Dental Billing Manual
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1 General Information

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

1.1 Purpose of the Manual

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

1.2 Policy

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

1.3 Maintenance

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

1.4 Distribution

This manual is available via the Web Portal at www.dc-medicaid.com to all providers who participate in the DC Medicaid Program. This manual may be requested on CD by contacting Conduent as listed in Appendix A.

1.5 Organization

This manual is organized into 13 sections. When a revision occurs to any part of this manual, the revised manual will be posted on the Web Portal at www.dc-medicaid.com. Notification of the updated manual will be indicated in the “What’s Hot” section of the Web Portal. Outdated copies of material should be discarded.

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

- “His” refers to both genders throughout the manual.
- Terms used throughout this manual are defined in Section 3.0-Glossary.
- Addresses and telephone numbers referenced throughout this manual are included in Appendix A (Address and Telephone Directory).

1.6 DHCF Website

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

1.7 Web Portal

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

- Bi-monthly bulletins and transmittals
- Provider Type Specific Billing Tips
- Provider Type Specific FAQ (Frequently Asked Questions)
- Provider Type Specific Forms
- Provider Type Specific Policies
- Provider Training Modules and Computer Based Training (CBT)
- Latest News/What's Hot
- Online Claim and Prior Authorization submission
- Remittance Advice Retrieval
- Beneficiary Eligibility Verification

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

1.8 Fiscal Agent

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

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

1.8.1 Telephone Contact

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

Table 1: Contact List

Conduent Provider Inquiry **PO Box 34734** **Washington, DC 20043-4734**	(202) 906-8319 (inside DC metro area) (866) 752-9233 (outside DC metro area) (202) 906-8399 (Fax) providerinquiry@conduent.com (Email)
Conduent EDI Gateway Services	(866) 407-2005 http://edisolutionsmmis.portal.conduent.com/gcro/

1.8.2 Mailing Contact Information

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

2 Introduction

The following subsections provide information regarding the DC Medicaid Program.

2.1 District of Columbia Medicaid Program

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

2.2 Legal Authority

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

2.3 Administration

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

2.4 Covered Services

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

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

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

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

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

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

2.5 Non-Covered Services

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

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

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

2.6 Inquiries

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

3 Health Information Technology (HIT) Healthcare Reform

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

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

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

Key HIT goals include:

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

3.1 Health Information Exchange

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

3.1.1 HIE Services

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

- **Provider Query Portal***: Access to real time clinical information including lab results, radiology reports and discharge summaries.
- **Encounter Reporting Service*** (ERS): Reports to hospitals on utilization trends across multiple independent facilities.

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

3.1.2 Partnership with Department of Health

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

4 DC MEDICAID MANAGED CARE

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

4.1 Program Overview

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

The services offered to all Medicaid managed care enrollees include:

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

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

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

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

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

Medicaid Managed Care Contacts:

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

Enrollment Broker:

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

4.2 Participants

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

4.3 Providers

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

4.4 Special Requirements for Managed Care Organizations

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

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

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

4.5 Quality Assurance Program for DC Medicaid Managed Care

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

5 PROVIDER PARTICIPATION INFORMATION

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

5.1 Participating Provider

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

5.2 Provider Types

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

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

5.3 Provider Eligibility Requirements

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

5.3.1 District Providers

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

5.3.2 Out-of-District Providers

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

5.3.3 Group Practice Providers

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

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

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

5.3.4 Health Facilities

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

5.4 Application Procedures

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

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

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

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

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

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

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

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

5.4.1 How Track the Status of Your Enrollment Application

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

My Providers

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

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

5.4.2 Screening Providers or Suppliers Classified As "High Risk"

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

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

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

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

5.4.3 Screening Providers or Suppliers Classified As "Moderate Risk"

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

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

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

- Verification that the provider or supplier meets requirements set forth in the D.C. Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C.

Official Code § 3-1201.01 et seq.) and implementing rules, as well as all other applicable Federal and District laws and regulations.
- Verification of appropriate licensure, including licensure in states other than the District, in accordance with 42 C.P.R. § 455.412.
- Both pre- and post-enrollment database checks to ensure the provider or supplier continues to meet the enrollment criteria that corresponds to its provider or supplier type, in accordance with 42 C.P.R.§ 455.436; and
- On-site visits conducted in accordance with 42 C.P.R. § 455.432.

5.4.4 Screening Providers or Suppliers Classified As "Limited Risk"

Pursuant to 42 C.P.R. § 455.450, any provider or supplier not designated as "Moderate Risk" or "High Risk" under §§ 9405 and 9404, shall be classified within the "Limited Risk" category. Screening for providers or suppliers classified as "Limited Risk" shall include the following:
- Verification that the provider or supplier meets requirements set forth in the D.C. Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 et seq.) and implementing rules, as well as all other applicable Federal and District laws and regulations.
- Verification of appropriate licensure, including licensure in states other than the District, in accordance with 42 C.P.R. § 455.412; and
- Both pre- and post-enrollment database checks to ensure the provider or supplier continues to meet the enrollment criteria that corresponds to its provider or supplier type, in accordance with 42 C.P.R. § 455.436.

5.4.5 Crossover Only Providers

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

5.4.6 Ordered or Prescribed Services

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

5.5 Enrollment Application Approval

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

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

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

6 REGULATIONS

The regulations that govern the DC Medicaid Program are contained in Title XIX of the Social Security Act, 42 U.S.C. 1396, (et siq.) and authorized by enabling legislation P.L. 90-227, 12/27/67. The Department of Health Care Finance (DHCF) is the single state agency responsible for administering the Medicaid program.
An overview of the regulations governing provider activities follows.

6.1 Beneficiary Freedom of Choice of Providers

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

6.2 Discrimination

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

6.3 Interrelationship of Providers

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

6.4 Record Keeping

Providers shall retain for a minimum of ten (10) years (unless otherwise specified), medical and fiscal records that fully disclose the nature and extent of the services rendered to beneficiaries. These records must meet all criteria established by federal and District regulations. Providers shall make such records readily available for review and copying by District and Federal officials or their duly authorized agents. The term "readily available" means that the records must be made available at the provider's place of business. If it is impractical to review records at the provider's place of business, upon written request, the provider must forward without charge, the original records, or facsimiles. If DHCF terminates an agreement with a provider, the records relating to services rendered up to the effective date of the termination remain subject to the requirements stated in this manual.

6.4.1 Medical Records

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

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

- Are signed and dated by the responsible licensed provider. Stamped signatures will not be accepted. All care by ancillary personnel must be countersigned by the responsible licensed provider. Any alterations to the record must be signed and dated.
- Contains a preliminary working diagnosis as well as final diagnosis, including elements of a history and physical examination upon which the diagnosis is based.
- Document in compliance with the service definitions and descriptions found in Physicians' Current Procedural Terminology (CPT), ICD-9/10, HCPS, CTD, Axis I
- Reflect treatments as well as the treatment plan.
- List quantities and dosages of drugs or supplies prescribed as part of the treatment and wellbeing of the patient.
- Indicate the progress of the beneficiary at every visit, the change of the diagnosis, the change of treatment, and the response to the treatment.
- Contain summaries of all referrals, hospitalizations, and reports of operative procedures
- Contains the results of all diagnostic tests and reports of all consultations.
- Reflect the disposition of the case.

6.4.2 Cost Reporting

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

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

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

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

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

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

6.4.3 Fiscal Records

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

6.4.4 Disclosure of Information

Records and information acquired in the administration of any part of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in the rules and regulations of the Department of Health and Human Services and the DC Medicaid program.

6.4.5 Penalties for Non-Compliance

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

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

6.5 Division of Program Integrity

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

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

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

Pursuant to the authority set forth in §1902(a) (30) of the Social Security Act, 42 C.F.R. § 455, and 42 C.F.R. § 456, and in conjunction with 29 DCMR § 1300, et seq. and 1900, et seq., the DHCF has established procedures for reviewing the utilization of, and payment for, all Medicaid services. Accordingly, providers are required, upon request, to provide DHCF, designated DHCF agents, the Department of Justice, or the Secretary of Department of Health and Human Services with medical records. In addition, providers must fully cooperate with audits and reviews made by DHCF or their designee to determine validity of claims or the medical necessity of services rendered by the provider. Any of the above entities have the right to request complete information about the ownership of any contractor with whom the provider has had business transactions. In addition, requests may be made about significant business transactions between the provider and any wholly owned supplier, or subcontractor, during the ten (10) year period from the date of the request. This information must be supplied within 35 days of request.

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

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

Provider audits may be announced or unannounced. If announced, the Division of Program Integrity will send intent to audit/notification letter to the provider announcing the audit and the time frame of the audit.

When possible, the Division of Program Integrity will coordinate with the provider to minimize inconvenience and disruption of health care delivery during the audit. Providers can prepare by doing the following:

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

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

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

Providers will normally have 30 days (depending on the category of service being delivered and the specific regulations that govern that service) from receipt of the draft audit report or preliminary clinical review notice to dispute the draft audit or preliminary clinical review findings. Providers must submit the

dispute in writing, include what findings they are contesting, and supply documentation to support their position.

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

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

There are several Federal government audit/review and program integrity initiatives administered by the Centers for Medicare and Medicaid Services (CMS) or CMS contractors and may include the Office of Inspector General (OIG). District of Columbia's Medicaid providers may receive notification letters and record requests from CMS contractors advising them they have been selected for an audit or review. These audits or reviews could involve the following programs or contractors:

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

6.6 Utilization Review

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

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

6.7 Consequences of Misutilization and Abuse

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

6.8 Quality Assurance Program for DC Medicaid Managed Care

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

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

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

6.9 Consequences of Fraud

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

6.10 Reporting Fraud, Waste, and Abuse

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

Department of Health Care Finance
Division of Program Integrity
441 4th Street, NW Washington, D.C. 20001
Telephone Number: 202 698-1718
Hotline Phone Number: 1-877-632-2873

https://www.dc-medicaid.com/dcwebportal/nonsecure/reportFraud

7 LANGUAGE ACCESS

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

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

7.1 Laws and Regulations

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

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

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

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

7.2 Coordinating Translation Services

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

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

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

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

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

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

8 ADMINISTRATIVE ACTIONS

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

8.1 Recoupment

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

8.2 Termination

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

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

8.2.1 Notification

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

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

- The Centers for Medicaid and Medicare Services
- District, State, and local agencies involved in providing health care
- Medicaid agencies located in other states
- State and county professional societies
- General public

8.2.2 Consequences of Termination

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

8.3 Appeal Process

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

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

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

8.4 Reinstatement

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

8.4.1 Criteria for Reinstatement

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

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

9 BENEFICIARY ELIGIBILITY

This subsection provides an overview of beneficiary eligibility.

9.1 Eligibility Determination

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

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

9.2 Individual Eligibility

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

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

9.3 Eligibility Identification

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

9.3.1 Medical Assistance Card

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

If the beneficiary has provided this information to the eligibility-determining agency, a provider should ask the beneficiary if he has other health insurance coverage not shown on the card. The provider is obligated to determine that the person to whom care is being rendered is the same individual listed on the eligibility card.

Figure 1: Medical Assistance Card – Front Image

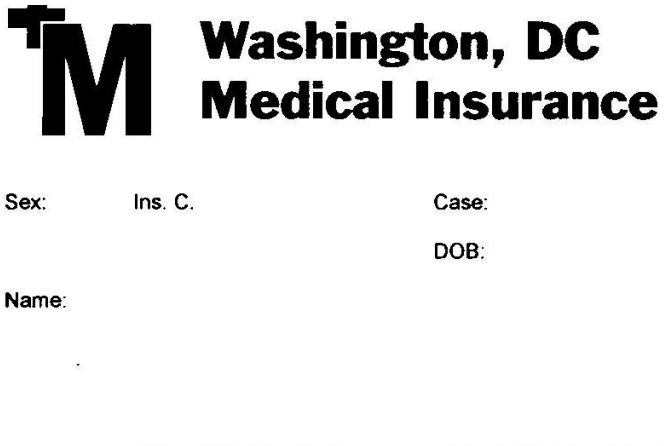
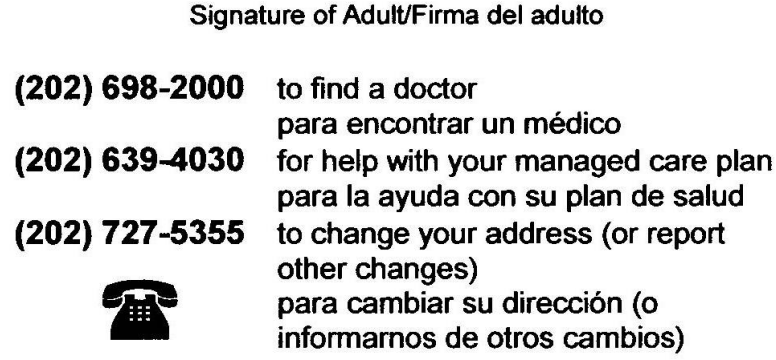


Figure 2: Medical Assistance Card – Back Image



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

9.3.2 Notice of Presumptive Eligibility

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

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

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

9.3.3 Office of the Health Care Ombudsman and Bill of Rights

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

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

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

9.4 Provider Responsibility

The provider is responsible for the following eligibility verification activities.

9.4.1 Eligibility Verification

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

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

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

9.4.2 Third-Party Liability

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

- Lien - is put in place to protect Medicaid's interest in the beneficiary's former home and its rights to recover Medicaid spending that result in settlements from inquiries that involve lawsuits.

- Subrogation – notice sent out of intent to collect a debt.
- Notice of other insurance – is sent when the beneficiary has an insurance policy other than Medicaid. This will not result in loss of Medicaid benefits.
- Estate – property owned by a Medicaid beneficiary that can result in Medicaid placing a lien against it to insure the reimbursement of Medicaid funds after the beneficiary's death.

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

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

9.4.3 Medicaid Beneficiary Restriction Program

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

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

9.4.4 Qualified Medicare Beneficiary (QMB)

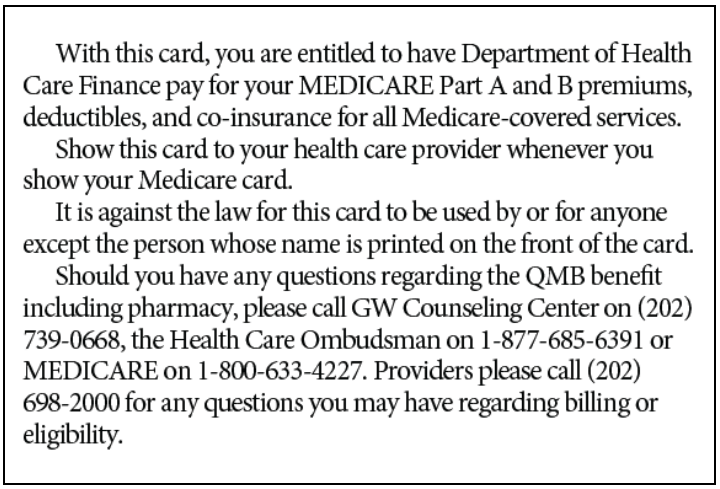
Qualified Medicare Beneficiaries (QMBs) are persons who are entitled to Medicare Part A, are eligible for Medicare Part B, and have an income below 100% of the federal poverty level are determined to be eligible for QMB status by their state Medicaid agency. Medicaid pays only the Medicare Part A and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

9.4.4.1 Qualified Medicare Beneficiary Program

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

Figure 3: QMB Medical Assistance Card – Front Image

Figure 4: QMB Medical Assistance Card – Back Image



9.4.4.2 Billing for Services Provided to QMB's

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

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

9.4.4.3 Balance Billing of QMBs is prohibited by Federal Law

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

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

10 CLAIMS PROCESSING PROCEDURES

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

10.1 Receive and Record

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

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

10.2 Review

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

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

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

10.3 Transaction Control Number

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

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

Figure 5: TCN Structure

20021	1	0123	000001	7
Julian Date (YYDDD)	Media Type (By Value)	Batch Number (By Position)	Document Number	TCN Type (By Value)
	1 = Web 2 = Electronic Crossover 3 = Electronic Submitted Claim 4 = System Generated 5 = Web w/attachment 6 = Special Batch 7 = Retro-rate 8 = Paper 9 = Paper w/attachment 0 = Encounter	1 = Machine number 2 - 4 = Assigned batch		0 – 4 = PBM 5 - 6 = Available 7 = Original 8 = Credit (void) 9 = Debit (adjustment)

10.4 Input

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

10.5 Edits

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

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

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

The Remittance Advice (RA) document sent to providers shows the status of each claim submitted by the provider and entered 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.
- Suspended claims (in process).
- Paid claims MTD.
- Denied claims MTD.
- Adjusted claims MTD.
- Paid claims YTD.
- Denied claims YTD.

