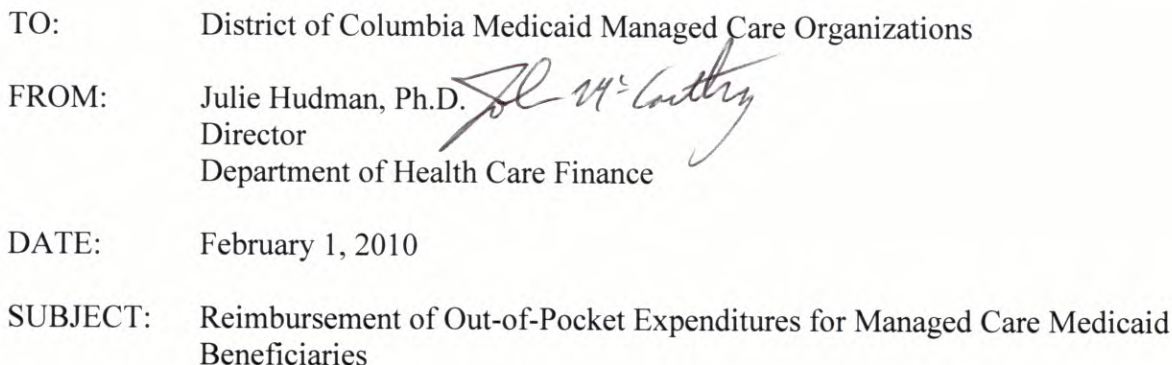
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Director

DHCF Transmittal No.: 10-06



TO: District of Columbia Medicaid Managed Care Organizations

FROM: Julie Hudman, Ph.D.
Director
Department of Health Care Finance

DATE: February 1, 2010

SUBJECT: Reimbursement of Out-of-Pocket Expenditures for Managed Care Medicaid Beneficiaries

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Pursuant to the terms of the contract entered into by the Managed Care Organizations (MCO's) and the District of Columbia, each DC Medicaid MCO is required to comply with the terms of the *Salazar* Settlement Order, including any subsequent Orders entered by the Court.

On September 2, 2005, in the *Salazar* case, Judge Gladys Kessler approved and entered the Order Setting Reimbursement Procedures for Medicaid Beneficiaries Enrolled with a DC Medicaid Managed Care Organization. The Order sets the procedure for the MCO's to make and communicate to their enrollees, determinations on reimbursement claims that are submitted by an MCO enrollee to the MCO directly or to the Recipient Claims Research Team at the Department of Health Care Finance (DHCF).

The Medicaid Reimbursement Form (Attached) is available from DHCF in Spanish, Mandarin Chinese, Vietnamese, Amharic, Korean, and French for your enrollees with limited English proficiency.

The general procedure for such reimbursement requests is as follows:

(1) The enrollee or their representative will submit the claim to DHCF. The Medicaid Reimbursement Form will ask the Medicaid recipient to identify, if known, the managed care organization with which he or she is currently enrolled.

(2) DHCF will verify the recipient's MCO enrollment status at the time the expense was incurred.

(3) If the claimant was an MCO enrollee at the time the expense was incurred, DHCF will notify the enrollee that his or her claim will be determined by the MCO. DHCF will also provide the enrollee with basic information regarding his or her rights to file a grievance or request a fair hearing should he or she be unhappy with the determination made by the MCO.

(4) Reimbursement will be subject to the following: (a) the individual was eligible for Medicaid and a member of the MCO at the time medical service was given, (b) the medical expense (e.g., drug prescription, doctor visit or hospitalization) was medically necessary and covered under Medicaid, and (c) the reimbursement request is submitted within six months after the medical expense was incurred.

(5) DHCF will forward the claim, along with the notice letter that is sent to the claimant, to the MCO. DHCF will complete this task within 30 days from the date the claim was submitted and inform the enrollee that the claim will be determined by your MCO. See Sample Notice Letter, Exhibit B to the Order.

