It's how we **treat people.**

2021

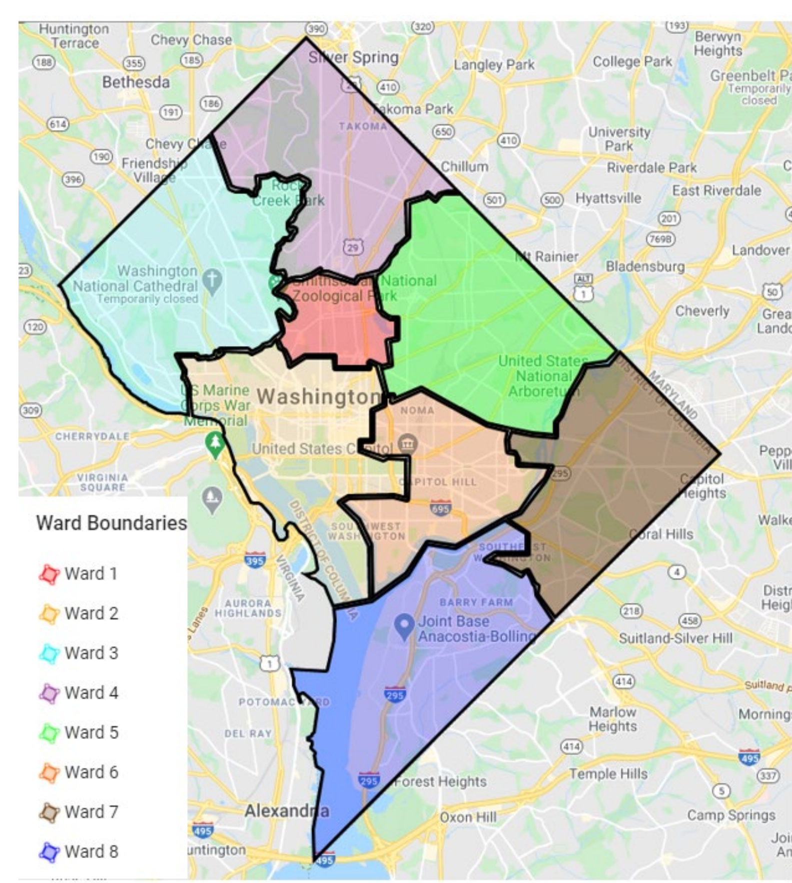
Provider Education

District of Columbia Healthy Families (including Immigrant Children's program)

District of Columbia Healthcare Alliance

What is MedStar Family Choice-District of Columbia (MFC-DC)?

- A Managed Care Organization (MCO)
- MedStar Family Choice-DC:
  - DC Healthy Families and Immigrant Children's program
  - DC Healthcare Alliance
- Part of the MedStar Health System
- Service Area
  - District of Columbia (DC)



Map overlay created via Google Maps: https://www.google.com/maps/d/viewer?mid=1DpJu2DbYssvxH0XsK6f6iXV6BN4&hl=en_US&ll=38.89392092000488%2C-77.01469049999999&z=12

Contacts and Phone Numbers

Description	MFC-DC (Healthy Families and Alliance)
Provider Relations (problem solving, orientations/training, recruitment, and credentialing)	Phone: 855-798-4244 opt. 2 Fax: 202-243-6254 (Local) 855-616-8763 (toll-free)
Outreach (assists in outreach attempts for preventive care and enrollee compliance)	Phone: 855-798-4244 Fax: 202-243-6252
Utilization Management (authorization for required services, DMEs, medications requiring authorization, injectables, etc.)	Phone: 855-798-4244 Fax: 202-243-6258
Case Management Services (care coordination, high-risk pregnancy, early intervention, social work)	Phone: 855-798-4244 Fax: 202-243-6253
Claims Processing Center (processes claims and encounter data and resolves claims issues)	Phone: 800-261-3371

Additional Provider Resources can be found at:
medstarfamilychoicedc.com

Contacts and Phone Numbers
MFC-DC Vendor Partners

Name		Phone Number
Magellan HEALTHCARE	Behavioral Health MH / SUD Treatment	800-777-5327
avēsis a GUARDIAN company	Dental and Vision	844-391-6678
CVSHealth	Pharmacy	800-364-6331 (pharmacy claims issues)
Access2Care	Transportation	866-201-9974
Carenet Health Engaging. For the better.	Nurse Advice Line	855-798-3540

Overview of the Department of Health Care Finance (DHCF)

- DHCF selected MFC-DC as one of the Medicaid Managed Care Organizations in the District of Columbia.
- MFC-DC works with DHCF to help transform the system into a person-centered one that best supports the Medicaid enrollees in managing and improving their healthcare needs.

Enrollee Eligibility

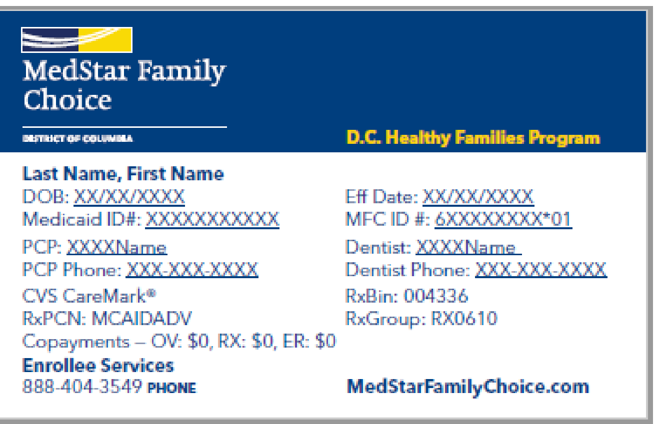
Populations we serve:	
	Children twenty (21) years of age and under, including children eligible for Children's Health Insurance Program (CHIP);
	Parent, caretaker, relatives twenty (21) years of age and over;
	Childless adults nineteen (19) to sixty-four (64) years of age;
	Adults with special health care needs twenty (21) and older who are ineligible for Medicare;
	Enrollees placed in foster care who, upon the discretion of the Child and Family Services Administration (CFSA) elects to remain in the DCHFP;
	Adult Alliance beneficiaries, twenty-one (21) years and older, who are not US citizens and are a resident of the District of Columbia; and
	Immigrant children under age 21 who are not US citizens; ineligible for Medicaid or CHIP.