10.5.1 Approval Notification

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

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

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

The following examples show the importance of adjusting or voiding a previously adjudicated claim on which errors have occurred:

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

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

10.5.2 Denied

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

Listed below are some examples of denial reasons:

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

10.5.3 Suspended

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

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

10.6 Timely Filing

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

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

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

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

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

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

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

11 BILLING INFORMATION

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

11.1 Billing Procedures

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

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

- CMS1500
- ADA 2019 or 2024 Dental Form
- UB-04

11.1.1 Form Availability

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

11.1.2 Procedure and Diagnosis Code Sources

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

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

11.2 Electronic Billing

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

- Web Portal
- EDI
- WINASAP

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

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

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

11.3 Medicare/Medicaid Crossover Billing

When a beneficiary has been determined as dual-eligible (Medicare and Medicaid), Medicare should always be billed first. The Medicare claim must include both the patient's Medicare and Medicaid identification number. After Medicare processes the claim, the claim will be transmitted to Conduent for processing electronically. The claim must be received by Conduent no later than 180 days after the Medicare paid date as indicated on the Explanation of Medical Benefits (EOMB) statement.

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

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

11.4 Medicare Coinsurance and Deductibles

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

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

11.5 Medicaid Claims with Third Party Payments

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

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

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

11.6 Resubmission of Denied Claims

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

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

Instructions for resubmitting a denied claim are as follows:

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

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

11.7 Claim Appeals

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

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

12 REIMBURSEMENT

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

12.1 Maximum Fees or Rates

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

12.2 Changes in Fees or Rates

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

The regulation recognizes the following exceptions:

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

12.3 Payment Inquiries

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

12.4 Coordination of Benefits

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

12.4.1 Benefit Programs

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

12.4.2 Coordination of Payment

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

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

If the District of Columbia Medicaid fee rate is more than the third-party fee or rate, the provider can bill DC Medicaid for the difference by submitting a claim and attaching all documentation relating to the

payment. If a third-party resource refuses to reimburse the provider, DC Medicaid can be billed by receiving a claim with attached documentation relating to the refusal.

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

12.5 Levies

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

12.6 Paid-in-Full

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

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

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

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

Table 2: Crossover Pricing Logic

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

12.7 Method of Payment

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

12.7.1 Reassignment

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

12.7.2 Business Agents

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

12.7.3 Employers

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

13 PRIOR AUTHORIZATION

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

13.1 Written Request

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

Written prior authorization is required for the following:

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

13.2 Verbal Request

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

13.3 Authorization Waiver

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

13.4 Authorization Procedures

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

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

14 DENTAL SPECIFIC BILLING INSTRUCTIONS

14.1 Eligibility Criteria for Dentists Participating in the District Medicaid Program

To enroll in the District of Columbia Medicaid Program, a dentist must be a graduate of a recognized school of dentistry and maintain a current license in the jurisdiction in which he practices. To enroll, the dentist or his representative must contact Maximus Provider Data Management System at the address listed in Appendix A or register through the web enrollment process at https://www.dcpdms.com.

14.2 Dental Classifications

When the provider enrolls in the Medicaid program, he will be assigned a classification based on the information submitted on his enrollment form. The classification assigned to the provider will determine the services for which he can be reimbursed.

14.2.1 Role of Dental Providers

14.2.1.1 General Dentist

A general dentist is a licensed dentist who devotes his professional activities to the general practice of dentistry.

14.2.1.2 Dental Network Practitioners

The dental network practitioner agrees to provide care to network enrollees within the scope of services and parameters of care afforded by individual plans administered by DHCF. There may be variances in scope as well as compensation among the plans administered by DHCF. It is advisable to study the protocols for each plan. It is understood that providers will provide in writing risk factors associated with all services they perform. This informed consent must be provided by either the patient or guardian by their signature on the form provided by the practitioner. It is the responsibility of the provider to be sure that the patient understands the risks and be given information about alternative care if it exists. The provider must also be qualified to treat the complications of the procedures performed by them by virtue of their training.

14.2.1.3 Specialist Dentist

Every specialist dental provider in the network must meet the minimum credentialing requirements, specified by the DC Board of Dental Examiners and the American Dental Association. This generally means that an individual has graduated from a certified educational program and has met the requirement for Board Eligibility or Board Certification in a branch of dentistry recognized by the American dental association as a specialist. The provider will render specialized care that is designed to enhance the total care of an individual that exceeds the usual training afforded a general practitioner.

A licensed dentist who engages in the practice of a dental specialty and is:

- Certified by the appropriate dental specialty board.
- Qualified or eligible for admission to the examinations of such a board.
- A holder of an active staff appointment in a hospital approved for training in the appropriate specialty with privileges in that specialty.

14.3 Providers Rights and Responsibilities

14.3.1 All Dental Practitioners

Practitioners and Providers shall facilitate advance directives for individuals as defined in 42 C.F.R 489.100, a written instruction, such as a living will or durable power of attorney for health care recognized under District of Columbia law (whether statutory or as recognized by the courts of the District) relating to the provision of health care when the individual is incapacitated. Practitioners and Providers can receive information about procedures for advance directives from Caring Connections, 1-800-658-889, www.caringinfo.org.

14.3.2 General Dentists

- Examine patients and develop a treatment plan that falls within the scope of acceptable care as outlined by the ADA for his or her patients.
- Although a procedure may fall outside of the benefit structure for the plan coverage, the provider should, nevertheless, recommend the appropriate care to the patient.
- At all times, recommend procedures that are appropriate and fall within the code of behavior advocated by the Board of Dental Examiners for the District of Columbia. Have the right to appeal denials to DHCF and while doing so, inform the patient. Appeals also extend to credentialing denials.

14.3.3 Specialists

- Specialists must be appropriately credentialed by the American Dental Association to promote themselves or limit their practices under this classification.
- All the above criteria obtain to specialists.
- Have the right to appeal to a body consisting of their peers.

14.3.4 Interns and Residents

Hospital-based dentists in training, whether in an approved program, are not eligible for individual reimbursement for services rendered to patients in the Medicaid Program, when rendered in or through the facility in which they are based.

14.4 Professional Ethical Standards

Written documents can only serve as guides to good conduct. The principles of dental ethics, as prepared and approved by the Judicial Council of the American Dental Association, and as approved by the Board of Trustees of the National Dental Association, will serve as the standard by which ethical conduct is measured for not only the individual dentist but for those dentists in partnership, in group practice or clinic practice.

14.4.1 Medicaid Specific Ethical Standards

The Department of Health Care Finance has established certain standards that are required to maintain the quality of care for the Medicaid patient. Following are the specific guidelines established by Department of Health Care Finance:

- A Medicaid enrolled dentist may not establish his practice in such a way to be composed of more than 75% Medicaid eligible clients.
- In the selection of a dentist from a group or facility to render dental care, there shall be no discrimination against either the Medicaid patient or the selected dentist due to the race, religious or political creed, color, or sex of the individual.
- Individuals qualifying under the Medicaid Program shall be free to choose any participating dental facility, group, or dentist.

- Dentists participating in the Medicaid Program shall not discriminate against eligible individuals by discrimination in scheduling of office visits, separate waiting areas, or other similar means.
- Eligible individuals shall be free to change to other dental facilities, groups, or dentists at any time during their period of eligibility. Occasionally a specific beneficiary may be limited (locked-in) to obtaining services from a specific provider.
- Solicitation of Medicaid patients by dentists, dental groups, or facilities shall be deemed unethical.
- Methods of rendering dental services shall safeguard the confidential relationship between patient and dentist.
- Each dentist or dental group shall be responsible for providing to other dentists, groups, or facilities, without charge, information necessary for the individuals transferring from one dentist or dental group to another.
- No dentist, dental group or facility shall profit in any way, directly or indirectly, from the provision of dental services for the treatment and care of an eligible individual above that amount supplied as a benefit under the Medicaid Program.

14.4.2 Dental Program Standards

- General dentists shall take on the responsibility for general supervision of the dental health of those eligible individuals who select him, provide dental health counsel and advice, diagnose, and treat conditions, arrange for consultation with specialists and for laboratory services, when necessary, coordinate the findings of consultants and laboratories and conduct periodic dental health status on dental health services rendered.
- Specialists shall render only those services for which they are qualified by training and shall make a complete report of all consultations to the referring dentist. If the patient requires continued special therapy, the specialist shall keep the referring dentist informed of the patient's progress.

14.5 Scope of Dental Services

The Department of Health Care Finance (DHCF) shall reimburse for dental services, as further described in these rules, provided to the following eligible populations:

- Medicaid beneficiaries under the age of twenty-one (21)
- Medicaid beneficiaries twenty-one (21) years of age and older who reside in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or are enrolled in the 1915(c) Home and Community-Based Services (HCBS) Waiver for Individuals with Intellectual and Developmental Disabilities, as described in 29 DCMR §§ 1900 et seq.
- Medicaid beneficiaries twenty-one (21) years of age and older who do not reside in an ICF/IID and are not enrolled in the 1915(c) HCBS Waiver for Individuals with Intellectual and Developmental Disabilities.

Medicaid reimbursement shall be provided for dental services furnished to Medicaid beneficiaries, in a dental facility, under the direction of a dentist who meets the requirements.

Medicaid beneficiaries under the age of twenty-one (21) shall be eligible to receive dental services as a required component of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Medicaid reimbursement for dental services provided under the EPSDT benefit to Medicaid beneficiaries under the age of twenty-one (21) shall include those services provided:

- At intervals that meet reasonable standards of dental practice as determined by DHCF after consultation with recognized dental organizations involved in child health.
- At such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
- Which include, at a minimum, preventive services; relief of pain and infections; restoration of teeth; and maintenance of dental health.

Medicaid beneficiaries under the age of eighteen (18) shall not be eligible to receive dental implants without prior authorization from DHCF or its agent.

Medicaid beneficiaries under the age of twenty-one (21) shall be eligible to receive orthodontic services subject to the following requirements:

- Before delivering an orthodontic service to a Medicaid beneficiary under the age of twenty-one (21), a provider shall obtain prior authorization from DHCF or its agent. To be eligible for reimbursement of orthodontic services, the beneficiary's dental or orthodontia provider shall demonstrate that the beneficiary meets at least one (1) of the following criteria:
    - Has an adjusted score greater than or equal to fifteen (15) on the Handicapping Labio-Lingual Deviation (HLD) Index.
    - Exhibits one (1) or more of the following Automatic Qualifying Conditions that causes dysfunction due to a handicapping malocclusion and is supported by evidence in the beneficiary's treatment records:
        1. Cleft palate deformity.
        2. Cranio-facial anomaly.
        3. Deep impinging overbite causing the destruction of soft tissues of the palate where tissue laceration and/or clinical attachment loss are present.
        4. Cross bite of individual anterior teeth causing clinical attachment loss where recession of the gingival margins is present.
        5. Severe traumatic deviation; or
        6. Overjet greater than nine (9) millimeters or mandibular protrusion greater than three and one half (3.5) millimeters; or
    - Has otherwise established a medical need for orthodontic treatment by demonstrating two (2) or more of the conditions below and justified the need in an accompanying narrative prepared by the ordering or referring dentist, orthodontist, primary care physician, speech pathologist, or behavioral health provider:
        1. A speech pathology that has proven non-responsive to medical treatment without orthodontic treatment, which has been diagnosed by a licensed speech therapist.
        2. Dysfunctional masticatory capacity because of the existing relationship between the maxillary and mandibular arches.
        3. Significant facial asymmetry.
        4. Severe maxillary, mandibular, or hi-maxillary protrusion or other physical deviation; or
        5. Other conditions that affect the medical, social, or emotional function of the patient as demonstrated by objective evidence provided by the patient's primary care physician or behavioral health provider.

To be reimbursed by Medicaid, providers of dental services, except for children's fluoride varnish treatments, shall be dentists or dental hygienists working under the supervision of a dentist, who meet the following requirements:

- Provide services consistent with the scope of practice authorized pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 et seq. (20 12 Rep I. & 2016 Supp.)), or consistent with the applicable professional practices act within the jurisdiction where services are provided; and
- Have a current District of Columbia (District) Medicaid Provider Agreement that authorizes the provider to bill for dental services for the covered populations.

A primary care physician or pediatrician may administer, and receive Medicaid reimbursement for providing, preventive fluoride varnish treatment to children, unless expressly prohibited by the scope of practice in the state where the physician is licensed.

To be reimbursed by Medicaid, any dental service provided to a Medicaid beneficiary twenty-one (21) years of age or older that requires inpatient hospitalization or general anesthesia shall be prior authorized by DHCF or its agent.

Medicaid beneficiaries twenty-one (21) years of age and over shall be eligible to receive, the following dental services:

- General dental examinations consisting of preventive services, which include routine cleaning and oral hygiene instruction every six (6) months.
- Emergency, surgical, and restorative services including crowns and root canal treatment.
- Dentures reline and rebase, limited to one (1) over a five (5) year period unless additional services are prior authorized.
- Complete radiographic survey, including full mouth series, bitewing, and panoramic x-rays, limited to one (1) every three (3) years unless additional services are prior authorized.
- Periodontal scaling and root planning, provided that the following criteria are met:
    1. Evidence of bone loss must be present on the current radiographs, full mouth x-ray series or bitewing x-rays to support the diagnosis of periodontitis.
    2. There must be current periodontal charting with six (6) point measurements and mobility noted, including the presence of pathology and periodontal prognosis.
    3. The pocket depths must be greater than four (4) millimeters; and
    4. The classification of the periodontology case type must be in accordance with guidelines established by the American Academy of Periodontology, available at: https://www.aapd.org/globalassets/media/policies_guidelines/bp_classperiodiseases.pdf (last accessed January 23, 2023).
- Initial placement of a removable prosthesis, limited to one (1) per arch every five (5) years per beneficiary unless prior authorized; and
- Dental implants, only if prior authorized and provided that the following criteria are met:
    1. The requested dental implants are for the replacement of permanent teeth.
    2. Any active periodontal disease must be treated and under control prior to requesting dental implants.
    3. Existing teeth with caries and endodontic lesions must be treated prior to requesting dental implants; and
    4. The tooth or teeth to be replaced must have an opposing occlusion.
- Four (4) dental implants for the maxillary arch and two (2) dental implants for the mandibular arch shall be authorized for a completely edentulous beneficiary.
- When teeth adjacent to the site of requested dental implants require crowns or demonstrate significant disease or injury, and/or there are multiple missing teeth, more conservative treatment shall be considered as an alternative to dental implants to treat the condition and replace all missing teeth.
- A provider shall submit the following written documentation with a prior authorization request for the replacement of a removable prosthesis:
    - A letter from the beneficiary to the provider describing the reason for the denture replacement request, which includes the beneficiary's DC Medicaid number, date, home address, telephone number, and signature.
    - For beneficiaries who attest that a denture no longer fits due to a significant medical condition, the request shall include a letter from the beneficiary's physician or surgeon documenting the medical condition and a letter from the beneficiary's dentist stating that the existing denture cannot be made functional by adjusting, relining, or rebasing it.
- The following documentation shall be submitted with a prior authorization request for dental implants:
    - Clinical justification for dental implants, including the reasons conventional removable dentures cannot be used to replace the missing teeth.
    - A summary of the beneficiary's medical history indicating the absence of systemic, behavioral, psychological, neurologic, and/or psychiatric disorders, including habits (e.g., substance abuse, tobacco use, and alcohol use) that may affect dental implant surgery, healing, and/or response to therapy.
    - An evaluation of the proximity of the site of the requested dental implants to adjacent vital structures including but not limited to maxillary sinuses, fossae, foramina, mandibular canals, and adjacent teeth or roots.

