THE HSC HEALTH CARE SYSTEM

Health Services for Children with Special Needs, Inc.

*Caring. Serving. Empowering.*

# PROVIDER MANUAL


APRIL 2022

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## Welcome

**Welcome to Health Services for Children with Special Needs, Inc. (HSCSN).** The HSC Health Care System is a nonprofit health care organization committed to serving families with complex health care needs and eliminating barriers to health care services. The System combines the resources of a care coordination plan, a pediatric specialty hospital (The HSC Pediatric Center), a home health agency (HSC Home Care), and a parent Foundation (The HSC Foundation), to offer a comprehensive approach to caring, serving, and empowering individuals with disabilities.

This provider manual was created for you, the provider, to use in your practice to treat our enrollees. As a provider within our network, you agree to use this manual and other manuals, and/or tools provided to you to care for the enrollees of HSCSN.

HSCSN reserves the right to make periodic changes to this provider manual and any other manual/resources available to the health plan's providers. HSCSN will always notify you of any changes to the manual and/or procedures. We ask that you check our website to stay up to date with any changes at **www. hschealth.org.**

**Thank you for joining the HSCSN Provider network!**

## About HSCSN

Health Services for Children with Special Needs is a health plan to provide and coordinate care to Supplemental Security Income-eligible youth and young adults in the District of Columbia through a care management network that helps to ensure that our enrollees have what they need to manage their daily health and that our enrollees are connected to social support services.

HSCSN started as a demonstration pilot to serve Supplemental Security Income (SSI) beneficiaries and was incorporated in 1994 to develop a national model of managed care services for children and youth with complex health care needs. HSCSN provides health care services for eligible Medicaid recipients from birth to 26 years of age and has extensive experience in developing and managing services essential to achieving access to care for vulnerable populations.

Each enrollee has a care manager responsible for coordinating access to primary and specialty care, developing an individualized care coordination plan, and educating an HSCSN enrollee's family on how to best prepare for care transitions. HSCSN is committed to helping HSCSN enrollees and their families reach their potential and lead more fulfilling lives by expanding access to health care and coordinating the delivery of comprehensive, cost-effective services.

Our enrollees' health benefits include traditional Medicaid benefits plus an array of expanded

health care and wrap around services, such as individualized care management, outreach services, respite care, and reasonable medically necessary home modifications.

## MISSION STATEMENT

The HSC Health Care System provides and coordinates innovative, high quality, community-based care for individuals with complex needs and their families. HSC empowers all we serve to improve the quality of their lives.

## MEDICAID

Medicaid is a federal and state government program that pays for medical care for people who meet specific technical, income and asset criteria. The Federal Government sets guidelines for services and pays part of the cost. Each State designs and operates its own Medicaid Program based on federal and state guidelines.

## Enrollment and Eligibility

HSCSN is contracted with the District of Columbia to administer the Child and Adolescent Supplemental Security Income Program (CASSIP). HSCSN serves children and young adults from birth to 26 who have complex medical and behavioral health needs and are eligible for Supplemental Security Income (SSI) or have SSI-eligible diagnoses that meet Social Security Administration's (SSA) medical disability criteria. We focus on young people with special health care needs. We give each enrollee the kind of attention and level of care that helps make their life as full as possible.

### Benefits available to all enrollees include but are not limited to:

- An assigned Care Manager
- Respite Care (168 hours, every 6 months)
- Home Modifications (medically necessary and when other eligibility requirements are met)
- Adaptive Equipment and Supplies
- Dental Care
- Home Health Care (inclusive of Private-Duty Nursing and Personal Care Aide Services, where medically necessary)
- Long Term Care
- Behavioral Health and Substance Use Disorder Services, including evidence-based outpatient services
- Inpatient Physical Health and Mental Health services
- Psychiatric Residential Treatment (PRTF) and Psychiatric sub-acute care, for defined populations

- Intermediate Care Facility Placements for Individuals with Intellectual and Developmental Disabilities
- Behavioral Health Rehabilitation Services (Day Treatment or Partial Hospitalization Programs)

## Verifying Enrollee Eligibility

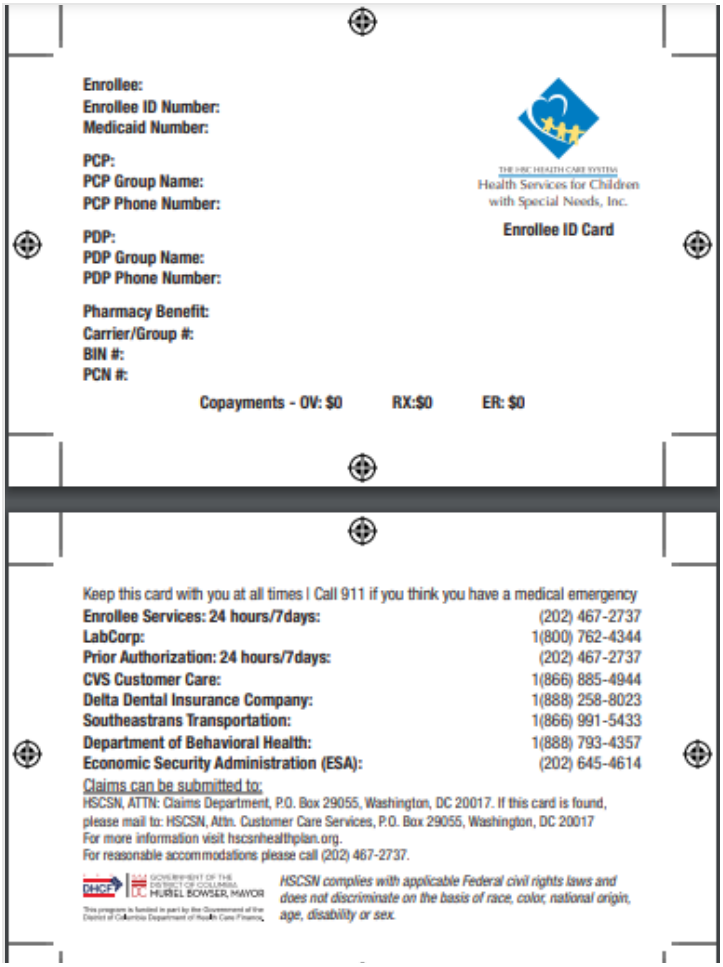
The Department of Health Care Finance (DHCF) which oversees DC Medicaid Managed Care and CASSIP Program Eligibility requirements, provides HSCSN a list of eligible enrollees each month. Providers should verify an HSCSN enrollee's plan membership and eligibility prior to providing any service, this includes requesting to see an HSCSN enrollee's health plan card, checking eligibility in HSCNS's Provider Portal, or via DHCF's eligibility platform. Hospitals and other Emergency Care Providers are responsible for providing immediate services for an enrollee's emergency medical condition in accordance with the provider's license and scope of practice, regardless of insurance eligibility. For further information regarding emergency services, please review the Emergency Medical Treatment and Labor Act (EMTALA). **It is your responsibility to obtain and verify all insurance plans/coverage the enrollee may have, including commercial plans, Medicare, and other insurance information.**

## Eligibility can be verified in 3 distinct ways:

- **HSCSN Provider Portal**: you can search for an enrollee in the portal and review their current eligibility status 24/7 by visiting **https://physician.connectcenter.changehealthcare.com/#/site/home?payer=214707.**
- **The District of Columbia's DHCF Web Portal**: you can search for an enrollee's eligibility for Medicaid or which Managed Care Organization the enrollee is connected to by visiting www.dc-medicaid.com/dcwebportal/home
- **HSCSN Customer Care Line**: you can call the HSCSN Customer Care Line at (202) 467-2737.

## The HSCSN Enrollee ID Card

Below is a sample of the HSCSN Enrollee ID Card. Providers and Provider Groups are responsible for ensuring HSCSN enrollees or their caregivers bring their card or a copy of their card to services to assist with the verification of eligibility for services.




# Enrollee Rights and Responsibilities

## Enrollee Rights

- Be treated with respect and dignity
- Know that when they talk with their doctors and other providers it's private
- Have an illness or treatment explained to you in a language you can understand
- Participate in decisions about your care
- Receive a full, clear, and understandable explanation of treatment options and risks of each option so they can make an informed decision
- Refuse treatment or care
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation of physical and chemical restraints except for emergency situations
- Can see their medical records and to request a change if incorrect
- Choose an eligible PCP/PDP from within HSCSN's network and to change their PCP/PDP
- Make a Grievance about the care provided to them and receive an answer

- Request an Appeal or a Fair Hearing if they believe HSCSN was wrong in denying, reducing, or stopping a service or item
- Receive Family Planning Services and supplies from the provider of their choice
- Obtain medical care without unnecessary delay
- Receive information on Advance Directives and choose not to have or continue any life-sustaining treatment
- Receive a copy of HSCSN'S Enrollee Handbook and/or Provider Directory
- Continue treatment they are currently receiving until you have a new treatment plan
- Receive interpretation and translation services free of charge
- Refuse oral interpretation services
- Receive transportation services free of charge
- Get an explanation of prior authorization procedures
- Receive information about HSCSN's financial condition and any special ways we pay our doctors
- Obtain summaries of customer satisfaction surveys
- Receive HSCSN''s "Dispense as Written" policy for prescription drugs
- Receive HSCSN's drug formulary (covered drugs)
- Receive fair treatment if Enrollee Rights and Responsibilities are exercised
- Be furnished with health care services that are timely, coordinated, and sufficient in amount, duration, and scope.
- Request medical records, free of charge.
- Comply with applicable Federal and State laws (including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.
- Exercise their rights without any bad treatment from HSCSN, its providers, sub-contractors, or the District.

## Enrollee Responsibilities:

- Meeting with their Care Manager as often as needed to coordinate services
- Treating HSCSN's staff and health care providers with respect and dignity
- Following the rules of the DC Medicaid Managed Care and CASSIP Program and of HSCSN
- Following instructions received from their doctors and other providers
- Going to scheduled appointments
- Telling a health care provider at least 24 hours before the appointment if an appointment must be cancelled
- Asking for more explanation if the doctor's recommendations are not understood
- Going to the emergency room only if there is a medical emergency

- Telling their PCP/PDP about medical, dental, and personal problems that may affect your health
- Reporting to the Economic Security Administration (ESA) and HSCSN if the HSCSN enrollee or a family member has other health insurance or if an HSCSN enrollee has a change in their address or phone number
- Reporting to the Economic Security Administration (ESA) and HSCSN if there is a change in the HSCSN enrollee's family (i.e., deaths, births, etc.)
- Trying to understand their health problems and participate in developing treatment goals
- Helping their health care providers in getting medical records from providers who have treated them in the past
- Telling HSCSN if they were injured as the result of an accident or at work

**Note:** All HSCSN Enrollees have the right to a second opinion with a network provider or with an out-of-network provider, at no cost to the HSCSN enrollee or enrollee's designee. Enrollees who request a second opinion should contact their assigned Care Manager for help with accessing a second opinion.

## Plan Privacy and HIPAA (Health Insurance Portability & Accountability Act) Procedures

Health Services for Children with Special Needs (HSCSN) complies with all District and Federal regulations and guidelines regarding an HSCSN enrollee's privacy and data security, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Standards for Privacy of Individual Identifiable Health Information as outlined in 45 CFRa Parts 160 & 164. All HSCSN enrollee health information, including enrollment and treatment plans are used, disseminated, and stored in accordance with HSCSN Plan guidelines to ensure security, confidentiality, and proper use of materials. As an HSCSN provider, you are required to be familiar with your responsibilities under HIPAA Guidelines and take all necessary steps to fully comply with the Federal and District laws and guidelines.

## Provider Credentialing Process

Credentialing involves gathering and reviewing information from regulatory agencies, professional associations, and educational institutions to ensure that the prospective network provider is legally qualified to practice under their stated scope of practice. HSCSN uses various credentialing criteria and guidelines to verify the provider meets and maintains the standards for network participation. Credentialing with HSCSN begins after the Provider or Group has started the contracting process with HSCSN via the Contracting Department. During the credentialing process HSCSN verifies the following items where applicable:

- Acceptable professional liability (malpractice) insurance coverage, State Professional License, State-Controlled Dangerous Substance Certificate, and Clinical Laboratory Improvement Amendments (CLIA) Certificate

- Completion of the required HealthCheck Training for HealthCheck practitioners (PCPs)
- All active permits and registrations, including Drug Enforcement Administration
- Proof of Board Certification
- An Accreditation Certificate from a recognized accrediting body, Centers for Medicare and Medicaid Services (CMS) State Survey, or any applicable State Survey
- The absence of negative actions taken by any State board and/or governing entity
- Curriculum vitae and/or work history

HSCSN works with the Council for Affordable Quality Healthcare (CAQH) to offer providers a Universal Provider Data source that simplifies and streamlines the data collection process for credentialing and re-credentialing. Through CAQH, providers submit credentialing information to a single storehouse, via a secure internet site, to fulfill the credentialing requirements of health plans that participate with CAQH. HSCSN's credentialing and re-credentialing process adheres to the National Committee for Quality Assurance (NCQA) guidelines. All practitioners, facilities, groups and/or organizations are re-credentialed every three (3) years.

## Initial Credentialing – Criteria, Verification, and Time Limits

Each practitioner must complete a standard application form when applying for participation at HSCSN. Applicants must utilize the CAQH ProView system. To learn more about CAQH, please visit their website at www.CAQH.org. or contact the CAQH Help Desk at 1-888-599-1771. Dental providers interested in participating with HSCSN should contact Delta Dental at 800-357-8258 or PR_governmentprograms@delta.org.

### *Next Steps:*

Once you have completed the application process within the CAQH ProView system, please send your CAQH ID to the Credentialing Department to: C6@hschealth.org. Completed applications will be downloaded and processed. Applications are considered complete when all required documents have been received. Ensure all sections of the application are complete and accurate along with the required documentation on CAQH Proview. You have the right to be advised of your application status and may contact the HSCSN Credentialing Department via phone at (202) 974-4693 or by email at: C6@hschealth.org. Once the application process is completed, you will be notified via email of the Credentialing Committee's decision.

If you are a facility and/or need to contact either the Contracting or Credentialing Departments, please see the contact information below:

| Groups Contracted with HSCSN | Prospective Providers |
|---|---|
| Send request to C6@hschealth.org | Send request to Cdept@hschealth.org |

## EPSDT/HealthCheck

HSCSN requires Primary Care Providers (PCPs) to follow the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Guidelines for enrollees from 0 to age 20 (called HealthCheck in DC through the growth and developmental needs of enrollees using the appropriate coordination of health care services.

All HSCSN PCPs are responsible for providing HealthCheck services to HSCSN enrollees from 0 to age 20, according to the DC Medicaid HealthCheck Periodicity Schedule and the DC Medicaid Dental Periodicity Schedule to determine the existence of a physical or mental health condition. Periodic Screenings must have:

- An undressed comprehensive health exam
- Appropriate immunizations
- Diagnosis, treatment, referral, and follow up as appropriate
- Dental, Vision, and/or Hearing Screenings (in accordance with the DC Health Check Periodic Guidelines and at other intervals as needed to identify any suspected illness or condition
- Comprehensive health and developmental history (including physical and mental health development)
- Laboratory Testing (including blood lead testing for children 2 years of age up to 6 years of age)
- Health Education

## Credentialing Committee/Chief Medical Officer Review

Completed credentialing applications are forwarded to the Chief Medical Officer (CMO) for review and final approval. Files containing noted disputes, such as settled malpractice cases, license sanctions, etc. will be presented quarterly to the Credentialing Committee for review and determination.

## Appeal of Credentialing Committee Decision

If the Credentialing Committee denies an application, the Committee will offer the applicant an opportunity to appeal the decision. HSCSN does not accept participation of providers who have a current license that has restrictions. HSCSN accepts or denies based on our review criteria. No Provider who has been excluded from the Medicaid Program may receive reimbursement by HSCSN, either directly or indirectly, while such sanctions are in effect. For more information on appealing a denied credentialing application, please reach out to our Credentialing Department via the Customer Care Line at 202-467-2737 or via email at C6@hschealth.org.

## Practitioner Credentialing Rights

During the credentialing and re-credentialing process, applicants are entitled to certain rights:

- The right to review the information submitted to support their credentialing application

- The right to correct erroneous information. When information is obtained by the Credentialing Department that varies substantially from the information provided, the Credentialing Department will notify the practitioner to correct the discrepancy
- The right upon request, to be informed of the status of their credentialing or re-credentialing application, except peer-review protected information. Requests can be made via phone and/or email. The Credentialing Department will respond via email or phone call to the practitioner.
- The right to be notified within sixty (60) calendar days of the Credentialing Committee or Chief Medical Officer's decision
- The right to appeal any credentialing and/or re-credentialing denial within thirty (30) calendar days of receiving written notification of the decision.

