HEALTH SERVICES FOR CHILDREN WITH SPECIAL NEEDS, INC.

Becoming a Provider

General Claims and Billing

The HSC Health Care System

Health Services for Children
With Special Needs, Inc.
(HSCSN)

October 2013

WELCOME

We're committed to a better way of life for children and young adults with special health care needs.

Children and young adults with special health care needs deserve a unique kind of attention and a level of comprehensive care that helps to make their lives as fulfilling as possible. That is the commitment you'll find with Health Services for Children with Special Needs (HSCSN). Our innovative care management plan coordinates health, social, and education services for the pediatric Supplemental Security Income (SSI) and SSI-eligible populations of Washington, DC.

HSCSN is a dedicated District of Columbia Medicaid health plan that coordinates all aspects of physical, mental, behavioral, and developmental care and services for its members, utilizing our network of more than 2,000 providers.

Exclusively focused on special needs children and young adults up to age 26 our plan is impressively comprehensive. Our dedicated, caring staff of health care professionals is genuinely committed to helping our members and their families reach their full potential and lead better, more fulfilling lives.

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ABOUT US

Helping to fulfill the lives of children and young adults with special health care needs.

Children and young adults with special health care needs deserve a level of care that consistently and comprehensively looks out for their best interests. This belief represents the foundation of all that we seek to accomplish.

Health Services for Children with Special Needs, Inc. (HSCSN) provides innovative care to the pediatric Supplemental Security Income (SSI) and SSI-eligible populations of Washington, DC through a management network that coordinates health, social, and education services for our members.

All members are care managed individually by health care professionals. Our approach begins with a thorough screening to determine health care needs. A clinical assessment is performed and an environmental scan is conducted to check for things such as lead in the home. Plus, an assessment is made of the social aspects of a member's environment that may affect health. This in-depth analysis helps us to personalize each individual's care management plan.

Benefits to members and their families include traditional Medicaid benefits plus expanded health services including:

- Individualized care management
- 24-hour access to care coordination
- Outreach services
- Respite care
- Medically necessary home modifications
- Mental, behavioral, and developmental services

Holistic and proactive, HSCSN coordinates all aspects of physical, mental, behavioral and developmental care and services for its members. HSCSN is a subsidiary of The HSC Foundation, along with The HSC Pediatric Center and HSC Home Care, LLC.

A. Provider Credentialing Process

Initial Credentialing – Criteria, Verification and Time Limits

Interested parties may apply for participation by completing an application through the Council for Affordable Quality Care (CAQH) at https://upd.caqh.org/oas or contact the CAQH Help Desk at 1 (888) 599-1771.

All dental providers interested in participating with HSCSN, should contact the Quality Plan Administrators (QPA) at (202) 722-2744.

Already a CAQH Provider

Providers who have previously obtained their CAQH ID and are interested in joining HSCSN may submit a **Provider Interest Form** (***See Forms Section***) via electronic mail to TThompson@hscsn.org or via fax to (202) 480-2333. Please be sure that CAQH has the most current and accurate information as this will expedite the credentialing process.

Becoming a CAQH Provider

Providers who have not yet obtained a CAQH ID, complete and submit a **Provider Interest Form** *(See Appendix A – Forms)* via email to TThompson@hscsn.org or via fax to (202) 480-2333.

Next Steps:

1. A pending file will be created and you will be notified of your CAQH ID.
2. Once you have been provided with a CAQH ID, you will then need to login to CAQH to ***complete*** your provider application.
3. Upon completion of your application, CAQH will send you a confirmation that they have received your data.
4. Notify the Credentialing department (phone or email) that your application has been received by CAQH.

Your CAQH ID may be used by any health plan that is actively participating with CAQH.

Completed applications will be downloaded and processed within 60 days. You have the right to be advised of your application status and may contact the Credentialing department via phone at (202) 974-4693 or in writing. Once the application process is completed, you will be notified by certified mail of the Credentialing Committee's decision.

Recredentialing

HSCSN re-credentials its providers every three years. HSCSN will only contact the provider if your CAQH information is outdated.

Medicaid requires that Primary Care Providers contact HSCSN, if patient panel exceeds 2,000 Medicaid-eligible patients. You must notify HSCSN at least 30 days in advance of reaching maximum capacity.

i. Frequently Asked Questions (FAQs) About the Credentialing Process

This FAQ is provided to health care personnel and practitioners to familiarize you with HSCSN's credentialing process and how it relates to CAQH (Council for Affordable Quality Healthcare). Please visit https://upd.caqh.org/oas to complete the credentialing application.

1. What is CAQH?

CAQH is a national organization used to collect provider data for credentialing purposes. The application may be used by any participating health plan with CAQH. This streamlines the credentialing process for practitioners by reducing paperwork.

2. What if I do not have a CAQH ID?

HSCSN will only accept CAQH applications. In order to obtain a CAQH ID, please complete the provider interest form and forward to TThompson@hscsn.org. Please have the following available:

a. Practitioner's first and last name
b. Address and telephone number
c. Date of Birth
d. Social Security Number
e. Specialty

3. How long does the credentialing process take?

On average, applications are processed within 30 days.

4. What can cause a delay in the credentialing process?

When an application is not complete in CAQH, this will cause a delay in the credentialing process. Prior to informing HSCSN of your intent to become a provider, please be sure to:

a. Review your CAQH application
b. Check for expiring licensures and certificates
c. Sign and date the Attestation
d. Update all material as needed

5. I've completed my application on CAQH. Why is it not current with HSCSN?

When an application is complete on CAQH, there are several reasons HSCSN will request updates and/or additional information:

a. CAQH may not meet the specific guidelines required by HSCSN
b. It takes several days for CAQH to scan documents i.e. (license, liability) Please allow 72 hours for CAQH data base updates.

6. How soon am I able to begin seeing patients?

Upon approval of your application, you will receive a certified letter informing you of the effective date.

7. Can I become credentialed before I have a contract with HSCSN?

No. A contract should be obtain prior to you being credentialed. Please contact JFord@hscsn.org or (202) 495-7644 if you are interested in joining HSCSN.

8. Who can I contact for further assistance?

Please contact Tyhisia Thompson at TThompson@hscsn.org for further assistance.

B. Contracting

HSCSN recruits licensed, Board-certified or Board eligible Providers needed to provide comprehensive, accessible, and Culturally Competent care on an ongoing basis.

INSTRUCTION FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (DC-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, AND XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the District of Columbia state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required.

Failure to submit requested information may result in a refusal by the D.C. State Agency to enter into an agreement or contract with any such institution or in termination of existing agreements. ***(See Appendix A for Disclosure Form.)***

C. Provider Services

HSCSN's Provider Service staff is available to help your office with all Provider relation functions including but not limited to the following:

i. Training procedures for authorization and Claims payments;

ii. Assisting Providers to resolve billing and other administrative problems;

iii. Responding to Provider concerns about administrative processes;

iv. Assisting the Department of Health Care Finance (DHCF) in notifying Providers of DHCF initiatives; and

v. Responding to Provider concerns about Enrollees.