  - Periodontal charting, radiographic documentation of the absence of clinical calculus, oral hygiene status, and the date of the most recent oral prophylaxis not to exceed six (6) months prior to the request for the dental implants.
  - Documentation of adequate quality, mass and density of alveolar bone and soft tissues.
  - Documentation of at least three (3) millimeters of inter-dental space between the site of the requested dental implants and adjacent roots to maintain periodontal health and form; and
  - A complete restorative treatment plan for the requested dental implants.
- Dental implants shall not be replaced within five (5) years of initial placement without prior authorization from DHCF or its agent.
- Medicaid beneficiaries twenty-one (21) years of age and over shall not be eligible to receive the following dental services:
  1. Local anesthesia is used in conjunction with surgical procedures that are billed separately.
  2. Hygiene aids, including toothbrushes and dental floss.
  3. Cosmetic or aesthetic procedures.
  4. Medication dispensed by a dentist that a beneficiary could obtain over the counter from a pharmacy.
  5. Acid etch for a restoration that is billed separately.
  6. Fixed prosthodontics (such as a bridge), unless prior authorized.
  7. Gold restoration, inlay, or onlay, including cast non-precious and semiprecious metals.
  8. Duplicative x-rays.
  9. Space maintainers.
  10. Denture replacement when reline or rebase would correct the problem.
  11. Prosthesis cleaning.
  12. Removable unilateral partial dentures that are one-piece cast metal including clasps and teeth; and
  13. Dental implants replacing wisdom teeth.

Reimbursement for dental services provided to Medicaid beneficiaries twenty-one (21) years of age and older who do not reside in an ICF/IID and are not enrolled in the 1915(c) HCBS Waiver for Individuals with Intellectual and Developmental Disabilities shall be made according to the DHCF fee schedule, available online at http://www.dc-medicaid.com, and shall cover all services related to the procedure.

Reimbursement for dental services provided to Medicaid beneficiaries twenty-one (21) years of age and older who reside in an ICF/IID or are enrolled in the 1915(c) HCBS Waiver for Individuals with Intellectual and Developmental Disabilities shall be made at the increased rate described in 29 DCMR § 1921 and reflected in the DHCF fee schedule, available online at http://www.dc-medicaid.com

14.5.1 Covered Services

Dental services for Medicaid beneficiaries twenty-one (21) years of age and older include but are not limited to the services set forth below:

Diagnostic

- Periodic dental examinations (D0120) are limited to once every six (6) months.
- D0150, D0160, and D0180 will not be reimbursed on the same date of service as D4355.

Table 3: Diagnostic Procedure Codes

Code	Description	Limit
D0120	Periodic oral evaluation-established patient	Once every six (6) months
D0140	Limited Oral Evaluation - Problem Focused	
D0145	Oral assessment for children under three years of age	

D0150	Comprehensive oral evaluation-new or established patient	Once every six (6) months and cannot be billed on the same date of services as D4355.
D0160	Detailed and Extensive Oral Evaluation- Problem Focused	Cannot be billed on the same date of service as D4355.
D0170	Re-evaluation-Limited Problem Focused (Established patient; Not Post-Operative Visit)	
D0180	Comprehensive Periodontal Evaluation- New or Established Patient	One per 12 months and cannot be billed on the same date of service as D0150 and D4355.
D0190	Screening of a Patient	
D0191	Assessment of a Patient	

X-Rays

- Complete radiographic survey, full series of X-rays or panoramic X-ray of the mouth is limited to once every three years. Additional complete radiographic survey, full series of X-rays, or panoramic X-ray of the mouth requires prior authorization.
- Bitewing series
- Cone Beam CT

Table 4: X-Ray Procedure Codes

Code	Description	Limit
D0210	Intraoral, complete series of radiographic images (including bitewings)	Once (1) every 3 years and not in conjunction with D0330.
D0220	Intraoral, periapical, first radiographic image	One per day per provider or location.
D0230	Intraoral, periapical, each additional radiographic image	Any combination of D0220 and D0230 that exceeds the maximum allowable payment for a full mouth series of radiographs will be reimbursed at the D0210 rate.
D0240	Intraoral-occlusal radiographic image	Two per calendar year
D0270	Bitewing, single radiographic image	Once (1) every year
D0272	Bitewings, 2 radiographic images	Once (1) every year
D0274	Bitewings, 4 radiographic images	Once (1) every year
D0330	Panoramic Radiographic Image	Once (1) every 3 years and not in conjunction with D0210.
D0340	2D Cephalometric Radiographic Image-acquisition measurement and analysis	Once (1) every 3 years
D0350	2D Oral/Facial Photographic Image obtained intra-orally or extra-orally	One per calendar year
D0364	Cone Beam CT capture and interpretation with limited field of view-Less than one whole jaw	One per calendar year
D0365	Cone Beam CT capture and interpretation with field of view of one full dental arch-Mandible	One per calendar year
D0366	Cone Beam CT capture and interpretation with	One per calendar year

	field of view of one full dental arch-Maxilla, with or without Cranium	
D0367	Cone Beam CT capture and interpretation with field of view of Both Jaws, with or without Cranium	One per calendar year

Tests and Examinations

- Caries Risk Assessment (D0601, D0602, and D0603) is a procedure to determine and record the caries risk assessment of an individual during the evaluation process. The reimbursement for caries risk assessment is included in the reimbursement for an oral evaluation (D0120, D0150, and D0180).
- Clinical and Laboratory Improvement Amendment (CLIA) of 1988 applies to a dental practice performing D0604, D0605, and D0606.

Table 5: Tests and Examination Procedure Codes

Code	Description	Limit
D0460	Pulp Vitality Tests	One per visit
D0470	Diagnostic Casts	
D0601	Caries Risk Assessment and documentation, with a finding of low risk	
D0602	Caries Risk Assessment and documentation, with a finding of moderate risk	
D0603	Caries Risk Assessment and documentation, with a finding of high risk	
D0604	Antigen Testing for a public health related pathogen, including coronavirus	
D0605	Antibody Testing for a public health related pathogen, including coronavirus	
D0606	Molecular Testing for a public health related pathogen, including Coronavirus	

Preventive

- Routine oral prophylaxis (D1110) with oral hygiene instructions is limited to once every six (6) months.
- D1110 and D1120 are not allowed on the same date of service as D4341, D4342, D4346, D4355, and D4910
- D1351 is reimbursed for beneficiaries up to the age of 15.
- D1351 will not be covered when placed over a tooth with a restoration and the tooth must be without decay.
- D1510, D1516, and D1517 (Space Maintainers) will be reimbursed only to prevent tooth movement following premature loss of primary (baby) teeth so permanent teeth can erupt into proper position.
- D1510, D1516, and D1517 (Space Maintainers) are reimbursed for beneficiaries up to the age of 12 and will not be reimbursed for adults.

Table 6: Preventive Procedure Codes

Code	Description	Limit
D1110	Prophylaxis, adult	Once every six (6) months
D1120	Prophylaxis, child	Once every six (6) months
D1206	Topical application of fluoride varnish	Once every six (6) months
D1208	Topical application of fluoride	Once every six (6) months
D1321	Counseling for the Control and Prevention of Adverse Oral, Behavioral, and Systemic Health Effects	
D1351	Dental Sealant, per tooth	One (1) per lifetime per tooth
D1510	Space Maintainer-Fixed Unilateral-Per Quadrant	One (1) per lifetime per quadrant
D1516	Space Maintainer-Fixed-Bilateral Maxillary	One (1) per lifetime per arch
D1517	Space Maintainer-Fixed-Bilateral Mandibular	One (1) per lifetime per arch
D1551	Re-cement or Re-bond Bilateral Space Maintainer-Maxillary	
D1552	Re-cement or Re-bond Bilateral Space Maintainer-Mandibular	
D1553	Re-cement or Re-bond unilateral space maintainer-per quadrant	
D1556	Removal of fixed Unilateral Space Maintainer-per quadrant	One (1) per lifetime per quadrant
D1557	Removal of fixed Unilateral Space Maintainer-Maxillary	One (1) per lifetime
D1558	Removal of fixed Unilateral Space Maintainer-Mandibular	One (1) per lifetime
D1575	Distal Shoe Space Maintainer-Fixed Unilateral-per quadrant	One (1) per lifetime per quadrant

Restorative

- D2799 is not to be used as a temporary crown for a routine prosthetic restoration.
- D2799 is placed for an extended period of time (generally 6 months or more) to allow for other treatment and/or completion of diagnosis prior to the final impression/restoration.
- Billing for primary, permanent, provisional crowns, and post and cores, are to be billed on the date of cementation.

Table 7: Restorative Procedure Codes

Code	Description	Limit
D2140	Amalgam- one surface, primary or permanent	One per calendar year per tooth, per surface, per location
D2150	Amalgam, 2 surfaces, primary or permanent	One per calendar year per tooth, per surface, per location,
D2160	Amalgam, 3 surfaces, primary or permanent	One per calendar year per tooth, per

		surface, per location,
D2161	Amalgam, 4 or more surfaces, primary or permanent	One per calendar year per tooth, per surface, per location,
D2330	Resin-Based Composite One Surface, Anterior	One per calendar year per tooth, per surface, per location
D2331	Resin-Based Composite Two Surfaces, Anterior	One per calendar year per tooth, per surface, per location
D2332	Resin-Based Composite Three Surfaces, Anterior	One per calendar year per tooth, per surface, per location
D2335	Resin-Based Composite Four or More Surfaces (Anterior)	One per calendar year per tooth, per surface, per location
D2391	Resin-Based Composite One Surface, Posterior	One per calendar year per tooth, per surface, per location
D2392	Resin-Based Composite Two Surfaces, Posterior	One per calendar year per tooth, per surface, per location
D2393	Resin-Based Composite Three Surfaces, Posterior	One per calendar year per tooth, per surface, per location
D2394	Resin-Based Composite Four or More Surfaces or Involving Incisal Angle, (Posterior)	One per calendar year per tooth, per surface, per location
D2710	Crown- Resin Based Composite (Indirect)	One per 60 months per tooth
D2722	Crown-Resin with Noble Metal	One per 60 months per tooth
D2740	Crown- porcelain/ceramic	One per 60 months per tooth
D2750	Crown Porcelain Fused to High Noble Metal	One per 60 months per tooth
D2751	Crown Porcelain Fused to Predominantly Base Metal	One per 60 months per tooth
D2753	Crown Porcelain Fused to Titanium and Titanium Alloys	One per 60 months per tooth
D2790	Crown- Full Cast High Noble Metal	One per 60 months per tooth
D2799	Provisional Crown- Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	One per lifetime per tooth
D2920	Re-cement or Re-bond Crown	
D2928	Prefabricated Porcelain/Ceramic Crown-Permanent Tooth	One per 60 months per tooth
D2930	Prefabricated Stainless Steel Crown-Primary Tooth	One per 60 months per tooth
D2931	Prefabricated Stainless Steel Crown-Permanent Tooth	One per tooth per lifetime
D2934	Prefabricated Esthetic Coated Stainless Steel Crown-Primary Tooth	One per 60 months per tooth
D2941	Interim Therapeutic Restoration-Primary Dentition	One per year per tooth

D2950	Core Buildup, including any pins when required	One per 60 months per tooth
D2952	Post and Core in Addition to Crown, Indirectly Fabricated	One per 60 months per tooth
D2954	Prefabricated Post and Core in Addition to Crown Fabricated	One per 60 months per tooth

Endodontics

Table 8: Endodontic Procedure Codes

Code	Description	Limit
D3110	Pulp Cap Direct Excluding Final Restoration	
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	Once (1) per lifetime per tooth
D3310	Endodontic therapy, anterior tooth (Excluding Final Restoration)	Once (1) per lifetime per tooth
D3320	Endodontic therapy, bicuspid tooth (Excluding Final Restoration)	Once (1) per lifetime per tooth
D3330	Endodontic therapy, posterior tooth (Excluding Final Restoration)	Once (1) per lifetime per tooth
D3346	Retreatment of Previous Root canal therapy (Anterior)	Once (1) per lifetime per tooth.
D3347	Retreatment of Previous Root canal therapy (Bicuspid)	Once (1) per lifetime per tooth.
D3348	Retreatment of Previous Root canal therapy (Posterior)	Once (1) per lifetime per tooth.
D3351	Apexification/recalcification-initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	Once (1) per lifetime per tooth.
D3410	Apicoectomy-anterior	Once (1) per lifetime per tooth.
D3421	Apicoectomy-bicuspid (first root)	Once (1) per lifetime per tooth.
D3425	Apicoectomy-molar (first root)	Once (1) per lifetime per tooth.
D3426	Apicoectomy-each additional root	Once (1) per lifetime per tooth.
D3428	Bone Graft in Conjunction with Periradicular Surgery-Per Tooth, Single Site	
D3429	Bone Graft in Conjunction with Periradicular Surgery- Each Additional Contiguous Tooth in the Same Surgical Site	
D3430	Retrograde filling- per root	Once (1) per lifetime per tooth.
D3432	Guided Tissue Regeneration Resorbable Barrier Site in Conjunction with Periradicular Surgery	
D3450	Root Amputation	

D3471	Surgical repair of root resorption- Anterior	One per tooth per lifetime
D3472	Surgical repair of root resorption- Premolar	One per tooth per lifetime
D3473	Surgical repair of root resorption- Molar	One per tooth per lifetime
D3921	Decoronation or Submergence of an erupted tooth.	One per tooth per lifetime

Periodontics

- Periodontal scaling and root planning, if:
  a) evidence of bone loss is present on current radiographs to support the diagnosis of periodontitis.
  b) there is a current periodontal charting with six-point reading per tooth and mobility noted, including the presence of pathology and periodontal prognosis.
  c) the pocket depths are greater than four millimeters; and
  d) classification of the periodontology case type is in accordance with documentation established by the American Academy of Periodontology.
- D4212 requires the following:
  a) Removal of gingival tissue to provide access to the margins of a crown preparation
  b) Removal of gingival tissue for cavity preparation and may aid in placing a restoration such as an amalgam or composite
  c) Improves the isolation of the preparation while taking an impression.
  d) Not to be used for cosmetic purposes
- D4249 requires the following:
  a) Rendered in a healthy periodontal environment.
  b) Reflection of a full thickness flap for the respective tooth.
  c) Bone removed to expose more tooth structure.
  d) Modifies the crown to root ratio of the respective tooth.
  e) A minimum of six-week healing period prior to the crown preparation appointment.
  f) Not to be used for cosmetic purposes or soft-tissue crown lengthening.
- D4341 is not allowed on the same date of service as D1110.
- D4346 is not allowed on the same date of service as D1110, D4341, D4342, D4355 and D4910.
- D4355 is not to be billed with D0150, D0160, or D0180 on the same date of service.
- D4910 requires prior D4240, D4241, D4341, and D4342 to be rendered to the beneficiary.