To request, provide, or correct any information in your credentialing file, please send an email to: C6@hschealth.org or call (202) 495-7526. To appeal any credentialing/re-credentialing decision please send a written request to:

Health Services for Children with Special Needs (HSCSN)

**Attention: Credentialing**

1101 Vermont Avenue NW

Ste 12

Washington, DC 20005

## Re-Credentialing

The HSCSN credentialing process is repeated every three (3) years to verify that licenses and certifications remain current for each provider and that there are no adverse circumstances that would prevent continued participation with the plan. HSCSN will only contact you if your CAQH information is outdated or you are denied due to missing or erroneous information during the re-credentialing process.

## Site Visits

HSCSN also conducts an initial site visit with all Primary Care Providers (PCPs) and Behavioral Health Providers upon application to become part of the HSCSN Provider Network. These site visits consist of confirming the ADA accessibility and safety of the facility, the practice and/or location of service. Home-based service agencies do not receive an HSCSN Provider Relations Site Visit (ADA Accessibility Site Visit). However, Home Health Agencies receive monthly oversight and site visits from the Home Health Oversight Reviewer.

HSCSN Network Facilities that require accreditation (such as The Joint Commission) that have not met the accreditation status receive a full site visit from HSCSN's Quality Management

Department. During the facility site review, the HSCSN reviewer assesses the facility for the following:

- ADA accessibility
- Record retention, recordkeeping
- Quality of care procedures

Provider Sites covered under Delegated Credentialing Arrangements receive an annual site visit which follows the full HSCSN Delegated Site Visit steps along with reviewing the Credentialing Methods used by the entity for the hiring of new practitioners.

## Clinical Practice Standards

### Primary Care and Specialty Services

Primary Care is the integration of services that promote and preserve health, prevent disease, injury, and dysfunction, and provides a regular source of care for acute and chronic illnesses and disabilities. The Primary Care Medical Home serves as the usual entry point into broader health and human service systems and incorporates community culture, needs, risks, strengths, and resources into clinical practice. The Primary Care Provider (PCP) shares with the family an ongoing responsibility for the enrollee's health care.

### Medical Home

The American Academy of Pediatrics defines a Medical Home as the "provision of care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent." HSCSN strives to ensure that such a partnership exists between the primary care physician and the family of the HSCSN enrollee. Care Management staff carefully monitors communications, collaboration, coordination of services, and effectiveness of care between enrollees and their selected PCP or Medical Home. Our Care Management Team also plans for "enabling services" such as transportation and respite care, to complement customary health care and ensure accessibility.

Each HSCSN enrollee selects a personal Primary Care Provider who serves as the medical home and is responsible for coordinating care with the Care Manager. The PCP is responsible for obtaining documentation from other providers to ensure coordination of care. The PCP is responsible for reviewing, providing input and approving the HSCSN Care Coordination Plan. Practitioners in the following specialties may serve as a PCP:

- Pediatrics
- General Practice
- Internal Medicine
- Family Practice
- Obstetrics/Gynecology
- Osteopathy

- Sub-Specialties as appropriate to meet an Enrollee's special health care needs

Additionally, Clinics, Federally Qualified Health Centers (FQHC) and Nurse Practitioners (practicing in the areas listed above) may also serve as a PCP.

The PCP is required to perform all relevant EPSDT screenings and services, physicals, adult wellness, as well as any additional assessments, using the appropriate tools where necessary to determine if the enrollee has any additional needs.

## Primary Care Provider (PCP) Responsibilities

Primary Care Providers are responsible for providing or arranging the following:

- Office Visits
- EPSDT/HealthCheck Services for Enrollees 21 and younger
- Physical Examinations
- Vision and Hearing Screenings
- Immunizations
- Health Education
- Monitor and participate in the coordination of care for all medical and behavioral services being provided to the enrollee, including pharmacy, subspecialty and ancillary services, home care, equipment, and supplies.
- Diagnostic services and referrals to participating network providers, laboratory, and radiology providers

### *Restriction on Size of PCP Panel:*

In accordance with DHCF (Department of Health Care Finance)C.5.100.12 section of the CASSIP (Child and Adolescent Supplemental Security Income Program) Contract, PCP and PCP-like providers are required to report to HSCSN within 24 hours of notice that they have reached the maximum panel capacity for their practitioner size. Maximum Capacity is defined as no more than 200 assigned enrollees per practitioner.

Notification must be made in writing via official letterhead of the PCP and/or PCP Group or via email; requesting the panel be closed and the official closure date. When the Provider is below capacity, the provider may request in writing, via official letterhead and/or email to have the panel reopened. Providers found to be at 80% capacity without official notification to HSCSN, will have their panels closed and are subjected to corrective action up to termination from the network.

## Specialty Care Physician

Prior authorization from HSCSN is not required for most outpatient specialty visits. HSCSN Participating Specialists are responsible for providing services within the scope of their specialty. It is the responsibility of the specialist to work closely with the PCP and Care Manager to enhance

the continuity of medical care and recommend appropriate treatment. The specialist must also keep the PCP informed with written documentation. HSCSN Specialists are responsible for:

- Providing specialty care as indicated by any received referral
- Reporting clinical findings to the referring PCP
- Ordering the appropriate diagnostic tests (radiology, laboratory, etc.) related to the treatment of the enrollee, as requested by the referring practitioner via the referral
- Documenting all care rendered in a complete and accurate manner including maintaining a current medical record
- Refraining from referring enrollees to other specialists without the intervention of the HSCSN enrollee's PCP
- Verify an HSCSN enrollee's eligibility and review the referral prior to the provision of services

### Ancillary Provider

HSCSN enrollees can receive ancillary care, however prior authorization is required for most ancillary services. In general, HSCSN enrollees may not self-refer nor receive ancillary care services not listed on their treatment plan without prior coordination from their PCP or Care Manager.

Ancillary Providers are responsible for providing services within the scope of their specialty. HSCSN Ancillary Providers are responsible for:

- Providing ancillary care as indicated by the referral
- Reporting clinical findings to the referring PCP
- Documenting all care rendered in a complete and accurate manner including maintaining a current medical record
- Refraining from referring enrollees to other specialists without the intervention of the enrollee's PCP
- Verify an enrollee's eligibility and review the referral prior to the provision of services

## Covered Services

HSCSN provides medical coverage in the District of Columbia to Supplemental Security Income-eligible children from birth to 26 years through a health care plan that provides a comprehensive set of benefits, including behavioral health, long-term care and social support services for enrollees.

Statements made within this manual, the Provider Contract or any other educational/training guides do not prohibit a provider from acting lawfully within their scope of practice. These documents also do not suggest providers restrict any medically necessary covered services to HSCSN enrollees. Providers are able to advocate on the behalf of the enrollee including providing information about diagnosis, testing, medical conditions, treatments, and any other information

to HSCSN enrollees and their caregivers in order to make informed decisions about their health care. HSCSN enrollees and their caregivers should be fully informed about all options, risks and benefits and have the right to refuse treatment and express concerns about future treatment decisions regardless of benefit coverage.

## Preventive Health Services

The following physical health services are part of the HSCSN Preventive Health Benefit Package:

- Preventive, acute, and chronic health care services generally provided by a Primary Care Provider (PCP)
- Child Wellness Services/HealthCheck (EPSDT) services
- Adult Wellness Care
- Immunizations
- Women's wellness care, consisting of annual gynecology examinations, routine pelvic exams, Pap smears, and cervical cancer screening
- HIV/AIDS screening, testing and counseling
- Services at a Federally Qualified Health Center (FQHC)
- Diet and nutrition counseling
- Diabetes screening & referral
- Screening for nutrition problems, including obesity
- Screening for kidney disease
- Screening for tobacco use
- Screening and immunization for Human Papilloma Virus (HPV)
- Screening and counseling for sexually transmitted infections/diseases
- Screening for depression
- Tobacco cessation services

## Immunizations

Primary Care Providers (PCPs) are required to administer immunizations in accordance with the CDC's Advisory Committee on Immunization Practices (ACIP). Providers are also required to prepare for the simultaneous administration of all vaccines for which the enrollee, under age 21, is eligible to receive at each visit. Providers must participate in the Vaccines for Children Program (VFC). The Vaccines for Children Program (VFC) is part of the DC Health's Immunization Program. It is a federally-funded entitlement program that provides vaccines free of charge to enrolled providers that serve eligible patients. For further information on childhood, adolescent and adult immunizations, visit https://www.cdc.gov/vaccines/. For more information on how to enroll in the VFC Program visit https://dchealth.dc.gov/service/vaccines-children-vfc.

For HSCSN enrollees age 19 years and older, VFC is not eligible however HSCSN will cover any medically necessary vaccinations. Providers can bill HSCSN, per their contract for immunizations administered to HSCSN enrollees over the age of 18. For more information, contact the HSCSN Provider Affairs Department at (202) 497-2737 or via email at PRelations@hschealth.org.

## Emergency Services

For HSCSN enrollees, HSCSN ensures the availability of emergency services and care 24 hours a day, seven days a week (24/7). HSCSN is responsible for coverage and payment of emergency services and post stabilization care services for HSCSN enrollees regardless of whether or not the provider that furnishes the services has a contract with HSCSN. Plan coverage responsibility for post stabilization care that has not been approved ends when:

- A physician contracted with the plan and with privileges at the treating hospital assumes responsibility for the enrollee's care
- A physician contracted with the plan assumes responsibility for the enrollee's care through a transfer
- The enrollee is discharged

HSCSN will not deny payment for treatment obtained when an HSCSN enrollee had a medical emergency and/or when the condition presented as a medical emergency but in nature was non-emergent after medical screening. HSCSN does not require prior authorization for emergency services provided by either contracted or non-contracted providers when an enrollee seeks emergency medical care.

HSCSN will not deny coverage for emergency services for enrollees based on the emergency room, hospital and/or fiscal proxy not informing HSCSN, the HSCSN enrollee's Primary Care Provider (PCP), or any other applicable District Entity. HSCSN enrollees with emergency medical conditions cannot be held liable for payment of any subsequent screenings and/or treatment needed to diagnose the specific condition or stabilize the HSCSN enrollee.

## Specialty Services

The following specialty services are part of the HSCSN Specialty Health Benefit Package:

- Health Care Services provided by specially trained doctors or Advanced Nurse Practitioners
- Podiatry services and foot care
- Speech and Language Therapy
- Occupational Therapy
- Physical Therapy
- Vision Therapy
- Vision Benefit (eyeglasses and exams)
    - Subsequent eyeglasses can be dispensed to an enrollee without prior authorization if the enrollee has not received a pair of eyeglasses within the last 730 calendar days (2 years of last dispense).
- Hearing Services
    - Diagnosis and Treatment of conditions related to hearing, including exams, testing, hearing aids and hearing aid batteries
- Respiratory Therapy

- The assessment and treatment of lung disease or condition when part of a treatment plan developed by a Physician or Advanced Practice Nurse
- Services provided on a part-time basis in the enrollee's home by a Respiratory Therapist or other Health Care Professional trained in respiratory therapy

## Behavioral Health and Substance Use Disorder (SUD) Services

All residents residing in the District of Columbia are eligible for Mental Health Services through DBH. Behavioral Health Services can be accessed through DHB's Access Help Line. HSCSN Enrollees have access to DBH Services as well as a host of private practice Behavioral Health Providers. Providers are encouraged to contact the assigned HSCSN Care Manager to assist with the referral to DBH's Access Help Line and the coordination of additional medically necessary treatments.

The following services are part of the HSCSN Behavioral Health Benefit Package:

- Diagnostic and Assessment Services
- Inpatient Hospitalization and Emergency Services
- Intermediate Care Facilities for the Intellectually Disabled (ICF-ID/DD)
- Individual Counseling, Group Counseling, and Family Counseling
- Counseling Services provided by a Federally Qualified Health Center (FQHC)
- Medication Management
- Crisis Services
- Day Services
- Intensive Day Treatment
- Psychiatric Residential Treatment Facilities (PRTFs)
    - Available to enrollees under age 21
- Partial Hospitalization Programs
- Psychological and Neuro-Psychological Testing
- Care management Services
- Inpatient Drug and Alcohol Detoxification and Treatment
- Outpatient Drug and Alcohol Treatment

## Dental Services

HSCSN contracts with Delta Dental to provide dental services to all HSCSN enrollees. Dental providers are required to complete a contract with Delta Dental prior to services being provided to HSCSN enrollees. All dental providers will have an assigned Provider Affairs Representative from Delta Dental. Dental providers must furnish covered services to HSCSN enrollees in a manner consistent with the requirements of the Medicaid statutes, CMS regulations, and Delta Dental's contractual obligations, policies and practices, as well as professionally recognized standards of dental health care. For more details please see Section 7 of the Delta Dental HSCSN Provider Manual or contact your assigned HSCSN Delta Dental Rep at 888-258-8023 or via email

at PR_GovernmentPrograms@delta.org.

## Additional Available Services

The following additional services are part of the HSCSN Benefit Package:

- Prosthetic Devices
    - Corrective, supportive, and replacement devices prescribed by a licensed provider (includes orthotics and prosthetics)
- Home Health Services
    - Skilled Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, Speech Therapy and Licensed Clinical Social Work Services
- Home Modification
    - HSCSN enrollees whose home require medically necessary equipment, personnel, or structural change for safety of the HSCSN enrollee (lifetime maximum benefit of $40,000)
    - The parent/caregiver must own the home that requires home modification
- Long Term Support Services
    - Personal Care Aide and/or Private Duty Nursing Care
- Respite Services
    - Respite services for families/caregivers with responsibility for maintaining a demanding treatment and/or monitoring regime for a child with a catastrophic medical or behavioral condition
- Long Term Care and Intermediate Care Facility Services (ICF)
    - Long term care services for HSCSN enrollees residing in a skilled nursing facility, rehabilitation hospital or Intermediate Care Facility for the Intellectually Disabled
- Care Coordination under services of Community Based Intervention (CBI), Multi-Systemic Therapy (MST), Assertive Community Treatment (ACT), and/or Rehabilitation Option Services
- Transportation Services (non-emergency medical transportation services)
- Durable Medical Equipment (DME)
- Assistive Technologies
- Disposable Medical Supplies (DMS)
- Hospice Care and Palliative Care Services
- Home Modification Services

## Home Modifications

HSCSN enrollees are eligible for home modifications to ensure that they are able to continue to have a quality of life within their current environment. Parents/Caregivers must own the home where the HSCSN enrollee resides. The maximum benefit for each HSCSN enrollee is $40,000. Home Modification Requests, including documentation of home ownership/deed information and requested modifications, must be sent to the UM Department via email at

UM@hschealth.org *or faxed to* (202) 721-7190.

## Transportation

Transportation is available for all HSCSN enrollees for non-emergency scheduled medical appointments to and from participating provider/provider group offices for scheduled appointments. HSCSN enrollees and/or designees, included but not limited to Providers and staff of a provider's office staff, can schedule transportation by contacting the HSCSN Transportation Vendor, Southeastern Trans (SET) at 866-991-5433.

**Note: Per DHCF Transmittal 21-48, all Emergency Medical Transportation services remain a benefit available to HSCSN enrollees but providers are reimbursed directly by DHCF instead of HSCSN. Network providers and/or facilities should submit all applicable claims for Emergency Transportation services to DHCF. For more information, see DHCF Transmittal 21-48.**

## Family Transportation to Psychiatric Residential Treatment Facilities (PRTFs)

HSCSN is proud to offer our enrollees family therapy travel services when placed in a Psychiatric Residential Treatment Facility (PRTF).
HSCSN will pay for the travel and a hotel during the stay for participation in the family therapy sessions. Family therapy at the PRTF must be part of enrollee's Treatment Plan to be approved by the HSCSN Medical team. For more information, see https://hscsnhealthplan.org/enrollees/forms.

## HSCSN Health and Family Support Programs

HSCSN enrollees have access to free health and family support programs. These programs include fitness and nutrition classes, parent advocacy groups, health education classes and health management programs. Those available programs are:

- Community Service Advisory Council
- Healthy Living Program
- Male Caregivers Advocacy Support Group
- Parent Advocate Leaders Support Group
- Young Adult Support Group
- Youth Athletic Program
- Baby and Me Program
- Community Support
- Summer Benefit Program

## Summer Program Benefit

HSCSN enrollees are eligible to receive Summer Program Benefits. Each enrollee can participate in one summer program of their choosing up to a maximum cost of $2000.00. The program must be a formal program provided by an organization that is accredited, certified and/or licensed as appropriate. The programs must be a formal program with a program description, admission

criteria, and allow for participation by anyone who meet the admission the criteria. All summer programs should benefit the enrollee with the promotion of socialization, recreation, self-care, fitness, vocational or other skills, and/or education about their condition. The Summer Program Benefit will pay for day programs and/or overnight programs including summer camps. The summer program must occur between Memorial Day and Labor Day, when the enrollee is not in school.