D. Provider Resources

Visit our website at www.hscsn-net.org. Our online Resource Center provides access to pertinent information (from the home page click "Provider Services," then "Provider Resources").

Provider Manual

Clinical Practice Guidelines

Provider Directory

Mental Health Screening Tool

Dental Periodicity Schedule

HealthCheck Provider Education System

HIV Resource Directory

Transportation Guidelines

Newsletters

New HSCSN Home-Based BH Services

HSCSN BH Home Services Referral Form

BHHS ISP Tool

BHHS Assessment Tool

OIG Notification

UM Authorization and Appeal Process

Authorization Update

Home Care Referral Form

Mental Health Provider Letter

Perinatal Collaborative Fact Sheet

Global Auth and PsychoSocial Form

Perinatal Communication Tool

2011 Provider Training-DC Collaborative to Improve Birth Outcomes

E. Overview of Care Coordination

HSCSN is a managed care organization specializing in care coordination services for SSI eligible Medicaid recipients in the District of Columbia between birth and 26 years of age. The goals of the care coordination program are to ensure enrollees receive high quality health care, are knowledgeable of HSCSN benefits and resources, and work effectively with providers and agencies to improve and/or maintain enrollee health and well-being.

Care coordination is a series of activities provided by HSCSN Care Managers to assist enrollees in gaining access to necessary services (medical, behavioral and others), coordinate preventative and specialty services, and facilitate communication and coordination in the medical home. Care coordination is individualized, empowering, comprehensive, and outcome-focused.

Note: HSCSN is not a social services agency nor does its staff provide clinical services. HSCSN Care Managers cannot function as a surrogate parent/guardian or decision maker for the enrollee or caregiver.

What are the Care Manager's role and responsibilities?

- Develop a relationship with and support the enrollee and/or caregiver
- Develop relationships with physicians and providers servicing enrollees
- Communicate with enrollee, caregiver, treating physician(s) and providers
- Assist the family with identifying their medical needs
- Facilitate access and coordinating services for the enrollee (identify provider, schedule appointments, coordinate transportation)
- Develop and monitor the care coordination plan
- Educate enrollees and families on HSCSN benefits, resources and processes
- Identify and coordinate enrollee/caregiver education needs (classes, literature, referrals)
- Support the relationship between the enrollee and their providers
- Connect the enrollee/caregiver with resources
- Make referrals to educational advocates and attend educational meetings (with permission of enrollee/caregiver)
- Assist the provider with obtaining home evaluations and/or social work assessments
- Assist the provider and family to address overutilization and underutilization of services and noncompliance

What are the functions of the Care Manager in care coordination?

Activity	Care Manager
Assessments - Initial and periodic	• Perform structured interview with enrollee and/or caregiver to assess medical, physical, functional, psychosocial, behavioral, environmental, legal, vocational and educational needs and concerns • Incorporate assessment findings in a CCP; use to help determine acuity level and frequency Care Manager interventions
Care Coordination Plan (CCP)- Initial and periodic	• To develop a summary and plan of the enrollee's needs, strengths goals, resources and needed actions • Obtain Provider and Family input and signature
Appointment and Referral Support	• Assisting the family with identifying providers • Scheduling/assisting with the scheduling of appointments and transportation • Coordinating the delivery of services to reduce fragmentation of care • Facilitating communication and collaboration among all service providers and the enrollee • Making referrals and facilitating access to community based support services and programs • Assisting the enrollee as he/she transitions through levels of care
Preventive and Chronic Care Monitoring/ Follow-up	• Monitor compliance with all PCP and specialty appointments • Monitor ER visits and hospitalizations and follow-up • Monitor EPSDT and immunization compliance • Monitor services being provided and progress toward goal in accordance with the CCP • Monitor for changes in the needs or health status • Conduct Face to Face visits as per acuity level
Coordination of transitions	• Participate with DCPS to coordinate Early intervention and school-based services (IFSP and IEP) • Identify enrollees meeting the requirements for Developmental Disabilities Administration (DDA) programs, assist families with the application process, and coordinate medical services covered by HSCSN • Discharge from hospital (acute or ED), long-term care or residential facilities (PRTF) to home

Results of the initial and periodic Assessment are used to assign enrollees to an Acuity Level (I-III). The Acuity Level determines the frequency of CCP and Face to Face visit interventions by the assigned Care Manager.

	CCP	F2F Visits
Level I	Updated once yearly and as warranted	1 visit/ year and as warranted
Level II	Updated once yearly and as warranted	2 visits/year and as warranted
Level III	Updated twice yearly and as warranted	3 visits/year and as warranted

Working with the Care Manager – what is the role of the Provider?

- Comply with EDSDT and adult preventive care requirements and guidelines
- Collaborate in development of the Care Coordination Plan (review, edit, sign, and return)
- Follow the HSCSN Referral Guidelines for services requiring preauthorization
- Ensure that referrals for home care, durable medical equipment and medical supplies are complete and that services are monitored as indicated
- Communicate with the HSCSN Care Manager about concerns (risks, noncompliance, overutilization, underutilization, health education needs, etc.) and progress

F. Referrals and Authorization of Services

HSCSN encourages the primary care provider (PCP) to coordinate specialty services for the enrollee. Prior authorization is not required for identified services to participating (in network) providers. The enrollee should possess a referral from their PCP, or other referring provider, to present to the service provider when presenting for an appointment.

If a provider elects to refer enrollees to nonparticipating (out of network) specialists for any reason these requests must receive prior authorization from HSCSN before the enrollee accesses the service.

The following services <u>DO NOT REQUIRE</u> prior authorization:

- Specialty office visits (except behavioral health)
- Primary care visits
- Well woman care (including Depo-Provera shots)
- Vision services (including eye glasses)
- Labs and radiology (including X-Rays, sonograms, MRIs, CT and PET Scans)
- Dialysis – end-stage renal disease

The following services <u>REQUIRE</u> prior authorization:

Behavioral

- Psychiatric and neuropsychiatric evaluations
- Psychological testing and evaluations

- Psychotherapy, counseling and applied behavioral analysis (ABA)
- Psychotropic medication management visits
- Intensive outpatient programs and day rehabilitative services
- Partial hospitalization programs
- Sub-acute admission
- Substance abuse treatment (inpatient and outpatient)
- Residential treatment facility
- Intermediate care facility for mental retardation (ICF-MR)
- Dialysis – end-stage renal disease

Medical/Surgical

- Early intervention services
    - Under 3 years of age – authorizations are issued by enrollees assigned Care Manager.
    - Over 3 years of age – authorizations are issued by enrollees assigned Care Manager.
- Rehabilitative therapies (physical, speech, occupational)
- OB global services and services associated with pregnancy
- Home health (nursing, personal care aide and rehab therapies) and hospice care
- Durable medical equipment, orthotics, prosthetics, and assistive technology
- Supplies and nutritional supplements
- Anesthesia for dental procedures
- Elective medical admissions (including feeding programs)
- Facility admissions (sub-acute, rehab, transitional and long-term care)
- Elective surgery (including plastic surgery), outpatient and inpatient
- Home modification

G. General Claims and Billing Information

HSCSN will process all claims through an automated system. Our goal is to pay providers for covered services within 30 days of receipt of each completed clean claim form. Your tax identification number is your provider ID. Please include it and the NPI on every claim to help expedite payment.