Table 9: Periodontal Procedure Codes

Code	Description	Limit
D4210	Gingivectomy or Gingivoplasty-Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	One per 24 month(s) per quadrant
D4211	Gingivectomy or Gingivoplasty- One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	One per 24 month(s) per quadrant
D4212	Gingivectomy or Gingivoplasty to allow access for restorative procedure, per tooth	Once per lifetime per tooth
D4240	Gingival Flap Procedure, Including Root Planing- Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	One per 24 month(s) per quadrant
D4241	Gingival Flap Procedure, Including Root Planing- One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	One per 24 month(s) per quadrant

D4249	Clinical Crown Lengthening Hard Tissue	Once per lifetime per tooth
D4260	Osseous Surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	One per 24 month(s) per quadrant
D4261	Osseous Surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	One per 24 month(s) per quadrant
D4263	Bone Replacement Graft – Retained Natural Tooth First Site in Quadrant	One per 24 month(s) per tooth
D4264	Bone Replacement Graft – Retained Natural Tooth Each Additional Site in Quadrant	One per 24 month(s) per tooth
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	One per 24 month(s) per site
D4266	Guided tissue regeneration- resorbable barrier, per site	One per 24 month(s) per site
D4267	Guided tissue regeneration- non-resorbable barrier, per site (includes membrane removal)	One per 24 month(s) per site
D4341	Periodontal scaling and root planning, 4 or more teeth per quadrant	One (1) per quadrant per 12 month(s).
D4342	Periodontal scaling and root planning, One to Three teeth per quadrant	One (1) per quadrant per 12 month(s).
D4346	Scaling in presence of generalized moderate or severe gingival inflammation-Full Mouth after oral evaluation	One per 12 month(s)
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	One (1) per 36 month(s)
D4910	Periodontal Maintenance	One (1) per 6 month(s).

Dentures

- Removable, partial, and complete dentures

Table 10: Denture Procedure Codes

Code	Description	Limit
D5110	Complete Denture-maxillary	Once every 60 months
D5120	Complete Denture-mandibular	Once every 60 months
D5211	Upper partial denture-resin base (including any conventional clasps, rests, and teeth	Once every 60 months
D5212	Lower partial denture-resin base (including any conventional clasps, rests, and teeth	Once every 60 months
D5213	Maxillary partial dentures-cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth.	Once every 60 months
D5214	Mandibular partial denture, cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth	Once every 60 months
D5221	Immediate Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials Rests and Teeth)	Once (1) per lifetime

D5222	Immediate Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials Rests and Teeth)	Once (1) per lifetime
D5223	Immediate Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials Rests and Teeth)	Once (1) per lifetime
D5224	Immediate Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials Rests and Teeth)	Once (1) per lifetime
D5225	Mandibular partial denture- flexible base (including retentive /clasping materials, rests, and teeth)	Once every 60 months
D5226	Maxillary partial denture- flexible base (including retentive /clasping materials, rests, and teeth)	Once every 60 months
D5227	Immediate Maxillary Partial Denture-Flexible Base (Including any clasps, rests, and teeth)	Once every 60 months
D5228	Immediate Mandibular Partial Denture-Flexible Base (Including any clasps, rests, and teeth)	Once every 60 months

Prosthesis

- Initial placement or replacement of a removable prosthesis (any dental device or appliance replacing one or more missing teeth, including associated structures, if required, that is designed to be removed and reinserted), once every five (5) years per beneficiary, unless the prosthesis:
    a) was misplaced, stolen, or damaged due to circumstances beyond the beneficiary's control.
    b) cannot be modified or altered to meet the beneficiary's dental needs.
- Denture replacements within the five (5) year frequency limitation period require prior authorization from DHCF.
- A removable partial prosthesis is covered if:
    a) the crown to root ratio is better than 1:1.
    b) the surrounding abutment teeth and the remaining teeth do not have extensive tooth decay; and
    c) the abutment teeth do not have large restorations or stainless-steel crowns.

Denture Repair

- Reline or rebase of a removable denture is limited to one per arch every 60 months unless there is a prior authorization.

Table 11: Denture Repair Procedure Codes

Code	Description	Limit
D5511	Repair broken complete denture base — Mandibular	One per 12 months
D5512	Repair broken complete denture base — Maxillary	One per 12 months
D5520	Replace missing or broken teeth	
D5611	Repair resin denture base — Mandibular	One per 12 months
D5612	Repair resin denture base — Maxillary	One per 12 months
D5621	Repair cast framework — Mandibular	One per 12 months
D5622	Repair cast framework — Maxillary	One per 12 months
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth — per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	

D5710	Rebase complete maxillary denture	Once every 60 months
D5711	Rebase complete mandibular denture	Once every 60 months
D5720	Rebase maxillary partial denture	Once every 60 months
D5721	Rebase mandibular partial denture	Once every 60 months
D5725	Rebase Hybrid Prosthesis	Once every 60 months
D5730	Reline complete maxillary denture (chairside)	Once every 60 months
D5731	Reline complete mandibular denture (chairside)	Once every 60 months
D5740	Reline maxillary partial denture (chairside)	Once every 60 months
D5741	Reline mandibular partial denture (chairside)	Once every 60 months
D5765	Soft Liner for complete or partial removable denture (indirect)	Once every 60 months

Implant Services

Table 12: Implant Procedure Codes

Code	Description	Limit
D6010	Surgical Placement of Implant Body: Endosteal Implant	Four (4) dental implants per arch will be authorized for the partially edentulous patient. For the completely edentulous patient, four (4) in the maxilla and two (2) in the mandibular area. Once per 60 months per Implant site
D6056	Prefabricated Abutment-includes modification and placement	Once per 60 months per Implant Site
D6058	Abutment Supported Porcelain/Ceramic Crown	Once per 60 months per Implant Site
D6081	Scaling and Debridement in the presence of inflammation or mucositis of a single implant including cleaning of the implant surfaces without flap entry and closure	The dental provider cannot bill for D6081 on the same date of service for the following scenarios: 1) D1110 and D4910 are billed. 2) D4341, D4342, D4240, D4241, are billed for the same quadrant. Once per 12 months per implant site.
D6082	Implant Supported Crown-Porcelain Fused to Predominantly Base Alloys	One per 60 months per implant site
D6083	Implant Supported Crown-Porcelain Fused to Noble Alloys	One per 60 months per implant site
D6084	Implant Supported Crown-Porcelain Fused to Titanium and Titanium Alloys	One per 60 months per implant site
D6085	Provisional Implant Crown	One per lifetime per implant site

D6089	Accessing and Retorquing Loose Implant Screw per Screw	One D6089 per 12 Month(s) per patient per tooth. Not allowed within 6 months of delivery of the dental implant.
D6096	Remove Broken Implant Retaining Screw	One per lifetime per implant site
D6097	Abutment Supported Crown- Porcelain Fused to Titanium and Titanium Alloys	One per 60 months per implant site
D6100	Surgical Removal of Implant body	One per lifetime per implant site
D6101	Debridement of a peri-implant defect or defects surrounding a single implant and surface cleaning of the exposed implant surfaces including flap entry and closure	
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and surface cleaning of the exposed implant surfaces including flap entry and closure	
D6103	Bone graft for repair of peri-implant defect- does not include flap entry and closure	
D6104	Bone graft at time of implant placement	
D6105	Removal of Implant Body not requiring bone removal or flap elevation	One per lifetime per implant site
D6106	Guided tissue regeneration - resorbable barrier, per implant	Once per 24 months per implant site
D6107	Guided tissue regeneration - non-resorbable barrier, per implant	Once per 24 months per implant site
D6110	Implant/Abutment Supported Removable Denture for Edentulous Arch - Maxillary	Once every 60 months
D6111	Implant/Abutment Supported Removable Denture for Edentulous Arch - Mandibular	Once every 60 months
D6112	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch - Maxillary	Once every 60 months
D6113	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch - Mandibular	Once every 60 months
D6190	Radiographic/Surgical Implant Index by Report	
D6191	Semi-precision Abutment - Placement	One per 60 months per implant site
D6192	Semi-precision Attachment - Placement	One per 60 months per implant site

Oral Surgery

- Services provided in connection with dental or oral surgery services will be limited to those required for emergency repair of accidental injury to the jaw or related structures.
- D7910 (Sutures small wounds up to 5cm). D7910 is for the repair of a laceration (trauma) and billed when closing a wound. Not to be billed for the routine closure of a surgical incision that is inclusive in another covered dental procedure.
- D7911 (Complicated Suture – Up to 5 cm). D7911 excludes closure of surgical incisions that is inclusive in another covered dental procedure.

Table 13: Oral Surgery Procedure Codes

Code	Description	Limit
D7111	Extraction, Coronal Remnants – Primary Tooth	Once (1) per lifetime per tooth
D7140	Extraction Erupted Tooth Extraction, Single Tooth	Once (1) per lifetime per tooth
D7210	Extraction erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	Once (1) per lifetime per tooth
D7220	Removal of Impacted Tooth-Soft Tissue	Once (1) per lifetime per tooth
D7230	Removal of Impacted Tooth Partially Bony	Once (1) per lifetime per tooth
D7240	Removal of Impacted Tooth-Completely Bony	Once (1) per lifetime per tooth
D7241	Removal of Impacted Tooth Completely Bony, unusual surgical	Once (1) per lifetime per tooth
D7250	Surgical removal of residual tooth roots (cutting procedure)	Once (1) per lifetime per tooth
D7251	Coronectomy-Intentional Partial Tooth Removal	Once (1) per lifetime per tooth
D7270	Tooth Reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Once (1) per lifetime per tooth
D7280	Exposure of an unerupted tooth	Once (1) per lifetime per tooth
D7282	Mobilization of Erupted or Malpositioned Tooth to aid eruption	Once (1) per lifetime per tooth
D7284	Excisional Biopsy of Minor Salivary Glands	
D7285	Incisional biopsy of oral tissue- Hard (bone, tooth)	
D7286	Incisional biopsy of oral tissue-Soft	
D7310	Alveoloplasty in conjunction with extractions- Four or more teeth or tooth spaces, per quadrant	Once (1) per lifetime per quadrant
D7320	Alveoloplasty not in conjunction with extractions- Four or more teeth or tooth spaces, per quadrant	Once (1) per lifetime per quadrant
D7340	Vestibuloplasty-ridge extension (secondary epithelialization)	
D7350	Vestibuloplasty-ridge extension	
D7410	Excision of Benign Lesion up to 1.25 cm	
D7411	Excision of Benign Lesion Greater than 1.25 cm	
D7412	Excision of Benign Lesion Complicated	
D7413	Excision of Malignant Lesion up to 1.25 cm	
D7414	Excision of Malignant Lesion greater than 1.25 cm	
D7415	Excision of Malignant Lesion Complicated	
D7451	Removal of odontogenic cyst or tumor-lesion greater than 1.25 cm	
D7460	Removal of odontogenic cyst or tumor-lesion diameter up to 1.25 cm	
D7471	Removal of lateral exostosis (Maxilla or Mandible)	Once per lifetime per site
D7472	Removal of Torus Palatinus	Once per lifetime
D7473	Removal of Torus Mandibularis	Once (1) per lifetime per quadrant
D7509	Marsupialization of odontogenic cyst	Once (1) per lifetime per tooth
D7510	Incision Drainage Abscess-Intra-Oral Soft Tissue	
D7520	Incision Drainage Abscess-Extra-Oral Soft Tissue	
D7530	Removal of Foreign Body from Mucosa, Skin, or Subcutaneous Alveolar Tissue	
D7610	Maxilla-Open Reduction (Teeth Immobilized If	

	Present)	
D7620	Maxilla-Closed Reduction (Teeth Immobilized If Present)	
D7630	Mandible- Open Reduction (Teeth Immobilized If Present)	
D7640	Mandible- Closed Reduction (Teeth Immobilized If Present	
D7650	Malar and/or Zygomatic Arch-Open Reduction	
D7660	Malar and/or Zygomatic Arch-Closed Reduction	
D7670	Alveolus-Closed Reduction. May include stabilization of teeth	
D7820	Closed Reduction of Dislocation	
D7840	Condylectomy	
D7850	Meniscectomy	
D7860	Arthrotomy	
D7870	Arthrocentesis	
D7910	Sutures small wounds up to 5cm	
D7911	Complicated Suture-Up to 5 cm	
D7940	Osteoplasty- For Orthognathic Deformities	
D7950	Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Maxilla-Autogenous or Nonautogenous, By report	
D7953	Bone Replacement Graft for Ridge Preservation-Per Site	
D7956	Guided tissue regeneration, edentulous area - resorbable barrier, per site	Once per 24 months per site
D7957	Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	Once per 24 months per site
D7961	Buccal/Labial Frenectomy (Frenulectomy)	Once (1) per lifetime
D7962	Lingual Frenectomy (Frenulectomy)	Once (1) per lifetime
D7970	Excision of Hyperplastic Tissue-Per Arch	
D7972	Surgical Reduction of Fibrous Tuberosity	Once (1) per lifetime per quadrant
D7979	Non-Surgical Sialolithotomy	
D7982	Sialodochoplasty	

Orthodontic

- Only Medicaid beneficiaries under the age of twenty-one (21) are eligible to receive orthodontic services.
- D8080 requires the submission of the District of Columbia Handicapping Labio-Lingual Deviation (HLD) Score sheet for approval.

Table 14: Orthodontic Procedure Codes

Code	Description	Limit
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	Once (1) per lifetime
D8210	Removable Appliance Therapy	Once (1) per lifetime
D8220	Fixed Appliance Therapy	Once (1) per lifetime
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s).	Once (1) per lifetime
D8695	Removal of Fixed Orthodontic Appliances for	Once (1) per lifetime

	reasons other than completion of treatment	
D8703	Replacement of lost or broken retainer-Maxillary	Two (2) per lifetime
D8704	Replacement of lost or broken retainer-Mandibular	Two (2) per lifetime
D8999	Unspecified Orthodontic Procedure, by report	Two (2) per lifetime

Adjunctive General Services

- Any dental service that requires inpatient hospitalization must be prior authorized by the State Agency.
- Elective surgical procedures requiring general anesthesia must be prior authorized by the State Agency.
- **Sleep Apnea is not a dental condition. Therefore, ordering, and interpreting objective tests aiming to establish the diagnosis of obstructive sleep apnea (OSA), or primary snoring is conducted by the physician board certified by the American Academy of Sleep Medicine (AASM) or sleep board eligible.**
- **Sleep apnea appliances must be prescribed by a physician who is board certified by the AASM or sleep board eligible.**
- The qualified dentist to provide the sleep apnea appliance (D9947) or reline the sleep apnea appliance (D9953) must have at least one of the following: certification in dental sleep medicine by a non-profit organization, designation as the dental director of a dental sleep medicine facility accredited by a non-profit organization, or recognized continuing education in dental sleep medicine (e.g., American Dental Association Continuing Education Recognition Program [ADA CERP] or Academy of General Dentistry Program Approval for Continuing Education [AGD PACE]) provided by a dental sleep medicine focused non-profit organization or accredited dental school in the last two years
- Any adjustment or repair of sleep apnea appliances are included in the first six (6) months of wear after delivery.
- D9951 will not be reimbursed when the procedure involves minor bite adjustments in the routine post-delivery care for a direct/indirect restoration of fixed/removable denture.

Table 15: Adjunctive General Services Procedure Codes

Code	Description	Limit
D9110	Palliative (Emergency) treatment of dental pain- minor procedure	Not to be billed if other definitive treatment procedures are rendered on the same date of service
D9222	Deep sedation/general anesthesia, first 15 minutes	One (1) unit per procedure
D9223	Deep sedation/general anesthesia, each additional 15 minutes	Seven (7) units per procedure
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	
D9310	Consultation-Diagnostic service provided by Dentist or Physician other than requesting Dentist or Physician	
D9420	Hospital or Ambulatory Surgical Call Center	
D9430	Office Visit for Observation (During Regularly Scheduled Hours) – No other services performed	
D9944	Occlusal Guard- Hard Appliance, Full Arch	One per 24 months
D9945	Occlusal Guard- Soft Appliance, Full Arch	One per 24 months
D9946	Occlusal Guard- Hard Appliance, Partial Arch	One per 24 months
D9947	Custom Sleep Apnea Appliance Fabrication and	One per 60 months

	Placement	
D9948	Adjustment of Custom Sleep Apnea Appliance	Two per 60 months
D9949	Repair of Custom Sleep Apnea Appliance	Two per 60 months
D9951	Occlusal Adjustment-Limited	Two per 12 months
D9952	Occlusal Adjustment-Complete	Once per lifetime
D9953	Reline custom sleep apnea appliance (indirect)	Once every 60 months
D9955	Oral Appliance Therapy (OAT) Titration Visit	Once every 6 months
D9997	Dental Case Management – Patients with Special Health Care Needs	

14.5.2 Unbundled Dental Services

Effective **January 1, 2019**, procedure codes D0150, D0160, and D0180 should not be performed on the same date of service as D4355.