Personal Care Aides (PCAs), Home Health Aides, ABA Services and/or other therapy services during the hours when the HSCSN enrollee is in the summer program will not be covered. Transportation to Summer Programs will not be covered however the transportation costs can be included in the cost of the summer program if provided by the same program.

Prior Authorization is required for all Summer Programs. Prior authorization requests must include a printed description of the program, start dates, end dates, costs, and a Physician Order/Letter acknowledging that the Physician is aware that the HSCSN enrollee will participate in the summer program, feels the program is appropriate, there are no medical contraindications and agrees to sign any orders necessary for the enrollee to participate in the summer program. Providers must submit all required documentation to the UM Team at UM@hschealth.org *or faxed to* (202) 721-7190. The costs for Summer Programs billed directly to the HSCSN enrollee or their caregiver will be covered by HSCSN by out-of-pocket reimbursement. For more information on the Summer Program Benefit, contact your assigned Provider Relations Rep at (202) 467-2737.

For more information on all of the specific programs, please visit https://hscsnhealthplan.org/enrollees/health-family-support-programs or reach out to the assigned Care Manager at 202-467-2737.

## Non-Covered Services

HSCSN does not cover the following services and HSCSN enrollees are able to use community/local services, as appropriate:

- Infertility Treatments
- Sterilizations for persons under the age of 21
- Sterilization reversals
- Cosmetic Surgery
- Experimental or investigational services, surgeries, treatments or medications
- Services that are part of a clinical trial
- Abortion, unless medically necessary
- Any service or treatment that is not medically necessary
- Any service not described in the list of covered benefits
- Any service that is of an amount, duration, or scope in excess of a limit expressly set by the Department of Health Care Finance

- Transportation Services to or from covered services when the transportation is availably furnished by DCPS or a DCPS Contractor
- Services furnished in a school setting by a DCPS Employee or DCPS Contractor or a Private School; unless services are provided by the FQCH School Based Clinic and/or Early Intervention/Strong Start program

**Providers should contact HSCSN for further clarity on any covered or non-covered benefits at (202) 467-2737.**

## Department of Family and Community Development

HSCSN's Department of Family and Community Development (FCD) is dedicated to the wellbeing of our enrollees. The FCD is responsible for enrollment, retention, community engagement and the administration of HSCSN's support groups and HSCSN enrollee education programs. The Department of Family and Community Development is located at 3400 Martin Luther King Jr. Avenue SE, Washington, DC, 20032, inside of the National Children's Center. The Department of Family and Community Development helps members and their families improve their health, social and environmental needs by collaborating with community partners, government agencies and the local school system to increase awareness of HSCSN benefits. The Department of Family and Community Development connects HSCSN enrollees to community-based services and programs to encourage independence. FCD hosts various meetings and training sessions where childcare is provided for many of these meeting. The FCD office is open to the community, to walk into the facility and inquire about services and benefits, receive resource information as well as the use and access to a computer and printer. To learn more about HSCSN's Family and Community Development Department, visit www.hschealth.org or contact the Family and Community Development Department at (202) 580-6485.

## Community Support Projects

- **Community Services Advisory Council (CSAC)** – The CSAC is the special advisory arm of HSCSN that provides advice on methods to improve health care services for our enrollees. CSAC is comprised of HSCSN enrollees, caregivers, HSCSN enrollee's designees and community members. The members of CSAC recommend methods to improve and enhance HSCSN's capability to actively and proactively improve the health care delivery services to children and youth with special health care needs, their families, and their communities.
- **Community Awareness** – The FCD staff plan many of HSCSN's community events such as health fairs, collaborative meetings and other local events. The FCD staff also attend local, national, and international conferences on behalf of HCSN to increase awareness of health services available to children with special health care needs as well as promote awareness of the HSCSN initiatives.
- **Community Support Groups** – The staff at the FCD also organize and run several support groups for HSCSN enrollees and their designees or caregivers. These support groups provide

various types of help, by sharing coping strategies and promote our enrollees to feel more empowered while developing a sense of community.

- **Community Partnerships** – The staff at the FCD have established partnerships with several community organizations. These organizations help to conduct research for measureable outcomes related to HSCSN's support group activity and provide training to HSCSN support group members. Some of these partners include Advocates for Justice and Education, Breathe DC, Whitman Walker, DC Department of Parks and Recreation, Georgetown University, Goodwill of Greater Washington, Lead Safe DC, Lead Safe Washington, Melwood Recreation Center, National Fatherhood Initiative, Quality Trust for Individuals with Disabilities, United Planning Organization, and the University of the District of Columbia.

HSCSN welcomes our provider community to participate in any of our Family and Community Development programs. Providers interested in participating or for more information, providers can contact the Family and Community Development Department at (202) 580-6485.

## Care Coordination

HSCSN is a DC Medicaid Health Plan specializing in care coordination for SSI eligible Medicaid beneficiaries in the District of Columbia from birth to age 26. The goals of the care coordination program are to ensure that enrollees receive high quality health care and are knowledgeable about HSCSN benefits and resources.

Care Coordination is a series of activities provided by HSCSN Care Managers and Care Management Support Staff who work with the Primary Care Providers within the Medical Home to assist enrollees in gaining access to necessary services (medical, behavioral, and other services); coordinate preventive care and specialty services; and facilitate communication. Care Coordination is individualized, collaborative, comprehensive, and outcome focused. Each HSCSN enrollee has an assigned Care Manager. To reach the Care Management Department or an enrollee's assigned Care Manager, call the HSCSN Customer Care Department at 202-467-2737.

**Note: HSCSN is not a social service agency. HSCSN's staff does not provide clinical services. HSCSN Care Managers cannot function as a surrogate parent/guardian or decision-maker for the enrollee or caregiver.**

### What is the Care Manager's Role and Responsibilities?

- Develop a relationship with and support the HSCSN enrollee and/or caregiver
- Develop relationships with providers servicing HSCSN enrollees
- Communicate with HSCSN enrollees, caregivers, and treating providers
- Assist the HSCSN enrollee with identifying their medical needs

- Facilitate access and coordinate services for the HSCSN enrollee (identify provider(s), schedule appointments, coordinate transportation)
- Develop and monitor the care coordination plan
- Educate HSCSN enrollees and families on HSCSN benefits, resources, and processes
- Identify and coordinate HSCSN enrollee and/or caregiver education needs (classes, literature, referrals)
- Support the relationship between the HSCSN enrollee and their providers
- Connect the HSCSN enrollee and/or caregiver with resources
- Make referrals to educational advocates and attend educational meetings (with permission of HSCSN enrollee and/or caregiver)
- Assist the provider and family to address overutilization and underutilization of services and noncompliance

Care Managers perform structured assessments both initially and periodically. Each HSCSN enrollee receives an individualized assessment outlining anticipated preventive, diagnostic and treatment services. From the assessments, a Care Plan (CP) is created, which is a summary and plan of the HSCSN enrollee's needs, strengths, goals, resources, and needed actions. Results of the initial and periodic assessments are used to assign HSCSN enrollees to an acuity level (I-III). The acuity level determines the minimum frequency of Care Coordination, face-to-face, or virtual visits or assessments that are needed. The CP is family and person-centered with goals being driven by the HSCSN enrollee or designee. The CP is re-evaluated at a minimum annually, and more frequently based on the medical and/or behavioral health needs of the enrollees. The CP is a shared plan of care in that the Care Manager develops the CP collaboratively with the HSCSN enrollee, their designee, the PCP, and other providers and agencies as appropriate. The CP is reviewed, signed and dated by the PCP, the HSCSN enrollee, and their designee, then returned to the Care Manager. **The PCP must maintain copies of current and past CPs in the enrollee's medical record.**

## Working with the Care Manager – What is the role of the Provider?

- Collaborate to create a shared Care Plan.
- Communicate with the HSCSN Care Managers and/or Care Management Staff about concerns and progress (risks, non-compliance, overutilization, underutilization, health education needs, etc.).
- Follow HSCSN's requirements for obtaining prior authorization (**Note: HSCSN's Care Managers and Care Management Staff do not provide and/or approve prior authorization for services. Please see the Utilization Management section of this manual for further information).**

## IDEA and Care Coordination for Children participating in Strong Start/Early Intervention Program

The Individuals with Disabilities Education Act (IDEA) is a Federal Law originally passed in 1975 and reauthorized in 1991. In 2004, it was reauthorized and renamed The Individuals with Disabilities Education Act. This act requires that all children receive free, appropriate, public education regardless of the level or severity of their disability. IDEA provides funding to enable States to provide a public education to students with disabilities. Under IDEA, children can receive a public education via an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) that meets the needs of the child in the least restrictive environment. The IEP and IFSP are legally mandated documents developed by a multidisciplinary assessment team that specifies goals and services for each child eligible for special educational services or early intervention services.

These federally legislated safeguards establish that children with disabilities and their parents share the same legal right to a free and appropriate education as children without disabilities. Federal legislation requires that each child recognized as having a disability that interferes with learning has a written plan of service: an IFSP for infants and toddlers, birth through three (3) years, an IEP for children aged 3 through 21years, and a Transitional Services Outcome Plan (TSOP) that is part of the IEP for youth at 16 years of age. Federal legislation defines transition from school as a coordinated set of activities for a student designed to promote movement from school to post-school activities, including post-secondary education, vocational training, integrated employment, continuing and adult education, adult services, independent living, and community participation. This transition plan highlights and validates the lifelong needs of individuals with disabilities and is the beginning of an integrated program that enables adults with disabilities to live, work and play in our towns and cities. The PCP is in a key position to participate in planning services and to provide care for these children and young adults.

Pediatricians need to be knowledgeable of federal, state, and local requirements; establish linkages with early intervention, educational professionals, and parent support groups; and collaborate with the team working with each child. For additional information about the IDEA Act, please visit https://sites.ed.gov/idea/.

**Of Note: HSCSN Care Managers, Care Management Staff, nor does the Care Management Department develop the IDEA documents (IEPs, IFSPs, etc.).** HSCSN Care Managers may participate in meetings, but HSCSN staff are not the original creators and/or owners of and only receive copies of the documents from Strong Start and their affiliates. If you need any copies of documents, please reach out to the Care Manager and/or the appropriate Strong Start contact person.

## Other portions of the law provide the following:

The IEP/IFSP evaluation team may recommend related services: transportation; developmental; therapeutic services (including speech-language pathology, audiology, psychological services, and physical and occupational therapy); recreation (including therapeutic recreation); social work services (including rehabilitative counseling) and medical services (for diagnostic and evaluative

purposes only). These services may be required to assist a child to benefit from special education and include early identification and assessment of disabling conditions. If the parents approve the IEP/IFSP, they sign the document, and the school district is committed to providing these outlined services.

The rights of the caregiver and child to "due process" shall be protected. This ensures the caregiver's rights to be involved in developing the educational plan and for the meeting to be conducted in their native language or other mode of communication if it is not a written language understandable to the public. Interpreter or Translation services are available if English is not the native language of the home, if the caregiver has a hearing or visual impairment.

Furthermore, caregivers have the right to appeal when they view the team's decision as inappropriate or harmful. For further information or to submit a referral to the District of Columbia's Strong Start Program please visit the DC's Office of the School Superintendent Strong Start Program at https://osse.dc.gov/service/strong-start-dc-early-intervention-program-dc-eip

## Non-Covered Services

HSCSN does not cover the following services and HSCSN enrollees are able to use community/local services, as appropriate:

- Infertility Treatment
- Sterilization for people under the age of 21 years
- Sterilization reversal
- Cosmetic Surgery
- Transplant surgery (covered by DHCF with prior authorization)
- Paternity testing
- Experimental or investigational services, surgeries, treatments, or medications
- Abortion, unless medically necessary
- Any service or treatment that is not medically necessary
- Any service not described in the list of covered benefits
- Any service that requires prior authorization and authorization was not obtained prior to rendering the service
- Any service that is of an amount, duration, or scope in excess of a limit expressly set by the Department of Health Care Finance
- Transportation Services to or from covered services when the transportation is furnished by DCPS or a DCPS Contractor
- Services furnished in a school setting by a DCPS Employee or DCPS Contractor or a Private School, unless services are provided by the FQHC School Based Health Clinic and/or Early Intervention/Strong Start program

Providers should contact HSCSN for further clarity on any covered or non-covered services at (202) 467-2737.

## Utilization Management

The purpose of HSCSN's Utilization Management (UM) Program is to review the requests received from providers for authorization and to make determinations about medical necessity and appropriateness of the services being requested.

UM activities are designed to assist the provider in the delivery of appropriate services to enrollees within our benefit structure. HSCSN Staff (nurses and social workers) work collaboratively with licensed, board-certified physician reviewers (Medical and Behavioral Health) to conduct utilization reviews of requested services and equipment, and to coordinate care across the continuum. UM decision making is based only on medical necessity, appropriateness of care, service, and existence of coverage. The organization does not reward practitioners, provider groups, or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. The UM program utilizes InterQual Criteria, For services that do not have applicable InterQual Criteria we use internally developed guidelines or apply national coverage standards or clinical practice guidelines.

The following is a list of the guidelines adopted by HSCSN to assist with determination of coverage and medical necessity decisions include the following:

- 2022 InterQual® Acute Adult Criteria
- 2022 InterQual® Acute Pediatric Criteria
- 2022 InterQual® Rehabilitation Criteria
- 2022 InterQual® Long-Term Acute Care Criteria
- 2022 InterQual® Subacute and Skilled Nursing Facility Criteria
- 2022 InterQual® Home Care Criteria
- 2022 InterQual® Outpatient Rehabilitation and Chiropractic Criteria
- 2022 InterQual® Procedures Criteria
- 2022 InterQual® Durable Medical Equipment Criteria
- 2022 InterQual® Behavioral Health Criteria, Adult and Geriatric Psychiatry
- 2022 InterQual® Behavioral Health Criteria, Child and Adolescent Psychiatry
- 2022 InterQual® Behavioral Health Criteria, Substance Use Disorders
- 2022 InterQual® Behavioral Health Criteria, Behavioral Procedures

In the absence of applicable criteria, HSCSN has internally developed medical necessity criteria based on Clinical Practice Guidelines and other scientific evidence published in the medical literature. Those UM cases that cannot be reviewed using an InterQual Criteria, are referred for review to the appropriate HSCSN Medical Officer and/or the Behavioral Health Services Director. In some cases, the CMO or CPMO may decide to send the case to an external reviewer or external review organization. The current internal, additional HSCSN Medical Necessity Criteria are:

- LTSS Policy (applied to authorization of Personal Care Aide Services)
- HSCSN Vision Therapy
- District of Columbia Subacute Criteria (Psychiatry)
- In Home Behavioral Intervention Criteria
- Applied Behavioral Analysis Policy
- Psychiatric Residential Treatment Facility Policy

The HSCSN UM Department is available to address any questions regarding authorization requests or UM decisions for any Medical or Behavioral Health Service for an HSCSN enrollee. If the treating provider would like to discuss the case with a Physician Reviewer, the requesting provider can contact the UM Department at (202) 721-7162 and for TTY Users please call (202) 467-2709. To request the medical necessity criteria used for a specific decision, send a request via fax to (202) 721-7190 and/or mail [HSCSN, Attn. Appeals Coordinator 1101 Vermont Avenue, 12th floor suite, Washington, DC 20005] for the specific criteria needed. Responses will be provided within five (5) business days for requests received by fax and/or mail.

## HSCSN follows NCQA Standards for Utilization Management

The National Committee for Quality Assurance (NCQA) is a private, non-profit organization dedicated to improving health care quality and accredits and certifies a wide range of health care organizations. NCQA standards provide a framework for implementing evidence-based best practices to ensure:

- Efficient and cost-effective case management processes and service delivery:
- Manage patients as they move between care settings.
- Use patient-centered assessment to determine care needs.
- Develop personalized, patient-centered care plans.
- Provide access to qualified case management staff.
- Protect patients' personal health information.

To learn more about NCQA, visit their website at www.ncqa.org.

## Referrals

HSCSN encourages the Primary Care Provider (PCP) to coordinate specialty services for enrollees. The enrollee should possess, on file, a referral from their PCP or other referring provider when presenting services at a specialty care appointment. The PCP can refer the enrollee to any in-network physician specialist without prior authorization. Care Management staff are available to assist Providers and Enrollees with help in obtaining and/or managing referrals.