Enrollee Information

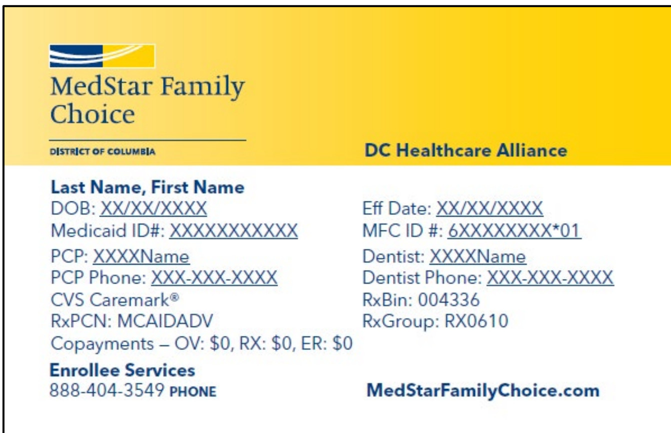
- **Enrollee ID Cards**
  - Primary Care Provider (PCP) name is printed on card
  - Enrollees may change PCPs at any time
  - Enrollees may see any MFC-DC PCP even if the PCP name is not listed on the ID card
    - Enrollee must be eligible on DOS
    - Provider must be par on DOS
  - Have enrollees call the Enrollee Service number on back of card to change PCPs

Sample MFC-DC Enrollee ID Cards

DC Healthy Families



DC Healthcare Alliance



Confirming Enrollee Eligibility

- **Confirm Eligibility**
  - Verify enrollees are assigned to MFC-DC prior to rendering services*
  - District of Columbia Government Medicaid IVR system
    - Phone: 202-906-8319 (inside Metro area)
    - Phone: 866-752-9233 (outside DC Metro area)
- **MFC-DC Provider Portal**
  - Must be registered
  - Access Eligibility Tab
  - Enter enrollee Information & Provider Information
  - Hit Check Eligibility button

Welcome to the MedStar Professional Web Portal

To access the MedStar Facility Web Portal, please click here

*** Provider Alert ***
Important information for providers regarding the Novel Coronavirus

Returning Users

Username *

Password *

LOGIN

Forgot your user name or password?

Verify Patient Eligibility / Start Claim

Location

Provider

Date of Service

Subscriber ID and date of birth

Subscriber ID

Date of Birth

Last name, first name, and date of birth

Reset VERIFY ELIGIBILITY

Information Center

Payments

Recent Historical

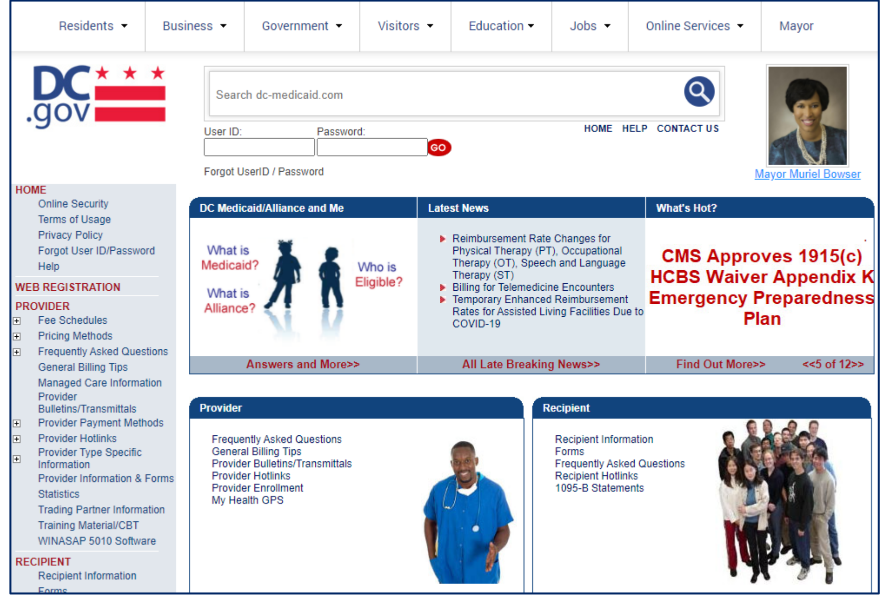
Last five payments are shown.

Date	Amount	View
10/09/2020	$0.00	
10/02/2020	$74.83	
09/25/2020	$673.47	
09/11/2020	$74.83	
09/04/2020	$74.83	

* **Please note:** The Provider must have their 9 digit Medicaid Provider ID or 10 digit NPI to access the IVR system

DHCF Portal Information

https://www.dc-medicaid.com/dcwebportal/home



Provider Inquiry and Automated System Information

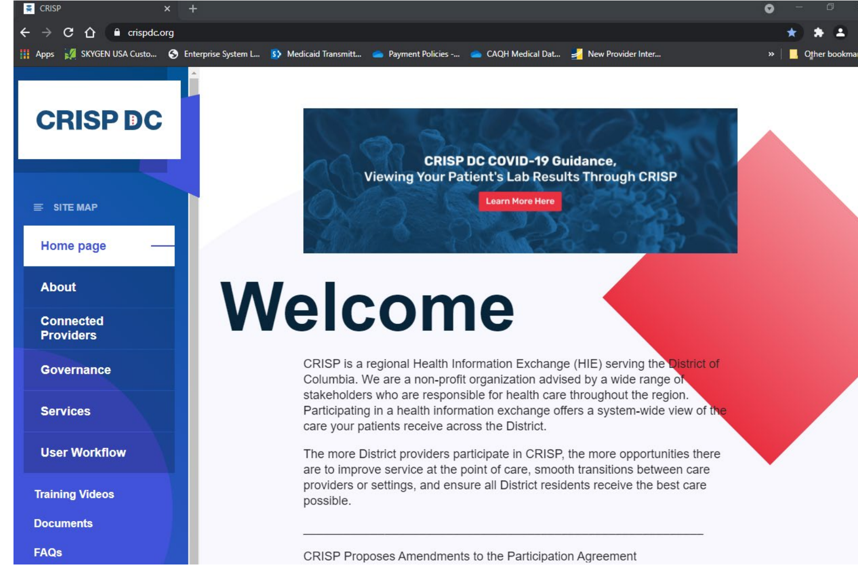
You can access the DC Provider Inquiry and Automated System by:

- Calling (inside DC): 202-906-8319
- Calling (outside DC): 866-752-9233
- Emailing: providerinquiry@conduent.com

In addition to eligibility information, Providers can also access the DC Medicaid Fee Schedule through this website as well.

The District of Columbia's Health Information Exchange (DC HIE)

- DHCF leads the implementation of the HIE to:
  - Provide real-time access to health-related information
  - Support person-centered care
  - Improve health outcomes
- DC CRISP – Chesapeake Regional Information System for our Patients
  - crispdc.org/
- Enrollment to CRISP is required for all MFC-DC providers who anticipate having more than hundred (100) claims to the DC Medicaid program in the upcoming year



DISTRICT OF COLUMBIA

Primary Care Assignment

- **Auto-assignments**
  - PCPs and Primary Dental Providers (PDP) only
  - Enrollees who do not select a PCP or PDP are assigned one based on geography
- **PCP Enrollee Rosters are mailed monthly**
- **PCP Capacity Limits**
  - Individual Full-time (> 20 hours per week)
  - PCP shall not have more than 500 enrollees at any time
  - Provider must notify MFC-DC 30 days in advance of reaching capacity
  - If PCP is near reaching capacity, MFC-DC will:
    - Close the provider's panel
    - Remove the provider from the PCP Auto-Assignment
    - Perform Monthly Monitoring
    - Notify DHCF within 2 business days of reaching capacity notification

Anti-Discrimination Policy and Americans with Disabilities Act (ADA)

- It is the expectation and law to not discriminate against Medicaid enrollees based on:
  - Race
  - Color
  - National Origin
  - Age
  - Gender / Gender Identity
  - Religion
  - Sexual Preference
  - Physical / Mental Disability
  - Ancestry
  - Political Affiliation
  - Personal Appearance
  - Creed
  - Marital Status
  - Other status prohibited by Law