14.5.3 Non-covered Services

The following non-covered dental services include but are not limited to individuals 21 years old and over who are not living in an institution.

- Local anesthetic that is used in conjunction with a surgical procedure and billed as a separate procedure.
- Hygiene aids, including toothbrushes.
- Medication dispensed by a dentist that a beneficiary can obtain from a pharmacy.
- Acid etch for a restoration that is billed as a separate procedure.
- Prosthesis cleaning.
- Removable unilateral partial denture that is a one-piece cast metal including clasps and teeth.
- Replacement of a denture when reline or rebase would correct the problem.
- Duplicate x-rays.
- Space maintainers
- Fixed prosthodontics (unless it is cost effective for a beneficiary who cannot use a removable prosthesis and prior authorization is required).
- Gold restoration, inlay or onlay, including cast nonprecious and semiprecious metals.
- Dental services for cosmetic or aesthetic purposes.

14.5.4 EPSDT

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federally mandated program for children up to age 21 which emphasizes the importance of prevention, early detection of medical, dental, and behavioral health conditions and timely treatment of conditions detected as a result of screening.

Dental services for individuals under the age of 21 are covered under EPSDT services. The service descriptions and reimbursement rates are set forth in a fee schedule published in the District of Columbia Municipal Regulations.

All DC children eligible for the Medicaid program are entitled to receive the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit. EPSDT, also known as the DC HealthCheck program, is a mandatory Medicaid benefit and includes dental services that cover a comprehensive oral exam and dental cleaning every six months, as well as any needed diagnostic or treatment services identified by the provider.

Please refer to the EPSDT billing manual for additional billing instructions.

14.6 Dental Care for Children

The American Academy of Pediatric Dentistry (AAPD) recommends that children visit a dentist at the time of the eruption of the first tooth, or no later than 12 months of age, and then every six (6) months thereafter.

According to the American Academy of Pediatrics (AAP) and Centers for Disease Control and Prevention, Early Childhood Caries (ECC) is the most prevalent communicable disease impacting our children. The American Academy of Pediatric Dentistry (AAPD) also recognizes ECC as a "significant public health problem." Fortunately, ECC is preventable and treatable with early preventive measures and early detection and treatment. To increase the number of young children seen by dentists and to prevent and minimize the effects of ECC, DHCF has added two new Current Dental Terminology (CDT) codes to the fee-for-service DC Medicaid fee schedule - D0191 (Oral Health Assessment for Children Under Three (3) Years of Age) and D1206 (Topical Application of Fluoride Varnish).

Oral health assessments are a required part of every primary care well-child visit for young children so that primary care providers should perform oral health assessments at well-child visits according to the DC HealthCheck Periodicity Schedule to assist in identifying children in need of dental care. However, an oral health assessment by a primary care provider should not replace a more comprehensive oral health assessment by a dentist within six months of the eruption of the first tooth, or by twelve months of age. All children should have an established Dental Home by three years of age. Dentists may bill DC Medicaid for an oral health assessment for children under three (3) years of age using CDT Code D0145. D0145 is reimbursable once every six (6) months per patient at a rate of $40 per exam.

In addition to the regular oral health assessments, the application of fluoride varnishes every three to six months has been proven to decrease the incidence of ECC. Children at high risk for ECC are believed to benefit from quarterly applications of fluoride varnish, while those with low to moderate risk should receive the fluoride varnish applications once every six months. Dentists may bill DC Medicaid for applications of fluoride varnish using CDT code D1206. D1206 is reimbursable up to once every three (3) months per patient at a rate of $29 per application. There are no patient age restrictions on D1206 when billed by a dentist enrolled with DC Medicaid.

Refer to Transmittal #13-07 for additional information.

14.7 Reimbursable Oral Health Procedures in Primary Care Setting

In addition to regular oral health assessments, the application of fluoride varnishes every three to six months has been proven to decrease the incidence of early childhood caries (ECC). A child is considered to have ECC when there is one or more decayed, missing (due to caries), or filled tooth surface in any primary tooth before the child turns 6 years of age. Primary care providers may bill DC Medicaid for oral health assessments using Current Dental Terminology (CDT) code D0191. CDT code D0191 is reimbursable at a rate of $30.00 per application.

Children at high risk for ECC benefit from quarterly applications of fluoride varnish, while those with low to moderate risk should receive fluoride varnish applications every 6 months. The application of fluoride varnish for children under the age of 3 by a trained primary care provider is a reimbursable oral health procedure. To receive Medicaid reimbursement, primary care providers must complete the fluoride varnish training offered through DC Health Check. Once trained, primary care providers may bill DC Medicaid for the fluoride varnish application on a child less than 3 years of age using the Current Procedural Terminology (CPT) code 99188. CPT code 99188 is reimbursable once every 3 months per beneficiary at a rate of $11.44 per unit.

Refer to Transmittal #20-05 for additional information.

14.8 Reimbursable Dental Procedures in Dental Office

According to the American Academy of Pediatric Dentistry, early detection and management of oral conditions can improve a child's oral health, general health and well-being, and school readiness. A child's first dental examination should occur the time of the eruption of the first tooth and no later than 12 months of age. Comprehensive oral exams, dental sealants, and dental cleanings, as well as any needed diagnostic or treatment services identified by dental providers, are covered by DC Medicaid.

Caries risk assessment is a key element of preventive oral health care for infants, children, and adolescents. Children at high risk for caries benefit from quarterly applications of fluoride varnish, while those with low to moderate risk should receive fluoride varnish applications every six months. The application of fluoride varnish is a reimbursable dental procedure. Dental providers may bill DC Medicaid for fluoride varnish application using CDT code D1206. CDT code D1206 is reimbursable once every 3 months per beneficiary at a rate of $29.00 per application.

The application of dental sealants to the chewing surfaces of the back teeth is another method to prevent tooth decay. The American Academy of Pediatric Dentistry recommends the application of dental sealants on caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and/or fissures on children ages 24 months and older. Dental providers may bill DC Medicaid for dental sealants on children ages 24 months and older using CDT code D1351. CDT code D1351 is reimbursable at a rate of $38.00 per tooth.

Refer to Transmittal #19-06 for additional information.

14.9 CDT Coding Changes for the Topical Application of Fluoride

The American Dental Association has eliminated the following CDT codes effective January 1, 2013. For dates of services on or after January 1, 2013, the following CDT codes will no longer be reimbursed by the DC Department of Health Care Finance.

- D1203 - Topical Application of fluoride-child
- D1204 - Topical Application of fluoride-adult

The CDT code (D1208) listed below has been added to the DC Medicaid fee for service schedule effective for dates of services on or after January 1, 2013. The new dental procedure code replaces the two deleted CDT codes above and will be reimbursed at $25.00 per application. The frequency limitations are also the same as the deleted procedure codes; one per six (6) months per patient.

- D1208 - Topical application of fluoride

If your dental office provided Topical Fluoride Application to a DC Medicaid beneficiary since January 1, 2013, and you have submitted a claim using D1203 or D1204, your claim will be denied. Please resubmit your claim using CDT code D1208.

Refer to Transmittal #13-07 for additional information.

14.10 Prior Authorization Procedures

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

The 719A form is the physician or authorized prescriber's written prescription for services and/or supplies. The provider intending to fill the prescription (e.g., for a wheelchair, etc.) and then seek reimbursement for the service or product must submit the 719A form to DC Medicaid or its designated agent for prior

authorization, if required. **The 719A form is effective for one (1) year from the date of the physician's signature and needs to be renewed annually.** The 719A form may be requested from Conduent or viewed and downloaded on the DHCF website. See Appendix A for contact information related to Conduent and the DHCF web address. Instructions on how to complete the 719A form are in Appendix B. See Appendix C for directions on where to submit PA requests via the 719A form.

14.10.1 Determining Medical Necessity

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

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

Services determined as medically necessary must be:

1. Appropriate to the individual's physical, mental, developmental, psychological, and functional health
2. Clinically appropriate in terms of type, frequency, extent, setting and duration.
3. Reasonable and necessary part of the beneficiary's treatment plan
4. Not furnished for the convenience of the beneficiary's family, attending practitioner or other practitioner or supplier.
5. Be necessary and consistent with generally accepted professional medical standards (i.e., not experimental, or investigational).
6. Be established as safe and effective for the beneficiary's treatment protocol.
7. Be furnished at the most appropriate level that is suitable for use in the beneficiary's home environment.

14.10.2 Required Documentation

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

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

15 Dental Specific Billing Procedures

To be reimbursed for the services performed on behalf of the Medicaid patient, the American Dental Association (ADA) Dental Claim Form must be completed following the procedures outlined below. The American Dental Association claim form is used to bill Medicaid covered dental charges.

The following provides instructions for completing the required fields for billing Medicaid covered dental services for the District of Columbia Medicaid program.

15.1.1 Completing the ADA 2024 Dental Form

Hard Copy Billing Quick Tips

- The NPI **is** required for the treating provider.
- Do not use correction fluid to make corrections on the claim form. Use correction tape.
- An original blue/black ink signature is needed on the claim form. Signature stamps are not accepted.

Table 16: ADA Claim Form Instructions

Field #	Field Description	Guideline
1	**Type of Transaction**	Select the appropriate response
2	**Predetermination/ Preauthorization Number**	Enter the prior authorization number for services that require a PA and approval by the Comagine
3	**Company/Plan Name, Address, etc.**	If Medicaid is primary, enter the following address: Conduent District Medicaid Claims Processing PO Box 34768 Washington, DC 20043 Note: Complete Fields 12-15.
3a	**Payer ID**	Enter the Payer Identification number for the company plan specified in “3” – above. (Leave blank if not known.)
4	**Other Dental or Medical Coverage**	Select the appropriate box to indicate if the patient has other insurance. If yes, complete fields 5-11.
5	**Name of Policyholder/ Subscriber**	Enter in last name, first name, middle initial format
7	**Gender**	Select the appropriate response
10	**Patient’s Relationship to Person Named in #5**	Select the appropriate response
11	**Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code**	Enter the name and address of the primary insurance if applicable
11a	**Other Payer ID**	Enter the Payer Identification Number for the Other Insurance Company/Dental Benefit Plan specified in “11.” above. (Leave blank if not known.)
12	**Policy/Subscriber Name, Address, etc.**	If Medicaid is primary, the beneficiary’s name as it appears on their Medical Assistance Card in the following format: • 1st Line: Last Name, First Name, Middle Initial • 2nd Line: Street Address • 3rd Line: City, State, Zip code

Field #	Field Description	Guideline
13	**Date of Birth**	Enter date of birth using MM/DD/CCYY format
14	**Gender**	Select the appropriate response
15	**Policyholder/Subscriber ID**	If Medicaid is primary, enter the beneficiary's Medicaid ID as it appears on their Medical Assistance Card
18	**Relationship to the Policyholder/Subscriber in #12 above**	Select the appropriate response
21	**Date of Birth**	Enter date of birth using MM/DD/CCYY format
22	**Gender**	Select the appropriate response
23	**Patient ID/Account #**	If Medicaid is secondary or tertiary, enter the beneficiary's Medicaid ID as it appears on their Medical Assistance Card
24	**Procedure Date**	Enter the date of service on which services were rendered
25	**Area of Oral Cavity**	Leave this field blank if the area of oral cavity code is not applicable for the procedure. *Area of Oral Cavity* • **00 Whole area — Whole of the oral cavity** • **01 Maxillary — Maxillary area** • **02 Mandibular — Mandibular area** • **03 Upper right — Upper right sextant** • **04 Upper anterior — Upper anterior sextant** • **05 Upper left — Upper left sextant** • **06 Lower left — Lower left sextant** • **07 Lower anterior — Lower anterior sextant** • **08 Lower right — Lower right sextant** • **10 Upper right — Upper right mouth quadrant** • **20 Upper left — Upper left mouth quadrant** • **30 Lower left — Lower left mouth quadrant** • **40 Lower right — Lower right mouth quadrant**
26	**Tooth System**	Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation System (1-32 for permanent dentition and A-T for primary dentition).
27	**Tooth Number(s) or Letters**	Enter the appropriate two-digit tooth code. • **A - T for the primary teeth dentition** • **00 Not Entered — Tooth number not entered.** • **01 UR tooth 1 — Upper right permanent 3rd molar** • **02 UR tooth 2 — Upper right permanent 2nd molar** • **03 UR tooth 3 — Upper right permanent 1st molar** • **04 UR tooth 4 — Upper right permanent 2nd bicuspid** • **05 UR tooth 5 — Upper right permanent 1st bicuspid** • **06 UR tooth 6 — Upper right permanent canine** • **07 UR tooth 7 — Upper right permanent lateral incisor** • **08 UR tooth 8 — Upper right permanent central incisor** • **08 UL tooth 9 — Upper left permanent central incisor** • **10 UL tooth 10 — Upper left permanent lateral incisor** • **11 UL tooth 11 — Upper left permanent canine**

