims Processing
P.O. Box 34693
Washington, DC 20043

For Dental and Pharmacy claims:

ACS
District Medicaid Claims Processing
P.O. Box 34714
Washington, DC 20043

For Adjustments and Voids:

ACS
District Medicaid Claims Processing
P.O. Box 34706
Washington, DC 20043

For Medicare Crossover claims:

ACS
District Medicaid Claims Processing
P.O. Box 34770
Washington, DC 20043

Telephone Inquiries:

ACS Provider Inquiry Unit
1-866-752-9233

CPT-4 Coding Information

American Medical Association
100 Enterprise Place
P.O. Box 7046
Dover, Delaware 19903-7046
Attention: Order Department = 1-800-621-8335

ICD-9-CM Orders

MEDICODE
5225 Post Way
Suite 500
Salt Lake City, Utah 84116
1-800-999-4600

District of Columbia Managed Care Enrollment Broker

ACS State Healthcare (Formerly known as Concera) = (202) 639-4030

Durable Medical Equipment (DME)

Request/Approval Information = (202) 698-2043
Pharmacy Consultant Office = (202) 698-2043

Electronic Claims Submission/Electronic RA Information

EDI (Electronic Data Interchange) Telephone Number: 1-866-775-8563

Eligibility Determination Information

Income Maintenance Administration = (202) 724-5506

Eligibility Verification

Eligibility Verification System (see Appendix D) = (202) 610-1847

General Program Information

Medical Assistance Administration
2100 Martin Luther King, Jr. Avenue, SE
Suite 302
Washington, DC 20020
Telephone Number = (202) 698-2000

Medicaid Payment Schedule Information

ACS, Inc.

Provider Inquiry Unit
P.O. Box 34743
Washington, DC 200043
Telephone Number: 1-866-752-9233

Nurse Aide Recertification

Medical Assistance Administration
2100 Martin Luther King, Jr. Avenue, SE
Suite 302
Washington, DC 20020
Attention: Nurse Recertification
(202) 698-2000

Payment Schedule Information (see Appendix B)

Pharmacy Consultant

Medical Assistance Administration
2100 Martin Luther King, Jr. Avenue, SE
Suite 302
Washington, DC 20020
Telephone Number = (202) 698-2043

Prior Authorization Form Submission

Office of Quality Management
825 N Capital St. NE, 5th Floor
Washington, DC 20020
Attention: Prior Authorization Request

Provider Enrollment Information

ACS
Provider Enrollment Unit
P.O. Box 34761
Washington, DC 20043-4761
Telephone Number = 1-866-752-9231

Recipient Eligibility HelpDesk

EVS backup = 1-866-752-9233

Taxicab Voucher/Medical Necessity Form Submission

Department of Health
Medical Assistance Administration
2100 Martin Luther King, Jr. Avenue, SE
Suite 302
Washington, DC 20020
Attention: Transportation Department
Telephone Number = (202) 698-2000

Taxicab Voucher Pick-Up

Department of Health
Medical Assistance Administration
2100 Martin Luther King, Jr. Avenue, SE
Suite 302
Washington, DC 20020
Telephone Number = (202) 698-2000

Third Party Liability

Department of Health
Medical Assistance Administration
825 North Capitol Street, NE
Washington, DC 20002
Attention: Third Party Liability/Surveillance Utilization

Telephone: Health Insurance – (202) 442-9048
Casualty – (202) 442-9096 or (202) 442-9049
States – (202) 442-9221
SURS or General Information – (202) 442-9227

APPENDIX B: CURRENT CLAIM AND PAYMENT SCHEDULE

ELECTRONIC CLAIMS SCHEDULE

Listed below is the Medicaid electronic claims schedule for fiscal year 2007. Electronic claims received by 12:00 noon on the submission dates indicated below will be included in that payment cycle. Those received after that time will be included in the next payment cycle.