(6) Some claimants may submit reimbursement claims directly to the MCO. Whether the reimbursement claim is received directly from the enrollee or via DHCF, the MCO has 60 days from the receipt of the claim to complete its investigation into the claim and mail to the claimant a final written determination. Final written determinations consist of one of the following: (1) full payment of the claim; (2) partial payment of the claim with a full explanation of the reasons for the denial of part of the claim; or (3) denial of the claim with a full explanation of the reasons for the denial. All denials of reimbursement claims, in whole or in part, shall include a statement of the claimant's due process appeal rights and rights concerning grievances as set forth in sub-paragraphs (a)-(h) below. MCOs are not obligated to reimburse for claims unless the claim is for the type of medical assistance that the MCO would have been obligated to provide under its contract with DHCF.

The written explanation must contain, at a minimum, the following language and the Language Access taglines agreed upon by DHCF and the MCOs:

(a) "Your request for reimbursement for _____ has been denied for the following reasons: ____."

Each element of the claim that is being denied, in part or in whole, should be given a separate explanation stating the basis for the denial. Provide as much detail as possible, writing at a fifth-grade reading comprehension level.

(b) "If you are not happy with any of these decisions, you have the right to file a grievance with the ____ **Department of this MCO at telephone number** _____, **address** _____. You also have the right to request a fair hearing with the District of Columbia Office of Administrative Hearings. You must make either of these requests within 90 days."

(c) "If you wish to file a grievance with the MCO, you may do so either in writing or orally. If you file a grievance orally, you must submit a written statement within 10 days of your oral statement, unless the MCO has already decided your grievance. You will receive a written resolution within 14 working days unless the MCO gives you written reasons why it cannot decide your claim in this time period. The total period of time cannot exceed 30 working days. The written resolution will either be full or partial payment of your claim or a statement denying payment. If your payment is denied, the MCO will state the reason for the denial and your right to request a fair hearing."

(d) "You may request a fair hearing immediately, as well as before, during or after you have filed a grievance with the MCO. You do not need to file a grievance to request a fair hearing. You must request the fair hearing within 90 days of receiving the determination from your MCO. Your request should be submitted to the D.C. Office of Administrative Hearings, 825 N. Capitol St., N.E., Suite 4150, Washington, DC 20002, 202-442-9091."

(e) "If you are not happy with the result of your fair hearing, you have the right to appeal that decision to Judge Gladys Kessler of the U.S. District Court for the District of Columbia. You must file your appeal within 30 days after the results of your fair hearing are issued."

(f) "If the MCO's decision is reversed during the fair hearing or on appeal to Judge Kessler, the MCO has 10 working days to provide the reimbursement."

(g) "If you would like assistance in filing a grievance or a fair hearing request, you may contact your MCO's ______ **Department at telephone number** _____, **address** _____. You have the right to request access to documents, records and other information you may require to understand the determination and effectively argue against that determination. You also have the right to reasonable assistance which includes, but is not limited to, competent professional interpreter services and access to toll-free telephone numbers that have adequate TTY/TTD."

(h) "To obtain free legal assistance, please contact Terris, Pravlik and Millian, LLP, 1121 12th Street, N.W., Washington, DC 20005, 202-682-0578."

(7) If the MCO fails to issue a written determination within the 60-day time period, it is required to pay the claim, in full, within 5 working days.

(8) If DHCF fails to submit the claim to the MCO and in the event of such failure DHCF fails to issue a written determination within 90 days from the date of the submission of the claim, DHCF is required to pay the claim, in full, within 15 working days. If DHCF pays the claim, it is entitled to a full recovery from the MCO if it is later determined to be a proper reimbursement request.

In addition to being under a general obligation to comply with Court Orders pertaining to *Salazar v. District of Columbia*, the requirements in this Order are consistent with those found in the contractual language.

As you know, if the claimant is successful during the fair hearing, you cannot appeal that decision.

For additional information, please contact Colleen Sonosky, Associate Director, Office of Preventive and Acute Care, DHCF, on (202) 442-5913.