** In accordance with Title VI of the Civil Rights Act of 1964, Americans with Disabilities Act (ADA)*

Access to Care / Appointment Standards

Access to Appointments

- Requirements set by the DHCF for DC Healthy Families, Immigrant Children's Program, and DC Healthcare Alliance enrollees
- Requirements set by MedStar Family Choice-District of Columbia
  - Providers must maintain appointment standards
    - 24-hour phone coverage with emergency directions
    - Enrollees waiting room time should be no more than 30 minutes and emergency cases should be seen immediately
    - Office hours for MFC-DC enrollees must be equivalent to the office hours offered to commercial or other Medicaid enrollees

Appointment Standards

Type of Appointment	Appointment Standard
Urgent Care Appointment	Within 24 hours
Newborns: High Risk Assessment	Within 48 hours of discharge
Children: Well-Child Assessment	Within 30 days of request
Initial EPSDT Screens	Within 60 days of enrollment date or earlier when possible
EPSDT Screenings: Laboratory tests/ X-ray / Immunizations	• EPSDT within 30 days if under the age of two (2) • EPSDT within 60 days for 2 years and older

Appointment Standards

Type of Appointment	Appointment Standard
IDEA multidisciplinary treatment for infants and toddlers at risk of disability	Within 25 days of receipt
Adults (Healthy): Initial office visit	• Within 45 days of enrollment • Within 30 days of request
Routine/Preventative Care office visits (PCPs)	Within 30 days
Follow up visits (Specialists)	Within 30 days
Pregnant/Post-partum and family planning: Initial Appointment	Within 10 calendar days of request

Network Standards and Capacity

Mileage and Travel Time Standards: 30 minutes or a 5-mile radius of each enrollee's residence

Capacity	
Provider Type	**Ratio of Provider Type to Enrollees**
Primary Care Provider	1 : 500
Primary Care Provider with Pediatric Training / Experience / Pediatrician	1 : 500
Dentist	1 : 750

Panel Size	
Provider Type	**Maximum # of Enrollees**
Primary Care Provider	500
Clinic Deemed as a Primary Care Provider	2,000

Outreach Department

Outreach Department

- **Outreach assists with:**
  - Educating on preventive care and enrollee compliance
  - Transportation
  - Community based resources
  - Scheduling appointments
  - Repeated missed appointments
  - Repeated ER usage
  - Administers various outreach programs via Head of Household Approach
    - Momma and Me/Postpartum
    - Well-Child 30 months
    - Lead testing 12 and 24 months
    - Diabetes annual services
    - Mammogram/Pap Program
  - Coordinating community-based wellness events with mobile mammography, retinal screenings, and lab services

Outreach Department Newborn Coordinator

- **Point of contact for providers**
  - Eligibility
  - PCP selection
  - Coordination of in-network and out of network care
  - ID cards
  - Claims
  - General newborn issues
- **DC newborns:** Call 855-798-4244, option 1, then 2

Clinical Operations Department

(Care Coordination/Case Management & Utilization Management)

Case Management Programs

Complex Care: The goal of the Complex Case Management Program is to identify enrollees at highest risk for needing intensive resources at high cost, and objectively improve health, function, safety and enrollees' satisfaction.

Comprehensive Condition Care: Condition Care is designed for Enrollees who require additional assistance, health education, and care coordination in managing their chronic conditions. The aim of the Condition Care Program is to promote self-management skills that prevent elevation into a higher risk level.

Transition Care: The Transition Care Program will focus on Enrollees who are at the very vulnerable point of transitioning from the acute care setting to home and at-risk for readmission to the hospital. Specialized discharge assessments are completed with these Enrollees to identify factors that may lead to readmissions and barriers that may impact engagement with outpatient services.

Emergent Care: Program offers care coordination services for those Enrollees who exhibit a pattern of frequent ED utilization. The Emergent Care program is designed to reduce the likelihood of return ED encounters for services that could otherwise be provided by a PCP or urgent care center.

Resource Management: Enrollees who request assistance for low-risk needs, such as locating a new PCP but do not have needs that rise to the level of requiring a care plan; or Enrollees who are assessed or found to have needs appropriate for case management but decline participation.

Case Managers assist with:

- Pediatric Asthma
- Adult Respiratory
- High Risk Pregnancy
- Substance Use Disorder
- Adult Hypertension
- Strong Start/ Early Intervention
- Diabetes (Adult and Pediatric)
- Adult Cardiovascular Disease
- Pain Management
- HIV / AIDS
- Adult Heart Failure
- Mental Illness

Care Coordination and Case Management

Complex Case Management is available for:

- Enrollees identified as High Risk by our predictive model software; and meeting criteria for Adult and Pediatric Care Complex Case Management services
- Complex psycho-social or behavioral needs
- Transplants
- Catastrophic conditions/Special Healthcare Needs requiring coordination of care
- 1 Inpatient admission or 2 ERs in past six months AND some combination of the following:
  - Multiple chronic conditions with high utilization requiring education or interventions
  - A critical event or diagnosis that requires care coordination or extensive use of resources
- If you would like to refer an enrollee to any of our Programs, send a fax to **202-243-6253** or call Care Management Department at **855-798-4244, option 2 then 1.**

Utilization Management

Referral Procedures – Writing a Referral

- Use “Find-A-Provider” on the MFC-DC website (**MedStarFamilyChoiceDC.com**)
- Referrals are valid for 180 days
  - Number of visits is required or the referral defaults to one visit
  - Authorizing signature box must be signed by PCP
- PCP Referral forms
  - Uniform Consultation Referral Form
  - Forms generated by an EMR system are accepted if all information on the Uniform Consultation Form is completed
  - PCP may give verbal consent to a specialist for one visit if referral is not ready on DOS

Note:

- Referrals do not take the place of an authorization
- Do not send referrals to the MFC-DC Claims Processing Center
- Do not attach to claims submission

Referral Procedures (Continued)

- **Specialty Care Provider**
  - Directly refer MFC-DC enrollees for radiology and laboratory services
    - Do not send the patient back to the PCP for these services
    - Use a LabCorp or Quest Requisition Form for labs
    - Use a referral form or write a script to participating radiology providers (must include diagnosis)
  - Specialists can refer to other specialists if they receive written or verbal approval from the PCP
    - Document approval in the chart
    - OB can refer to a high-risk OB without PCP approval

Obtaining Prior Authorization (PA)

- **Rendering/ordering provider must:**
  - Complete the MFC-DC Prior Authorization Form or Uniform Referral Form.
  - Attach most recent clinical documentation to support the request.
    - For pharmacy requests, check the PA Table prior to sending the request.
  - Fax the form to: **202-243-6258**.
  - If authorized procedures dates of service change or service added/changed, call MFC-DC to revise the auth.
    - ICD-10/CPT/HCPCS codes in the medical record must match what is being requested for authorization and what is billed to MFC-DC.

Please Note: To avoid unnecessary delays, please send requests for authorization at least fourteen days in advance.