Professional providers and Home Health Agencies are required to submit for payment of covered services on the Centers for Medicare and Medicaid Services (CMS)-1500 Health Insurance Claim Form and Home Health Agencies. Hospitals are required to submit for payment of covered services on the CMS UB04. These forms are available at www.cms.hhs.gov/CMSForms.

Providers have the option of submitting claims electronically through EMDEON or via mail. HSCSN's payor ID is 37290. Claims should be mailed to: HSCSN, P.O. Box 29055, Washington, DC 200017.

Do not submit a duplicate claim for at least 45 days after submitting the original claim.

As a managed care organization for DC Medicaid, HSCSN is always payer of last resort. If the enrollee has other insurance coverage, submit to the other carrier first. HSCSN will only consider the claim after it is submitted with an Explanation of Benefits from the other carrier or with a letter of denial.

i. Electronic Submission of Claims

HSCSN is able to accept claims electronically that are processed through EMDEON clearinghouse. It is not necessary that you use EMDEON—only that your claims management company is able to submit claims through EMDEON as a clearinghouse.

If you have any questions, contact your claims management provider. To submit claims, you will need the HSCSN Payor ID which is: 37290.

Advantage of Electronic Claims Submission

- Claims can be tracked electronically via www.emdeon.com/PayerLists/payerlists.php
- Improved patient collections
- Rapid and accurate payment processing

If you are currently not submitting electronically and have an interest in doing so, please let us know. HSCSN's payor ID for electronic submission is 37290 and Emdeon is the clearinghouse that we use.

ii. Claims Payment Capacity

HSCSN shall pay all claims for Covered Services provided to Enrollees on dates of service when they were eligible for enrollment.

HSCSN has written policies and procedures for processing claims submitted for payment from any source and monitors compliance with those procedures. The procedures, at a minimum, specify time frames for:

- Submission of Claims
- Date stamping Claims when received
- Determining, within thirty (30) days from receipt, whether a Claim is a Clean Claim
- Payment of Claim in accordance with the Prompt Payment Act, D.C. Code §31-3132
- Follow-up of pending and denied Claims to obtain additional information
- Reaching a determination following receipt of additional information
- Payment of Claims following receipt of additional information

- Sending notice of a denied Claim to the Enrollee and the Provider, which includes a Provider's Appeal rights.

- HSCSN shall utilize the standard Denial of Claim form provided by the Department of Health Care Finance

iii. Timely Processing of Claims

- In accordance with D.C. Code § 31-3132, HSCSN shall accept Network and non-Network Provider initial Claims for Covered Services no later than one hundred and eighty (180) days from the date of service.

- HSCSN will pay ninety percent (90%) of all Clean Claims within thirty (30) days of receipt consistent with the claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act and 42 C.F.R.§§ 447.45.

iv. In-Patient Authorizations

HSCSN has a Utilization Review Mailbox. Hospital providers are required to provide the following information within 24 hours of admitting an enrollee:

- Patient name, date of birth
- Room number (if applicable)
- Diagnosis (if known,)
- Date/time of admission

Hospital providers are requested to call the Utilization Review mailbox at (202) 721-7162 with the aforementioned information. For more information, please contact the HSCSN Customer Care Department at (202) 467-2737.

v. Coding Manuals

International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM)
ICD-9-CM was sponsored in 1979 as the official system for assigning codes to diagnoses (inpatient and outpatient care, including physician offices) and procedures (inpatient care). The ICD-9-CM is available from commercial publishing companies and are helpful in manual coding because they contain color-coded entries that identify required additional digits, nonspecific and unacceptable principal diagnoses.

International Classification of Diseases 10th Clinical Modification (ICD-10-CM)
Effective October 1, 2013, ICD-10-CM codes will be required. The biggest difference is that the new ICD-10 codes are alphanumeric. ICD-10-CM far exceeds ICD-9-CM in the number of codes provided, having been expanded to 1) include health-related conditions, 2) provide much greater specificity at the sixth digit level, and 3) add a seventh digit extension (in some conditions).

Assigning the sixth and seventh characters when available for ICD-10-CM is mandatory because they report information documented in the patient records.

Current Procedural Terminology (CPT®)
Current Procedural Terminology (CPT) is a listing of descriptive terms and identifying 5-digit codes for reporting medical services and procedures. Procedures and services submitted must be linked to the ICD-9-CM code that justifies the need for the service or procedure.

Modifiers
The CPT® coding system includes two-digit modifiers that are used to report that a service or procedure has been "altered or modified by some specific circumstance" without altering or modifying the basic definition or CPT code. The proper use of CPT modifiers can speed up claim processing and increase reimbursement, while improper use of CPT modifiers may result in claim delays or claim denials.[1]

Heath Care Common Procedure Coding System (HCPCS)
Healthcare Common Procedure Coding System and is used to describe durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), and certain other services reported on claims.

CMS1500
The insurance claim used to report professional and technical services is known as the CMS-1500 claim. ***(See page 27 for complete instructions on the CMS1500.)***

The National Uniform Claim Committee (NUCC) is responsible for the design and maintenance of the CMS-1500 form. Neither CMS nor HSCSN supplies the forms to providers for claims submission.

In order to purchase claim forms, you should contact the U.S. Government Printing Office at 1-866-512-1800, local printing companies in your area, and/or office supply stores. Each of the vendors above sells the CMS-1500 claim form in its various configurations (single part, multi-part, continuous feed, laser, etc).

The only acceptable claim forms are those printed in Flint OCR Red, J6983, (or exact match) ink. Although a copy of the CMS-1500 form can be downloaded, copies of the form cannot be used for submission of claims, since your copy may not accurately replicate the scale and OCR color of the form. The majority of paper claims sent to carriers and DMERCs are scanned using Optical Character Recognition (OCR) technology. This scanning technology allows for the data contents contained on the form to be read while the actual form fields, headings, and lines remain invisible to the scanner. Photocopies cannot be scanned and therefore are not accepted by all carriers.

[1] CPT PLUS! 2011

vi. Place of Service Codes

01 Pharmacy
03 School
04 Homeless Shelter
05 Indian Health Services Freestanding Facility
06 Indian Health Services Provider-based Facility
07 Tribal 638 Freestanding Facility
08 Tribal 638 Provider- based Facility
09 Prison Correctional Facility
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
15 Mobile Unit
16 Temporary Lodging
18 Residential Facility
20 Urgent Care Facility
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance land
42 Ambulance – air or water
49 Independent Clinic
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility – Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility- Mentally retarded
55 Residential Substance Abuse treatment facility
56 Psychiatric Residential Treatment Center
57 Nonresidential Substance Abuse Facility
60 Mass Immunization Center
61 Comprehensive Inpatient Rehab Facility
62 Comprehensive Outpatient Rehab Facility
65 End-stage Renal disease treatment facility
71 Public Health Clinic
72 Rural Health Clinic
81 Independent Lab
99 Other place of service

vii. National Provider Identifier (NPI)

A **National Provider Identifier** or **NPI** is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).