Attachment

TO ALL DISTRICT OF COLUMBIA MEDICAID RECIPIENTS
WHO PAID FOR MEDICAL EXPENSES THAT SHOULD HAVE BEEN
PAID BY MEDICAID

If you do not speak and/or read English, please call (202) 442-5988 between 8:15 a.m. and 4:45 p.m. A representative will assist you.

Si no habla o lee inglés, llame al (202) 442-5988 entre las 8:15 a.m. y las 4:45 p.m. Un representante se complacerá en asistirle.

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(202) 442-5988 ወዋነጲጽሆዩ። ኚት ቅነቾወ ወማዊጰኖቆሀ።

Nếu bạn không nói và/hoặc đọc tiếng Anh, xin gọi (202) 442-5988 từ 8 giờ 15 sáng đến 4 giờ 45 chiều. Sẽ có người đại diện giúp bạn.

如果您不能講和/或不能閱讀英語，請在上午 8:15到下午 4:45之間給

(202) 442-5988 打電話，我們會有代表幫助您。

영어로 대화를 못하시거나 영어를 읽지 못하시는 경우, 오전 8시 15분에서 오후 4시 45분

사이에 (202) 442-5988번으로 전화해 주시기 바랍니다. 담당 직원이 도와드립니다.

Si vous ne parlez pas ou lisez l'anglais, s'il vous plaît appeller (202) 442-5988 entre 8:15 du matin et 4:45 du soir. Un représentant vous aidera.

If you paid for drug prescriptions, doctor visits, or hospitalizations during a time that you were eligible for Medicaid, you may be able to be reimbursed for the expenses.

REQUIREMENTS: You may be eligible for reimbursement if during a period of time you or a family member were eligible for Medicaid, if:

a. You paid for drug prescriptions, doctor visits, or hospitalizations; or
b. You are still paying a bill or being asked to pay a bill by a pharmacy, clinic, doctor or hospital for drug prescriptions, doctor visits, or hospitalizations.

If you believe that you are entitled to reimbursement, you must request reimbursement within 6 months of the date you went to the pharmacy, clinic, doctor or hospital, or within 6 months of the date you learned you were eligible for Medicaid.

DEFINITION OF "ELIGIBLE FOR MEDICAID": The period of time for which you are "eligible for Medicaid" and may be eligible for reimbursement means:

1. The dates that the District of Columbia stated you (and/or your family members) were eligible for Medicaid.
2. The 3 months before you submitted your application for Medicaid (and you were later found eligible).
3. The time after you filed your application for Medicaid and were waiting for a decision (and you were later found eligible).
4. Any time you were improperly denied eligibility or services:
   a. If the District of Columbia improperly stopped your eligibility at the time of recertification.
   b. If the pharmacy, clinic, hospital, or doctor's office required you to pay because they said you were not on Medicaid when you actually were.

IN ORDER TO BE REIMBURSED, YOU MUST:

1. Complete the enclosed Medicaid Reimbursement Form.
2. Attach the receipt from the doctor, clinic, hospital or pharmacy that shows the expenses you paid.
3. If you do not have a receipt from the doctor, clinic, hospital or pharmacy, you may provide a signed and dated letter explaining why you do not have the receipt.

4. Submit the Medicaid Reimbursement Form with the receipt(s) (or the letter explaining why you do not have a receipt) to the address on the Medicaid Reimbursement Form.
5. **Remember** that you have 6 months from the date you went to the pharmacy, clinic, doctor or hospital or from the date you learned you were eligible for Medicaid to pay the expense, to submit the Medicaid Reimbursement Form. If you do not have all of the information, you should submit as much information as you have available.
6. Reimbursement will only be made for expenses that should have been paid by Medicaid. You should carefully review the documents you submit to be sure that they are fully accurate.

IF YOU HAVE QUESTIONS OR IF YOU NEED HELP COMPLETING THE FORM OR OBTAINING REQUESTED INFORMATION CONTACT:

- The Medicaid recipient Claims Research Team of the D.C. Department of Health Care Finance (DHCF) at (202) 698-2009.