## Authorizations

The UM Program includes the effective processing of pre-service, concurrent and post-service review determinations by qualified personnel in any of the following areas, or for other services,

as determined:

- Applied Behavior Analysis (ABA) therapy
- In-Home Behavioral Intervention (IBI) services
- Outpatient Rehabilitative Therapies:
    - Speech-Language Therapy (ST)
    - Physical Therapy (PT)
    - Occupational Therapy (OT)
    - Other: Acupuncture, Massage Therapy, Chiropractic Treatment, etc.
- Home Health Services:
    - Skilled Nursing Visits
    - Home Health Aide Services
    - Home Based PT, OT, or ST
- Private-Duty Nursing (PDN) Services
- Personal Care Aide (PCA) Services
- Durable Medical Equipment (DME) and Disposable Medical Supplies (DMS)
- Home Modifications
- Respite Care Services
- Psychological / Neuropsychological evaluation/testing
- Elective Procedures and Surgeries
- Intensive Day Treatment / Partial Hospitalization / Day Rehabilitation Programs
- Admission or Transfer to subacute facilities:
    - Rehabilitation facilities
    - Skilled Nursing Facilities (SNF)
    - Psychiatric Residential Treatment Facilities (PRTF)
    - Intermediate Care Facilities for Individuals with Intellectual Disability (ICF-IID)
- Inpatient medical and behavioral health admissions
- **All Out-of-Network Services**

Authorizations are provided in accordance with HSCSN policies, procedures, and criteria approved by the Chief Medical Officer, Benefits and Utilization Management Committee, and the HSCSN Quality Council (which includes external Physician Advisors). The UM review process is consistent with nationally recognized standards of care.

For all services requiring authorization, providers must send requests to the UM Department via email at UM@hschealth.org or via fax at (202) 721-7190. For issues requiring urgent attention such as surgery, clinical review submission and notification of admissions, submit your request to expeditedrequests@hscheath.org or fax to 202-407-8955. For phone inquiries concerning authorization requests please call (202) 721-7162 and TTY Users please call (202) 467-2709. Those requests will be reviewed and answered within two (2) business days of receipt. Any

authorization requests received outside of the outlined process will be denied due to administrative reasons. The following services **DO NOT REQUIRE** prior authorization when performed by an in-network provider:

- Primary Care Office Visits
- Specialty Office Visits
- Women Well Care Visits (including Depo-Provera shots)
- Vision Services (the first pair of standard eyeglasses do not require prior authorization)
    - Subsequent eyeglasses can be dispensed to an enrollee without prior authorization if the enrollee has not received a pair of eyeglasses within the last 730 calendar days (24 months from last dispense).
- Labs and Radiology Services (including x-rays, sonograms, MRIs, CT, and PET Scans)
- Outpatient Behavioral Health Services (psychiatric evaluations, substance abuse, medication management, and therapy services [individual, family])
- Incontinence supplies, nebulizers and supplies and CPAP supplies when the enrollee has a CPAP machine.
- Breast Pumps

**Note: Emergency and Stabilization Services (ER Services) never require an authorization request regardless of the network status of practitioner, providers or facility providing ER Services.**

## Inpatient Hospital Care

HSCSN does concurrent review of inpatient hospitalizations. HSCSN must be notified of all hospitalizations within 24 hours of admission. Initial clinical documents must be submitted within 24 hours of admission or the next business day. Initial submission of clinical documents for weekend and/or holiday admissions are due the next business day by 2:30pm EST. Observation Stays beyond 48 hours require authorization and submission of clinical information, see previous statements for timelines. **Post-service review for inpatient hospitalization will only be considered when there are extenuating circumstances and on a case-by-case basis.**

Clinical documents must be submitted for vaginal and/or Cesarean section deliveries if the mother and/or newborn is hospitalized for more than 48 hours for vaginal deliveries or 96 hours for Cesarean section deliveries.

**All acute care level (both acute medical and acute behavioral health) transfers require prior authorization.**

**Out of Network services always require prior authorization**. If a provider elects to refer an HSCSN enrollee to a non-participating (out-of-network) provider for any reason, this request must receive prior authorization from HSCSN before the HSCSN enrollee accesses the services.

Requests for authorization and physician orders require the following information:

- HSCSN Enrollee Name
- HSCSN Enrollee ID# and/or Date of Birth
- ICD 10 Code (the diagnosis for the service ordered)
- Specific information on the requested services/procedures
- Physician Printed Name and Signature
- Ordering Physician's NPI Number
- Name of requested specialty provider (if a preference is identified)
- Reason for authorization or request
- Number of visits needed and frequency/duration of treatment
- Supporting Medical Records (as appropriate)
- All other information that should be communicated to HSCSN

**Failure to follow the established timelines and UM procedures can result in an adverse benefit determination.**

## Behavioral Health

HSCSN provides a large spectrum of behavioral health and substance abuse services to our enrollees. Most of the behavioral health and substance abuse services do not require prior authorization, however, some outpatient services require authorization that is provided by the UM Department. Prior Authorizations are required for In-Home Behavioral Intervention Services, Applied Behavior Analysis Services (ABA), Psychological Testing and Neuropsychological Testing.

## In-Home Behavioral Intervention Services

The In-Home Behavioral Intervention (IBI) Services program is intended for enrollees diagnosed with a DSM-V diagnosis, have the potential for improvement and exhibit symptoms/behaviors which are consistent with emotional and or behavioral disruption in multiple areas of function (home, school, and community). Coordination of care is an essential element of the program. Guiding principles for this service include:

- that treatment should be home and community based;
- treatment should be child centered and family focused;
- care should be culturally competent; care should be individualized;
- care should be integrated across providers;
- care should incorporate evidenced-based principles and techniques;
- treatment should actively seek to overcome barriers to service usage;
- and extensive quality assurance measures should be taken to maintain quality of care.

Working under the supervision of a Licensed Behavioral Health/Developmental Disabilities Professional, a Behavioral Specialist provides clinical support services to children and adults with

behavioral health diagnoses. The Behavioral Specialist participates in the Individual Service Plan (ISP), keeping record of, and reporting changes in the enrollee's behavior and/or progress toward care plan goals. The Behavioral Specialist's role is to establish a positive relationship with the enrollee; implement specific interventions outlined in the Plan; and assess needed resources, building functional relationships with others. The Independent Licensed Behavioral Health Professional assesses and provides ongoing monitoring of progress toward treatment goals and supports the provision of appropriate, effective, coordinated behavioral home-based services. Participation in outpatient therapy as well as parent/caregiver participation is required as part of this service. All requests require a completed physician/provider referral using the HSCSN IBI Authorization Request Form. No other referral form is acceptable for request of IBI. IBI must be part of an ISP, based on a physician order and defined by an Independent Licensed Behavioral Health Professional. Requests must be medically necessary and related to the enrollee's condition. All requests should be submitted with the required documentation to HSCSN UM Department via email at UM@hschealth.org or via fax to (202) 721-7190.

## Applied Behavior Analysis Services (ABA)

Requests for ABA services should be sent to the HSCSN UM Department by an enrollee's treating Medical Doctor (MD) or Nurse Practitioner (NP) using the ABA Evaluation Request Form. All ABA services require prior authorization. Enrollees who meet medical necessity criteria for an ABA Evaluation are referred to an in-network ABA Provider. The ABA Provider completes the Evaluation to determine the appropriateness of ABA for the enrollee and makes a recommendation for the intensity of treatment. The ABA Provider submits their written Evaluation report to the HSCSN UM Department for review of medical necessity. Enrollees who are found to meet medical necessity criteria for ABA service are referred to an in-network ABA Provider. Providers will receive responses within the standard HSCSN review timeframe of fourteen (14) business days. Enrollees who meet the medical necessity requirements for ABA services can receive those services from HSCSN participating providers once authorization is received. There is no benefit and/or age limit on ABA services however services must be clinically appropriate and medically necessary. All requests and documents should be submitted to the HSCSN UM Department via email at UM@hschealth.org or via fax to (202) 721-7190. To find the ABA Services Form, please visit https://hscsnhealthplan.org/health-providers/current-providers/forms.

## Psychological and Neuropsychological Testing

HSCSN Enrollees have access to psychological and neuropsychological testing, when needed. Medical necessity must be met for services to be rendered and prior authorization is required for both Psychological and Neuropsychological Testing. A Medical Doctor (MD) or Nurse Practitioner (NP) must order the psychological or neuropsychological testing. The psychologist completing the testing may submit the appropriate Testing Authorization Request Form. The Psychological or Neuropsychological Testing Authorization Request Form is required to be submitted for all testing requests. The Psychological Testing Authorization Request Form and the

Neuropsychological Testing Request Form should be submitted to the HSCSN UM Department via email at UM@hschealth.org or via fax to (202) 721-7190. All Psychological or Neuropsychological Testing Requests are subject to standard review timelines; fourteen (14) business days for response.

To find the Psychological Testing and/or Neuropsychological Testing Authorization Request Forms, please visit https://hscsnhealthplan.org/health-providers/current-providers/forms.

## Substance Use Disorder (SUD) Services

### Medically Managed Intensive Inpatient Service (Detox)

Inpatient medical detox is available and offered to all HSCSN enrollees who wish to access services. Enrollees can present for treatment for detox at the closest inpatient acute medical care facility. If active detox medical necessity is met, enrollees may be admitted for detox. Upon presentation for admission for detox, the admitting facility must notify HSCSN following the inpatient hospital care admission guidelines. Those guidelines indicate that notification of admission must be received by HSCSN within 24 hours or the next business day, following admission. Additionally, within 48 hours of admission or the next business day following a holiday, all facilities must provide HSCSN with clinical information for continued medical necessity review. Clinicals can be emailed to the UM Department at UM@hschealth.org or via faxed to (202) 407-8955.

### Outpatient SUD Treatment and Maintenance

HSCSN enrollees have access to the full spectrum of outpatient SUD treatment services available to District Residents. Outpatient SUD treatment and maintenance does not require prior authorization, I accordance with the Mental Health Parity and Addiction Equity Act of 2008 (U.S.C. §1185a) and DC Behavioral Health Parity Act of 2018 (D.C. Code §22-242) which require HSCSN to treat mental health and SUD benefits equal to medical and surgical benefits.

**Note: Intensive Outpatient Treatment does require prior authorization. Providers who wish to provide this treatment should follow the procedures and clinical documentation requirement for submitting a prior authorization request to HSCSN.**

### Substance Use Disorder (SUD) Residential Treatment

HSCSN enrollees may present for an assessment and level of care determination for substance use disorder (SUD) at any DC Department of Behavioral Health (DBH) certified (SUD) treatment provider. Providers are required to check eligibility of every enrollee who present for treatment. Providers must use the Co-Triage assessment tool to determine an initial level of care. If an HSCSN enrollee requires a residential level of care, the provider should refer the enrollee to an in-network SUD provider. SUD Residential Treatment Providers must submit the initial clinicals to the HSCSN UM Department within 48 hours of entrance into the program, per DHCF Transmittal 21-23. HSCSN is required to authorize 15 days of treatment (per calendar month) if the treatment

meets medical necessity. If an enrollee needs care for more than 15 days of treatment, referred to as "in lieu of" scope of coverage per 42 §438.3, the SUD Residential Treatment Provider must seek authorization from DHCF's contracted Quality Improvement Organization (QIO). If the services requested do not meet ASAM/InterQual criteria, it is the provider's obligation to refer the enrollee to the appropriate level of care. For more information, please review DHCF's Managed Care Program Authorization Guidance for SUD Residential Treatment Services #21-23 Transmittal published on June 11, 2021. To submit clinicals for authorization, SUD Residential Treatment Providers should submit clinicals via secure email, marked urgent in the subject line to the UM Department at UM@hschealth.org or via fax to 407-8955.

### Psychiatric Residential Treatment Facility (PRTF)

A Psychiatric Residential Treatment Facility (PRTF) is a non-hospital facility offering intensive inpatient services for enrollees under the age of 21. The goal of a PRTF is to stabilize or improve an enrollee's condition until inpatient therapeutic services are no longer needed. All referrals for HSCSN enrollees to a PRTF must be reviewed for medical necessity and receive an HSCSN Pre-Residential Placement/Care Management Planning Team Meeting. The HSCSN Pre-Residential Placement/Care Management Planning Team is a multidisciplinary team typically consists of the assigned Care Manager, HSCSN's CPMO, the referring entity, the assigned PCP, treating Mental Health Practitioner(s), and other involved agencies such as CFSA, DYRS, OSSE or DCPS. For more information on referring an enrollee to a PRTF, please reach out to the HSCSN Enrollee Services Department at (202)467-2737 and request to speak with the PRTF Care Manager.

### Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) are a facilities that provide comprehensive and individualized health care and rehabilitation services to enrollees to promote their functional status and independence. ICF-IID facilities are long-term residential programs under the oversight of the Department on Disability Services in the District of Columbia. For any providers giving a referral to and/or any enrollee seeking admission to an ICF-IID, prior authorization is required. For more information regarding placement in an ICF/IID, please contact the assigned Care Manager via the HSCSN Customer Care line at 202-467-2737.

### Long-Term Services and Supports (LTSS)

HSCSN coordinates long-term care services and supports (LTSS), defined below, for enrollees who need support for chronic physical and behavioral health conditions that limit their abilities to care for themselves. LTSS can be provided in a person's home, in another community-based setting, or by a long-term care facility. LTSS provide assistance with activities of daily living such as eating, bathing, grooming, dressing, walking, using the toilet, getting up or down from a chair or the bed, and preparing meals.

HSCSN has contracted with Liberty Healthcare to perform LTSS assessments and reassessments using the InterRAI tool, a nationally recognized and accepted, standardized instrument for

assessing the support needs of people with disabilities. LTSS assessments are used by the HSCSN UM Department for making determinations regarding an enrollee's eligibility and level of care for LTSS services. Additionally, the HSCSN Care Management (CM) staff use the LTSS assessments and reassessments during the development of enrollee care plans.

LTSS Assessments are required for initiation of personal care aide (PCA) services to an enrollee as well as Annual Reassessments are required for continuation of services. All assessments are directly scheduled with the enrollee and/or their caregiver by Liberty Healthcare. Delays in scheduling the assessment and/or failure to respond to Liberty's efforts to conduct the assessments may result in delays in authorization of services and/or otherwise administrative denials due to failure to follow contracted policies and procedures. Ongoing PCA services require a request for re-authorization every 120 days. Requests for re-authorization should be submitted prior to the end of the authorization period and should include the Plan of Care, supervisory nursing notes, and progress notes.

**Note: Private Duty Nursing service providers must send their visit note and assessment within 90 days of a visit.**

## Private-Duty Nursing (PDN)

Private-duty Nursing (PDN) is defined for Medicaid in 42 C.F.R. § 440.80 and by Title 29 (Public Welfare) Chapter 9, Section 947 of DCMR, Private Duty Nursing Services. PDN services are nursing services for technology-dependent enrollees and/or enrollees who require more individualized and continuous care than is available from a visiting nurse under the Skilled Nursing Home Health Services benefit available under the State Plan.

Private duty nursing services are ordered by a physician. In addition to a detailed physician order, the authorization request should include a recent visit note. The visit note should include justification for PDN or a separate letter of medical necessity can be submitted. PDN services require an updated Home Health Plan of Care by the home care agency every 60 days and signed by the supervising physician. Re-authorization requests must be submitted by the home care agency prior to the start of the authorization period.
The completed HSCSN Home Care Referral Form and required documentation must be emailed and/or faxed to the HSCSN UM Department at UM@hschealth.org *or* (202) 721-7190.

## Home Health Services

Per Federal Guidelines, all home health services require orders from a physician and/or nurse practitioner. The ordering practitioner must submit a completed HSCSN Home Care Referral Form, medical records to support the request and including a visit note documenting a face-to-face visit within the 90 days prior to service initiation. The completed HSCSN Home Care Referral Form and required documentation must be emailed and/or faxed to the HSCSN UM Department

at UM@hschealth.org *or* (202) 721-7190.

**Note: Private Duty Nursing and Personal Care Aides are not considered Home Health Services per federal regulations. Home Health Services are Skilled Nursing Visits, Home Health Aide Services, In-Home Physical Therapy, In-Home Occupational Therapy, and In-Home Speech Therapy Services. HSCSN must receive requests for continuing authorization prior to the end of the current authorization period for all home health services. HSCSN will not authorize services rendered prior to the request for authorization and will deny claims for any home health services rendered without authorization.**

Home Health Services requested must be appropriate for the home setting and for the HSCSN enrollee's needs. All requests will be reviewed every sixty (60) days by the UM Department for medical necessity. The requesting provider must review and sign all care plans (plan of care) from the Home Care Agency every sixty (60) days to ensure that services are appropriate and continue to be medically necessary. For additional instructions, please contact HSCSN's UM Department at (202) 721-7162.