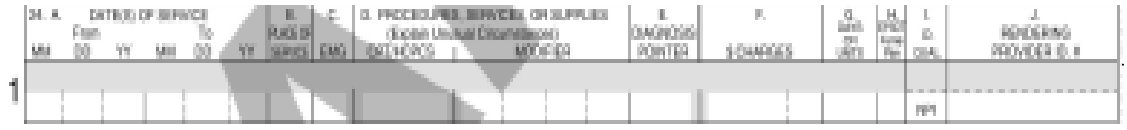
The NPI has replaced the unique provider identification number (UPIN) as the required identifier for Medicare services, and is used by other payers, including commercial healthcare insurers. The transition to the NPI was ***mandated*** as part of the Administrative Simplifications portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans were required by regulation to use only the NPI to identify covered healthcare providers by May 23, 2007.

All individual HIPAA covered healthcare providers (physicians, physician assistants, nurse practitioners, dentists, chiropractors, physical therapists, etc.) or organizations (hospitals, home health care agencies, nursing homes, residential treatment centers, group practices, laboratories, pharmacies, medical equipment companies, etc.) must obtain an NPI for use in all HIPAA standard transactions, even if a billing agency prepares the transaction. Once assigned, a provider's NPI is permanent and remains with the provider regardless of job or location changes.

The NPI number can be obtained online through the National Plan and Provider Enumeration System (NPPES) at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

NPI and the CMS-1500

Block – 24J – Enter the 10 digit NPI for the provider who performed the service.



Block 33a – Enter the 10 digit NPI for billing provider or group practice/clinic.

Block 31 – Enter the name and credentials of the provider rendering the service.

Any claims submitted without the NPI will be denied.

viii. Coordination of Benefits

Health Services for Children with Special Needs, Inc. (HSCSN), is always the payer of last resort when the enrollee has another insurance coverage. As a provider, you must always submit your claims to the other insurance company first. Once you receive

an explanation of payment from them, you should file the claim with HSCSN. You must attach a copy of the explanation of payment from the other carrier or a copy of the letter of denial. HSCSN will coordinate the payment with the other carrier's payment. HSCSN will pay the provider charge or the amount that is contracted, whichever is less. When there is a primary payor HSCSN will pay the lesser of the charge or contracted amount, less amount paid by primary.

ix. Early Intervention

Special Note:

- ❑ Under 3 years of age – bill HCPCS code T1025
- ❑ After 3 years of age – each therapy (physical, occupation and speech) must be billed separately. Therapies cannot be bundled for billing purposes.

x. EPSDT Billing

Office Visit Codes

The following office visit codes are used to bill for EPSDT visits and are **age specific**. There are also different codes to distinguish between new and established patients.

- ❑ **When billing for an EPSDT visit and a sick visit for either new or established patient, use modifier 25 with the office (sick) visit.**
- ❑ ***For example*:** 99384 and 99201 with a modifier 25 or 99212 with modifier 25.

New Patient

Code	
99381	Infant under 1 year of age
99382	Early Childhood – age 1 to 4 years
99383	Late Childhood – age 5 to 11 years
99384	Adolescent – age 12 to 17 years
99385	Age 18 to 22 years

Established Patient

These codes include the reevaluation and management of an individual including a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of appropriate laboratory and diagnostic procedures for an established patient.

Code	
99391	Infant under 1 year of age
99392	Early Childhood – age 1 to 4 years
99393	Late Childhood – age 5 to 11 years
99394	Adolescent – age 12 to 17 years
99395	Age 18 to 22 years

Immunization Codes

HSCSN pays for the administration of vaccines only.
Codes for administration 90465-90474
Codes for vaccine rejected 90476 - 90749

Code	
90700	Diphtheria, Tetanus Toxoids and Acellular Pertussis vaccine (DTap)
90701	Diphtheria, Tetanus Toxoids and Pertussis vaccine (DTP)
90702	Diphtheria and Tetanus Toxoids
90703	Tetanus Toxoid
90707	Measles, Mumps and Rubella virus vaccine, live (MMR)
90712	Poliovirus vaccine, live, oral (any type)
90716	Varicella (chicken pox) vaccine
90718	Tetanus and Diphtheria Toxoids absorbed, for adult use (Td)
90720	Diphtheria, Tetanus Toxoids and Pertussis (DTP) and Hemophilus Influenza B (HIB) vaccine
90744	Immunization, active, Hepatitis B vaccine; newborn to 11 years

Labs and Screens

Code	
85013	Hemoglobin
85014	
85018	
83655	Lead screen
81000	Urinalysis
86580	TB Test
86585	
83718	Cholesterol
83719	
85660	Sickle Cell