Services Requiring Prior Authorization

- **Specialty visits to out-of-network providers or out-of-network hospitals**
  - Services for out-of-network providers or hospitals are not covered for DC Healthcare Alliance enrollees
- **Common outpatient services requiring prior authorization:**
  - Pain Injections including Epidural, Facet blocks, Rhizotomies
  - Cardiac Rehab
  - Pulmonary Rehab
  - Bariatric Surgery - including Outpatient Surgeries
  - Genetic Testing
  - Inpatient elective procedures
  - Any out-of-network service
  - Audiology services

These are just a few of the procedures requiring Prior Authorization. Please confirm if the services require Prior Authorization and enrollee eligibility prior to rendering services

- **Where to find services requiring authorization**
  - Refer to the MFC-DC Quick Authorization Guide on our website (List of services that require pre-authorization)

Procedures and Tests Not Requiring Authorization

Procedures performed by an in-network provider at an in-network facility

- Blood Transfusions
- Chemotherapy
- CT Scan
- Breast Biopsy
- Circumcisions
- Colonoscopies
- Dialysis catheter insertion or removal
- EEG's Regular (non-video)
- EGD's
- PICC line insertion, Port-a-cath, Hickman insertion & removal
- Sterilizations - male or female
- 30-day event monitors
- Dialysis (In network)
- MRI
- Screening Mammograms
- Holter Monitors
- AFI's, Amniocentesis, BPP's, Fetal Fibronectin, Fetal Echo, Fetal Stress/Non-Stress tests
- Pacemaker readings
- Radiation Therapy
- TPN
- PET scans

Benefit Limitations/Non-Covered

The following are benefit limitations and non-covered services for DC Healthy Families and Alliance enrollees

DC Healthy Families and DC Healthcare Alliance
Abortion
Chiropractic Services
Cosmetic Surgery
Experimental or investigational services
Non-covered services in the State Plan
Services that are not medically necessary
Services that are part of a clinical trial protocol
Sterilizations for persons under the age of 21
Infertility Treatment

Benefit Limitations/Non-Covered Continued

DC Healthcare Alliance	
Screening and stabilization services for Emergency Medical Conditions provided outside the District	Experimental treatment and investigational services and items
Emergency Medical Conditions as described in DHCF Policy Number HCPRA-2013-02R	Sclerotherapy
Cosmetic Surgery	Vision care for adults
Any covered services when furnished by Providers that are not in the Contractor's Provider Network	Treatment for obesity
Services and supplies related to surgery and treatment or temporal mandibular joint problems (TMJ)	Treatment for Behavioral Health and Substance Use Disorder services, except services related to medical treatment received in a hospital for life threatening withdrawal or withdrawal symptoms from alcohol or narcotic drugs
For Alliance enrollees, they are to obtain HIV/AIDS drugs from the District of Columbia's AIDS Drug Assistance Program (DC ADAP)	Deliveries, Therapeutic Abortions
Open Heart Surgery, Organ Transplantation	Services furnished in schools

Please note: Please always check enrollee's eligibility and benefits coverage prior to rendering services to MFC-DC enrollees.

Inpatient Authorizations/Concurrent Review

- **Initial Request for Inpatient Authorization**

  All initial **Requests for Authorization** of inpatient days must be accompanied by clinical information. MFC-DC will make an authorization decision within three days of receipt of clinical information.

- **Notification of Admissions:** MFC-DC will document the information on the Daily Communication Log sent to the hospital; until clinical information is received, or notification is received that the enrollee is discharged.

- **Concurrent Review**

  For ongoing inpatient reviews/authorization, MFC-DC will document the next scheduled review due date on the Daily Communication Log. We will make a determination within three (3) calendar days of receipt of clinical information. If clinical information is not received on the scheduled review due date, the day(s) may be subject to denial for lack of information.

Inpatient Authorization Denial Recourse

- Submitting medical records or clinical information for the date of service will assist greatly in the decision process.

- If an Inpatient day is denied, the hospital can request an expedited or urgent Appeal either verbally or in writing; only if the enrollee is still inpatient.

- If an Inpatient day is pended or denied, the facility or attending physician can request a peer-to-peer review with an MFC-DC's Medical Director, while the enrollee remains inpatient or up to three (3) business days after discharge.

Contact Information

- Main Number: 855-798-4244
- Prior Authorization
  - Fax: 202-243-6258
  - Email: DCMFCURPharm@medstar.net

  - Inpatient Concurrent Review
  - Fax: 202-243-6256
  - Email: DCMFCConcurrentRev@medstar.net
- Post-Acute (SNF/Rehab)
  - Fax: 202-243-6307
  - Email: DCMFCPostAcuateCare@medstar.net
- Case Management Referrals
  - Fax: 202-243-6253
  - Email: DCMFCCaseMgmt@medstar.net

Pharmacy

Pharmacy

Formulary

- Includes Over-The-Counter (OTC) medications
- Updated quarterly and available as a PDF on the MFC-DC website
- Additional copies available upon request
- Prior Authorization (PA) Table is available on the MFC-DC website: https://www.medstarfamilychoice.com/for-district-of-columbia-providers/pharmacy/

Prior authorization is required for non-formulary and select medications

- Call Pharmacy Nurse at **855-798-4244, Option 2 then 1**
- Have clinical information available
  - Refer to PA Table on website for guidance
  - Prior Authorization / Non-Formulary Medication Request Form
- Examples: High-cost specialty medications and expensive brands

Pharmacy (Continued)

- **Synagis (palivizumab)**
  - Complete the Statement of Medical Necessity Form
    - Forms can be obtained from our website
    - Contact Provider Relations for a hard copy of form
    - Authorization is based on criteria set by the American Academy of Pediatrics 2014 Criteria

Pharmacy (Continued)

- **Over-the-Counter Medications (OTC)**
  - Scripts are required for OTC medication, or the provider may contact the pharmacy directly
  - Refer to MFC-DC Formulary for covered medications
  - Refills are permitted
  - Scripts are not required for Latex condoms and Plan B
  - Examples of OTC medications that are covered include:
    - Antacids
    - Antibacterial creams
    - Antifungals
    - Cough and cold medicines
    - Laxatives

Pharmacy (Continued)

Pharmacy Denials

- If an enrollee or provider disputes a denial of a prescription drug or pharmacy service through the Appeals process, MFC-DC will fill a prescription for the following:
  - 72 hours for prescription drugs that are administered or taken daily or more than once per day.
  - One full course for prescription drugs that are administered or taken less frequently than once per day.
- MFC-DC will contact the provider who wrote the prescription to resolve any outstanding issues while the Grievance or Appeal is pending.

Rejected Pharmacy Claims

- Pharmacies should contact MFC-DC for rejected claims.
- Providers should contact MFC-DC to discuss rejections when contacted by pharmacy at **855-798-4244, Option 2 then 1.**
- MFC-DC Enrollees should contact Enrollee Services at **888-404-3549.**

Mandatory Prescription Drug Monitoring Program Query – Effective March 16, 2021

- **MANDATORY PDMP QUERY:** Mandatory query is now in effect in the District of Columbia. *DC Law 23-251. Prescription Drug Monitoring Program Query and Omnibus Health Amendments Act of 2020* became effective on March 16, 2021. The law requires prescribers and dispensers to query the PDMP:
  - Prior to prescribing or dispensing an opioid or benzodiazepine for more than seven consecutive days, and
  - Every ninety days thereafter while the course of treatment or therapy continues, or
  - Prior to dispensing another refill after ninety days.