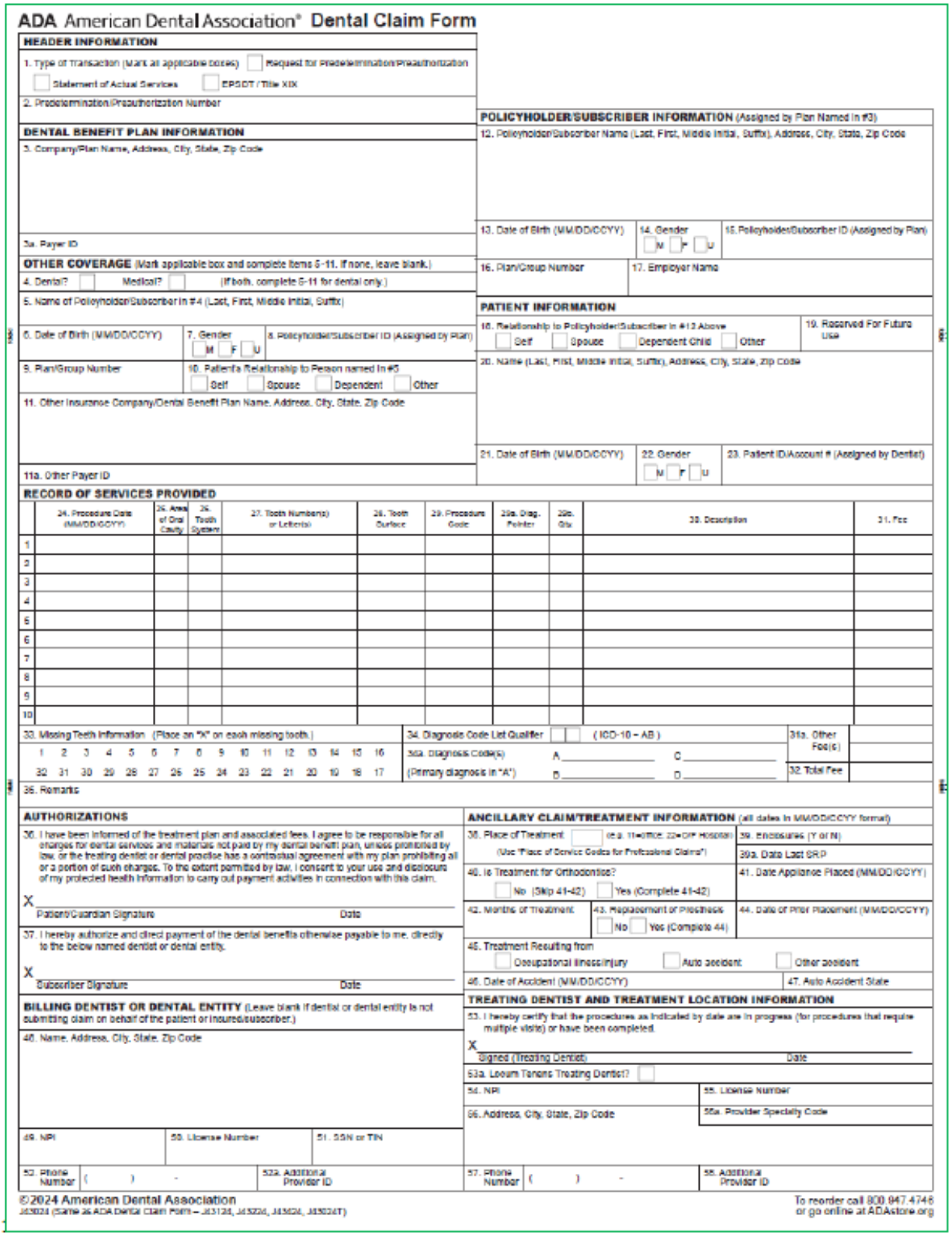
Field #	Field Description	Guideline
		• **12 UL tooth 12 Upper left permanent 1st bicuspid** • **13 UL tooth 13 Upper left permanent 2nd bicuspid** • **14 UL tooth 14 Upper left permanent 1st molar** • **15 UL tooth 15 Upper left permanent 2nd molar** • **16 UL tooth 16 Upper left permanent 3rd molar** • **17 LL tooth 17 Lower left permanent 3rd molar** • **18 LL tooth 18 Lower left permanent 2nd molar** • **19 LL tooth 19 Lower left permanent 1st molar** • **20 LL tooth 20 Lower left permanent 2nd bicuspid** • **21 LL tooth 21 Lower left permanent 1st bicuspid** • **22 LL tooth 22 Lower left permanent canine** • **23 LL tooth 23 Lower left permanent lateral incisor** • **24 LL tooth 24 Lower left permanent central incisor** • **25 LR tooth 25 Lower right permanent central incisor** • **26 LR tooth 26 Lower right permanent lateral incisor** • **27 LR tooth 27 Lower right permanent canine** • **28 LR tooth 28 Lower right permanent 1st bicuspid** • **29 LR tooth 29 Lower right permanent 2nd bicuspid** • **30 LR tooth 30 Lower right permanent 1st molar** • **31 LR tooth 31 Lower right permanent 2nd molar** • **32 LR tooth 32 Lower right permanent 3rd molar** Supernumerary teeth in the primary dentition are identified by the placement of the letter “S” following the letter identifying the adjacent primary tooth (e.g., supernumerary “AS” is adjacent to “A”; supernumerary “TS” is adjacent to “T”). Supernumerary teeth in the permanent definition are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (e.g., supernumerary #51 is adjacent to the upper right molar #1; supernumerary #82 is adjacent to the lower right third molar #32)
28	**Tooth Surface**	Leave this field blank if the tooth surface code is not applicable for the procedure. *Tooth Surface Codes* • **B Buccal Buccal tooth surface** • **D Distal Distal tooth surface** • **F Facial Facial tooth surface** • **I Incisal Incisal tooth surface** • **L Lingual Lingual tooth surface** • **M Mesial Mesial tooth surface** • **O Occlusal Occlusal tooth surface**
29	**Procedure Code**	Enter the appropriate dental procedure code for the services rendered
29a	**Diag. Pointer**	Enter the line letter listed in field 34a of the diagnosis associated with the procedure
29b	**Qty**	Enter the total number of the procedure performed

Field #	Field Description	Guideline
30	**Description**	Enter the description of the services performed
31	**Fee**	Enter your usual and customary charges. *Note: List only a single date and single procedure per line*
32	**Total Fee**	Enter the total of the line-item charges. *Note: Each individual claim form must be totaled in this section. Do not submit forms that are continued on a second page.*
33	**Missing Teeth Information**	Chart the tooth or teeth requiring service(s) on this claim form. Missing teeth are to be charted by placing "X" over the tooth.
34	**Diagnosis Code(s)**	Enter the appropriate diagnosis code
35	**Remarks**	Enter the Special Program Code (03) when billing for waiver services
36	**Patient/Guardian Signature Date**	The patient or authorized person must sign for the delivery of dental health care.
37	**Subscriber Signature**	
38	**Place of Treatment**	Select the appropriate response identifying where services were rendered.
39	**Enclosures (Y or N)**	Enter the appropriate response
39a	Date Last SRP	Enter the date of service for the last Scaling and Root Planing procedure (e.g., D4341) delivered to the patient in the space immediately to the right of this data element caption; date format is MM/DD/CCYY. (Leave blank if not applicable to claim or if not known.).
40	**Is Treatment for Orthodontics**	Select the appropriate response. If yes, complete fields 41-42.
41	**Date Appliance Placed**	Enter the date in MM/DD/CCYY format
42	**Months of Treatment Remaining**	Enter the appropriate response
43	**Replacement of Prosthesis?**	Select the appropriate response. If yes, complete field 44.
44	**Date Prior Placement**	Enter the date in MM/DD/CCYY format
45	**Treatment Resulting from** Occupational Illness/Injury Auto Accident Other Accident	Enter the appropriate response
46	**Date of Accident**	Enter the date in MM/DD/CCYY format
47	**Auto Accident State**	Enter the state in which the auto accident noted in field #45 occurred. Otherwise leave blank.
48	**Name, Address, etc.**	Enter the dentist's full name (last name, first name, middle initial format) and address information. Include the +4-zip code in the address.
49	**NPI**	Enter the National Provider Identifier (NPI) of the billing provider. Do not enter the MEDICAID PROVIDER ID here; see 52A for an atypical provider.
50	**License Number**	Enter the license number of the billing provider
51	**SSN or TIN**	Enter the social security number or tax ID of the billing provider
52	**Phone Number**	Enter the telephone number of the billing provider
52A	**Additional Provider ID**	Enter the billing provider's taxonomy code. If billing for waiver services, instead of using the NPI in field 49, you may elect to enter the billing provider's Medicaid Provider ID* in this field.
53	**Signature/Date Treating**	Must be signed by the dentist or legal representative. Unsigned

Field #	Field Description	Guideline
	Dentist	claims or claims without an original signature will not be processed and will be returned to the provider.
53a	Locum Tenens Dentist	Mark box if the treating dentist is providing services in a locum tenens capacity. (Leave blank if not applicable.).
54	**NPI**	Enter the National Provider Number of the treating provider. Leave blank if the treating provider is an atypical provider.
55	**License Number**	Enter the license number of the treating dentist
56	**Address, City, State, Zip Code**	Enter the address of the treating dentist
56A	**Provider Specialty Code**	Enter the treating dentist's taxonomy code. Otherwise leave it blank if the treating provider is atypical. Refer to field 58.
57	**Phone Number**	Enter the telephone number of the treating dentist
58	**Additional Provider ID**	If billing for waiver services, instead of using the NPI in field 54, you may elect to enter the treating provider's Medicaid provider ID***** in this field

**Note: If dental providers are going to bill for waiver services, they can use either the NPI or Medicaid Provider ID. DO NOT USE BOTH*

Figure 6: Sample ADA 2024 Claim Form



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) ☐ Request for Predetermination/Preauthorization ☐ Statement of Actual Services ☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

3a. Payer ID

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

33. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

33a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee

34. Remarks

AUTHORIZATIONS

35. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION (All dates in MM/DD/CCYY format)

38. Place of Treatment (e.g. 11=Office, 22=Off Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) | 39a. Date Last SRP

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto Accident ☐ Other Accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

15.1.2 Instructions for Billing for Medicare Deductible and Coinsurance

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

Medicare must be billed first when billing for a Medicaid patient, who is also covered by Medicare. After Medicare processes the claim, submit a Medicare Crossover claim to Medicaid using the CMS1500 claim form.
NOTE: When billing for Medicare Part B deductible and/or coinsurance, you must submit a CMS1500 claim form with all required fields completed or the claim will be returned. The Medicare EOMB must be attached, reflecting the amount of deductible/coinsurance. The procedure code information will allow Conduent to determine Medicaid's payment obligation in accordance with the district's state plan.

16 Remittance Advice

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

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

Figure 7: Remittance Advice Mailer Page

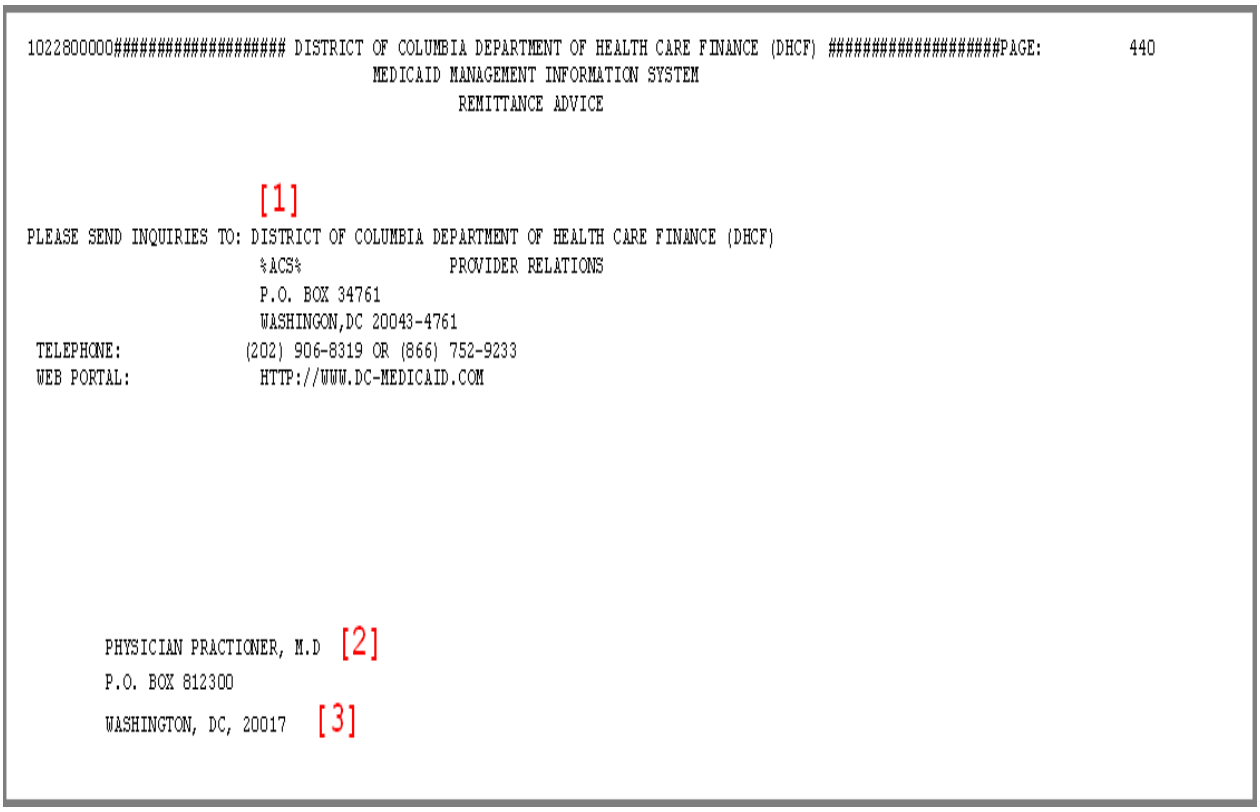
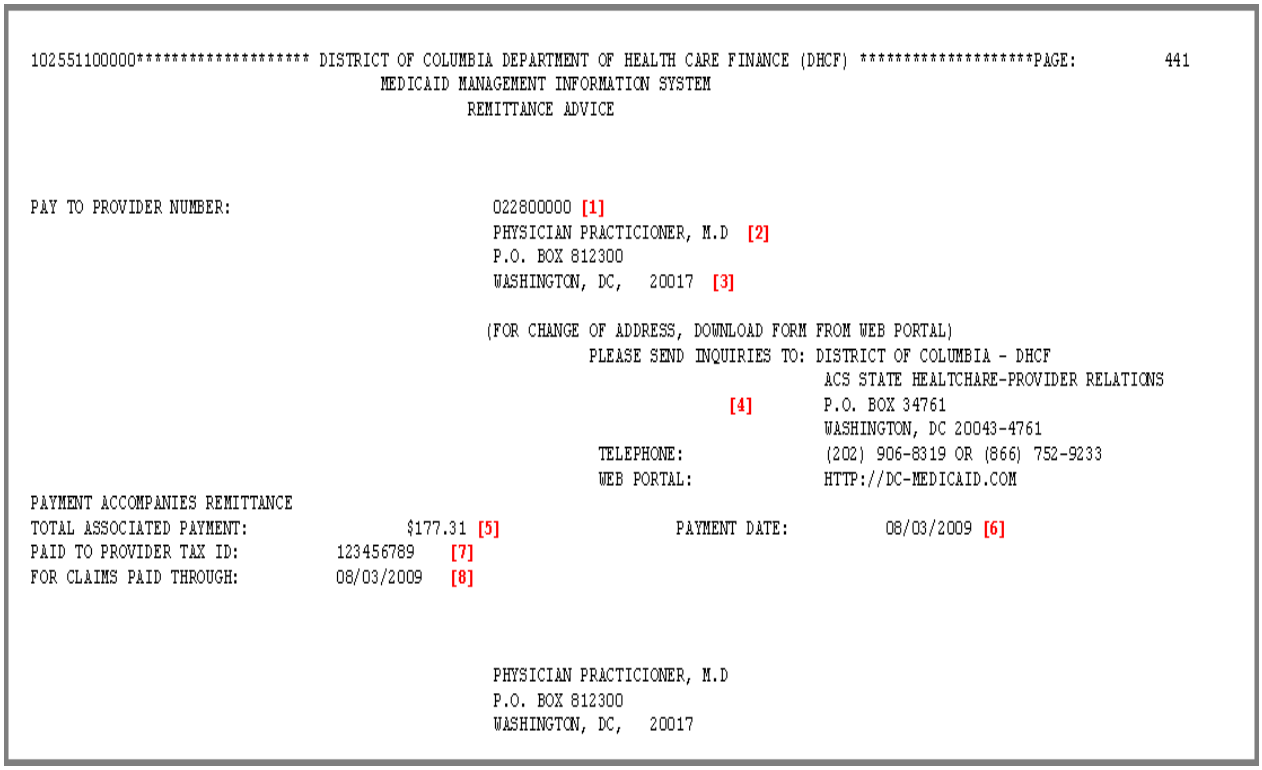