Dental

Code	
00120	Basic EPSDT Exam

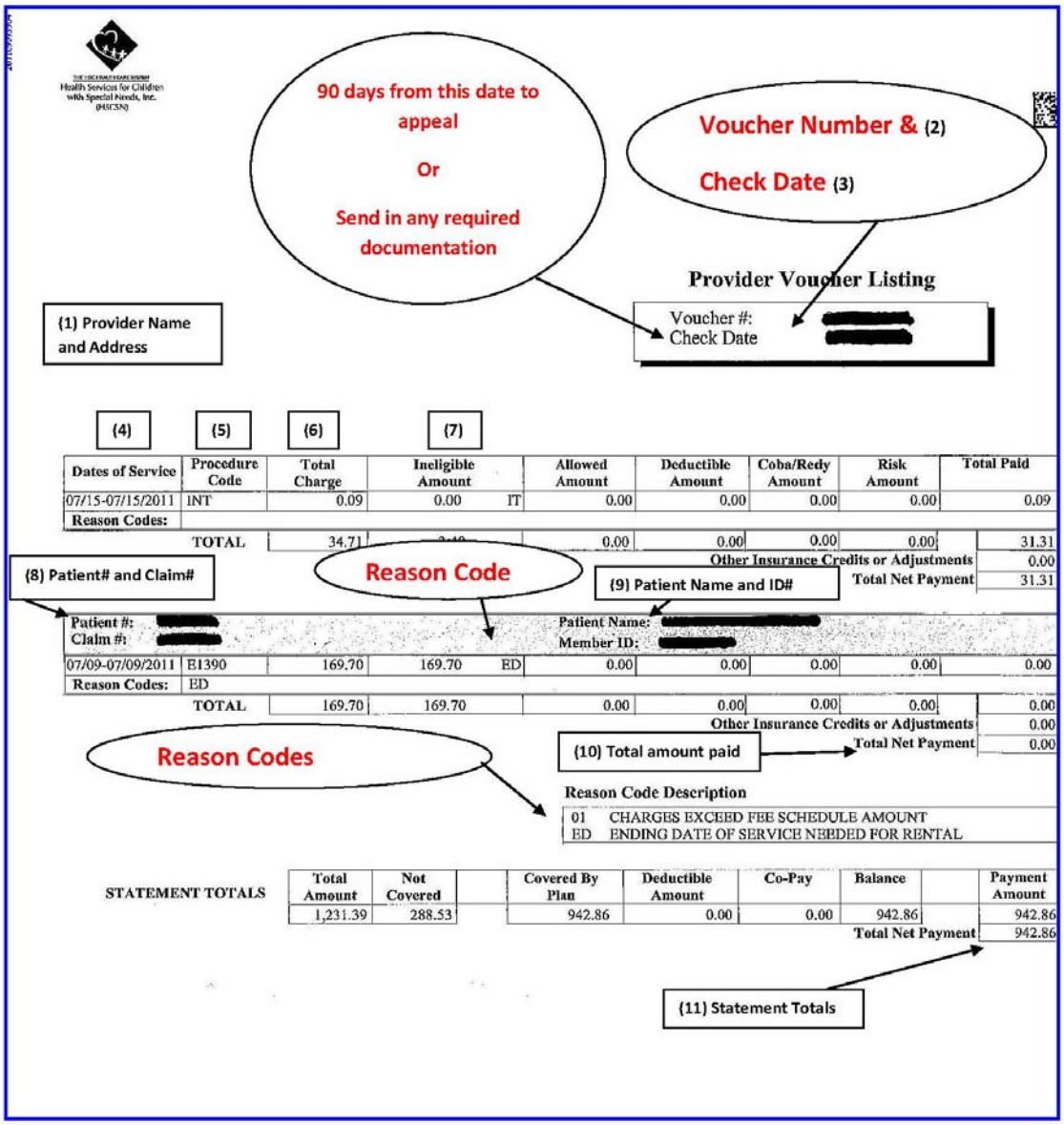
xi. Provider Voucher Listing

HSCSN generates checks once a week and uses an outside vendor to print and mail checks. As a result, it is not possible to pick up checks from the health plan.

It is imperative that you read your voucher, post your payments and review the reason code description in a timely manner. Failure to do so could result in lost revenue and worse yet, claims denied for timely filing. You have 90 days from the date on the voucher to appeal claims and/or resubmit claims with required documentation.

How to read the voucher:

1. Provider's name and mailing address
2. The voucher number
3. Check date
4. Dates of service
5. Procedure code
6. Total charge
7. Ineligible amount
8. Patient number and Claim number
9. Patient's name and Member ID (Medicaid number)
10. Reason code description
11. Statement totals



xii. Balance Billing

All members of Health Services for Children with Special Needs, Inc. are Medicaid members and cannot be billed for balances over HSCSN's paid amount. When accepting our members as patients, you agree to accept our payment as payment in full.

xiii. Appeals

Claim payments or denials can be appealed in writing ***within 90 days*** of the denial or payment.

- Appeals disputing the payment amount should include a letter requesting an adjustment of payment and the reason the payment is not correct. If the reason for incorrect payment is due to a Single Case Agreement, please include a copy of that document.
- Appeals of denied claims that include, but are not limited to, late filing or services not authorized must include the documentation that supports your case for reconsideration. This may involve sending medical records or proof of timely submission.

Examples of appeals are:

- Claim was denied because it was filed with HSCSN after the 180 day limit – The original claim was filed on time with DC Medicaid. A letter requesting reconsideration should be sent along with a copy of the rejection from DC Medicaid showing they had received it timely but rejected it because it was an HSCSN member.
- Payment amount was less than expected because of a Single Case Agreement. – A letter stating the issue should be sent along with a copy of the Single Case stating the correct payment.
- Claim was denied as not authorized – A letter stating the issue should be sent along with a copy of the authorization.
- Claims was denied for medical records, nursing notes, manufacturers invoice, or any other documentation- this information must also be supplied within 90 days.

Appeals should be sent to:

HSCSN Appeals
P.O. Box 29055
Washington, DC 20017

xiv. Claims Tips

Coding Services on the same date of service
Help us to process your claims quicker and more accurately. Do you do multiple shifts on the same day or make multiple trips to transport one of our members? If your answer is yes and you bill the services on separate claim forms for the same member, your claim may appear to be a duplicate submission and may be delayed for further investigation or may even be denied incorrectly as a duplicate. Please help us out and help us to expedite your claims by billing all services for the same date on the same claim form. If the code is the same, you can put the

services on the same claim line and indicate the number of units in box 24G of the CMS 1500. Multiple claims submissions for the same date require us to void the original claim and to reprocess your total claim all over again, extending the time to get your claim paid. Making this change will help us all to get payments out faster

Do give complete information on the member

Please provide complete information for items such as the name, birth date, and sex. Verify that this information matches the patient's insurance card. Watch out for name variations and changes. **Errors and omissions of these items cause an unnecessary delay in processing the claim.**

Do give complete information on you, the provider

Please provide complete information regarding the provider, including the names of both the treating provider and the billing entity. The taxpayer identification number for the billing entity must be given for the claim to be processed correctly. The billing or remittance address must be accurate for the check and/or voucher to be sent to the correct party.

Do ensure that the claim form is signed by the treating provider

It is important that the treating provider signs the claim form to verify that the services performed by the provider are accurately reflected in the services reported. The provider is legally responsible for the contents of the claim once the claim form is signed. **Do not give a signed claims form to the member to complete.**

Do include the complete diagnosis

If the patient has more than one Axis I diagnosis, please be sure to report all diagnoses on the claim. The diagnosis must match your authorization and the Revenue Codes (for facilities), CDT-2 (dental services) or CPT codes (for professional services) or HCPCS (for ancillary services**). Include all required 4th and 5th digits**.

Do list each date of service for each procedure code

We cannot accept dates of service combined together under "from" and "through" dates. Each date of service must be shown separately. It is permissible to use "from" and "through" date fields for consecutive dates, such as: FROM THROUGH #DAYS/UNITS 9/1/13 9/2/13
By doing so, we are able to see each date of service. **Any more than two service dates on one line will delay processing.**

Don't use invalid procedure or diagnosis codes

Only use current code sets (CPT, HCPCS, Revenue, and ICD-9) and select the code and diagnosis that most accurately describe the service provided. Codes other than CPT, revenue and HCPCS are generally not accepted in HSCSN's claims processing systems. **The claims may not be altered by the claims examiner; therefore, an incorrect code may result in denial of your claim.**

Don't omit information on the claim because you have already provided it on the encounter/treatment plan.
For confidentiality purposes, claims examiners do not have access to member encounters/treatment plans; therefore, it is necessary for you to give information on the claim that you may have already provided on the treatment plan. To assist with prompt claims processing, please be sure to provide all information required on the claim form. **Do not submit encounters/treatment plans with claim forms. Treatment plans are to be mailed to the Care Management Department that authorized the services.**

Don't use code 760-779.9 for children over 11 months.
ICD9 Diagnosis codes 760-779.9 are only for infants up to 11 months.