For your reference, the law is available here:
https://code.dccouncil.us/dc/council/laws/23-251.html

HIV Medications, Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

	Healthy Families Enrollees	Alliance Enrollees
Beneficiary has HIV/AIDS	Process through District of Columbia Fee-for-Service	Beneficiary must use ADAP Pharmacy*
Beneficiary needs PEP or PrEP	Process through District of Columbia Fee-for-Service	Any MedStar Family Choice in-network pharmacy

* LIST OF ADAP-PARTICIPATING PHARMACIES
https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/HIV%20AIDS%20Pharmacy%20Provider%20Network%20%20%28%20Feb%202020%29.pdf

* MEDICATIONS SUPPLIED THROUGH ADAP PHARMACIES (ADAP FORMULARY)-
https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/ADAP%20Formulary%20July%202020.pdf

HIV Medications, Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

- **DC Healthy Families Beneficiaries:** HIV/AIDS medications, PEP, and PreP for Healthy Families beneficiaries are covered through the District of Columbia Fee-for-Service only and are not the responsibility of MedStar Family Choice-DC.

- **DC Healthcare Alliance Beneficiaries:** For Alliance beneficiaries, medications for the treatment of HIV/AIDS are supplied through the AIDS Drug Assistance Program (ADAP). All members must apply to the ADAP program and renew every 6 months. Prescriptions for HIV and AIDS medications must be filled at ADAP-participating pharmacies. Prescriptions for PEP and PreP may be filled at any MedStar Family Choice-DC in-network pharmacy.

Ancillary Care and Services

Ancillary Care and Services

	DC Healthy Families	DC Healthcare Alliance
Audiology	Prior Authorization Required	Prior Authorization Required
Cardiac Rehabilitation	Prior authorization required	Prior authorization required
Dental * Self referral	Avesis **844-391-6678** • Exams and routine cleanings every 6 months • X-rays (full series limited to every 3 years) • Services include surgical extractions, removal of impacted teeth, filings, root canal therapy (limited to 2 molars per year), crowns, removable full and partial dentures. Includes dental implants as a treatment option. District covers deep sedation/general anesthesia, but not IV sedation. Some limitations may apply. • Orthodontic care for special problems for enrollees under 21. (routine orthodontic care is not included) • Fluoride varnish treatment up to 4 times a year for enrollees under 21. • Contact Avesis for additional information and full benefit list.	Avesis **844-391-6678** • Alliance enrollees are limited to $1,000 per calendar year for dental services. • Exams and routine cleanings every 6 months • X-rays (full series limited to every 3 years) • Services include simple and surgical extractions, filings, space maintainers (partial dentures – when medically necessary), dentures (every 5 years) • Does not include routine orthodontic care • Contact Avesis for additional information and full benefit list.

Ancillary Care and Services (Continued)

	DC Healthy Families	DC Healthcare Alliance
Diabetes and Nutritional Counseling	• In office (from 4 visits) • In Network Homecare agency (after 3 visits) • Hospital based visits • (from visit 4) require authorizations.	• In office (from 4 visits) • In Network Homecare agency (after 3 visits) • Hospital based visits (from visit 4) require authorizations.
Dialysis	Refer to in-network Dialysis facility	Refer to in-network Dialysis facility
Genetic Counseling	The OB meets with the family and charges a regular office visit.	The OB meets with the family and charges a regular office visit.
Genetic Testing (not done through LabCorp or Quest)	All genetic testing requires pre-auth	All genetic testing requires pre-auth
Hearing Aids Cochlear Implants Auditory Osseointegrated Devices	All hearing aids, cochlear implants, auditory osseointegrated devices require authorization regardless of cost	Hearing devices for enrollees over 21 are not covered

Ancillary Care and Services (Continued)

	DC Healthy Families	DC Healthcare Alliance
DME (Durable Medical Equipment) ** See website or contact Provider Relations for in-network vendors*	• > $1,000.00 needs PA • Equipment Rentals > than 90 days requires prior PA (exception is oxygen)	• > $1,000.00 needs PA • Equipment rentals > than 90 days requires prior PA (exception is oxygen)
DME: Soft Supplies and disposables	Soft supplies > $750 per vendor, per month	Soft supplies > $750 per vendor, per month
DME: Braces, Orthotics, Prosthetics and Splints (excludes foot orthotics)	> $500 need PA	> $500 need PA
DME: Foot Orthotics, Custom Shoes, Diabetic Orthotics or Shoes, CAM Walking Boot	PA required	PA required
DME: Insulin Pumps or Continuous Glucose Monitors	PA required	PA required

Ancillary Care and Services (Continued)

	DC Healthy Families	DC Healthcare Alliance
Home Health Care	Authorization required after first 6 visits with in-network provider	Authorization required after first 6 visits with in-network provider
Hospice, Skilled Nursing & Acute Rehab Facilities	PA required	PA required
Laboratory ** LabCorp Acct Setup: 800-788-8765* *•Quest Acct Setup up: 866-697-8378* *•Note for offices located at MWHC, there is a LabCorp on hospital grounds. At GUH there is a draw agreement in place.*	• Lab Corp or Quest • Use Requisition form • Specialists should forward all lab results to PCPs • PCPs perform Rapid strep tests, RSV and Flu Test in their office • Must ensure to include 01 suffix of MFC-DC ID# on req form	• Lab Corp or Quest • Use Requisition form • Specialists should forward all lab results to PCPs • PCPs perform Rapid strep tests, RSV and Flu Test in their office • Must ensure to include 01 suffix of MFC-DC ID# on req form
Mental Health/ Substance Use Disorder	• Magellan: 800-777-5327 • PCPs must perform annual mental health and substance use screenings using the ASQ-3, PSC or PHQ9 screening tool	Only covered as inpatient if life threatening withdrawal from alcohol or narcotic drugs *Alliance enrollees may contact the Department of Behavioral Health for BH services*

Ancillary Care and Services (Continued)

	DC Healthy Families	DC Healthcare Alliance
Outpatient rehab services PT, OT, ST	• Refer to in-network provider • PA required for >30 visits per injury, per service	• Refer to in-network provider • PA required for > 30 visits per injury, per service
Radiology ** See website or contact Provider Relations for in network providers*	• Use in network Radiology provider • Refer using uniform referral form or script • Both PCPs and Specialists can refer • Orthopedic providers may perform flat x-rays in their office (POS 11)	• Use in network Radiology provider • Refer using uniform referral form or script • Both PCPs and Specialists can refer • Orthopedic providers may perform flat x-rays in their office (POS 11)
Transplant Pre-transplant testing	PA required	Not a covered benefit
Transplant Surgery	Need PA from District of Columbia	Not a covered benefit

Ancillary Care and Services (Continued)

	DC Healthy Families	DC Healthcare Alliance
Vision	Avesis **844-391-6678** • Routine eye care is self-referral and includes diabetic eye exam (dilated eye exam) • Under 21 – exam and 1 pair of eyeglasses every calendar year. • Over 21 – exam and 1 pair of eyeglasses every 2 calendar years. • Medically necessary contact lenses are available in lieu of eyeglass and require prior auth. • Provider may initiate referrals and/or prior authorization for services by calling Avesis	Avesis **844-391-6678** There is no routine vision benefit for Alliance enrollees.

Other Services Available to MFC-DC Enrollees

ER Utilization

Ways Providers can help decrease ER utilization for minor illnesses or injuries:

- Encourage the enrollee to contact you first to discuss their condition before going to the ER.
- If during normal business hours, provide urgent sick appointments.
- If after hours or unable to provide an urgent sick appointment, encourage use of an Urgent Care Center.
- Enrollees can talk with a nurse about their condition by calling 24/7 Nurse Hotline at 855-210-6204.
- MedStar eVisit
  - 24 hours a day, seven days a week, 365 days a year video access to trusted medical providers for patients of all ages.
  - Connect from your tablet, smartphone, or computer for non-emergency medical conditions.
  - No appointments are necessary.
  - https://www.medstarhealth.org/medstar-health-evisit/

MEDSTAR EVISIT

MedStar eVisit offers 24/7 on-demand video access for minor health issues not requiring a physical exam or testing.