<u>Date of Cycle</u>	<u>Submission Date</u>	<u>Run Date</u>
10-01-2006	Thursday, 09-28-2006	09-29-2006
10-06-2006	Thursday, 10-05-2006	10-06-2006
10-13-2006	Thursday, 10-12-2006	10-13-2006
10-20-2006	Thursday, 10-19-2006	10-20-2006
11-01-2006	Thursday, 10-26-2006	10-27-2006
11-03-2006	Thursday, 11-02-2006	11-03-2006
11-10-2006	Thursday, 11-09-2006	11-10-2006
11-17-2006	Thursday, 11-16-2006	11-17-2006
11-24-2006	Thursday, 11-23-2006	11-24-2006
12-01-2006	Thursday, 11-30-2006	12-01-2006
12-08-2006	Thursday, 12-07-2006	12-08-2006
12-15-2006	Thursday, 12-14-2006	12-15-2006
12-22-2006	Thursday, 12-21-2006	12-22-2006
01-01-2007	Thursday, 12-28-2006	12-29-2006
01-05-2007	Thursday, 01-04-2007	01-05-2007
01-12-2007	Thursday, 01-11-2007	01-12-2007
01-19-2007	Thursday, 01-18-2007	01-19-2007
02-01-2007	Thursday, 01-25-2007	01-26-2007
02-02-2007	Thursday, 02-01-2007	02-02-2007
02-09-2007	Thursday, 02-08-2007	02-09-2007
02-16-2007	Thursday, 02-15-2007	02-16-2007
02-23-2007	Thursday, 02-22-2007	02-23-2007
03-01-2007	Thursday, 03-01-2007	03-02-2007
03-09-2007	Thursday, 03-08-2007	03-09-2007
03-16-2007	Thursday, 03-15-2007	03-16-2007
03-23-2007	Thursday, 03-22-2007	03-23-2007

<u>Date of Cycle</u>	<u>Submission Date</u>	<u>Run Date</u>
04-01-2007	Thursday, 03-29-2007	03-30-2007
04-06-2007	Thursday, 04-05-2007	04-06-2007
04-13-2007	Thursday, 04-12-2007	04-13-2007
04-20-2007	Thursday, 04-19-2007	04-20-2007
05-01-2007	Thursday, 04-26-2007	04-27-2007
05-04-2007	Thursday, 05-03-2007	05-04-2007
05-11-2007	Thursday, 05-10-2007	05-11-2007
05-18-2007	Thursday, 05-17-2007	05-18-2007
05-25-2007	Thursday, 05-24-2007	05-25-2007
06-01-2007	Thursday, 05-31-2007	06-01-2007
06-08-2007	Thursday, 06-07-2007	06-08-2007
06-15-2007	Thursday, 06-14-2007	06-15-2007
06-22-2007	Thursday, 06-21-2007	06-22-2007
07-01-2007	Thursday, 06-28-2007	06-29-2007
07-06-2007	Thursday, 07-05-2007	07-06-2007
07-13-2007	Thursday, 07-12-2007	07-13-2007
07-20-2007	Thursday, 07-19-2007	07-20-2007
08-01-2007	Thursday, 07-26-2007	07-27-2007
08-03-2007	Thursday, 08-02-2007	08-03-2007
08-10-2007	Thursday, 08-09-2007	08-10-2007
08-17-2007	Thursday, 08-16-2007	08-17-2007
08-24-2007	Thursday, 08-23-2007	08-24-2007
09-01-2007	Thursday, 08-30-2007	08-31-2007
09-07-2007	Thursday, 09-06-2007	09-07-2007
09-14-2007	Thursday, 09-13-2007	09-14-2007
09-21-2007	Thursday, 09-20-2007	09-21-2007
10-01-2007	Thursday, 09-27-2007	09-28-2007

MEDICAID HARDCOPY CLAIMS SCHEDULE

Listed below is the Medicaid schedule for the submission of hardcopy (paper) claims for fiscal year 2007. Claims received by 12:00 noon on the submission dates indicated below will be included in that payment cycle. Those received after that time will be included in the next payment cycle.