- Terris, Pravlik & Millian, LLP, 1121 12th Street, NW, Washington, D.C. 20005, (202) 682-0578, who will provide you with free legal assistance.

A DECISION ON YOUR REIMBURSEMENT CLAIM MUST BE MADE WITHIN 90 DAYS:

- The Medicaid Recipient Claims Research Team must make a decision on your reimbursement claim within 90 days from the time you file your claim. If no decision is made within those 90 days, you claim will be treated as valid, and you will be paid within 15 days after the end of the 90-day period.

- If you are not satisfied with the decision of the Medicaid Recipient Claims Research Team, you have a right to a fair hearing. You may request a fair hearing by calling (202) 442-9091. If you are not satisfied with the result of the fair hearing, you may appeal to the United States District Court of the District of Columbia within 30 days. You may obtain free legal assistance to help you present your case at the fair hearing or at the appeal by contacting Terris, Pravlik & Millian, LLP, 1121 12th Street, NW, Washington, D.C. 20005, (202) 682-0578.

MEDICAID MCO REIMBURSEMENT FORM

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Si vous ne parlez pas ou lisez l'anglais, s'il vous plaît appeller (202) 442-5988 entre 8:15 du matin et 4:45 du soir. Un représentant vous aidera.

Complete and return this form no later than 6 months after you went to the pharmacy, clinic, doctor or hospital and paid for your services, or within 6 months of the date you learned you were eligible for Medicaid, to:

Recipient Claims Research Team
D.C. Department of Health Care Finance
2100 Martin Luther King, Jr. Avenue, SE, Suite 302
Washington, D.C. 20020

Your Name: ____

Daytime Phone: ____________________ **Evening Phone:** ____________________

Mailing Address: ____

____

Social Security Number: ____________________ **Date of Birth:** ____________________

Do you belong to a Managed Care Organization?

_____**D.C. Chartered**
_____**Health Right, Inc.**
_____**Health Services for Children with Special Needs (HSCSN)**
_____**Unison**
_____**Don't know**

Please provide as much of the following information as possible. You may use additional paper if you need to. For example, if you are seeking reimbursement for expenses from both a doctor and a pharmacy, it may be easier to write the information on additional paper.

For each expense (drug prescription, doctor visit or hospitalization), provide:

(1) **Name of person (you or family member) for whom Medicaid did not pay for drug prescriptions, doctor visits or hospitalizations:**

(2) **Date (or approximate date) of the expense.**

(3) **Type of expense (drug prescription, clinic, doctor visit or hospitalization):**

(4) **Name and address of pharmacy, clinic, doctor or hospital:**

(5) **How much money you spent. Attach a copy of your receipt if you have it. If you do not have a receipt, provide a signed and dated letter explaining why you do not have it.**

(6) **If you are still paying money on a bill or being asked to pay on a bill that you think should have been paid by Medicaid, explain here. Attach a copy of any letters or bills you have that a pharmacy, clinic, doctor or**

hospital sent to you. If you received a letter from a credit collection company concerning the bill, also attach that letter.

I swear, and declare under penalty of perjury that the statements I have made above and on any attached documents are true and correct.

Signature: ____ **Date:** ___________________________

In the alternative, if you wish to submit your claim directly to your managed care organization (MCO), please send this form to the claims research department of your MCO.

D. C. Chartered Health Plan, Inc.
Member Services
1025 15th Street, N.W.
Washington, D.C. 20005
Phone: 202-408-4720

Health Right, Inc.
Customer Service & Enrollment
1101 14th St. N.W.
Suite 900
Washington, D.C. 20005
Phone: 202-218-0373

Health Services for Children with Special Needs (HSCSN)
Customer Care
1101 Vermont Avenue, N.W.
12th Floor
Washington, D.C. 20005
Phone: 202-467-2737

Unison
Member Services
1225 I Street, N.W.
Suite 510
Washington, D.C. 20005
Phone: 800-701-7192