Conditions we can treat:

- Cold or mild flu symptoms, allergies, pink eye, rash, minor cut, known urinary tract infection or yeast infection, gout flare-up

MedStar eVisit is not appropriate for:

- Conditions requiring a physician to look into your ear, listen to your heart or lungs with a stethoscope, or use other exam techniques
- Conditions requiring in-person testing, such as a blood or urine test
- Prescription refills for controlled substances (e.g. narcotics for pain, and ADHD or short-acting anxiety medications)
- Severe flu symptoms, or any flu symptoms for those under 2 or over 65

Health Education

- **Health Education Classes**
  - Provided by MedStar Health Hospitals.
  - Free to all MFC-DC enrollees.
  - Document in the chart if an enrollee has been asked to attend a session or has attended a class.
  - Listings are on the MFC-DC website or contact Provider Relations for a schedule of classes.
- **For new onset of illnesses, such as Diabetes, please contact the Clinical Operations Department.**
- **Enrollees needing assistance locating classes can call the Outreach Department.**

Interpretation Services

- Free of charge to DC Healthy Families and Alliance enrollees.
- Schedule telephonic translation services through Outreach.
  - DC Healthy Families/DC Healthcare Alliance: **855-798-4244 opt. 2**
- Providers can schedule an in-office translator.
  - DC Healthy Families/DC Healthcare Alliance
    - **MFC-DC Provider Relations: 855-798-4244 opt. 2**
- In office translator requests must be received no less than 5 days in advance for routine appointments unless the appointment is urgent.

Transportation for DC Enrollees

- Benefit for DC Healthy Families, DC Healthcare Alliance, and ICP
- Transportation provided by Access2Care
- 3-day advance notice preferred; immediate requests will be accommodated as quickly as possible
- Non-emergency transportation to medical appointments or services
- Will provide public transportation, Smart Trip Cards, wheelchair vans and ambulances (ACLS transportation covered separately)
- Transportation network also includes LYFT and Uber
- Contact Access2Care at **866-201-9974** to assist enrollees or enrollees can contact Access2Care directly to schedule transportation

Claims

Claims Submission/Timely Filing

- **Submit claims within 365 days of DOS**
- **Submit paper claims using the revised 1500 Claim Form**
  - Refer to the NUCC website for instructions: NUCC.org
- **Claims Address**

MFC-DC Claims Processing Center

PO Box 1624

Milwaukee, WI 53201

Phone: 800-261-3371

Electronic Claims Submission

- Submit claims electronically
- Submit professional or institutional claims via 837
  - EDI Payer ID#: **DCMED**
- On-line claims submission via Portal for professional claims only

MedStar Family Choice-District of Columbia – Clearinghouse Information

EDI Payer ID#: DCMED

Professional Claims	Facility Claims
Change Healthcare (formerly Emdeon)	Change Healthcare (formerly Emdeon)
Change Healthcare (formerly Relay Health)	Change Healthcare (formerly Relay Health)
Capario (formerly Medavant ProxyMed)	PayorPath (aka Allscripts)
SDS (Smart Data Solutions)	XactiMed (aka Medassetts)
	SDS (Smart Data Solutions)
Waystar	Waystar

Check Claims Status

- **Check claims status by phone at 800-261-3371**
- **Online Look up**
  - Register at **MedStarFamilyChoiceDC.com**
  - Need information from a current EOB to register
    - CS#, Name, Complete Address (exact match)

MedStar Family Choice DC

CS#: NNNNNNN CS Name: Provider Legal Name Remittance Date: MM/DD/YYY

Notes for Claims Submission

- **ER Facility claims:**
  - If the diagnosis code is not on the ER auto pay list, submit claim with medical documentation. The auto-pay list is available on the MFC-DC website.
- **Observation Authorizations:**
  - Required for observation status exceeding 48 hours (will be subject to medical review)
  - Required if observation placement becomes an inpatient stay (will require medical review)
- **Miscellaneous or unlisted CPT codes are not accepted**
- **ER Claims for Alliance enrollees with a primary diagnosis that is on the DC Emergency Medicaid list of ICD10 codes should be submitted to the District – applies to both Facility and Professional Fees**

Appeals

- Submit within 90 business days of denial letter date or Remittance Advice
- Written request, specific reason for the appeal and necessary documentation
  - Appeal form is available on MFC-DC website
- Medicaid Appeal form must be used and submitted to the address on the form
- Decision and notification will be provided within 30 days

Payment Disputes

- MFC-DC will accept correspondence through Payment Dispute Form
  - Payment Dispute Form must be used for any claims dispute and must be completed in its entirety
- Submit within 90 business days from date of denial
- A claims payment dispute may be submitted for multiple reason(s), including:
  - Contractual payment issues
  - Disagreements over reduced or zero paid claims
  - Other health insurance denial issues
  - Submit another carrier's EOB
  - Retro-eligibility issues
  - Paid to wrong provider
  - In/Out Network issue
  - Claim denied for lack of authorization, but you have proof of prior authorization

Payment Dispute Forms can be found on the MFC-DC Provider Website

Credentialing and Recredentialing

Credentialing

- **Contact Provider Relations**
- Providers interested in joining the MFC-DC network
  - May request credentialing / contract information
  - Must have an active DC Medicaid number
  - Providers participating with Counsel for Affordable Quality HealthCare (CAQH) must:
    - Have an updated profile on the CAQH website
    - Complete the MFC CAQH Medical Data Sheet
    - Complete and return Disclosure of Ownership and Control Interest Form
  - Providers not participating in CAQH can complete the full application
    - Can be obtained by contacting Provider Relations or by accessing it here: http://www.credentialingapplicationdc.org/
  - PCP Providers seeing children under the age of 21 years must be EPSDT certified
    - DC HealthCheck practitioners must recertify every two (2) years

Recredentialing

- Occurs at least every 36 months (3 years)
- MFC-DC follows NCQA, CMS and DHCF credentialing standards and guidelines
- Process begins six months prior to the recredentialing expiration date
- Providers who participate with CAQH must have current and up to date information on the CAQH Website or MFC-DC will request updated information
- Providers who do not have a CAQH account will be contacted to provide an updated Uniform Credentialing/Recredentialing Provider Application

Please Note: Disclosure of Ownership and Control Interest Form must be completed for all practitioners applying for participation

Site Evaluations

- Performed in accordance to NCQA and MedStar Family Choice-DC Credentialing Guidelines
- Site Evaluations must be completed:
  - New Office Locations
  - Complaints
- Helps to ensure that:
  - Site Exists
  - Cleanliness
  - HIPAA compliant
  - Fire Safety and Handicap Accessibility
  - Lab and radiology certificates are present (if applicable)
  - Refrigerated medications/injections are stored at the proper temperature (if applicable)