To access the required forms, providers should visit the HSCSN website at https://hscsnhealthplan.org/.

## Medical Supplies, Durable Medical Equipment, Nutritional Supplements, Orthotics, Prosthetics & Assistive Technology

Documentation required for authorization for medical supplies, durable medical equipment, nutritional supplements, orthodoxies, prosthetics, and assistive technology are dependent on the type of equipment requested. The following are standard requirements:

- Physician Orders for Services
- Certificate of Medical Necessity (CMN), Letter of Medical Necessity (LMN), or Physician Letter

Upon receipt of request, the UM Team will review the documents for clinical information and appropriateness. Approvals will be sent to the selected equipment supplier. All suppliers are required to submit confirmation of delivery to the UM Team DME Review Nurse within 24 hours of delivery. The Delivery Invoice must be faxed to (202) 721-7190. The Delivery Invoice must include:

- Signature of person taking possession of equipment at time of delivery
- Delivery Date
- Documentation of education conducted at time of delivery
- Brand Name, Model Name, Quantity, Serial/Identification Number(s) of Equipment

HSCSN verifies all new and replacement durable medical equipment, prosthetics, orthotics, and assistive technology delivered to the enrollee's home. **Note: for claims submission, DME/DMS**

**suppliers must also include the delivery invoice and manufacturer's receipt to HSCSN.**

## Prior Authorization Forms

HSCSN offers online resources to provide you with access to forms required for prior authorization. The following forms can be located on the https://hscsnhealthplan.org/ website or visit:

- In-Home Behavioral Intervention Referral Form
- In-Home Behavioral Intervention ISP Tool
- In-Home Behavioral Intervention Assessment Tool
- Neuropsychological Testing Request Form
- Psychological Testing Request Form
- ABA Evaluation Request Form
- ABA Telehealth Request Form
- Home Care Request Form
- Respite Services Request Form
- DME Request Form
- Home Assessment Modifications Request Form
- Nutritional Supplemental Order Request Form

## Peer to Peer Review

Providers may request a Peer-to-Peer Review only if within three (3) business days of the Adverse Benefit Determination. For Peer-to-Peer Requests, providers must contact the Appeals Coordinator at 202-974-4692.

## Contacting Utilization Management During After Hours

Accessibility to our UM Department is important to our providers, facilities, and enrollees. The UM Department ensures that there is a licensed UM Reviewer available twenty-four hours (24) hours, seven (7) days a week including holidays and weekends for emergent and/or urgent prior authorization requests.

During regular business hours, which consist of Monday through Friday from 7:30am – 5:30pm, excluding holidays, can be reached at (202) 721-7162. For access after business hours, weekends, major holidays, or office closures please contact the UM Department via the Customer Care Department at (2020 467-2737.

**Note: all emails sent to the HSCSN UM Department should be sent in the most secure format, which can include password protection and encryption.**

## Dental Benefits

HSCSN contracts with Delta Dental to provide dental services to all HSCSN enrollees. Dental providers are required to complete a contract with Delta Dental prior to services being provided to HSCSN enrollees. All dental providers will have an assigned Provider Affairs Representative from Delta Dental. Contracted network providers must furnish covered services to enrollees in a manner consistent with the requirements of the Medicaid statutes, regulations, Centers for Medicare and Medicaid Services (CMS) pronouncements, and Delta Dental's contractual obligations and policies and practices, as well as professionally recognized standards of dental health care. Contracted network providers must make services accessible and available to enrollees when medically necessary. Network providers must also ensure that covered services are provided to enrollees in a culturally competent manner, including those enrollees with limited English proficiency or reading skills, diverse cultural or ethnic backgrounds, or physical or mental disabilities, to ensure that enrollees receive effective communications that allow them to make decisions about treatment options, including the option of no treatment, and to ensure that instructions regarding follow-up care and training in self-care, if necessary, are delivered and understood.

**Non-Covered Services**

These services include, but are not limited to:

- Replacement of partial or full dentures prior to required time periods unless appropriately documented and justified;
- Dental work for cosmetic reasons or because of the personal preference of the enrollee or provider;
- Local anesthesia- considered part of the procedure(s), not payable separately;
- Maxillofacial prosthetics.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

## Pharmacy Benefits

HSCSN contracts with CVS/Caremark for its Pharmacy Benefits Management (PBM). HSCSN Formulary is based on the CVS/Caremark Managed Medicaid Template, which is developed by the CVS/Caremark National Pharmacy & Therapeutics (P&T) Committee and modified to meet the District of Columbia Department of Health Care Finance (DHCF) requirements.

The formulary can be viewed on the HSCSN at https://hscsnhealthplan.org/enrollees/pharmacy-benefits.

Which includes a searchable online version and downloadable machine readable and PDF versions to look-up specific medications. HSCSN uses the CVS/Caremark Network of retail

pharmacies for pharmacy services. A list of in network pharmacies in the District of Columbia is available on the Pharmacy Benefits page of the HSCSN website at the web address above. HSCSN enrollees are offered mail order through CVS Caremark Mail Order Service. Specialty Medications are obtained through CVS Specialty Pharmacy. To locate a network pharmacy outside of the District of Columbia, providers should contact CVS/Caremark Customer Care at (800) 237-2767.

## Formulary vs. Non-Formulary Medications

Medications on the formulary are called formulary medications and medications not listed are called non-formulary medications. Some of the medications listed on the formulary do require prior authorization. A non-formulary medication can be requested using a non-formulary exception form. HSCSN also covers certain Over the Counter (OTC) medications such as hydrocortisone and petroleum jelly. All OTC medications require a prescription from a Licensed Nurse Practitioner or Physician.

## How to Request a Prior Authorization or a Formulary Exception

Drugs and/or medications not approved by the Food and Drug Administration (FDA) are not approved by Medicaid and are therefore excluded from HSCSN formulary coverage. CVS has developed Prior Authorization (PA) tools to ensure safe, effective, and appropriate use of selected drugs. When a PA is needed for a prescription, the prescriber or authorized agent of the prescriber must contact CVS's Prior Authorization Department to answer questions to determine if the medication meets coverage criteria. A copy of the Clinical Prior Authorization Form, along with key phone numbers, can be found on the Pharmacy Benefits page of the HSCSN website here.

A prescriber can request coverage of a medication that is not on the formulary via a Formulary Exception Request. Providers can submit prior authorization and/or exception requests for a drug to CVS Utilization Management Department at (877) 433-7643 or via fax at (866) 255-7569.

## Management of Specialty Medications

HSCSN uses CVS Specialty Pharmacy exclusively for dispensing specialty medication and a list of Specialty Medications, along with instructions for access and required forms is on the CVS website at: https://www.cvsspecialty.com/wps/portal/specialty/patients/drugs-conditions/drugs-list/Prescribers. Providers can also reach the CVS Specialty Pharmacy at (866) 387-2573 or (866) 814-5506 for additional information or telephone inquiries.

## Mail Order

The CVS Mail Order Pharmacy is an option for HSCSN enrollees, upon enrollee request. Prescribers should follow all applicable local and federal guidelines for mail order prescriptions. All mail order prescriptions should be written for a ninety (90) day supply and faxed to the CVS Mail Order Pharmacy Department at (800) 378-0323.

### Overrides

The point-of-sale pharmacist can do overrides for certain situations to ensure continuity of medication care for HSCSN enrollees. Overrides include providing a seven (7) day supply of medication while:

- Waiting for prior authorization (if appropriate).
- An override for lost or spilled medication (up to once (1) per year, per medication).
- Allowing fill of medication requiring prior authorization during a transition of care (for example, an implementation of formulary change, or recent enrollment in HSCSN).

To request an override that cannot be done by the pharmacist at point of sale, call HSCSN Customer Care on 202-467-2737 to speak with the HSCSN Manager of Pharmacy Services. If a prescriber has any questions that cannot be answered by CVS Health, then they may call HSCSN Customer Care and ask to speak to the Manager of Pharmacy Services for assistance.

### HSCSN BIN, PCN, and Group# Information

- If HSCSN is the primary insurance then the BIN is 004336, PCN is ADV, and Group is RX6534
- If HSCSN is the secondary and primary is Medicare Part D, then BIN is 012114, PCN is COBADV, and Group is RX6534
- If HSCSN is the secondary and primary is another commercial plan, then BIN is 013089, PCN is COMADV, Group- RX6534

For questions regarding pharmacy services, HSCSN providers may contact CVS Customer Care at (866) 885-4944.

## Quality

Health Services for Children with Special Needs, Inc. (HSCSN) maintains an active Quality Management Department and Quality Assurance Performance Improvement Program (QAPI) for the purposes of oversight and assessment of the health plan's enrollees and to ensure that the children, youth, adolescents and young adults with special health care needs have access to appropriate, essential, quality and cost-effective health care.

The department focuses on the performance of organization-wide functions that significantly affect the health outcomes of HSCSN enrollees and their caregivers or families. This department also serves to guide the organizational structure and operation of quality measurement and improvement activities through the incorporation of our mission, vision, values and guiding principles into the Quality Assurance Performance Improvement Program (QAPI).
HSCSN's Quality Management Department and the QAPI incorporate and align with the DHCF's goals, as defined in its Managed Care Program Manual – Quality Management FY22.

### Quality and Performance Improvement Program Goals

As a component of the HSCSN's QAPI, provider, practitioner and facility quality site visits are conducted to assess the quality, safety and accessibility where care is delivered, and in accordance with the managed care industry, National Association for Quality Assurance (NCQA) credentialing standards.

In conjunction with the HSCSN Provider Relations Department, the Quality Management Department is responsible for conducting quality site visits. During quality site visits, HSCSN monitors the facility management, including Human Resources files, and the medical record documentation of practitioners/providers through the facility management and medical record reviews. Quality site visits may be conducted in response to an identified or potential quality of care or service issue; in response to an HSCSN enrollee grievance or HSCSN enrollee's designee grievance; or a provider or provider group reaching an occurrence threshold. *An occurrence threshold is defined as a provider or provider group that reaches three (3) of the same type of quality of care or quality of service issue grievance within a twelve (12) month period. The severity of an issue will always be considered. Quality site visits may be announced or unannounced.*
Additional goals of the QAPI are as follows:

- To ensure availability and/or access of services via:
  - Maintaining a network of appropriate providers; sufficient in number, mix, geographical distribution, and cultural competency.
  - Promoting and monitoring access to services.
  - Maintaining a process for credentialing and re-credentialing of physicians and other licensed health care professionals; and
  - Actively promoting the delivery of ethical and culturally competent care.
- Ensure the coordination of health care services, care management, and the inclusion of cultural considerations.
- Ensure organizational policies and procedures are in place for addressing compliance with all applicable privacy, confidentiality, information security requirements, language access and the provision of interpreter services, and periodic training/education of staff.
- Maintain an effective utilization management program as well as an annual program evaluation.
- Adoption/implementation of clinical practice guidelines based upon valid, reliable clinical evidence (periodically updated), as appropriate.
- Maintain an effective quality and performance improvement program with the inclusion of QI work plan and an annual evaluation.
- Satisfaction assessment of enrollees, families/caregivers, and the provider network.
- Comply with external quality review organizations, accreditation, certification, and other regulatory entity standards.
- Review of all Quality-of-Care Concerns and present findings to the Quality Council
- Review of medical records for Provider Performance to Clinical Practice Guidelines.

- Monitoring of Providers and Provider Groups' performance using scorecards and other measures to ensure quality care is provided to HSCSN enrollees.

## Quality Improvement Process Model

HSCSN uses the Plan, Do, Study, Act (PDSA) process improvement model to evaluate the development of new processes as well as the redesign or improvement of existing processes while considering applicable District and Federal guidelines, regulatory requirements, NCQA Accreditation standards, HEDIS specifications, national clinical and evidence-based guidelines.
The PDSA approach is utilized to:

1. Identify the new process or potential improvement
2. Assess/test the strategy for change
3. Analyze data from the test (to determine if the change produced the desired results)
4. Implement the improvement strategy system-wide when applicable

## External Quality Review Organization (EQRO)

The intent of the Medicaid program is to improve access to care, promote disease prevention, ensure quality care and reduce Medicaid expenditures. To ensure that the care provided meets acceptable standards for quality, access and timeliness, the Department of Health Care Finance (DHCF) is charged with the responsibility of evaluating the quality of care provided to recipients enrolled in a contracted health plan and assessing the effectiveness of its QAPI. DHCF contracts with Qlarant to serve as the External Quality Review Organization (EQRO) to conduct this annual evaluation.

In accordance with federal regulations, Qlarant assesses the effectiveness of Health Services for Children with Special Needs, Inc. (HSCSN) QAPI by utilizing performance standards based on the Balanced Budget Act (BBA) of 1997 and federal external quality review regulations. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs and prepaid inpatient health plan as set forth in Section 1932 of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR), part 438 et seq. The evaluation consists of an Operational Systems Review (OSR) assessing compliance for the following categories:

1. Information Requirements and General Provisions
2. Enrollee Rights and Protections
3. Disenrollment Requirements and Limitations
4. Managed Care Organization Standards
5. Quality Assessment & Performance Improvement Program
6. Grievance and Appeal System

The annual OSR is a mandated activity per the DHCF CASSIP contract and the BBA external quality review regulations.

## Healthcare Effectiveness Data and Information Set (HEDIS®)

Health care costs are escalating. As costs have increased, purchasers of health benefits—employers, member organizations, families and individuals, Medicare, Medicaid and Exchange programs have become increasingly concerned that health care value has not risen proportionately. The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that the public, policy makers and payers have the information they need to compare performance. It is a tool used by more than 90% percent of America's health plans to measure performance on care, service and utilization. As health benefits consume an ever-larger percentage of expenses, purchasers seek ways to assess the relative value of care. HEDIS offers a way to make an "apples-to-apples" comparison of organizations.

HEDIS consists of 91 measures across 6 domains:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care.
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems

Quality must be monitored at all levels if it is to improve across the health care system. HEDIS promotes improvement among many health care sectors and initiatives that track performance at the physician level. HEDIS offers health care organizations and individual practitioners the opportunity to differentiate themselves within a competitive market and with continual improvement of care.

## What is the Provider's Role in HEDIS?

Physician groups and practices use performance information to reduce variation in practice and to track progress in achieving goals defined by evidence-based guidelines. They also use it to help physicians improve preventive care, manage chronic care patients or decrease over-utilized services.

## HEDIS Reporting Adds Value:

HEDIS measures give the public an unprecedented ability to understand how well organizations achieve results, by answering questions such as:

- How effective and satisfying is the care and service that is delivered?
- How accessible is care?
- Are evidence-based health care services provided to the right person at the right time?
- Does care lead to better outcomes for enrollees?

## Why is HEDIS® Important to the Provider?

- It is a tool for providers to ensure timely and appropriate care for their patients.
- HEDIS assists providers in identifying and eliminating gaps in care for the patients assigned to their panel.

- Measurement rates can be used as a tool to monitor compliance.
- Serve as measurements for quality improvement processes and preventive care programs.
- Evaluate the health plan's ability to demonstrate improvement in its preventive care and quality measurements.
- Provide a picture of the overall health and wellness of the plan's membership.
- Identify gaps in care and develop programs/interventions to help increase compliance and improve health outcomes.
- Demonstrates the provider's commitment to quality care and improved patient outcomes.

## HEDIS Data Collection:

HEDIS measures can be collected by one or more data collection methods:

- **Administrative** gathered from claims, encounter, enrollment and provider systems.
- **Hybrid gathered from administrative and medical record data.**
- **Survey** measures compile data collected directly from enrollees via survey methods such as Consumer Assessment of Health Care (CAHPS), Providers, and Systems.

**The goal is for providers to submit claims/encounters with coding that administratively captures all required HEDIS® data. This decreases or removes the need for medical record (hybrid) review.**

## HEDIS Medical Record Review Process:

1. Data collection methods include fax, mail, onsite or electronic visits for larger requests and remote electronic medical record (EMR) system access, if available.
2. Medical record fax requests will include an enrollee list identifying their assigned measures and the minimum necessary information needed sent to the health plan.
3. Due to the shortened data collection timeframe, a turnaround time of 3-5 days is appreciated.
4. For on-site chart collections, the office will be contacted to schedule a time the abstractor can come to the office for chart review. A list of enrollee charts being reviewed will be provided ahead of time.