Top 10 Reasons Claims are Denied

1. Duplicate claim
2. Timely filing
3. Invalid Diagnosis
4. Invalid age
5. Invalid sex
6. Non covered procedure
7. Bilateral procedure
8. Exceeds authorization
9. Not authorized
10. Medical records requested

xv. Frequently Asked Claims Questions

1. Where do we send our claims for payment?

HSCSN Claims
P.O. Box 29055
Washington, DC 20017

2. How do I appeal a claim that has been denied or that I think has been paid incorrectly?

Send a letter of appeal and all documentation to the address above, attention: Donna Hawkins. Please be sure that you explain why the rejection or payment should be reversed. Include any documentation to support your request. If a claim was incorrectly sent to DC Medicaid and now we are denying it for late filing, please include a copy of the letter from DC Medicaid.

3. Where do I call for claim's status?

Please call our Customer Care Department at (202) 467-2737 to obtain the status of a claim. We ask that you wait 45 days from the date that you mail the claims to give the check time to get to you and for you to post the payments. More than 3 claim status checks should be faxed to the Customer Care Department at (202) 721-7169.

4. Can I bill the member?

No, all of our members are Medicaid recipients and cannot be billed. Denials and balances should be appealed to HSCSN.

5. Do I need to include my NPI number on the claim?

Yes, NPI's should be on each claim. If you do not include your NPI, you claim will be denied.

6. How long do I have to submit a claim?

Claims must be received within 180 days from the date of service.

7. When can I expect payment on claims?

HSCSN processes claims as they receive them and our goal is to process all claims within 30 days of the date we receive the claim. If your claims is not processed within 30 days and the claim was clean (it had all the needed information), we will pay you interest on the claim.

8. What diagnoses should be indicated on the claim?

The diagnoses on the claim should be the treating diagnoses. Please be sure that the diagnosis is age and sex appropriate and contains the required number of digits. All treating diagnosis should be indicated.

9. What procedure codes should be used?

All procedure codes must reflect the services being rendered and they must be current HIPAA compliant codes.

10. Where do I call if I have a question about my contract?

Please call the Contracting Department at (202) 467-2749 and someone will assist you.

11. Does HSCSN accept electronic claims?

Yes. If you are interested in submitting claims electronically, HSCSN's payor ID for electronic submission is 37290 and Emdeon is the clearinghouse that we use.

xvi. Claims Status Inquiry and Direct Claims Entry

HSCSN provider portal is a Web-based solution that simplifies the everyday tasks of physician practices by integrating claim status inquiry transactions. Providers may login to the secure portal for claim status inquiries or electronic claim submission which is another added feature.

1. Click on HSCSN Claims Status link and you will be directed to the portal login page.
2. For instructions click here HSCSN Provider Portal Self-Enrollment Process Instructions.

3. For online help use the Online Support tool to create a trouble ticket. Alternatively, you can call our toll-free customer support number at 1 (877) 667-1512.

This feature provides you with

- Secure, personalized web portal access
- Enables electronic claim inquiries from providers
- Fast implementation
- Real-time provider enrollment offering immediate electronic capability

Direct Claims Entry

This additional feature provides you with

- Direct claims entry system at no cost to the provider
- Once registered, provider may check the claim status via their Emdeon account
- Electronic Claims Tracking
- Improved patient collections
- Rapid and accurate payment processing
- Increased efficiency of the clinical encounter

Note: If you are currently using a practice management system that provides you the ability to submit claims electronically to Emdeon, please continue to utilize that service, as the HSCSN portal is not intended to replace your electronic claims process. If you are not sure if your current system has this feature, you may want to contact your practice management system vendor directly. HSCSN Emdeon payer id for electronic claims is 37290.

HSCSN pledges to provide accurate and efficient claims processing. To make this possible, we ask that providers submit claims promptly and to include all required information.

- HSCSN will process all claims through an automated system.
- HSCSN's goal is to pay providers for covered services within 30 days of receipt of each completed clean claim form.
- HSCSN requires your Tax identification number, which is also your provider ID.
- HSCSN requires your NPI on every claim to help expedite payment.

If you are unable to access the Internet, you may call our Customer Care Department at (202) 467-2737 to check the status of a claim.

If you have more than three (3) claims to check, please fax your request to (202) 721-7169. Please include the enrollee's name, Medicaid number, date of service, the amount billed, the Provider's name, and a contact name and number. Customer Care will check your claim and respond within 48 hours.

Claim Status Messages

Response not possible – error on submitted request data. Claim/Encounter not found. This means we have not processed the claim. If it has been not been 30 days – they need to wait. If it has been over 45 days – they need to resubmit paper.

Response not possible – error on submitted request data. Entity not approved. Provider
Again – claim not received. Typographical error when entering the claims status information.

Out-Area Covered Services
HSCSN follows procedures to identify appropriate providers and coordinate needed services that will be rendered outside the local (District of Columbia) area. Authorization will be generated, upon approval from the Chief Medical Officer.

xvii. Instructions for completing the CMS 1500-Form

Instructions for Completing the CMS-1500 Claim Form

The new CMS-1500 (version 08/05) claim form is to be used to bill DC Medicaid covered services. Effective **May 17, 2008, the District of Columbia Medicaid will accept this CMS-1500 claim form only**. No other versions of the form will be accepted after this date. These instructions describe the information that must be entered in the minimum required the fields of the CMS-1500 (version 08/05) claim form.