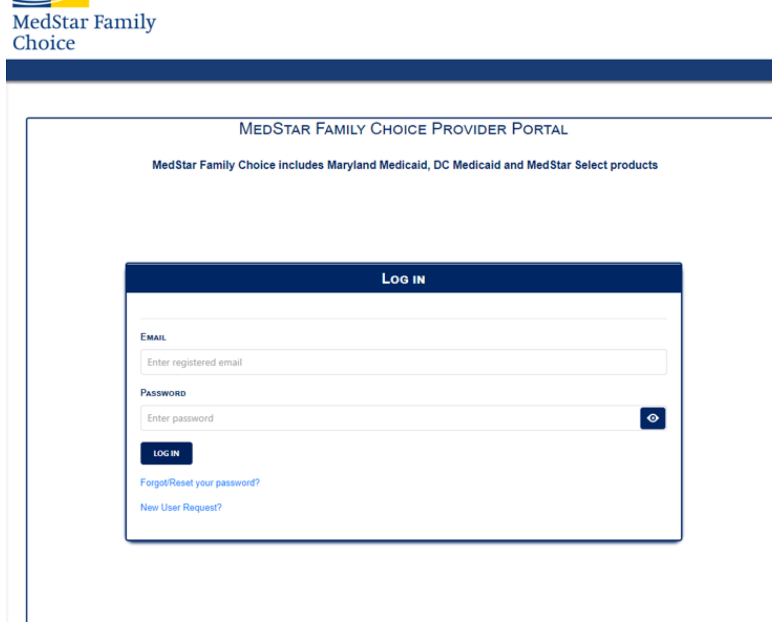
Please Note: Practitioners will not be credentialed without a current site evaluation on file for all locations.

Counsel for Affordable Quality HealthCare (CAQH) Reminder

- CAQH is Free to providers
- Providers no longer need to be invited to join
- Providers must designate MedStar Family Choice-DC as an authorized health plan to receive your information
- Providers must re-attest, **every 120 days**, that all the information in your profile is still correct. You will also receive a notification from CAQH to re-attest
  - Go to https://proview.caqh.org/pr
  - Select "Attest" from the home page
  - Review and update and upload any applicable supporting documents (Curriculum Vitae, MD License, Board Certification Certificate, DEA, CDS, Malpractice Ins, etc)
  - Click "Attest"

Provider Demographic Changes

- Provider Data Web Portal
  - https://providerportal.medstarfamilychoice.com/
  - Secure website
  - Validate Provider / Group Demographics Quarterly
  - Submit Provider / Group Changes
  - Review Summary of Changes
- Notify Provider Relations in writing
  - Letterhead
  - Practice Email Account
- Provider Profile Forms
  - For those without email / internet access
  - Faxed / mailed quarterly
  - Make changes to the form and return to Provider Data Management for updates
- Change Requirements:
  - New Tax ID – New Contracts
  - Billing Address Changes- W-9 Form
  - New location - Site Evaluation



Compliance

Compliance Program/Fraud and Abuse

- **MFC-DC Compliance programs monitor and detect fraud and abuse**
  - DHCF holds MFC-DC responsible for monitoring
  - MFC-DC uses claims encounter to monitor activity
  - Focused chart audits are performed
  - CCI edits (Correct Coding Initiative Edits) to ensure proper coding
- **Common examples of fraud and abuse are:**
  - Billing for a service that was never performed
  - Unbundling of procedures
  - Up-coding
  - Duplicate Billing
  - Performing unnecessary procedures
  - Altering or forging a prescription
  - Allowing others to use an enrollee's ID card for care
  - Pass Through Billing

Compliance Program/Fraud and Abuse

- **Federal False Claims Act:** individuals who "knowingly" submit false claims are liable for 3x the government's damages plus civil penalties per false claim.
- **DC False Claims Act:** Any person who commits fraudulent acts shall be liable to the District for 3 x the amount of damages and liable for the costs of a civil action brought to recover penalties or damages, and may be liable to the District for a civil penalty of not less than $5,000, and not more than $10,000, for each false claim
- Providers and Provider staff are required to notify MedStar Family Choice-DC of suspected fraud and abuse
- **"Qui tam plaintiffs"/"Whistleblowers"** may be entitled to portions of the judgments or settlement
  - Retaliation against "whistleblowers" is prohibited

Compliance Program/Fraud and Abuse

- Providers are required to self-report any over payments received

- Failure to report fraud and abuse can lead to state and federal sanctions. Sanctions can include loss of health benefits, termination of contract, loss of licensure, fines or imprisonment

Compliance Program/Contacts

Who to contact if you suspect an enrollee or provider of fraud and abuse

DC Healthy Families & DC Healthcare Alliance
MFC-DC Compliance Director for DC • **202-469-4482**
MedStar Health Integrity Hotline • **877-811-3411** or email: compliancefficer@medstar.net
Department of Health Care Finance Fraud Hotline • **877-632-2873** or in writing to: 899 N Capitol Street, NW Washington, DC 20002 Or online: dhcf.dc.gov/service/reporting-medicaid-fraud-and-abuse

Compliance Program/Fraud and Abuse

Overpayments

We encourage providers to conduct self-audits to ensure accurate payments.

If your practice determines overpayments or improper payments, you are required to:

- Return the overpayment to MedStar Family Choice-DC within 60 calendar days after the date on which the overpayment was identified.
- Notify MedStar Family Choice-DC in writing of the reason for the overpayment.
- Contact MedStar Family Choice-DC Claims Processing Center at **800-261-3371**
- Send the refund, the reason for the overpayment and a copy of the Explanation of Payment(s) identifying the overpayment to:

MedStar Family Choice-DC
DC Claims
PO Box 1624
Milwaukee, WI 53201
800-261-3371

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Compliance Program/Equal Access Laws

- Medicaid recipients must not be discriminated against in the provision of healthcare services
  - Federal laws exist to protect patients and ensure equal access to services
- Are entitled to receive care without regard to race, age, gender, color, sexual orientation, marital status, ancestry, national origin, religion, creed, political beliefs, personal appearance, physical or mental disability or type of illness/condition
  - Services may not be denied based on these factors
  - Services may not be performed in a different manner based on these factors
  - May not be subjected to segregation or separate treatment based on these factors

Compliance Program/Equal Access Laws Continued

- Report equal access or discrimination concerns to MFC-DC Provider Relations
- More information can be found at:
  - http://www.hhs.gov/ocr
  - U.S. Department of Health and Human Services Office for Civil Rights Hotline: **800-368-1019**

Compliance Program/Excluded Parties

- Medicaid and MCOs are prohibited from paying for items or services furnished by an excluded provider or organization
- MFC-DC monitors the appropriate exclusion lists on a routine basis
- Providers are responsible for monitoring the Medicaid exclusion lists to determine if any employees or contractors are on this list
  - HHS-OIG Website: http://oig.hhs.gov/exclusions/index.asp
  - Excluded Party List System: https://www.sam.gov/SAM/pages/public/searchRecords/advancedPIRSearch.jsf
  - GSA Exclusion List

Privacy

- Providers must follow all federal, state and district laws regarding privacy and confidentiality (including but not limited to HIPAA)
- Providers should only share patient data in accordance with appropriate laws.
- Providers should ensure patients receive a notice of privacy practice.
- Providers should ensure the security of patients' PHI.

Advance Directives

- Providers must discuss Advance Directives with enrollees.
- Providers should encourage enrollees complete an Advance Directive and make sure the enrollee gives a copy to his/her provider.
- Providers should have forms available for enrollees to complete if requested.

Cultural Competency

Cultural Competency

- Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.
- Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs, and activities receiving federal financial assistance, such as Medicaid.

