


GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



Office of the Senior Deputy Director/Medicaid Director

Transmittal # 17-13

TO: Federally Qualified Health Centers

FROM: Claudia Schlosberg, J.D. 
Senior Deputy Director and State Medicaid Director

DATE: April 1, 2017

SUBJECT: Request for Administrative Reconsideration of MCO Decisions on Claims for Reimbursement

A federally qualified health center (FQHC) may request administrative reconsideration from the Department of Health Care Finance (DHCF) in order to challenge a managed care organization's (MCO) denial, nonpayment, or underpayment of a claim. To be eligible for DHCF's administrative reconsideration, the FQHC must:

1. Exhaust the appeal process established by the MCO who issued the denial, nonpayment, or underpayment; and
2. Receive a final written notice of determination (WND) from the MCO, or provide documentation that the timeframe for the MCO to render a final WND has expired without decision.

Requests for an administrative reconsideration can be made to DHCF in writing by mail, email, fax, or in person to DHCF's Appeals Coordinator within thirty (30) calendar days of the date of the final WND from the MCO. If no final WND was provided, the request shall be made within thirty (30) calendar days of the date that the MCO was due to render its final WND.

For more details on this process, please review the amendment to Chapter 45 (Medicaid Reimbursement for Federally Qualified Health Centers) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

The following must be included with a request for administrative reconsideration:

- A copy of the final WND indicating that the FQHC has exhausted all available appeal opportunities with the MCO, or documentation indicating the deadline for the MCO to render a final WND has expired.

- An original fee-for-service equivalent claim for reimbursement which must include:
 - Date of Service;
 - Healthcare Common Procedure Coding System/Current Procedural Terminology code;
 - Payment amount at issue;
 - Medicaid ID of the enrollee; and
 - Name and Date of Birth of enrollee.
- A written statement describing why the MCO's decision should not be upheld, including any supporting documentation.

Complete requests for administrative reconsideration should be submitted to:

DHCF Appeals Coordinator
441 4th Street, NW, 900S
Washington, DC 20001
Phone: (202) 442-5988
Fax: (202) 442-4790
dhcfappeals@dc.gov

DHCF has attached a guide to the Administrative Reconsideration request process, as well as the associated form, which must be completed in its entirety for a request to be processed.

If you have additional questions about the information contained in this transmittal or need more information, please contact DHCF's Appeals Coordinator at dhcfappeals@dc.gov (202) 442-5988.

cc: Medical Society of the District of Columbia
DC Hospital Association
DC Primary Care Association
DC Health Care Association
DC Home Care Association
DC Behavioral Health Association
DC Coalition of Disability Service Providers

Attachment a/s

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



Guide: Request for Administrative Reconsideration of MCO Decisions on Claims for Reimbursement

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GOVERNMENT OF THE DISTRICT OF COLUMBIA

April 1, 2017

Department of Health Care Finance



Request for Administrative Reconsideration

Date: Click here to enter a date.

REQUESTOR INFORMATION	RECONSIDERATION INFORMATION
Name: Click here to enter text.	MCO Name: Click here to enter text.
Title: Click here to enter text.	
FQHC: Click here to enter text.	
FQHC NPI #: Click here to enter text.	MCO ID: Click here to enter text.
Fax: Click here to enter text.	
Phone #: Click here to enter text.	
Email: Click here to enter text.	

As part of my request for administrative reconsideration, I am submitting the following (*each item must be checked to ensure completion*):

- A copy of the final written notice of determination (WND) indicating that the FQHC has exhausted all available appeal opportunities with the MCO, or documentation indicating the deadline for the MCO to render a final WND has expired.
- An original fee-for-service equivalent claim for reimbursement which must include:
 - Date of Service;
 - Healthcare Common Procedure Coding System/Current Procedural Terminology code;
 - Payment amount at issue;
 - Medicaid ID of the enrollee; and
 - Name and Date of Birth of enrollee.
- A written statement describing why the MCO’s decision should not be upheld, including any supporting documentation.

This form must be completed in its entirety or the request will not be processed. If there are additional questions, please contact DHCF’s Appeals Coordinator (dhcfappeals@dc.gov). Allow forty-five (45) calendar days for review and adjudication of your request. Requestors will be notified of DHCF’s decision in writing via email and letter.