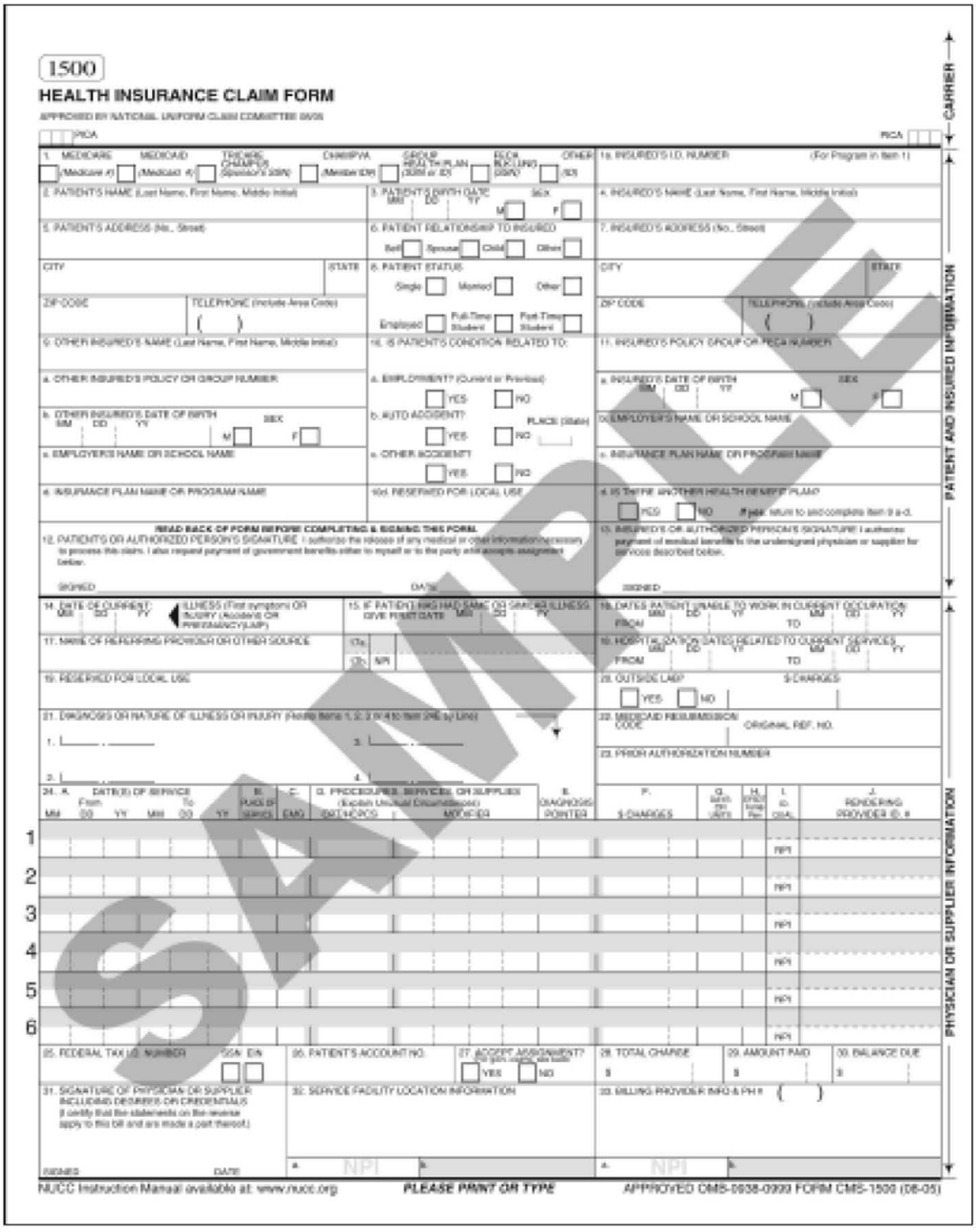
Field #	Field Description	Guideline
1	**Health Insurance Box**	Select Medicaid
1a	**Insured's ID Number**	Enter the patients' eight-digit DC Medicaid identification number excluding the leading zeroes. Verify the recipient's Medical Assistance Card to make certain that you have the recipient's correct and complete DC Medicaid Identification number and that the individual is eligible for the month in which the services are being provided. You may call the Eligibility Verification System (EVS) to verify eligibility. Receipt of a prior authorization does not verify recipient eligibility.
2	**Patient's Name**	Enter the patient's last name, first name, and middle initial as it appears on their Medical Assistance card.
3	**Patient's Birth Date**	Enter the patient's birth date and select the appropriate gender
9	**Other Insured's Name**	If the patient has other health insurance coverage, enter the name of the policyholder in last name, first name, middle initial format
9a	**Other Insured's Policy or Group Number**	Enter the policy number
9c	**Employer's Name or School Name**	Enter the name of employer or school
9d	**Insurance Plan Name or Program Name**	Enter the name of the plan/program
10	**Is Patient's Condition Related to**	
10a	**Current or Previous Employment**	Select the appropriate box to indicate if the patient's condition is an employment related injury
10b	**Auto Accident**	Select the appropriate box to indicate if the patient's condition is related to an auto accident
10c	**Other Accident**	Select the appropriate box to indicate if the patient's condition is related to a different type of accident
10d	**Reserved for Future Use**	Not required for processing
11	**Insured Policy Group or FECA No.**	Enter the policy group or FECA number
11b	**Employers Name or School**	Enter the name of the employer or school of the

Instructions for Completing the CMS-1500 Claim Form

Field #	Field Description	Guideline
	Name	policyholder
11c	**Insured Plan Name or Program Name**	Enter the name of the insurance company or program name
11d	**Is There Another Health Benefit Plan**	Select the appropriate box
12	**Patient's Signature**	Enter the signature or "signature on file" and include the date in MMDDYY format
17	**Name of Referring Provider or Other Source**	Enter the name (First Name, Middle Initial, Last Name) of the referring provider, if applicable.
17a	**Other ID#**	If using NPI in field 17b, enter the taxonomy code in 17a and the qualifier "ZZ" in the box to the left. If using a DC Medicaid provider ID for an atypical provider, enter the DC Medicaid provider ID* in field 17a and the qualifier "1D" in the box to the left.
17b	**NPI #**	Enter the referring provider's NPI.
18	**Hospitalization Dates Related to Current Services**	Enter the admission/discharge dates in MMDDYY format if the services are related to hospitalization
19	**Reserved for Local Use**	When billing for waiver services, enter "03" special program code.
21	**Diagnosis or Nature of Illness or Injury**	Enter the numeric ICD-9-CM diagnosis code.
23	**Prior Authorization Number**	Enter the 10-digit prior authorization number if applicable
24A	**Shaded area**	Enter the NDC qualifier "N4" and the 11-digit NDC number in the shaded (top portion) of field 24 for physician administered drugs, if applicable.
24A	**Date(s) of Service**	Enter the FROM and TO date of the service(s) in MMDDYY format.
24B	**Place of Service**	For each line, enter the one code that best describes the place of service: **11: Office** **12: Recipient's home** **15: Day Treatment** **18: Residential Treatment** **21: Inpatient Hospital** **22: Outpatient Hospital** **23: Emergency Room – Hospital** **24: Ambulatory Surgical Center** **31: Nursing Facility (SNF)** **32: Nursing Facility** **34: Hospice** **41: Ambulance – Land** **42: Ambulance – Air or Water** **51: Inpatient Psychiatric Facility** **52: Psychiatric Facility-Partial Hospitalization**

Field #	Field Description	Guideline
		53: Community Mental Health Center **54: Intermediate Care Facility/Mentally Retarded** **55: Psychiatric Residential Treatment Facility** **56: Psychiatric Residential Treatment Facility** **61: Comprehensive Inpatient Rehabilitation Facility** **62: Comprehensive Outpatient Rehabilitation Facility** **65: End Stage Renal disease Treatment Facility** **71: State or Local Public Health Clinic** **72: Rural Health Clinic** **81: Independent Laboratory**
24D	**Procedures, Services, or Supplies**	Enter the CPT or HCPCS code(s) and modifier (if applicable).
24E	**Diagnosis Pointer**	Enter the appropriate line number (i.e., 1, 2, 3 or 4) of the diagnosis code entered in field 21 that relates to services being billed on each line.
24F	**$ Charges**	Enter the usual and customary charges of the services being billed, right justified. Enter "00" in the cents area if the amount is a whole number.
24G	**Days or Units**	Enter the number of days or units.
24I	**ID Qualifier (shaded area)**	If using NPI in field 24J, enter the qualifier "ZZ". If using a DC Medicaid provider ID for an atypical provider, enter the qualifier "1D".
24J	**Rendering Provider ID (shaded area)**	Enter the taxonomy code of servicing provider if NPI was entered in 24J (white area); otherwise, enter the DC Medicaid provider ID* if an atypical provider in the shaded area.
24J	**NPI**	Enter the rendering provider's NPI.
25	**Federal Tax ID Number**	Enter the appropriate social security number or employer identification number
28	**Total Charge**	Enter the total of column 24F.
29	**Amount Paid**	Enter the amount received from other healthcare plan
30	**Balance Due**	Enter the amount remaining from payment
31	**Signature of Physician or Supplier**	Must have an original signature and date.
33	**Billing Provider Info & Ph #**	Enter the billing address for the pay-to-provider and include ZIP +4.
33a	**Billing NPI**	Enter the pay-to-provider's NPI.
33b	**Billing Provider**	If using NPI in field 33a, enter the taxonomy code in 33b and the qualifier "ZZ" in the box to the left. If using a DC Medicaid provider ID for an atypical provider, enter the DC Medicaid provider ID* in field 33a and the qualifier "1D" in the box to the left.