<u>Date of Cycle</u>	<u>Submission Date</u>	<u>Run Date</u>
10-01-2006	Thursday, 09-21-2006	09-29-2006
10-06-2006	Thursday, 09-28-2006	10-06-2006
10-13-2006	Thursday, 10-05-2006	10-13-2006
10-20-2006	Thursday, 10-12-2006	10-20-2006
11-01-2006	Thursday, 10-19-2006	10-27-2006
11-03-2006	Thursday, 10-26-2006	11-03-2006
11-10-2006	Thursday, 11-02-2006	11-10-2006
11-17-2006	Thursday, 11-09-2006	11-17-2006
11-24-2006	Thursday, 11-16-2006	11-24-2006
12-01-2006	Thursday, 11-23-2006	12-01-2006
12-08-2006	Thursday, 11-30-2006	12-08-2006
12-15-2006	Thursday, 12-07-2006	12-15-2006
12-22-2006	Thursday, 12-14-2006	12-22-2006
01-01-2007	Thursday, 12-21-2006	12-29-2006
01-05-2007	Thursday, 12-28-2006	01-05-2007
01-12-2007	Thursday, 01-04-2007	01-12-2007
01-19-2007	Thursday, 01-11-2007	01-19-2007
02-01-2007	Thursday, 01-18-2007	01-26-2007
02-02-2007	Thursday, 01-25-2007	02-02-2007
02-09-2007	Thursday, 02-01-2007	02-09-2007
02-16-2007	Thursday, 02-08-2007	02-16-2007
02-23-2007	Thursday, 02-15-2007	02-23-2007
03-01-2007	Thursday, 02-22-2007	03-02-2007
03-09-2007	Thursday, 03-01-2007	03-09-2007
03-16-2007	Thursday, 03-08-2007	03-16-2007
03-23-2007	Thursday, 03-15-2007	03-23-2007
04-01-2007	Thursday, 03-22-2007	03-30-2007
04-06-2007	Thursday, 03-29-2007	04-06-2007
04-13-2007	Thursday, 04-05-2007	04-13-2007

<u>Date of Cycle</u>	<u>Submission Date</u>	<u>Run Date</u>
04-20-2007	Thursday, 04-12-2007	04-20-2007
05-01-2007	Thursday, 04-19-2007	04-27-2007
05-04-2007	Thursday, 04-26-2007	05-04-2007
05-11-2007	Thursday, 05-03-2007	05-11-2007
05-18-2007	Thursday, 05-10-2007	05-18-2007
05-25-2007	Thursday, 05-17-2007	05-25-2007
06-01-2007	Thursday, 05-24-2007	06-01-2007
06-08-2007	Thursday, 05-31-2007	06-08-2007
06-15-2007	Thursday, 06-07-2007	06-15-2007
06-22-2007	Thursday, 06-14-2007	06-22-2007
07-01-2007	Thursday, 06-21-2007	06-29-2007
07-06-2007	Thursday, 06-28-2007	07-06-2007
07-13-2007	Thursday, 07-05-2007	07-13-2007
07-20-2007	Thursday, 07-12-2007	07-20-2007
08-01-2007	Thursday, 07-19-2007	07-27-2007
08-03-2007	Thursday, 07-26-2007	08-03-2007
08-10-2007	Thursday, 08-02-2007	08-10-2007
08-17-2007	Thursday, 08-09-2007	08-17-2007
08-24-2007	Thursday, 08-16-2007	08-24-2007
09-01-2007	Thursday, 08-23-2007	08-31-2007
09-07-2007	Thursday, 08-30-2007	09-07-2007
09-14-2007	Thursday, 09-06-2007	09-14-2007
09-21-2007	Thursday, 09-13-2007	09-21-2007
10-01-2007	Thursday, 09-20-2007	09-28-2007

MEDICAID PAYMENT SCHEDULE

Listed below is the payment schedule for fiscal year 2007.

<u>Date of Cycle</u>	<u>Run Date</u>
10-01-2006	09-29-2006
10-06-2006	10-06-2006
10-13-2006	10-13-2006
10-20-2006	10-20-2006
11-01-2006	10-27-2006
11-03-2006	11-03-2006
11-10-2006	11-10-2006
11-17-2006	11-17-2006
11-24-2006	11-24-2006
12-01-2006	12-01-2006
12-08-2006	12-08-2006
12-15-2006	12-15-2006
12-22-2006	12-22-2006
01-01-2007	12-29-2006
01-05-2007	01-05-2007
01-12-2007	01-12-2007
01-19-2007	01-19-2007
02-01-2007	01-26-2007
02-02-2007	02-02-2007
02-09-2007	02-09-2007
02-16-2007	02-16-2007
02-23-2007	02-23-2007
03-01-2007	03-02-2007
03-09-2007	03-09-2007
03-16-2007	03-16-2007
03-23-2007	03-23-2007
04-01-2007	03-30-2007
04-06-2007	04-06-2007
04-13-2007	04-13-2007
04-20-2007	04-20-2007