Table 17: Remittance Advice Mailer Page Table

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

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

Figure 8: Remittance Advice Header Page



```
1025511000000********************* DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF) ********************PAGE:         441
                                  MEDICAID MANAGEMENT INFORMATION SYSTEM
                                           REMITTANCE ADVICE



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

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



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

Table 18: Remittance Advice Header Page Table

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

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

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

Figure 9: Remittance Advice Provider Messages

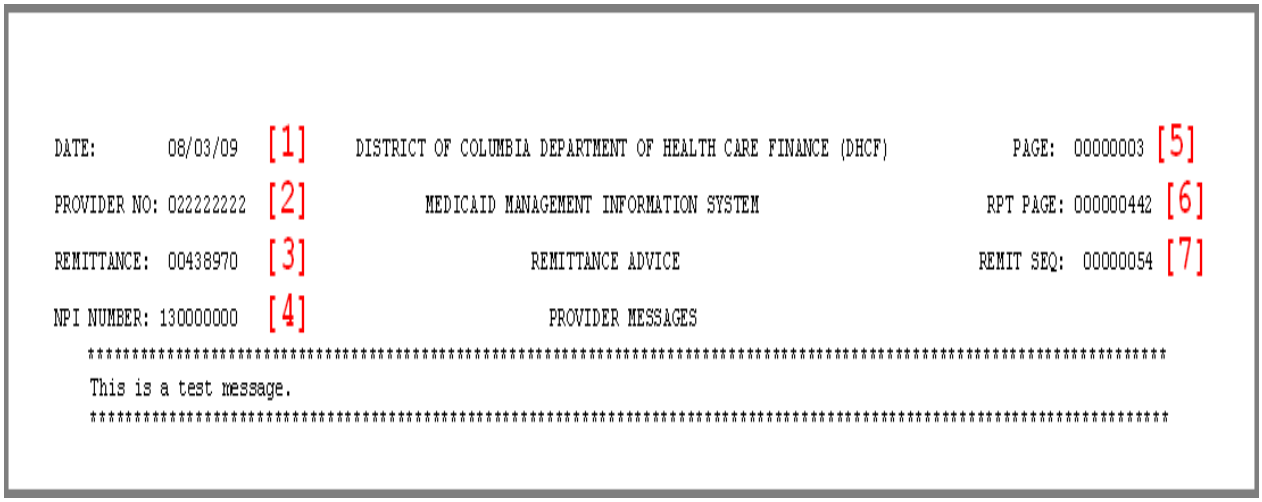


Table 19: Remittance Advice Provider Messages Table

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

Claim Detail Report - Paid/Denied Claims

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

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

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

Figure 10: Remittance Advice Paid Claims

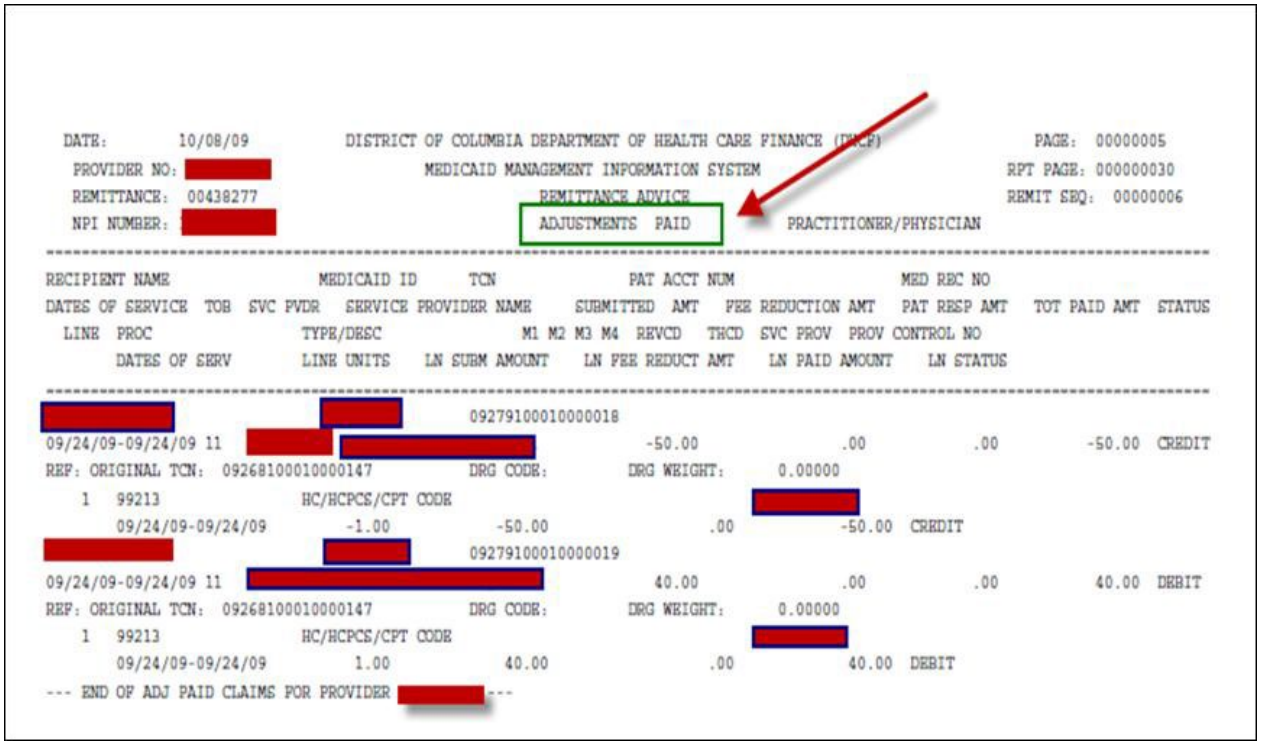


Table 20: Remittance Advice Paid Claims Table

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

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

Figure 11: Remittance Advice Adjustments

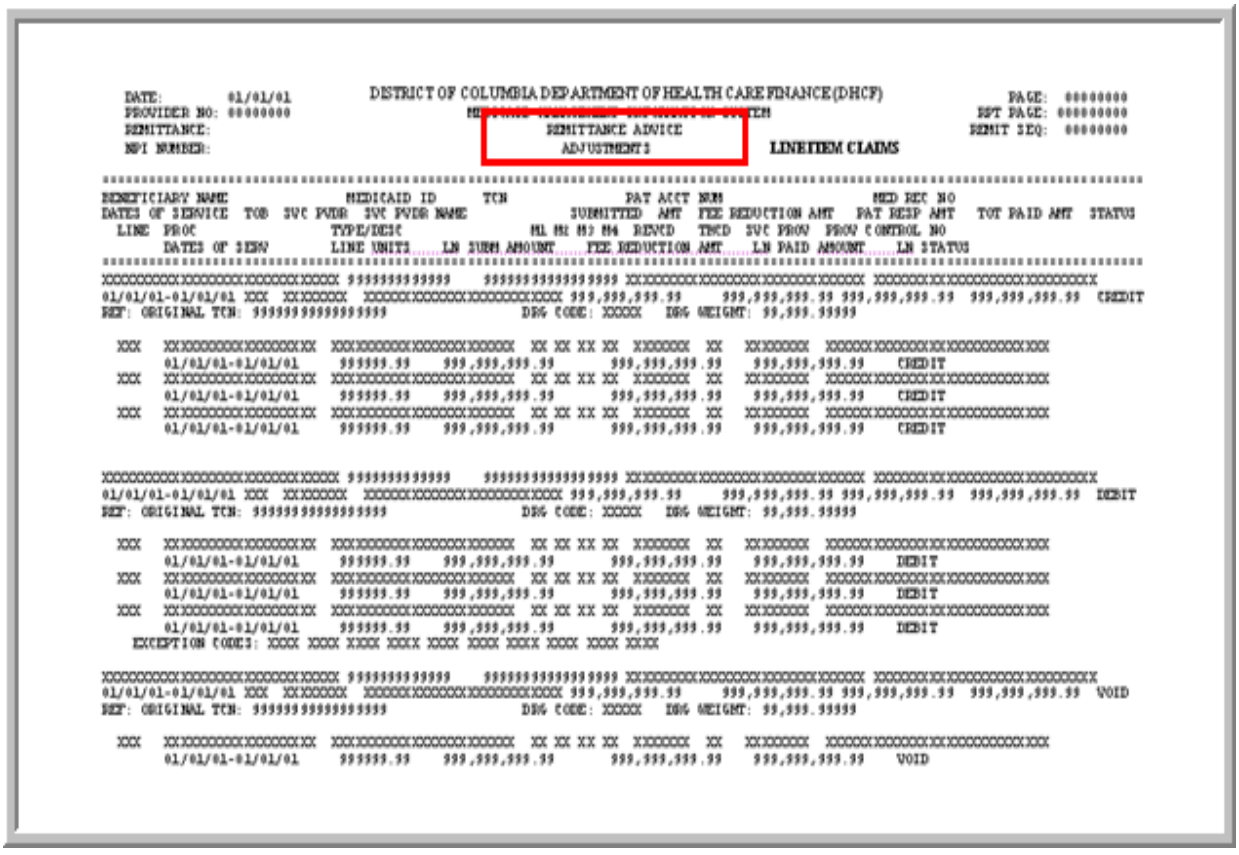
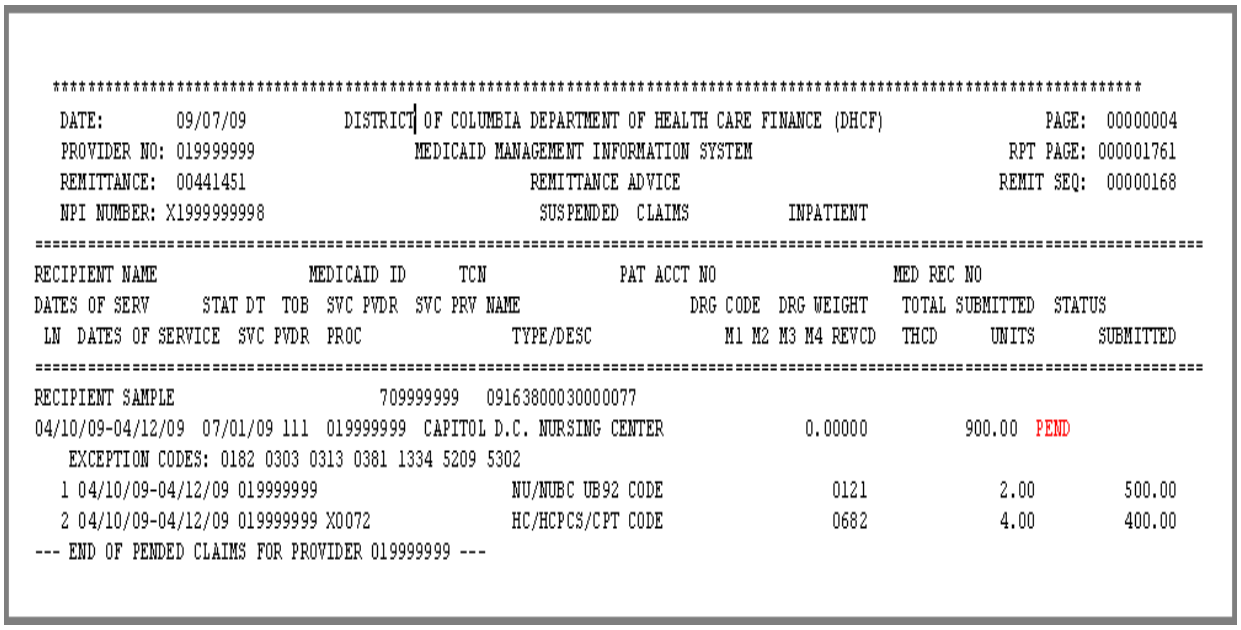


Table 21: Remittance Advice Adjustments Table

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

Figure 12: Remittance Advice Suspended Claims



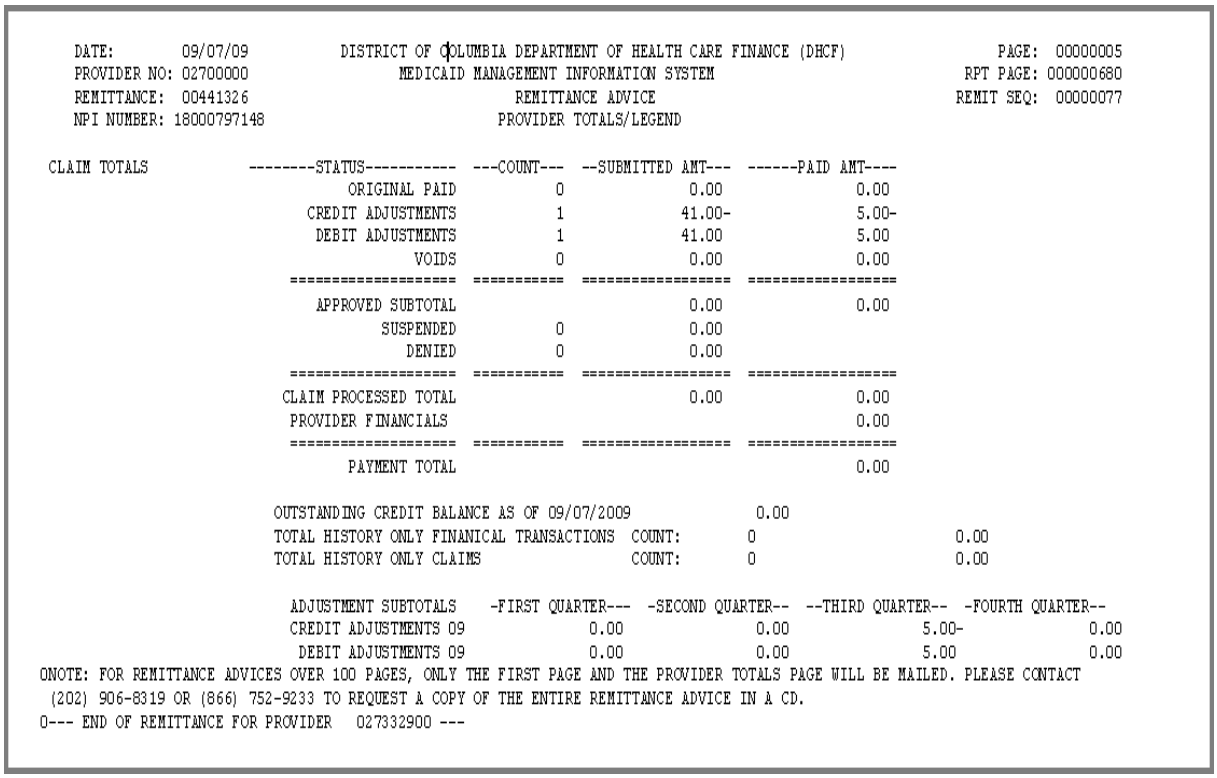
```
**********************************************************************************************************************************
 DATE:       09/07/09          DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)                PAGE:  00000004
 PROVIDER NO: 019999999              MEDICAID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

Table 22: Remittance Advice Suspended Claims Table

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

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

Figure 13: Remittance Advice Provider Totals/Legend



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

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

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

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

Table 23: Remittance Advice Provider Totals/Legend Table

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

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

16.1 Inquiries

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

16.2 Instructions for Submitting Adjustments and Voids

An Adjustment/Void claim is submitted when the original paid claim was filed or adjudicated incorrectly. Denied claims cannot be adjusted. All adjustment claims must be filed within 365 days of the date of payment. There is no timely filing limit on submitting voids. Voids may be submitted at any time.

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

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

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

Using the claim form, the provider must indicate whether the claim is being adjusted by writing the letter "A" in the top right-hand corner of the form. If the claim is being voided, the provider must indicate such by writing the letter "V" in the top right-hand corner of the form. The 17-digit TCN of the current paid claim is to be included at the top right-hand corner of both adjustments and voided claim forms in addition to the appropriate 3-digit adjustment/void reason code. For example, A 23xxxxxxxxxxxxxxxx 014 or V23xxxxxxxxxxxxxxxx 014. Select the appropriate adjustment/void reason code from the list below.