***DC Medicaid provider numbers may only be used for atypical providers. Atypical provider are providers that do not meet the definition of healthcare provider under the Health Insurance Portability and Accountability Act (HIPAA); for example waiver providers, attendant care providers, chore services providers, respite care providers.**



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

The HSC Health Care System

Health Services for Children With Special Needs, Inc. (HSCSN)

HSCSN Provider Interest Form

Thank you for your interest in joining the HSCSN network. Please complete this form in order to begin the first step towards the credentialing process. **This is not an application.** If you do not currently have a CAQH ID, we will obtain one for you. Once you have received your CAQH ID, please visit https://upd.caqh.org/oas to complete the CAQH application.

Last Name _____First Name _____
Middle _____

Practice Address

_____

City _____ State _____

Zip Code _____

Telephone _____ Email _____

DOB: _____ SS#: _____

CAQH ID # _____

Specialty (1) _____ Specialty (2)_____

Degree Type_____

DISCLOSURE OF OWNERSHIP

Directions: Follow these instructions to complete the document on the next page. Remember to sign the document.

INSTRUCTION FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (DC-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, AND XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the District of Columbia state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the D.C. State Agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete Part II (a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

GENERAL INSTRUCTIONS

For definitions, procedures and requirements refer to the appropriate Regulations:

Title V	-42CFR 51a.144
Title XVIII	-42CFR 420.200-206
Title XIX	-42CFR 455.100-106
Title XX	-45CFR 228.72-73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original copy to the State agency: retain the photocopy for your files.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I – Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

Item II – Self-explanatory

Item III – List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined, as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity, which may be maintained, by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV-VII – Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the ownership partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation or any change of ownership.

For Items IV-VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV – (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate that date in the appropriate space.

Item V – If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI – If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII – A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII – If yes, list the actual number of beds in the facility now and the previous number.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a). Name of Entity	D/B/A	Medicaid Provider No.	NPI Number
Telephone No.			
Street Address		City, County, State	Zip Code

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVII, XIX, or XX?

Yes No

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVII, XIX, or XX?

Yes No

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVII providers only)

Yes No

III. (a.) List names, addresses for individuals, or the EIN for organization having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on p. 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN

(b) Type of Entity: Sole Proprietorship Partnership Corporation
Unincorporated Associations Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions
(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

Yes No

Name	**Address**	**Provider Number**

IV.

(a). Has there been a change in ownership or control within the last year? Yes No

If yes, give date _____

(b) Do you anticipate any change of ownership or control within the year? Yes No

If yes, when? _____

(c) Do you anticipate filing for bankruptcy within the year? Yes No

If yes, when _____

(d) Is this facility operated by a management company, or leased in whole or part by another organization? Yes No

If yes, give date of change in operations _____

V. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) Yes No

Name EIN#

Address

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE D. C. STATE AGENCY AS APPROPRIATE.

Name of Authorized Representative	Title
Signature	Date

Appendix B: Acronyms

ACIP: Advisory Committee on Immunization Practices
ACOG: American College of Obstetricians and Gynecologists
ADA: Americans with Disabilities Act
ALOS: Average Length of Stay
AMBHA: American Managed Behavioral Healthcare Association
APRA: Addictions, Prevention, Recovery Administration
CAHPS: Consumer Assessment of Health Plans Studies
CARF: Commission on Accreditation of Rehabilitation Facilities
CASSIP: Child and Adolescent SSI or SSI-Related Plans
CBI: Community Based Intervention
CFR: Code of Federal Regulations
CFSA: Child and Family Services Agency
CHIP: State Children's Health Insurance Program
CLIA: Clinical Laboratory Improvement Amendment
CMO: Chief Medical Officer
CMS: Centers for Medicare and Medicaid Services
CQI: Continuous Quality Improvement
CQIC: Continuous Quality Improvement Committee
CQIP: Continuous Quality Improvement Plan
CRNP: Certified Registered Nurse Practitioner
DAW: Dispense as Written
DCHFP: District of Columbia Healthy Families Program
DCPS: District of Columbia Public Schools
DISB: Department of Insurance Securities and Banking
DME: Durable Medical Equipment
DMH: Department of Mental Health
DOH: Department of Health
DRG: Diagnostic Related Group
DSM-IV: Diagnostic and Statistical Manual of Mental Disorders
DUR: Drug Utilization Review
DYRS: Department of Youth Rehabilitative Services
EOB: Explanation of Benefits
EPSDT: Early and Periodic Screening, Diagnosis, and Treatment
EQR: External Quality Review
EQRO: External Quality Review Organization
ER: Emergency Room
EVS: Eligibility Verification System
FFS: Fee- for-Service
FQHC: Federally Qualified Health Center
HCFA: Health Care Finance Administration
HEDIS: Health Employer Data and Information Set
HIPAA: Health Insurance Portability and Accountability Act
HIT: Health Information Technology
HIV/AIDS: Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

HPV: Human Papillomavirus
ICF/MR: Intermediate Care Facilities for Mental Retardation
IDEA: Individuals with Disabilities Education Act
IEP: Individualized Education Plan
IFSP: Individualized Family Services Plan
IOM: Institute of Medicine
IOP: Intensive Outpatient Program
ITDO: District of Columbia Infants and Toddlers with Disabilities Office
LEP: Limited or No English Proficiency
MCO: Managed Care Organization
MD: Medical Doctor
MH: Mental Health
MHRS: Mental Health Rehabilitation Services
MIS: Management Information System
MMCP: Medicaid Managed Care Program
MST: Multi-systemic Therapy
NAIC: National Association of Insurance Commissioners
NCQA: National Committee for Quality Assurance
NDC: National Drug Code
NF: Nursing Facility
NICU: Neonatal Intensive Care Unit
OB/GYN: Obstetrics/ Gynecology
OIG: Office of Inspector General, U.S. Department of Health and Human Services
OTMP: Outreach and Transition Monitoring Plan
PBM: Pharmacy Benefits Manager
PCP: Primary Care Physician
PHP: Partial Hospitalization Program
PIHP: Prepaid Inpatient Health Plan
PMPM: Per Member Per Month
QI: Quality Improvement
QISMC: Quality Improvement System for Managed Care
RN: Registered Nurse
SA: Substance Abuse
SSI: Supplemental Security Income
TANF: Temporary Assistance to Needy Families
TPL: Third Party Liability
TTD: Telecommunications Device for the Deaf
TTY: Teletype
VFC: Vaccines for Children
WIC: Special Supplemental Food Program for Women, Infants and Children
YSA: Youth Services Administration