<u>Date of Cycle</u>	<u>Run Date</u>
05-01-2007	04-27-2007
05-04-2007	05-04-2007
05-11-2007	05-11-2007
05-18-2007	05-18-2007
05-25-2007	05-25-2007
06-01-2007	06-01-2007
06-08-2007	06-08-2007
06-15-2007	06-15-2007
06-22-2007	06-22-2007
07-01-2007	06-29-2007
07-06-2007	07-06-2007
07-13-2007	07-13-2007
07-20-2007	07-20-2007
08-01-2007	07-27-2007
08-03-2007	08-03-2007
08-10-2007	08-10-2007
08-17-2007	08-17-2007
08-24-2007	08-24-2007
09-01-2007	08-31-2007
09-07-2007	09-07-2007
09-14-2007	09-14-2007
09-21-2007	09-21-2007
10-01-2007	09-28-2007

APPENDIX C: EVS INSTRUCTIONS

It is the responsibility of the provider to ensure the patient is eligible for Medicaid. To access the District of Columbia Government Medicaid Recipient **Eligibility Verification System** (EVS), dial the following telephone number:

(202) 610-1847

After dialing the number, EVS will answer the call and respond with:

DC MEDICAID ELIGIBILITY SYSTEM

The system will then prompt you with:

PLEASE ENTER YOUR PROVIDER NUMBER

You should respond by using a touch-tone phone to enter your nine-digit provider identification number.

If no data is entered within the specified time period, or if insufficient data is entered, the system will respond with:

INELIGIBLE PROVIDER NUMBER

PLEASE REPEAT YOUR ENTRY

You will be given three (3) opportunities to enter a valid provider number. After three (3) invalid provider numbers have been entered, the call will be disconnected. After you have verified your provider number, you should redial EVS to verify the information.

Once a valid provider number has been entered, you will be prompted with:

PLEASE ENTER YOUR RECIPIENT NUMBER

The recipient identification number, an eight (8) digit code, should be entered exactly as it appears on the Medical Assistance Card. After entering the eighth digit, the system will respond:

PLEASE ENTER THE LAST NAME CODE

Respond by entering the numeric representation of the first letter of the recipient's last name. The numeric sequence for the last name is generated in the following manner:

1. Depress the key containing the desired letter. For example, for a last name beginning with an *A*, the first digit of the key will be 2.
2. Press a 1, 2, or 3 depending upon the letter's position on the telephone button. For example, the letter *A* is the first character on button 2; therefore, the second digit of the key is 1. The entire key for *A* is 21. Similarly, *B* is 22 and *C* is 23. Since the characters *Q* and *Z* do not appear on the keypad, the sequences of 11 for *Q*, and 12 for *Z* should be used to enter these alphabetic characters.

The following table may be used to enter the name keys for EVS:

A	21
B	22
C	23
D	31
E	32
F	33
G	41
H	42
I	43

J	51
K	52
L	53
M	61
N	62
O	63
P	71
Q	11
R	72

S	73
T	81
U	82
V	83
W	91
X	92
Y	93
Z	12

If you make an error entering the last name codes, the system will pre-prompt with:

INVALID RECIPIENT NUMBER

PLEASE REPEAT YOUR ENTRY

At this point, you should re-enter the Recipient Number. The system will prompt you as it did during the initial attempt to verify the data.

Upon successfully entering the last name code, the system will prompt you with the following:

PLEASE ENTER THE FIRST NAME CODE

You should respond by entering the numeric representation of the first letter of the first name. The algorithm used to enter the first name code is the same as for the last name code. Please refer to the table above for assistance translating the name to a numeric representation.

If an error is made when entering the first name, the system will re-prompt with:

INVALID RECIPIENT NUMBER

PLEASE REPEAT YOUR ENTRY

Now you must enter the recipient number and follow the process for entering the last name and first name. The system will prompt you through the process as it did during the first entry.

You will be given three (3) opportunities to enter a valid recipient identification number with valid name codes. After entering three invalid recipient identification numbers with name codes, the call will be disconnected.

If the recipient number exists in the database and matches the name code entered, the system will respond with one of the following messages based on the information available for the recipient:

- Eligible Medicaid HMO, including the name and telephone number of the Managed Care Organization
- Eligible Medicaid and Medicare
- Eligible Medicaid and Third Party
- Eligible Medicaid
- Eligible Medicaid Restricted

- Eligible for Pregnancy Related Services Only

The system will then prompt you with:

ENTER NEXT RECIPIENT

To verify another recipient, begin by entering the recipient number and follow the instructions above. Otherwise press asterisk (*) to end the call. A maximum of five (5) recipients can be verified during a single call.

If you encounter problems accessing the EVS system, call the Recipient Eligibility Help Desk (EVS backup) at 1-866-752-9233.