Figure 14: Ajustment Example

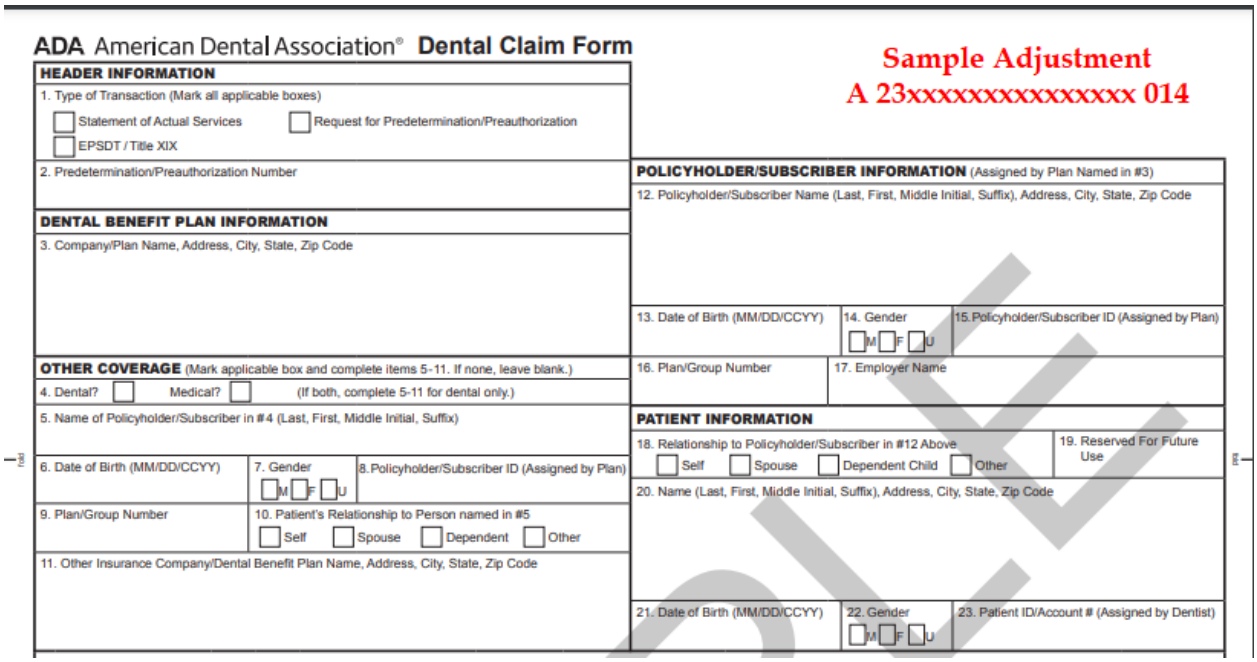


Figure 15: Void Example

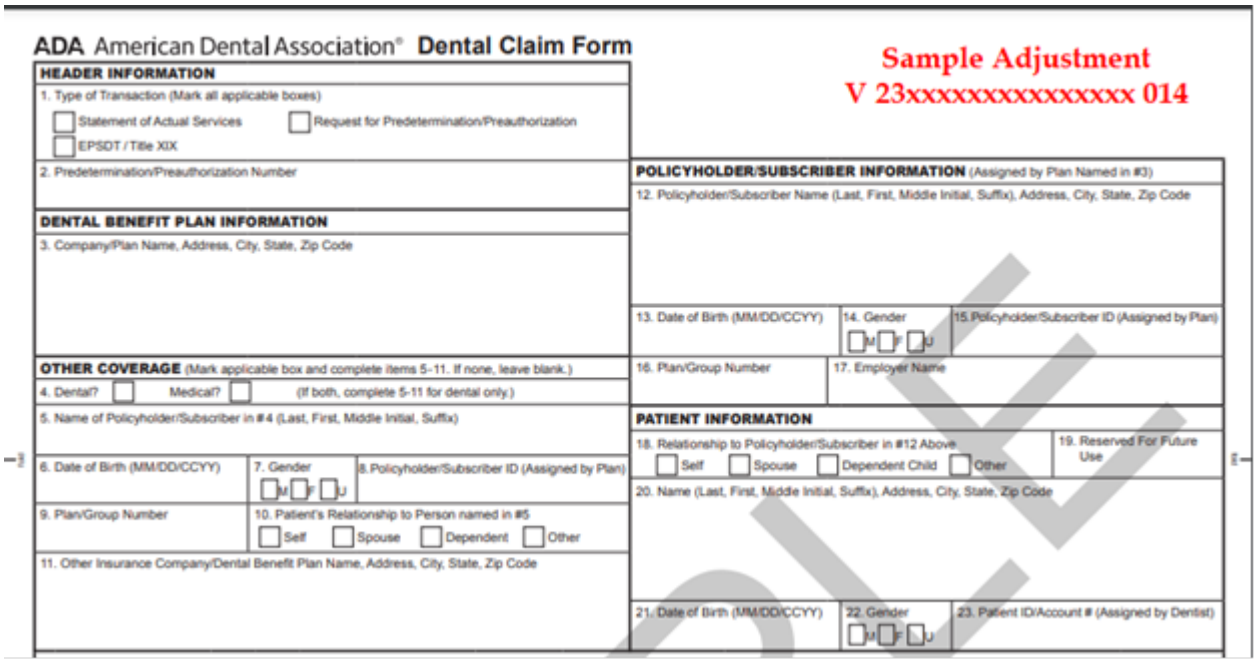


Table 24: Adjustment/Void Codes

011	RETRO RATE CHG / NO CUTBACK
014	PROV CLAIM FILING CORRECTION
019	POS PROV FILE CORR/LEGAL SETT
022	FISCAL AGENT CLM PROCESS ERROR
068	PROVIDER REFUND/CLM OVERPAYMNT
069	PROV RFND/OVERPAY FISC ERROR
070	PROV REFUND FOR HEALTH INSUR
071	PROV REFUND FOR CASUALTY INS
081	PROV CLAIM CORR/CLM FILED ERR
082	CLM VOID/FISC AGENT PROC ERROR
083	CLM VD/PD IN ERROR/RCP INCORRE
084	CLM VD/PD ERROR/PROV FIL INCOR
085	CLM VD/PD ERROR/INCORRECT PROV
086	CLAIM VOID MEDICARE RECOVERY
088	REFUND - PROVIDER ERROR
089	REFUND- FISCAL AGENT ERROR
090	PROV RTRN CHK/PD FOR INC BENE
099	PROV RETURN CHK/ INCORR PROV
101	VOID PAYMENT TO PIP HOSPITAL
102	ACCOMMODATION CHARGE CORRECT
103	PATIENT PAYMENT AMT CHANGED
104	PROCEDURE SERVICE DATES FIX
105	CORRECTING DIAGNOSIS CODE
106	CORRECTING CHARGES
107	UNIT VISIT STUDIES PRCD FIX
108	RECONSIDERATION OF ALLOWANCE
109	FIX ADMIT REFER PRESC PROVIDER
110	CORRECTING TOOTH CODE
111	CORRECTING SITE CODE
112	CORRECT TRANSPORTATION DATA
113	INPATIENT DRG
114	ADJUSTING PATIENT LEVEL CARE
115	RECOVERY BASED ON PRO REVIEW
116	ADJUSTED FOR RECP BEDHOLD DAYS
117	MANUAL CAPITATION VOID CLAIMS
118	REPROCESSED CLAIMS
119	AUTO RECOUPMENT SYSTEM ERROR
120	AUTO RECOUPMENT SYSTEM CHANG
121	PCG SERVICES
132	CLM VD/PROV SELF-IDENT FRAUD
300	BENEFICIARY DECEASED

16.3 Submitting Claim Refunds

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

APPENDIX A: ADDRESS AND TELEPHONE NUMBER DIRECTORY

Appeal Notification
Conduent State Healthcare
District Medicaid Claims Processing Fiscal Agent
PO Box 34734
Washington, DC 20043
Attention: Claims Appeal

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

Conduent Provider Inquiry Unit
(866) 752-9233 (outside DC metro area)
(202) 906-8319 (inside DC metro area)

Claim Status Information/Claims Payment Information
Conduent State Healthcare
District Medicaid Claims Processing Fiscal Agent
P.O. Box 34734
Washington, DC 20043
Attention: Provider Inquiry Unit
Telephone Numbers:
(866) 752-9233 (outside DC metro area)
(202) 906-8319 (inside DC metro area)

Claim Submission Information - Mail
For CMS-1500s:
Conduent
District Medicaid Claims Processing
P. O. Box 34768
Washington, DC 20043

For UB04s:
Conduent
District Medicaid Claims Processing
P. O. Box 34693
Washington, DC 20043

For Dental and Pharmacy Claims
Conduent
District Medicaid Claims Processing
P. O. Box 34714
Washington, DC 20043

For Adjustments and Voids:
Conduent
District Medicaid Claims Processing
P. O. Box 34706
Washington, DC 20043

For Medicare Crossover Claims
Conduent
District Medicaid Claims Processing
P. O. Box 34770
Washington, DC 20043

Telephone Inquiries
AmeriHealth DC
(800) 408-7511

CPT-4 Coding Information
American Medical Association
100 Enterprise Place
P.O. Box 7046
Dover, Delaware 19903-7046
Attention: Order Department
Telephone: (800) 621-8335

Dental Helpline
(866) 758-6807

District of Columbia Managed Care Enrollment Broker
Maximus
(800) 620-7802

Durable Medical Equipment (DME)
Comagine Health
Prior Authorization Unit: (800) 251-8890
Pharmacy Consultant Office – (202) 422-5988

General Program Information
Department of Health Care Finance
441 4th St NW
Suite 900
Washington, DC
Telephone: (202) 442-5988
www.dhcf.dc.gov

ICD-10-CM Orders
MEDICODE
5225 Post Way
Suite 500
Salt Lake City, Utah 84116
Telephone – (800) 999-4600

Electronic Claims Submission/Electronic RA Information
EDI (Electronic Data Interchange) – (866) 775-8563

Eligibility Determination Information
Economic Security Administration - (202) 724-5506
Inquiry Recertification - (202) 727-5355
Fax Request - (202) 724-2041

Eligibility Verification
Interactive Voice Response System (IVR)
(202) 906-8319

Health Services for Children with Special Needs HSCSN
(202) 467-2737

Medicare Customer Service
(800) 633.4227
www.cms.gov/Medicare/Medicare.html

Medicaid Payment Schedule Information
Conduent
Provider Inquiry Unit
P.O. Box 34743
Washington, DC 200043
Telephone Numbers
(866) 752-9233 (outside the District of Columbia)
(202) 906-8319 (inside the District of Columbia)

Medicaid Fraud Hotline
(877) 632-2873

Pharmacy Consultant
Department of Health Care Finance
441 4th St NW
Suite 900
Washington, DC 20001
Telephone Numbers
(202) 442-9078 or (202) 442-9076

Prior Authorization Form Submission
Comagine Health
Prior Authorization Unit: (800) 251-8890

Provider Enrollment Information
MAXIMUS
Provider Enrollment Unit
P.O. Box 34086
Washington, DC 20043-9997
Telephone Numbers
(844) 218-9700
www.dcpdms.com

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

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

APPENDIX B: COMPLETING 719A PRIOR AUTHORIZATION FORM

Patient

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

Prescribing Provider

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

Servicing Provider

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

Other health insurance coverage

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

Discharge Date:

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

Requested service

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

Beneficiary location

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

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

Diagnosis

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

Procedure code

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

Description of services, durable medical equipment, or supplies

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

Time required

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

Frequency or units

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

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

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

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

For Dental Use Only
a. Select the appropriate tooth number, quadrant(s), and surface area.

For DME, Home Health, Private Duty Use Only
a. This section must be signed by the physician or authorized prescriber attesting to a face-to-face encounter.
b. Select the appropriate provider type.
c. Enter the name and title of the allowed prescriber.
d. Enter the date the form was signed.

Durable Medical Equipment Face to Face Regulations
a. Select the equipment that the face-to-face attestation is for.

Signature of Requesting Provider & Date:
a. This form must be signed by the physician or authorized prescriber requesting the services to be prior authorized.
b. Enter the title of the person signing the form.

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

- Copies of the 719A form are acceptable for original prior authorization requests.
- All 719A forms must be typed or printed legibly.
- Use miscellaneous codes **ONLY** when a more precise and appropriate HCPCS code is not available.
- When using a miscellaneous code, include the manufacturer's quote, invoice, or paid receipt with the 719A form, in addition to the required documentation.
- Prior authorization (PA) does not guarantee payment. A PA only authorizes those services and/or equipment may be provided.
- Payment for services and supplies is rendered in accordance with the fee schedule.
- Do not submit claims for a procedure requiring prior authorization without first obtaining the PA number. If you submit a claim for a procedure code that requires a PA, your claims will be

denied. Please consult the fee schedule to verify if the procedure code requires prior authorization. Once the PA request has been approved, you will receive a Prior Authorization letter containing the prior authorization number to enter on your claim.

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

Figure 16: Sample 719A Prior Authorization Form

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

719A Prior Authorization Request

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

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

Justification

For Dental Use only

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

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

PRIMARY TEETH

For DME, Home Health, Private Duty Use Only

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

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

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

Durable Medical Equipment Face to Face Regulations

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

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

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

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

719A June 2018

APPENDIX C: SUBMITTING 719A FORM

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

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

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

APPENDIX D: IVR INSTRUCTIONS

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

Providers should verify the beneficiary's name and identification number, effective dates of eligibility, services restricted to specified providers, and whether other insurance is on file (commonly referred to as third party liability) before rendering services.

Beneficiary eligibility may be verified by calling the Interactive Voice Response System (IVR) using a touch-tone telephone and entering the beneficiary identification number found on the beneficiary's Medical Assistance ID card. The IVR is available 24 hours a day, seven days a week with an unlimited number of inquiries being performed per call. The IVR may be used up to 30 minutes per call. Providers should also have their DC Medicaid provider number or NPI number ready.

To access the District of Columbia Government Medicaid IVR, dial (202) 906-8319 (inside DC Metro area) or (866) 752-9233 (outside DC Metro area) from your touch-tone phone. Select one of the following options listed below and follow the prompts. The system will prompt you to enter your nine-digit Medicaid provider number or 10-digit National Provider Identifier (NPI) followed by the pound (#) key.

- Press 1 - To verify beneficiary eligibility and claims status.
- Press 2 - If you are a new provider and would like to enroll or if you are changing your provider number, contact MAXIMUS at 844.218.9700.
- Press 3 - For EDI Technical Support Services
- Press 4 - For all other questions

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

APPENDIX E: GLOSSARY

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

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

ADA – American Dental Association

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

ANSI - American National Standards Institute

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

ASC - Ambulatory Surgery Code

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

CFR – Code of Federal Regulations

CHAMPUS - Civilian Health and Medical Program of the Uniformed Services

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

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

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

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

CLIA – Clinical Laboratory Improvement Amendments

CMS - Centers for Medicaid and Medicare Services

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

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

Cost Settlement – Refers to a reimbursement method in which the reimbursement is made on actual cost information.
Covered Services - All services which providers enrolled in the DC Medicaid program are either required to provide or are required to arrange to have provided to eligible beneficiaries.

CPT - Current Procedural Terminology code

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

DCAS – District of Columbia Access System

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

DCMMIS - District of Columbia Medicaid Management Information System

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

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

DHHS - Department of Health and Human Services

DHR - Department of Human Resources

DHS - Department of Human Services

District - The District of Columbia

DME – Durable Medical Equipment

DMERC - Durable Medical Equipment Regional Carrier

DOH - Department of Health

DRG - Diagnosis Related Grouper

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

DX - Diagnosis Code

EDI – Electronic Data Interchange

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

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

EOMB - Explanation of Medical Benefits

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

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

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

FQHC – Federally Qualified Health Center

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

HCFA - Health Care Finance Administration

HCPCS- Healthcare Common Procedure Coding System

ICD-CM - International Classification of Diseases Clinical Modification

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

IMD – Intermediate Mental Disorder

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

LTAC - Long Term Acute Care

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

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

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

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

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

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

NCCI – National Correct Coding Initiative

NDC - National Drug Code

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

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

NPPES – National Plan and Provider Enumeration System

OIS – Office of Information Systems

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

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

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

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

PBM – Pharmacy Benefits Management

PID – District of Columbia nine-digit provider ID number

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

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

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

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

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

QIO - Quality Improvement Organization

QMB – Qualified Medicare Beneficiary

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

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

RTP - Return to Provider

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Web Portal – An internet gateway that provides tools and resources to help healthcare providers conduct their business electronically.

WINSASAP – Free software provided by Conduent that can be used to create claims in X12N format.