GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Deputy Director

D.C. Medical Assistance Program
Transmittal No.: 12-03

TO: District of Columbia Medicaid Managed Care Organizations

FROM: Linda Elam, PhD, MPH
Deputy Director - Medicaid

DATE: January 31, 2012

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 (MCOs) 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 MCOs 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, 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:

(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, 441 4th Street, NW; Washington, DC 20001; 202-442-9094."

(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.

If you have questions or need additional information, please call Colleen Sonosky, Associate Director of the Division of Children's Health Services, Department of Health Care Finance, at (202) 442-5913.

Attachments:
- Summary Notice
- Out-of-Pocket Reimbursement Form

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

If you do not speak and/or read English, please call toll-free 1-877-685-6391 between 8:15 a.m. and 4:45 p.m. and a representative will assist you.

Si usted no habla ni/o no lee Inglés, por favor llame gratis al 1-877-685-6391 entre las 8:15 a.m. y 4:45 p.m. y un representante lo ayudará.

如果您不會說和/或無法閱讀英文，請於早上 8:15 至下午 4:45 之間撥打免費電話 1-877-685-6391，將會有代表為您提供幫助。

Si vous ne parlez et/ou ne lisez pas l'anglais, veuillez appeler le numéro gratuit 1-877-685-6391 entre 8h15 du matin et 16h45 et un représentant vous assistera.

영어가 불편하시면 수화자 무료 전화번호인 1-877-685-6391 로 아침 8 시 15 분부터 오후 4 시 45 분 사이에 전화해 주세요. 고객 서비스 담당직원이 도와드리겠습니다.

Nếu quý vị không nói và/hoặc đọc được Tiếng Anh, xin hãy gọi đến số điện thoại miễn phí 1-877-685-6391 từ 8:15 sáng đến 4:45 chiều, và một nhân viên đại diện sẽ trợ giúp quý vị.

እንግሊዝኛ መናገር እና/ወይም ማንበብ የማይችሉ ከሆነ. እባክዎን ከክፍያ ነፃ በስልክ ቁጥር 1-877-685-6391 ከጠዋቱ 8:15 እስከ ከሰዓት 4:45 ባለው ሰዓት ውስጥ ይደውሉ እና ተወካይ ይረዳዎታል::

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 are 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 six (6) months of the date you went to the pharmacy, clinic, doctor, or hospital, or within six (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 three (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 of 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 six (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:

a. The Medicaid Recipient Claims Research Team of the D.C. Department of Health Care Finance (DHCF) at (202) 698-2009.
b. Terris Pravlik & Millian, LLP, 1121 12th Street, NW, Washington, DC 20005, (202) 682-0578, who will provide you with free legal assistance.

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

a. 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, your claim will be treated as valid, and you will be paid within 15 days after the end of the 90 day period.
b. 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 the Office of Administrative Hearings at (202) 442-9094. The Office of Administrative Hearings is located at 441 4th Street, NW; Washington, DC 20001-2714.
c. 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 at 1121 12th Street, NW; Washington, DC 20005 or (202) 682-0578.

MEDICAID REIMBURSEMENT REQUEST FORM

Today's date

DIRECTIONS: Complete and return, with receipts, within 6 months after you went to the clinic, doctor, hospital, or pharmacy – or 6 months of the date you learned you were eligible for Medicaid -- to:

Recipients Claims Research Team
DC Department of Health Care Finance
609 H Street N.E.
2nd Floor
Washington, DC 20002

Please give as much information as you can. Attach copies of your receipts. If you don't have a receipt, attach a signed and dated letter that explains why you don't have it. If you're asking for reimbursement of expenses from more than 1 provider (like a doctor *and* a pharmacy), please use separate lines for each.

Your Name	**Mailing address**	**Your phone numbers**
		Day
Social Security Number of Medicaid Recipient		Evening
		Cell
Birth Date of Medicaid Recipient	**Name & Medicaid ID # of Recipient Requesting Reimbursement**	

SUMMARY OF INFORMATION ON ATTACHMENTS

For each expense (drug prescription, doctor visit or hospitalization), give this information*

Date (or estimated date) of expense	**Name and address of pharmacy, clinic, doctor or hospital**	**How much you paid**	**How much you still owe**	**How much any other insurance paid**	**How much you want Medicaid to reimburse**

*Attach a copies of any letters or bills from the pharmacy, clinic, doctor or hospital; or letters from credit collection companies about the bill.

I swear and declare, under penalty of perjury, that the statements I made on this paper and on any attached papers are true and correct.

Signature