GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department on Disability Services
Developmental Disabilities Administration

DDS/DDA in collaboration with DHCF (and their vendors Delmarva and ACS) has jointing worked in partnership to create this document to provide guidance for the purpose of receiving service authorization to submitting claims. This document outlines the process for billing and identifies the required information according to DHCF policy and payment guidelines.

Process for Billing:

1. DDS Service Coordination request services within ISP/POC submitted to the Waiver Unit to authorize services.
2. The provider can access MCIS (MRDDA Consumer Information System) to see what services have been authorized for each participant that they are serve.

TIP: Service Authorization from DDS is the GREEN LIGHT to Provide Services

3. DDS sends a weekly file to Delmarva (DHCF vendor) on Fridays after 5pm. The file contains all services approved/authorized by DDS. The file contains the following information:
    - Consumer Name
    - Medicaid Number
    - Provider Medical Waiver
    - Service Number
    - Diagnosis Code
    - Start Date
    - End Date
    - Requested Units
    - Requested Rate
    - Approved Units
    - Approved Rate
    - Action Date
    - Status
4. Delmarva receives the file from DDS.
    - An email confirming that they have received the file is sent to DDS.
    - Delmarva validates that the file is complete and all of the information listed above is populated.
    - Delmarva has five (5) business days to process the file received from DDS.
    - Delmarva sends an email to DDS confirming the file has been processed and completed.

- If the file is incomplete, Delmarva will repost the file on the portal using the appropriate rejection code. An email will be sent to DDS alerting them of the issue with the file

5. Delmarva inputs file information into the MMIS (Medicaid Management Information System) /Omnicaid
6. Once all data has been placed in MMIS//Omnicaid (DHCF information management system):
    - Prior Authorization Number is generated
    - Prior Authorization Approval letter is generated and the provider prints this to submit a claim to ACS (DHCF fiscal agent serves as an intermediary between provider community and DHCF. ACS process's claims, assists providers with enrollment, provides education and onsite training to maintain and support MMIS)
7. ACS receives alert to send Prior Authorization letter to providers which includes:
    - Recipient 'sName
    - Recipient's ID
    - PA Number
    - Procedure Code/Modifiers
    - Units/Hours
    - Start and End Dates
    - Status Approved

Verifying Recipient's Medicaid Eligibility
Medicaid Eligibility is determined by Department of Human Service's Income Maintenance Administration. Use the Interactive Voice Response System to verify eligibility

- 202-906-8319
- Verify the following:
- Receipient's name and identification number
- Effective dates of eligibility
- Services restricted to specified providers
- If receipient has other insurance (eg, Medicare, HMO, Managed Care etc)

Correspondent Information:
Provider agency must confirm with ACS that the Correspondence Address is accurate in the ACS system.

- The Correspondence address must reflect to whom and where (the address) to send provider communications to the provider agency. [Note: The billing/payment address may be different from the correspondence address.]
- Providers should contact provider enrollment at 202-906-8318 or 866-752-9231 to confirm the correspondence information.
- If the billing entity for the provider agency is located in a different location than the main office/headquarters of the provider agency, the Correspondence address in ACS records need to reflect that address.
- **It is the responsibility of the provider agency to determine internal procedures to insure that this information (the Correspondent Information) is correct .**
- If the address needs to be updated, the provider may download the change of address form located on the Web Portal > Provider Information & Forms or submit the request on company letterhead requesting the address change. The request may be faxed to Provider Enrollment at 888-335-8465.

8. Provider receives Prior Authorization Approval letter from ACS

TIP: Prior Authorization Approval letter from ACS is a GREEN LIGHT to bill/claim for services. Provider can't bill unless they have receive Prior Authorization Approval letter.

PRIOR AUTHORIZATION APPROVAL DOES NOT GUARANTEE PAYMENT

9. Claim/bill submission to ACS (electronically or hardcopy using the CMS1500 form).
    - Provider submits claims to ACS electronically or in hardcopy using the CMS1500 form. All information must be complete when submitting claims to process (ie. PA#, Consumer Name, recipient ID, Procedure Code, Units, total billed amount, Start and End Dates, provider ID).
    - Providers should consult the MRDD Billing Manual posted on the Web Portal for complete claim form instructions. The billing manual is located under Provider Type Specific Information.
    - If Medicaid is the secondary payer, the only information that should be included with the claim is a copy of the Explanation of Benefits showing the payment or denial from the primary payer (i.,e Medicare, private insurance). If Medicaid is primary, no additional documentation is needed with the claim.

Submission of claims with incorrect information will be denied. For Example: If a provider uses an old PA# you received from ACS for a new Service Authorization (i.e. extended services), your claim will be denied.

10. ACS receives claims from the provider and begins the claim adjudication process. Claims are processed by ACS in accordance with DHCF policy and payment regulations.
    - Upon final disposition of the claims processing, the claim will fall into one of the following claim statuses: paid, denied, or suspended (pend)
    - The provider will receive a Remittance Advice (RA) indicating the status of all claims completing the adjudication cycle. The RA may be received in hardcopy, electronically (835) or downloaded from the Web Portal. RAs are generated weekly.
    - Clean claims; means claims meeting DHCF policy and payment guidelines, will result in the status of "paid" and the provider will receive payment.
    - Provider checks do not accompany the RA, checks are mailed from DC Treasury or payment is received by direct deposit. The provider should match the warrant number indicated on the paper check with the corresponding RA to determine which recipients the payment is for. [Instructions on how to read the RA is explained in the MRDD Provider Billing Manual.]
    - If services are Denied
        i. The summary page of the RA lists all of the exception codes that have posted on the claims with a description of the denial.
        [Note: This information is in the MRDD Billing Manual]
        ii. The provider may correct a denied claim and resubmit for payment,
        iii. Providers can also access the Web Portal/Inquiry Options/Claim Status for claim information. www.dc-medicaid.com
        iv. If the provider needs further clarification, they can contact ACS Provider Inquiry at: 202-906-8319 or 866-752-9233.
        v. If Provider Inquiry is unable to address the issue, the issue may be escalated to an ACS Provider Field Representative or the DHCF Health Care Operations Administration can assist providers. Provider can contact Laurie Rowe or Derrick Bailey at either 202-698-2000 or Laurie.rowe@dc.gov or derrick.bailey@dc.gov.
        vi. Providers may also send an email to dc.providerreps@acs-inc.com requesting assistance.