## HEDIS Timeline

| |
|---|
| **February – May**<br>HSCSN prepares for HEDIS season.<br>HEDIS Vendor and Team is remotely "chasing" data (medical record review) until **May.**<br>**CAHPS** survey administration begins. |
| **June**<br><br>HEDIS results are certified and reported to NCQA. |
| **September** |

| |
|---|
| NCQA releases results for all plans in the Quality Compass. |
| **October**<br><br>NCQA publishes the final HEDIS specifications for HEDIS current year. |

**HEDIS is a year-round effort.**

## HEDIS® Measures (select examples)

Below are examples of HEDIS reportable measures:

| | | | |
|---|---|---|---|
| **AAP** | **Adult Access to Preventive Health Services** | **ADV** | **Annual Dental Visits** |
| **CIS** | **Childhood Immunization Status** | **IMA** | **Immunizations for Adolescents** |
| **W30** | **Well-Child Visits 0-15 and 15-30 Months of age** | **WCV** | **Well-Child and Adolescents Visits Ages 3 - 21** |
| **LSC** | **Lead Screening in Children** | **APM** | **Metabolic Monitoring for Children and Adolescents on Antipsychotics** |
| **CBP** | **Controlling High Blood Pressure** | **KED** | **Kidney Health Evaluation for Patients with Diabetes** |

## Enrollee Records

Maintenance of all enrollee records must follow the guidelines below:

- Records must be stored in a safe and secure environment to maintain confidentiality.
- Index and file records according to standard medical record procedures, allowing for accessibility for patient treatment, timely documentation and availability of external review.
- Retain medical records for every enrollee in the provider files for a period of at least ten (10) years following the last encounter, and/or at least three (3) years after the enrollee reaches legal age.
- Obtain a signed release of information form from a parent, legal guardian, designee, or enrollee of legal age prior to releasing any medical information regarding an enrollee to anyone other than HSCSN personnel.

## Importance of Documentation:

1. Enable physician and other healthcare professionals to evaluate a patient's healthcare needs and assess the efficacy of the treatment plan.
2. Serves as the legal document to verify the care rendered and date of service.
3. Ensure date of care rendered is present and all documents are legible.

4. It serves as a communication tool among providers and other healthcare professionals involved in the patient's care for improved continuity of care.
5. Facilitates timely claim adjudication and payment.
6. An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and HEDIS chart requests.
7. The medical record documentation supports ICD-10, CPT and CPT II codes reported on billing statements.

## Enrollee and Provider Satisfaction

HSCSN works with an NCQA certified survey vendor to assess both enrollee and provider satisfaction. HSCSN also follows District guidelines by conducting quarterly access to care surveys of the covered services available to enrollees. All survey results are compiled and analyzed to identify trends and determine opportunities for improvement. HSCSN enrollees and providers have the right and opportunity to submit grievances and should follow all applicable steps to submit a grievance. Due to the strict timelines and other requirements, HSCSN encourages enrollees and/or providers not to use the satisfaction survey as the time to submit a grievance. For further information on how to file a grievance please see section the Grievance Section and Provider Operations section of the Provider Manual.

## Enrollee Satisfaction Survey

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an Agency for Healthcare Research and Quality (AHRQ) program that began in 1995. CAHPS is a part of the HEDIS Data set. CAHPS surveys ask consumers and patients to record and evaluate their experiences with healthcare.

Four global rating questions reflect overall satisfaction:

- Rating of All Health Care
- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

The CAHPS Survey includes a core set of questions about access to care and care delivery over the last 6 months of the year. Patients' experience with their provider is a focus in this survey. HSCSN uses the CAHPS Survey to evaluate the enrollee's experience with healthcare within the HSCSN Provider Network. Here are a few examples of the survey questions:

- When you needed care right away, how often did you get care as soon as you needed it?
- How often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
- When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

- On a scale of 0-10 where 0 is worst and 10 is best, what number would you use to rate your personal doctor?
- How often did your personal doctor listen to you and show you respect?

Paper surveys are mailed annually February through May and are followed by a reminder postcard and telephone follow-up to maximize response.

## Quality Site Visits

When there is a grievance and/or issue of quality of care for an enrollee at a Provider Site, the Quality Management Department and the Grievance Risk Analyst perform a site visit. In accordance with the NCQA standards and HSCSN's internal policy, if a practitioner/provider has incurred three (3) of the same type of enrollee grievance (quality of care or quality of service) within a twelve (12) month rolling year, a site visit will be conducted within sixty (60) calendar days of confirmation of the threshold being met.

The Quality Management Department assesses facility management and conducts a medical record review as deemed appropriate. These visits consist of reviewing the physical safety of the building the site is located within, the policies and procedures the sites follow, the clinical documentation and any other pertinent information related to the grievance and/or quality of care concern. A minimum score of 80% in both facility management and medical record portions of the site visit is required for passing. A score of less than 80% will necessitate that the practice/organization be placed on a Corrective Action Plan (CAP). **However, certain key, individual standards may require a CAP, regardless of the score.** The site reviewer will focus on the following areas:

*Environmental Care and Facility Management*

1. Access to Facility
2. Physical Appearance
3. Access to Care/Availability of Care
4. Clinical Services/Patient Education/Pharmaceutical & Vaccine Management/Laboratory Services/OSHA
5. Emergency /Safety/Infection Control
6. National Patient Safety Goals

*Administration*

7. Policies & Procedures

*Human Resources*

8. Personnel Information

*Health Information Management*

9. Medical Record Management

*Medical Record Review*

10. Rights & Responsibility

11. Patient Identification

*Plan of Care*

12. EPSDT & Physical Health Documentation
13. Behavioral/Mental Health Documentation
14. Clinical Documentation

## Corrective Action and Mitigation Plans

Providers who score less than 80% and/or do not meet the required standards will be given ten (10) business days after written notification of the survey results to submit a signed CAP. The practitioner/provider will receive immediate oral notification of the deficiency/ies and the probability of placement under corrective action with monitoring, if applicable.

A. Practitioner/Provider sites, placed on a CAP will be given ten (10) business days (based upon the date on the written notification (letter) of the quality site visit results) to sign and return the provided CAP and is responsible to correct the identified deficiencies within the specified timeframes noted in the CAP for each identified deficiency.
B. A follow-up review, either an on-site or desktop, will be performed to determine completion of the corrective action process.
C. Practitioners or Provider Groups can request results at any time, by contacting their assigned Provider Relations Representative via (202) 467-2737.

## Provider Site Visits specific to Home Health Agencies

a. The Quality Management Department conducts annual Provider Site Visits for all Home Health Agencies to include clinical records, financial and personnel records. Routine unannounced site visits are the preferred method of evaluating the agency. When announced site visits are conducted, the home health agency will be given no more than five (5) business days' advanced notice of the visit date.
b. The HSCSN Home Health Oversight Reviewer will select records to be reviewed after arrival on the day of the site visit. The home health agency may not pre-select the records to be reviewed.
c. The comprehensive Quality/Accreditation Site Visits are focused on compliance with completion of care plans, appropriate clinician signatures, timeliness of clinician signatures on care plans, orderliness of clinical recordkeeping, maintenance of enrollee Progress Notes, staff certification & licensure and required training and education documentation.
d. If a Home Health Agency is under a Corrective Action Plan (CAP) they will have Home Health Oversight Reviewer visits at least every six (6) months.
e. The Home Health Oversight Reviewer will conduct in-home point of service reviews. In-home point of service site visits requires written and/or verbal consent from the parent/caregiver/adult enrollee.

Any completed Quality Site Visit results and Corrective Action Plan (CAP), if applicable, are kept in the Quality Management Department; electronic copies are submitted to the Credentialing Department and become part of the re-credentialing process for network practitioners/providers.

## Grievances and Fair Hearings

### Fair Hearing Process

An HSCSN enrollee and/or their designee may seek a Fair Hearing with the District of Columbia Office of Administrative Hearings after exhausting the HSCSN appeals process and within 120 days from the date of notice of the HSCSN appeal resolution.

HSCSN Enrollees have the right to self-representation or to be represented by a family caregiver, legal counsel, or other representative during a Fair Hearing. HSCSN enrollees expressing dissatisfaction with a District's Agency denial of a request to transfer plans or disenroll are ensured access to a Fair Hearing.

To request a Fair Hearing, contact the following agency:

District of Columbia Office of Administrative Hearings Clerk of the Court
441 4th Street, NW, Suite 450 North
Washington, DC 20001
(202) 442-9094

If you need assistance filing a request for a Fair Hearing with the District of Columbia Office of Administrative Hearings, you may contact HSCSN's Grievance, Appeal, and Compliance Hotline at (202) 495-7582. You may also request assistance by sending a written request to:

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

Attn: Risk Management

1101 Vermont Avenue, NW, Ste 1200

Washington, DC 20005

In accordance with 42 C.F.R. § 438.424(a), if HSCSN or the District Office of Administrative Hearings reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, HSCSN will authorize the disputed services as expeditiously as the HSCSN enrollee's health condition requires and no later than 72 hours from the date it receives notice reversing the determination.

In accordance with 42 C.F.R. § 438.424(b), if HSCSN or the District Office of Administrative Hearings reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, HSCSN will pay for those services.

## Grievances

A grievance is an oral or written expression of dissatisfaction about any matter **other than an adverse benefit determination**. Grievances may include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider/employee, failure to respect an enrollee's rights, or operations of HSCSN. An HSCSN enrollee may file a grievance at any time either orally or in writing. A provider or designee may also submit a grievance on **behalf of an HSCSN enrollee with the enrollee's expressed consent.**

If an HSCSN enrollee has a grievance regarding the health or behavioral health care services received under HSCSN, that enrollee and/or designee should contact the HSCSN Risk Management. A Risk Management Representative will help the HSCSN enrollee file a grievance. HSCSN has two (2) business days from receipt of grievance to send an acknowledgement notification regarding the grievance. All Grievance resolutions will be provided in writing within ninety (90) calendar days. HSCSN will also make reasonable efforts to provide oral notice of a grievance resolution. Fourteen (14) Day Extensions may be requested by an enrollee or an enrollee's designee to provide additional supporting documentation for a grievance. HSCSN may also request a fourteen (14) day extension if additional time is needed to make a decision on any grievance received. Notification of an extension request will be sent in writing to the enrollee and/or the enrollee's designee within (2) calendar days and reasonable efforts will be made to provide prompt oral notification regarding the delay.

**To file a grievance on behalf of an HSCSN Enrollee:**

Call the Grievance, Appeal, and Compliance Hotline at (202) 495-7582

Or

Write to:

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

Attention: Risk Management

1101 Vermont Ave NW, Ste 1200

Washington, DC 20005

Or

Email: riskmanagement@hschealth.org

# Regulatory Standards

## Compliance Program

HSCSN administers a comprehensive Compliance Program consistent with the District of Columbia and Federal laws and regulations. The purpose of the program, at the direction of the Compliance Officer, is to detect, investigate, and prevent fraud, waste and abuse, and to report any suspicious fraudulent activity to the appropriate authorities. The Compliance Program is a vehicle that enables HSCSN to prevent, detect, and resolve situations or conduct that does not adhere to applicable laws, and HSCSN's Code of Conduct and business policies. The HSCSN Compliance Program activities include:

- Training and Education
- Fraud, Waste, & Abuse prevention, detection, and investigation
- Preserving HSCSN Enrollee Rights concerning Privacy and Confidentiality
- Oversight, auditing, and ongoing monitoring of delegated responsibilities of HSCSN's Provider Network
- HSCSN's provider and vendor contracts require that all entities engaged in business with HSCSN adopt and implement a Compliance Program commensurate with their business entity's size. The compliance program implemented by any business engaged in service delivery with HSCSN must adhere to the principles set forth in the applicable Compliance Program Guidance for providers, as published by the Department of Health and Human Services, Office of Inspector General (HHS OIG) and the Department of Health Care Finance (DHCF). These guidelines are specific to the various health care providers, and can be accessed at https://oig.hhs.gov/compliance/ and at https://dhcf.dc.gov/page/provider-compliance-programs.

## Audit and Oversight Activity

One of the elements of an effective Compliance Program is auditing and monitoring. To ensure that all HSCSN Enrollees receive appropriate health care services, the Compliance Department performs periodic audits of contract responsibilities and services provided by the HSCSN Provider Network. The objective of auditing and monitoring activities is to ensure that HSCSN fulfills its responsibility to identify and recover inaccurate payments which may be a result of inadvertent provider actions or misrepresentations; as well as to mitigate any fraud, waste or abuse. HSCSN reserves the right to conduct claim audits and reviews to ensure compliance with standard coding, billing, medical record documentation guidelines, and appropriate reimbursement.

To determine compliance, auditing and monitoring activities are conducted to ensure:

- Services billed are provided and substantiated in the medical record.
- Services billed are ordered by a physician and supported in the medical record.
- Services were rendered and the appropriate units were billed.
- Services are billed with the appropriate codes and in accordance with code requirements.
- Services billed are provided by a non-excluded, appropriate credentialed provider.

- Providers are compliant with the Provider Agreement, HSCSN Policies and Procedures, and/or relevant guidelines, regulations or laws.

Under the CASSIP contract, HSCSN receives State and Federal funding for payment of services provided to our enrollees. By accepting claim payments from HSCSN, health care providers are receiving District and Federal Program funds and are therefore subject to all applicable Federal and/or District laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud or abuse.

HSCSN providers are required to comply with all HSCSN policies and with all relevant legal or regulatory standards. Areas of compliance include but are not limited to:

- Americans with Disabilities Act (ADA)/Rehabilitation Act
- Health Insurance Portability and Accountability Act (HIPAA)
- District of Columbia Human Rights Act
- Fraud, Waste, and Abuse (FWA)
- Advanced Directives
- Salazar Consent Decree Requirements
- Katie Beckett Waiver Requirements (TEFRA Waiver Requirements)
- Deficit Reduction Act of 2005
- Mandatory Reporting Laws
- The CASSIP Provider Contract Requirements

## The Americans with Disabilities Act (ADA) and the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973 ("Rehab Act") and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and requires HSCSN providers to make their services and facilities accessible to all (grandfathered buildings are excluded). HSCSN expects all providers and practitioners to comply fully with all requirements.

## Health Insurance Portability and Accountability Act (HIPAA)

HSCSN is dedicated to strict adherence of the Health Insurance Portability and Accountability Act (HIPAA) and requires participating providers and groups to be familiar with HIPAA, its requirements and to take all necessary actions to fully comply. Any HSCSN enrollee record containing clinical, social, financial, or any Protected Health Information (PHI) of an HSCSN enrollee should be treated as confidential, and protected from tampering, loss, untimely destruction, and unauthorized disclosure.

## Advanced Directives

All practitioners are required to facilitate Advanced Directives for individuals as defined in 42 C.F.R 489.100. Advanced Directives are written instructions, such as a living will or durable power of attorney for health care, recognized under District law, relating to providing health care when

an individual is incapacitated. If an HSCSN enrollee is an adult (18 years of age or old), they have the right under Federal law to decide the medical care they want to receive. The enrollee has the right to choose a person to act on their behalf to make health care decisions for them. If they are unable to make or communicate a decision, they cannot have an Advance Directive.

HSCSN enrollees may call Customer Care Services to request information regarding Advance Directives, Living Wills or Power of Attorney. Once known, Care Management staff documents in the care coordination records when an advanced directive has been implemented by an HSCSN enrollee. **Contracted HSCSN Providers are required, within their scope of practice, to ensure enrollees have an Advance Directive in place.**

### Access to Provider Records

Upon reasonable request and in accordance with applicable confidentiality privacy laws, representatives of HSCSN, the Commissioner of Insurance and Securities, , Department of Health Care Finance, DC Medicaid Fraud Control Unit, United States Department of Health and Human Services, Comptroller General of the United States, Federal Bureau of Investigations, US General Accounting Office, or their designees (collectively "Inspectors") may inspect, during regular business hours, books and records customarily maintained by Practitioners including medical and financial records relating to HSCSN enrollees.

- Providers agree to provide access to records relating to HSCSN enrollees within 30 (thirty) calendar days of written notice to the provider. Failure to provide access within (thirty) 30 calendar days of written notice may result in denial of claims.
- The Inspectors may also inspect other books and records customarily maintained by providers as necessary for the purposes of verifying claims, coordinating benefits, or reviewing appropriate utilization of services, included but not limited to issues of quality of care.
- The Inspectors may inspect the affairs of providers, including onsite inspections and periodic medical audits, as reasonably necessary to protect the interests of the Department of Health Care Finance and the HSCSN enrollee and to otherwise evaluate (including periodic testing) the services being performed.
- Notwithstanding the foregoing, all requests for information shall be subject to applicable confidentiality laws. Providers shall provide HSCSN, free of charge, copies of medical records for claims payment determination, utilization reviews, quality assurance, annual compliance audits, HEDIS audits or matters involving potential fraud, waste and abuse.