MFC-DC Purpose/Scope/Policy

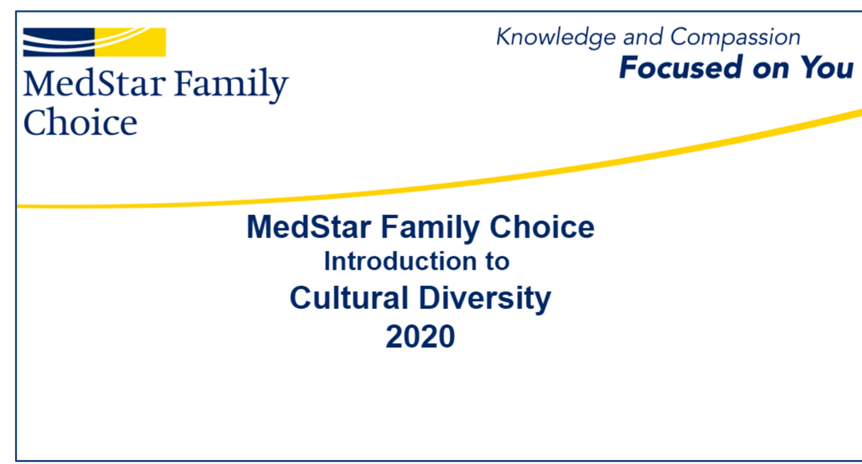
- **Our Purpose is to Ensure that**: All enrollees receive equitable and effective treatment in a culturally and linguistically appropriate manner
- **The Scope**: All MedStar Family Choice-DC Participating Providers
- **Policy**: MFC-DC encourages all providers treating our enrollees to provide culturally and linguistically appropriate services that improve the quality of care and health outcomes, and contribute to the elimination of racial and ethnic health disparities

MedStar Family Choice-DC Goals

- Improve communication to and for enrollees for whom cultural and/or linguistic issues are present
- Decrease health care disparities in the populations we serve
- Improve our associates' understanding and sensitivity to cultural diversity
- Improve services, care and health outcomes for enrollees (improved understanding leads to better adherence and satisfaction)

Cultural Competency Resources

- OnDemand (online) Training Course
  - www.sitelms.org
  - Type in Course ID # or course name MFC-DC FY21 Embracing a SPIRIT of Diversity
  - Click enroll and continue to confirm
  - Log in or Create SiTEL account
  - Click Get started to launch course



- Introduction to Cultural Diversity Provider Education
  - Offered to all provider offices
  - In-person / Virtual
  - Providers / Groups / Staff may request additional training anytime as a refresher or for new staff

Additional Resources

- **U.S. Department of Health & Human Services' Office of Minority Health**
  - A Physician's Practical Guide to Culturally Competent Care
  - Culturally Competent Nursing Care: A Competent Nursing Care: A Cornerstone of Caring
  - National CLAS Standards (Culturally Competency)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

DC HealthCheck Program

Focuses on key areas:

- Health and Developmental History (Mental and Physical)
- Comprehensive Physical Exam
- Laboratory Tests/At Risk Screenings
- Immunizations
- Health Education/Anticipatory Guidance

DC HealthCheck Program Continued

- **Primary Care Providers must be recertified every 2 years if seeing children, youth and young adults 21 and under**
  - Website training available at http://www.dchealthcheck.net/index.html
  - Documentation of certification is a requirement prior to acceptance of a provider into our network and recertification is a requirement to continue participation
  - Providers must give written and oral explanations of EPSDT services to pregnant women, parent(s) and or guardian(s), child custodians and sui juris teenagers
  - Providers must follow DC HealthCheck periodicity schedule
  - Providers must emphasize importance of preventative aspects of the service and benefits of early developmental anticipatory guidance for children under age three.
  - Providers must report any no-shows/missed appointments to the MFC-DC Outreach Department
  - Use the DC HealthCheck Periodicity Schedule for success
  - Screening tools and age appropriate EPSDT forms
    - Download from the DHCF HealthCheck website at: http://www.dchealthcheck.net/resources/healthcheck/smrf.html
    - There is no cost for these forms
    - DC endorses Bright Futures visit: https://brightfutures.aap.org/Pages/default.aspx

EPSDT Screening Requirements - LEAD

- **Federal Mandate**
  - Lead Risk Assessment Screening questionnaire must be completed at every well-child visit from age 6 mos. to 6 years of age
  - Check Blood lead level at ages 12 and 24 months and with any positives on Lead Risk Assessment

- **By District of Columbia Law**
  - Medicaid children should receive 2 blood lead tests (first blood test between ages 9 and 14 months and second between 22 and 26 months)
  - If no documentation of previous lead screening, federal law requires lead screening between the ages of 36 and 72 months as well as a blood lead test
  - Children 36-72 months require a test unless assessed as low lead risk
  - If blood lead level is greater than or equal to 5 ug/dL, screen with a blood test at each preventive health visit through 6 years of age
  - https://www.dchealthcheck.net/trainings/labs/lead.html

Developmental Screening Tools

- **Recommended tools for General Developmental Screening of children through age 5 include:**
  - **Ages and Stage Questionnaire, www.agesandstages.com**
  - **Parent's Evaluation of Developmental Status, www.pedstest.com**
    - There is a cost
    - Providers may bill per each screen that is submitted (96110)
  - **M-CHAT**
    - Modified checklist for autism in toddlers (can not be modified)
    - Use at 18 months and 24 to 30 months
    - Providers may bill per each screen (96110)
    - Use modifier 59 if performed on the same day as a different billable screening tool that uses CPT 96110
    - Form is free of charge (can be photocopied)
      - Available at www.MCHATScreen.com

Individuals with Disabilities Education Act (IDEA)

- IDEA is a national law that allows eligible children with disabilities access to free and appropriate education and ensures special education and related services to this population
- PCPs should work closely with MFC-DC Case management to identify individuals receiving Part B services to ensure needed support services can be offered
  - Part B: (3-21 years) MFC-DC will provide support services for needs not provided within the school system
  - Part C: (Birth to 3 years) Provides services to children who are "at risk" for a developmental, behavioral or physical care delay
- PCPs should refer enrollees who qualify for Part C to MFC-DC as soon as the need is identified to ensure Early Intervention Assessments occur timely

Quality Improvement

Quality Improvement

- **Quality Improvement programs**
  - Annual System Performance Review
  - HEDIS®
  - CAHPS®
  - CMS-416 Reporting – EPSDT Utilization
  - Performance Improvement Projects

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

CAHPS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Quality Improvement

- **Areas of Focus**
  - Prenatal & Postpartum Exams
  - Childhood Immunizations
  - Monitoring lead testing
  - Adolescent Immunizations, including HPV
  - Routine Well Child visits through 30 months
  - Annual Well Child visit 3-21
  - Controller medication coverage for people with asthma
  - Pap Smears
  - Chlamydia Screenings
  - Mammograms
  - Documentation of BMI percentile, nutrition counseling, and physical activity counseling
  - Controlling high blood pressure
  - Overall diabetic care
    - Hemoglobin A1c Testing
    - Hemoglobin A1c good control <8%
    - Retinal Exam or Dilated eye exams
- **Areas of Focus for 2021**
  - Review Gaps in care
  - Collect and establish baseline measurements for QI performance measures

Questions?

It's QUESTION TIME!!

Thank you

It's how we **treat people.**