## Enrollee Records

### Access to Enrollee Records

Providers are expected to maintain enrollee medical records in a manner that is consistent with clinical standard practices, detailed, organized, and are available for quality review. Maintenance of all enrollee records must follow the guidelines below:

- Store records in a safe and secure environment to maintain confidentiality.
- Index and file records according to standard medical record procedures, allowing for accessibility for patient treatment, timely documentation and availability of external review.
- Retain medical records for every enrollee in the provider files for a period of at least ten (10) years, following the last encounter, and or at least three (3) years after the enrollee reaches legal age.
- Obtain a signed release of information form from a parent, legal guardian, or enrollee of legal age prior to releasing any medical information regarding an enrollee to anyone other than HSCSN personnel.

Providers are required to make medical records accessible to the DC Department of Health Care Finance (DHCF), DC Department of Health (DOH), the United States Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) and/or the Office of the Inspector General (OIG), and their respective designees to conduct fraud, waste, abuse, and/or quality improvement activities.

## Permitted Uses and Disclosures

HSCSN may request Protected Health Information (PHI) for:

- Treatment, Payment, or Health Care Operations
- The Health Care Operations of another covered entity or Health Care Provider, if each entity has or had a relationship with the individual who is the subject of the PHI being requested, and the disclosure is:
    - For a purpose listed in the definition of health care operations; or
    - For the purposes of health care fraud and abuse detection or compliance
- Another covered entity that participates in an organized health care arrangement with HSCSN for any health care operation activities of the organized health care arrangement:
    - **Treatment:** The provision, coordination, or management of health care and related services by one or more health care providers; including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to an enrollee; or for the referral of an enrollee for health care from one health care provider to another.
    - **Payment:** Any activities undertaken either by a health plan or by a health care provider to obtain premiums or to determine or fulfill its responsibility for coverage and the provision of benefits under the health plan, or to obtain or provide reimbursement for the provision of health care.
    - **Health Care Operations**: Certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities are as follows:

- Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management, care coordination, contacting health care providers and enrollees with information about treatment alternatives, and related functions that do not involve treatment.
- Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities.
- Conducting or arranging for medical reviews, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
- Business planning and development, such as conducting cost-management and planning analyses related to managing and operating the entity; and
- Business management and general administrative activities, including those related to implementing and complying with the Privacy Rule and other Administrative Simplification Rules, customer service, resolution of internal grievances, sale or transfer of assets, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity. General Provisions at 45 CFR 164.506.

## Salazar Consent Decree Requirements

In accordance with the Salazar Order/Consent Decree, all DC Medicaid Managed Care Primary Care Practitioners are responsible for providing Medicaid HealthCheck Services to enrollees from birth to age 21. Practitioners must document any refusal of services in the enrollees' file. Practitioners in the following specialties qualify as HealthCheck Practitioners and are responsible for providing HealthCheck Services:

- Pediatrics
- General Practice (including Osteopathy)
- Internal Medicine
- Family Nurse Practitioners
- Family Practice Medicine

In addition, to providing Medicaid HealthCheck Services, identified HealthCheck Providers are required to complete the biannual HealthCheck Training. Failure to do so can result in termination from the network.

## Medical Consent by an Adult Caregiver

A parent, legal guardian, or legal custodian may authorize an adult person, in whose care a minor has been entrusted, to consent to any medical, surgical, dental, developmental screening and/or mental health examination or treatment, including immunization to be rendered to the minor under the supervision or upon the advice of a physician, nurse, dentist, or mental health professional licensed to practice in the District of Columbia. This is provided there is no prior order of any court in any jurisdiction currently in effect which would prohibit the parent, legal guardian, or legal custodian from exercising the power that they seek to convey to another person. Medical, surgical, and dental treatment or examination may include any x-ray or anesthetic required for diagnosis or treatment.

Any written form that is signed by the parent, legal guardian, or legal custodian may be used to convey this authority. Any written statement signed by a parent, legal guardian, or legal custodian is governed by the laws of forgery in the District of Columbia. A conveyance of authority shall be honored by any health care facility or practitioner. The existence of a written document conveying the authority described above creates a presumption that their authority has been lawfully conveyed.

The conveyance of authority described is revocable at will, unless other terms are agreed to by the parent, legal guardian, or legal custodian and the person to whom authority is being conveyed. The parties may provide for terms in writing which would require the revocation of authority to be in writing, make revocation effective only when a specified time period has elapsed after notification of intent to revoke, or any other terms that the parties deem appropriate.

A physician, surgeon, nurse, mental health professional, dentist, or other health care professional, or a hospital or medical facility, that relies on a written instrument which authorizes another adult to consent to medical treatment of the executor's minor child or ward shall not incur civil liability for treating a minor without legal consent if a reasonable and prudent health care professional would have relied on the written instrument under the same or similar circumstances.

## Minors and Health Care Decisions

The legal age of consent in the District of Columbia is 18 years old, however a minor (any person under the age of 18) may seek medical and/or mental health treatment by themselves. Any person under the age of 18-year-old may consent to health care services for themselves, their child or their spouse (see DC Code 22-B § 600.1). A minor parent may consent to health care services for their child without parental consent, see DC Code 22-B §600.3 for further details. Any health care services may be provided to a minor at any age without parental consent if in the judgement of the treating provider, the delay in care that would happen while attempting to obtain the parent/guardian's consent would put the minor's life in in danger, imminent harm or prolong suffering (see DC Code 22-B §600.4). Inclusive of this rule, minors may consent to treatment for pregnancy or its lawful termination; substance abuse, including drug and alcohol

abuse; a mental or emotional condition; and sexually transmitted diseases and/or infections. Minors may not consent to sterilization, such as tubal ligations or vasectomies.

For mental health treatment, a minor seeking treatment without a parent and/or guardian's consent, between age 14 and 18, can only have mental health information disclosed if both the minor and the parent/guardian authorize such disclosure. If a minor is under 14, the right to authorize disclosure is that of the parent and/or guardian. If the minor is seeking mental health treatment without the parent and/or guardian's consent, then the minor's consent is only needed to authorize disclosure.

## Fraud, Waste, and Abuse (FWA)

To combat fraud, waste, and abuse (FWA), providers must know what fraud, waste, and abuse is, the laws pertaining to FWA, and how to report suspected FWA.

**Fraud** is defined as the intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law. As applied to the federal health care programs (including CASSIP), health care fraud generally involves a person or entity's intentional use of a false statement(s) or fraudulent schemes (such as Kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a federal health care program.

**Waste** has not been defined by the Medicaid Fraud and Patient Abuse Unit under OIG. However, the general meaning is to use or spend carelessly, excessively, or to no purpose.

**Abuse** is defined as a practitioner who practices inconsistent with generally accepted business or medical practice and that results in an unnecessary cost to the Medicaid Program or in reimbursement for goods or services that are not medically necessary; that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to the Medicaid Program.

By accepting claims payment from HSCSN, health care practitioners are receiving District and Federal Program Funds, and therefore are subject to all applicable Federal and/or District Laws related to Fraud, Waste and Abuse (FWA):

- False Claims Act
- Civil Monetary Penalties Law (CMPL)
- Whistleblower Protection Act
- Exclusion & Debarment Statute
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Act)
- Deficit Reduction Act of 2005

Practitioners are essential to your organization and HSCSN's compliance with the False Claims Act. The codes used for diagnoses and procedures, the documentation kept, the claims filed,

and the dates recorded when procedures occur are subject to FCA reviews. Practitioners must have clear, accurate documentation and follow all rules and regulations. Practitioners must ensure all services are deemed medically necessary based on the HSCSN enrollee's needs. Practitioners must ensure that all billing, coding, and reimbursement rules are followed and do not retain any Medicaid funds that were improperly paid. For further information, please visit the Centers for Medicaid and Medicare website at https://www.medicaid.gov/medicaid/program-integrity/index.html.

As a contracted provider with HSCSN, providers are obligated, pursuant to 42 C.F.R § 1001.1901(b) and to the May 2013 HHS OIG Special Advisory Bulletin to screen all employees, contractors, and/or subcontractors in the practice/facility to determine whether any of them have been excluded from participation in federal health programs, such as Medicare and Medicaid. To obtain verification, provider groups can search the HHS-OIG LEIE website, at no cost, by using names of any individual or entity at https://oig.hhs.gov/exclusions/.

Provider groups must immediately report any exclusion information discovered to the HSCSN Compliance Hotline at 844-556-9152, and to the District of Columbia Medicaid Integrity Office, Department of Health Care Finance at (202) 698-2000 or via https://dhcf.i-sight.com/external/case/new.

Provider Groups and their staff shall cooperate fully in compliance with Fraud, Waste, and Abuse (FWA) investigations, and be available in person for interviews, consultations, grand jury proceedings, pretrial conferences, hearings, trials, or in any other judicial process, as necessary.

### Fraud, Waste, and Abuse Involving Enrollees

If you have information about potential fraud, waste and/or abuse that is committed by an HSCSN enrollee or someone claiming to be an HSCSN enrollee, notify either the HSCSN Compliance Officer or the Department of Health Care Finance using the contact information below.

### Fraud, Waste, and Abuse Involving Health Professionals

If you have information about potential fraud, waste, and/or abuse that is committed by another health professional or their staff, such as inappropriate billing or delivery of services, please notify the HSCSN Compliance Hotline at the contact information listed below.

HSCSN Compliance Hotline: 844-556-9152

**OR**

HSCSN Compliance Website: https://telabear.ethix360.com

**OR**

**Email – Compliance@hschealth.org**

**OR**

Health Services for Children with Special Needs (HSCSN)
Attn: Compliance Officer
1101 Vermont Ave NW, Ste 12
Washington, DC 20005

**OR**

The Department of Health Care Finance
https://dhcf.i-sight.com/external/case/new
Compliance Fraud, Abuse and Waste Hotline:
877-632-2873

**OR**

District of Columbia Medicaid Fraud Control Unit
Officer of the Inspector General
https://oig.dc.gov/page/use-form-submit-hotline-complaint-dc-oig
(800) 521-1639 or (202) 724-8477

All information provided to HSCSN regarding a potential fraud, waste or abuse occurrence is maintained in the strictest confidence and in accordance with the terms and conditions of the HSCSN Compliance Program policies and procedures and applicable laws. Any information developed, obtained or shared among participants in an investigation of a potential fraud and abuse occurrence is maintained specifically for this purpose and no other. HSCSN is committed to maintaining high ethical standards as reflected in our *Code of Conduct.* Concerns regarding HSCSN's adherence to our Code of Conduct should be reported to the Compliance Hotline as directed above.

## Mandatory Reporting

Providers participating in HSCSN's Plan are required by Federal and DC Regulations to report all occurrences of sexually transmitted infections, suspected child abuse or neglect, communicable diseases, vaccine preventable diseases, immunizations administered, lead levels, developmental delays in infants and children.

- Any suspected child abuse or neglect:
    - DC Department of Child & Family Services at (202) 671-SAFE or (202) 671-7233.
- Sexually Transmitted Infections, Communicable Diseases, including HIV or Tuberculosis (within 24 hours of identification/diagnosis):
    - Department of Health at (202) 442-5955 or https://dchealth.dc.gov/service/infectious-diseases
- Vaccine-Preventable Diseases in either children and/or adults:
    - Vaccine for Children (VFC) at (202) 442-9371 or https://dchealth.dc.gov/service/vaccines-children-vfc
- All blood lead screening test results must be reported to the Department of Health Care Finance (DHCF), DC Department of Environment, Division of Childhood Lead Prevention Program and HSCSN within 72 hours of identification:
    - For more information or to make a report contact the DC Lead Poisoning Prevention Division at (202) 536-2634 or (202) 535-1394 or https://doee.dc.gov/service/lead-district-health-care-providers
- Children experiencing developmental delays:
    - The Office of the State Superintendent of Education (OSSE) – Strong Start at (202) 727-3665 or https://osse.dc.gov/service/strong-start-dc-early-intervention-program-dc-eip

## Adverse Events and Potential Criminal Events

Health Services for Children with Special Needs, Inc. (HSCSN) is committed to the promotion of safety in health care and ensuring a safe environment for HSCSN enrollees. ***DHCF requires that all HSCSN Providers/Practitioners report any Adverse Event, Potential Criminal Event, Unusual Incident (UI) or PHI violations involving an HSCSN Enrollee to HSCSN within 24 hours of the incident.*** All reports should be reported on ***HSCSN's Unusual Incident (UI) Report form*** and faxed or emailed to HSCSN's Risk Management Department at (202) 635-5591 or riskmanagement@hschealth.org. You can download a copy of the UI Report Form on HSCSN's website, under the Provider Services section or visit https://hscsnhealthplan.org/health-providers/current-providers/appeals-hearing-unusual-incidents. Providers should keep in mind the following definitions and reportable situations concerning adverse events and/or potential criminal events.

An Adverse Event (as defined by DC Law 16-263) is an event, occurrence, or situation involving the medical care of a patient by a health care provider that results in death or an unanticipated injury to the patient.

The following are examples of an adverse event:

**Surgical or Invasive Procedure Events**

- Surgery or other invasive procedure performed on the wrong side
- Surgery or other invasive procedure performed on the wrong patient
- Wrong surgical or other invasive procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- Intraoperative or immediately postoperative/postprocedural death in an ASA class 1 patient (normal healthy patient)

**Product or Device Events**

- Patient death or serious injury associated with use of contaminated drugs, devices, or biologics provided by the healthcare setting
- Patient death or serious injury associated with the use of a device in patient care, in which the device is used other than intended
- Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

**Patient Protection Events**

- Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
- Patient death or serious injury associated with patient elopement (disappearance)
- Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting

**Care Management Events**

- Patient death or serious injury associated with a medication error
- Patient death or serious injury associated with unsafe administration of blood products
- Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy
- Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
- Patient death or serious injury associated with a fall while being cared for in a healthcare setting

**Environmental Events**

- Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting

- Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
- Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

**Radiologic Events**

- Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

**A Potential Criminal Event** is defined as a specific type of adverse event which must be reported to DHCF via a Potential Criminal Event Notification Form within 24 hours of the event.

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
  - Abduction of a patient/resident of any age
  - Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.
- Death or serious injury of a patient or staff member resulting from a physical assault (I.e., battery) that occurs within or on the grounds of a healthcare setting.

An Unusual Incident (as defined by HSCSN) is an unusual problem, incident, or other situation that is likely to lead to undesirable effects or that varies from established policies and procedures or practices.

- Major Unusual Incident (MUI)- are serious incidents that can pose a significant danger and/or likely to result or can result in serious health and safety issues for the enrollee.
- Minor Unusual Incident (UI)- are events that are not consistent with routine care of an enrollee, the routine operations of a provider office/facility, or a significant event that is outside the normal and/or established standards but does not result in serious injury and/or danger to an enrollee.

# Provider Network and Operations

## Provider Relations

The role of the HSCSN Provider Relations Team is to be the connection between the HSCSN Health Plan and the Contracted Providers. Provider Relations Representatives help the provider community by way of training (including new provider orientations), conducting forums, resolving provider inquiries, and helping with business functionality and quality improvement.

## Provider Access Standards

To ensure HSCSN's enrollees have every opportunity to access their needed health-related

services, providers must develop a collaborative relationship with HSCSN and work to ensure that HSCSN enrollees have access to their services. HSCSN Network Providers are required to meet all written standards for care accessibility defined for providers under the CASSIP contracts. This includes, but not limited to, appointment access and accessibility standards defined under the CASSIP contract. All contracted providers must provide the same hours of operations and/or access to services as provided to any commercial plan enrollees treated by the same provider and/or provider group. Providers found to be non-compliant with the standards below, will be subject to corrective action and/or termination from the network, as follows:

- Providers who are identified as noncompliant will receive official notice of non-compliance via written letter, be re-educated within 30 (thirty) days of the incident by the Provider Relations Team using the published HSCSN Provider Manual and contract. The provider will be required to attest to having received re-education on the Access and Availability Standards.
- Upon re-education, the provider will be resurveyed within 90 (ninety) business days.
- Should the provider continue to be non-compliant and/or fail to meet the standards, the provider's network participation status will be internally reviewed to issue sanctions, corrective action plans and/or termination of the provider's contract, where appropriate.

Those providers and/or provider groups who are unable to fulfill the requirements of the Corrective Action Plan will be terminated.

| **SPECIALTY** | **VISIT TYPE** | **ACCESS STANDARD** |
|---|---|---|
| All Medical and Mental Health Specialties including Acute Care | Emergency | Immediate with no Prior Authorization Required |
| Mental Health Providers | Emergency<br><br>These services shall be provided by practitioners with appropriate expertise in mental health with on-call access to a pediatric or | Telephone Assessment within<br><br>15minutes of request; when medically necessary face-to-face assessment within 90 minutes of the completion of the telephone assessment. |

| | | |
|---|---|---|
| | adolescent psychiatrist or mental health specialist | Accessible care on a 24-hour basis, 7 days a week, including weekends and holidays. |
| PCP & Mental Health Providers | Urgent | Within 24 hours of request |
| Specialists | Urgent | Within 48 hours of request with referral |
| Initial Pregnancy and/or Family Planning Visits | Initial Visit | Within 10 days of request |
| All Specialties | Routine Appointments, Non-Urgent Care, Non-Urgent Diagnosis and/or Non-Urgent Referrals | Within 30 days of request |
| Primary Care | New Enrollee Appointment | 45 days from enrollment or 30 days from request, whichever is sooner |
| Primary Care | Well-Health for Adults (21+) | 30 days from request |
| Primary Care | Diagnosis and Treatment of Health Condition (not urgent) | 30 days from request |
| Pediatrics | New Enrollee Appointment | 60 days from enrollment or sooner to comply with periodicity schedule |
| Pediatrics | EPSDT Examination | 30 days from request |

| | | |
|---|---|---|
| Pediatrics | IDEA Part C Multidisciplinary Evaluation | 30 days from referral |
| Pediatrics | IDEA Part C Treatment | 25 days from signed IFSP |
| Mental Health | Outpatient | Within 7 days of discharge from a Psychiatric Inpatient Facility or a Psychiatric Residential Treatment Facility (PRTF) |
| Mental Health | Outpatient | Within 30 days of discharge from an acute care facility |
| HealthCheck/EPSDT Screens | Screening, Laboratory Tests, and Immunizations | Shall take place within 20 days of their scheduled due date for children under the age of 2 and within 30 calendar days of their due dates for children over the age of 2. |
| HealthCheck Initial Screens | Initial Screens | Shall be completed within 60 days of the enrollee's enrollment date unless it is determined that the enrollee is up to date with their periodicity schedule. |

## Provider Education

In accordance with 42 CFR 422.112 (a)(8) and with local regulations such as the DC (District of Columbia) Human Rights Act of 1977, HSCSN requires that all credentialed and contracted providers must complete the organized trainings set forth within our Provider Education Policy (see below). This policy sets forth the organized training program for Network Providers based upon HSCSN's annual assessment of training needs. Those identified training needs include but are not limited to Cultural Competency training, HSCSN policies and procedures, EPSDT (Early and Periodic Screening Diagnosis and Treatment) Requirements, Claims Training, Annual CASSP Refresher Training, and Clinical Care/Disease Management Trainings. HSCSN also requires that providers attend training as directed by the Department of Health Care Finance and develops and/or adapts additional educational content to support adherence to such guidelines.

1) The HSCSN New Provider Orientation (which consists of):
    a) An overview of the CASSIP Program.
    b) An overview of the DC Department of Health Care Finance and it is health initiatives and priorities.
    c) An overview of the DC Department of Health's initiatives and priorities, applicable to the provider type.
    d) Enrollee access standards.
    e) The use of evidence-based guidelines, contractor's treatment guidelines and the definition of Medical Necessity.
    f) An overview of EPSDT, the periodicity schedule, compliance requirements, Salazar Consent Decree and other relevant Court Orders/Consent Decrees, and subsequent court orders.
    g) Policies and procedures on Advance Directives.
    h) Procedures for arranging referrals with other District agencies and services.
    i) HSCSN's Quality Assurance, Performance, and Improvement program and annual Quality Work Plan.
    j) The District of Columbia and HSCSN's fraud, waste and abuse policies and procedures and Compliance Plan.
    k) Cultural competency, the availability, and protocols for use of interpreters for enrollees who speak limited English and other skills for effective health-related cross-cultural communication, diversity, and inclusion.
    l) Reporting Requirements for child abuse/neglect, communicable disease reporting requirements and other reportable incidents.
    m) Privacy and Confidentiality of Protected Health Information, including HIPAA (Health Insurance Portability & Accountability Act) Privacy and Security Rule, and the DC Mental Health Information Act.
    n) HSCSN's level of care criteria and treatment guidelines, how to use this information, and the consequences of not using this information.
    o) Manifestations of mental illness and substance abuse as well as use of screening tools to identify such problems and how to make appropriate referrals for treatment services
    p) HSCSN claims, billing, and appeals processes
2) All newly contracted and/or credentialed providers who meet the criteria of providing well-child visits and/or services, must complete the biannual EPSDT and IDEA (Individuals with Disabilities Education Act) Training provided by the DC Health Check Provider Education system through Georgetown University Hospital. See more information below in the HealthCheck Section of this manual.
3) HSCSN will administer additional clinical trainings on a quarterly basis to contracted providers, provider groups and/or facilities inclusive of Continuing Medical Education (CME) and/or Continuing Education Unit (CEU) opportunities (for both clinical and non-clinical staff). These training courses will pertain to:

a) Clinical conditions for which HSCSN has developed Disease Management Program frameworks.
b) Conditions related to DHCF's Performance Improvement Projects.
c) Clinical Practice Guidelines including targeted training based on findings of medical record audits; and
d) Other clinical topics of interest.

4) HSCSN will also complete for Contracted Network Providers education and training opportunities to:
    a) Required Annual CASSIP Refresher (a refresher on the requirements of HSCSN and its contracted entities surrounding the CASSIP contract requirements).
    b) Provider Manual Review Sessions.
    c) Annual Claims Training.
    d) Provider Specific Trainings such as Behavioral Health/Substance Use Disorders, Home Health Care, Applied Behavioral Analysis, and other topics.
    e) Provider Forums.
    f) HEDIS (Healthcare Effectiveness Data and Information Set), Quality Feedback, Education, and Intervention.
    g) Support for Value0based Contracts (including intervention and quality improvement support).
    h) Direct feedback on results for enrollees who are their patients.
    i) Provider mailings and email notifications sharing general and targeted information on clinical topics.
    j) Clinical Practice Guidelines.
    k) And other items as identified as needed from either evaluation of the provider, provider group and/or by request of the provider, provider group.
    l) All training sessions provided by the HSCSN Provider Relations Representatives will be documented in the HSCSN Provider Documentation Warehouse.
5) Changes in CFR or rules and regulations affecting the Medicaid Program or CASSIP
    a) Including changes and/or updates to the DC State Plan Amendment (e.g., Transmittals and other documents)
6) Updates regarding the Provider Network such as:
    a) Network Composition
    a) Network Standards
    b) Network Guidelines
7) Other Transmittals or Notifications as deemed appropriate for dissemination from the Provider Network Management, Compliance, Quality Management or Medical Management department.

**Note: HSCSN reserves the right to provide these trainings either in-person and/or virtually, depending on the needs of the Provider and/or Provider Group.**

Should any Provider and/or Provider Group fail to comply with the HSCSN Provider Education Policy by failing to complete and/or attend any of the required and/or mandatory trainings; dependent upon the nature of the non-compliance, can result in termination from the HSCSN Contracted Network.

## HealthCheck

HealthCheck Providers (PCPs (Primary Care Providers)) are required to complete the District of Columbia's HealthCheck Provider Trainings prior to joining HSCSN's Network. The web-based training was developed by Georgetown University's National Center for Education in Maternal and Child Health in partnership with the District of Columbia Department of Health Care Finance and the Managed Care Organizations in the District.

HealthCheck Training is accessible online at www.dchealthcheck.net and requires a provider's NPI (National Provider Identifier) to log-in. The training program is free for participating providers who are due to receive the training. Successful completion of the program provides a maximum of five hours of continuing education credits for HealthCheck providers. PCPs (Primary Care Providers) and PCP-like Providers must ensure that they complete this training every two (2) years after the initial training.

## Cultural Competency

HSCSN is committed to ensuring that its Provider Network is comprised of practitioners, providers facilities, and systems of care that reflect that diverse enrollee population we serve and are equipped to meet their specialized care needs. This includes, but is not limited to, the ability to provide care to enrollees with diverse values, beliefs, behaviors along with the ability to tailor health care delivery to meet social, cultural, and linguistic needs.

HSCSN requires all providers joining the HSCSN Provider Network to complete Cultural Competency (CC) Training. Providers must attest to completion of the CC training or submit proof of CC training completion as part of their initial credentialing process to join the HSCSN Provider Network along with a certificate displaying the CEUs/CMEs received during that training. In the event the Provider(s) cannot provide proof of CC training during the credentialing process, the Provider or Provider Group is afforded additional time to complete the training. Cultural Competency Training must be completed within ninety (90) days of your credentialing effective date to remain in good standing. Any Provider that does not complete the training within the ninety (90) day timeframe is internally reviewed for sanctions.

## Language Access Requirements

In accordance with Title II of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, Language Access Act, 42 CFT sect 438.10, DC Code Sec. 2-1931 et seq., and guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against

National Origin Discrimination Affecting Limited English Proficient Persons, HSCSN provides methods for all enrollees to have interpretation services during care as well as providing written documents and materials in a culturally, appropriate manner along with a language and format that is easily understood.

HSCSN requires that all in-network providers, provider groups and facilities provide each HSCSN enrollee with access to interpretation services either in-person, telephonically and/or virtually but most important the interpretation must be in a format that is culturally appropriate and adequate for the enrollee to access the health services. All incoming provider groups and/or facilities are required to identify the type of language access the site has available and what non-English languages their practitioners and staff speak. This information is verified when the new provider orientation session is conducted and at the time of the ADA Site Visit. In addition, language (s) spoken by a provider, is captured by the Credentialing staff, and is listed within the Provider Directory. This information is updated at every site visit performed at that provider group's location. The Provider Directory is updated in accordance with the documentation provided by the providers, changes to the provider records, and/or any other identified material change.

We ask that providers do not use and do not encourage HSCSN enrollees to use family and/or friends as verbal translators. Any provider, provider group, facility and/or enrollee can contact the HSCSN Customer Care Line to access the available translation services for HSCSN enrollees, at any time. For enrollees who are hearing impaired, HSCSN makes available language services through a vendor who provides American Sign Language (ASL) via video services. Additionally, during the Provider Orientation and the new annual provider training, providers are educated and reminded of the requirement to have language access and how to access language translation services through HSCSN's contracted vendors, if necessary. The Language Line is available for use by all HSCSN enrollees and HSCSN contracted providers at no charge to interact and interpret major languages, such as, English, French, Spanish, Vietnamese, Chinese, Amharic and Korean. To access the HSCSN Language Line, please contact the HSCSN Customer Service Dept at 202-467-2737.

## Document Translation Services

For any medical documents, HSCSN recommends that providers give a copy of enrollee's medical document in the enrollee's either identified, natural and/or requested language. If a provider, provider group, and/or facility does not have the ability to translate the medical documents into a visual format that is easy for the enrollee to understand, the enrollee can submit the documents to HSCSN via their Care Manager for translation. The HSCSN Care Manager and/or any other representative of HSCSN will work with the HSCSN Customer Care Team to have the documents translated by one of the contracted language services vendors. HSCSN also provides enrollees with access to HSCSN staff through TTY Services during office hours and after hours along with

Sorenson Video Relay services. For more information on Documentation Translation Services, please contact our Customer Care Department at 202-467-2737.

## Teletypewriter (TTY) Services

A TTY (teletypewriter) is a communication device used by people who are deaf, hard-of-hearing, or have severe speech impairment. HSCSN provides TTY telephonic services to enrollees, providers and/or any person who needs to contact HSCSN at (202) 467-2709. Additionally, HSCSN provides Sorenson Video Relay or comparable services for people who are Deaf or Hard of Hearing. And Video Relay Services (VRS) are also available. Please contact HSCSN at (202) 467-2709 for additional details.

## Provider Advertising & Communications

Providers are allowed to provide factual information about HSCSN and HSCSN Programs. Providers are allowed to market and advertise for their businesses to the community at large, however, Providers and Provider Groups can make **no attempt** to steer CASSIP Eligible Prospects to HSCSN. Nor can Providers or Provider Groups provide written materials, oral methods, or other sensory tools to share false or misleading information regarding HSCSN. Providers and Provider Groups are prohibited from any marketing activities on behalf of HSCSN. Lastly, when Providers are providing enrollees branded HSCSN materials, Providers are only allowed to distribute HSCSN plan-approved materials to HSCSN enrollees and caregivers. Failure to adhere to this policy may result in termination from the HSCSN network.

## Provider Office Visits

The Provider Relations Department conducts regular office visits with HSCSN Network Providers. HSCSN Network Providers receive at least two (2) visits per year from their assigned Provider Relations Representative. During the provider office visits, the Provider Relations Representative will meet with the HSCSN provider and/or designated office staff and conduct a review of their practice rosters, review or share updated information from HSCSN regarding Health Plan initiatives and/or requirements, as well as address any support or issue resolution needs that ensure that the provider is meeting the needs of the enrollees. Additionally, the Provider Relations Representative ensures that all practitioner credentialing with HSCSN is up-to-date and/or current.

**Note: Additional visits throughout the contract year can be requested by the provider and/or provider group, depending on their needs. CSN Provider Relations Representative will also conduct additional visits throughout the year if the need arises due to contract adherence issues, provider administrative issues and/or any other relevant need for HSCSN.**

Provider office visits also include site observation checks that ensure /evaluate practice compliance with appointment access and accessibility standards. This includes, but is not limited to:

- Evaluation of office wait-times.
- Office survey: A review of the physical layout of the practice, facility, or office to ensure compliance with Americans with Disabilities (ADA) accessibility requirements are present and/or have been maintained.

Lastly, the Provider Relations Representative will review claims history and/or data with the provider and/or office manager to ensure that there are open claims issues or concerns. The visit is documented on our Office Visit Sheet (see attached) for record of the visit. Subsequently, each Provider Relations Representative has two (2) administrative office days per month, at that time the Office Visit Form has its contents submitted into the HSCSN CRM for record keeping purposes.

During Public Health Emergencies (PHE) and/or at the request of the Provider or Provider Group, a visit will be held virtually. During the virtual visit, the Provider Relations Representative will conduct the same activities as previously described during an in-person visit. This includes a virtual walkthrough of the practice, office, or facility to ensure ADA accessibility. The Provider Relations Representative may also drive out to the facility to ensure the office on record is still active and in service: thereby obtaining visual confirmation.

## Provider Portal

HSCSN Provider Portal, managed and maintained by Change Healthcare, called ConnectCenter, is available for providers to be more efficient in caring for HSCSN enrollees and alleviate administrative burdens to providers. The Provider Portal contains several functions that allow providers to view their demographic information, assigned practitioners, submit claims, and view claims submission statuses. The ConnectCenter also allows providers and the office staff to run claims reports to track and trend account receivables. Providers can register for access to the ConnectCenter at **https://physician.connectcenter.changehealthcare.com/#/site/home?payer=214707**. For further information and or training for the ConnectCenter, please contact the Change Healthcare ConnectCenter Provider Support Line at (800) 527-8133.

## Provider Complaints

Providers may file informal complaints about HSCSN policies, procedures, and organizational functions. HSCSN will investigate each complaint received using all available resources such as provider contracts, HSCSN policies and procedures, HSCSN clinical practice guidelines, and

District and Federal regulations. Providers may inform HSCSN of these complaints by calling Provider Relations at (202) 495-7526 or via written notice. All findings will be provided to the provider within 180 days of receipt of the complaint.

Written Notices can be sent to:
Health Services for Children with Special Needs (HSCSN)
Attn: Provider Relations
1101 Vermont Ave NW, Ste 12
Washington, DC 20005

## Claims and Billing

Our goal is to pay providers for covered services within thirty (30) days of receipt of each clean claim. Your National Provider Identifier (NPI) is your HSCSN Provider ID. Please include your Tax Identification Number (TIN/EIN), the billing provider NPI and when necessary; the servicing provider 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. Hospitals are required to submit for payment of covered services on the CMS UB-04. These forms are available from CMS at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List

### Claims Payment Capacity

HSCSN shall pay all claims for covered services and/or authorized services provided to Enrollees on dates of service during the enrollee's active enrollment period.

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 Appeal Rights and how to access the Fair Hearing process.

Providers have the option of submitting claims electronically through Change Healthcare (EDI Platforms), the HSCSN Change Healthcare Provider Portal (ConnectCenter), or via mail. Providers

who choose to use Change Healthcare's EDI Platform option must contact Change Healthcare to connect their billing software and/or register for the Change Healthcare ConnectCenter. Change Healthcare requires that the providers inform them of HSCSN's Payor ID upon connection. **HSCSN's Payor ID is 37290**. For all paper claims, clean claims should be mailed to:

Health Services for Children with Special Needs (HSCSN)
**Attn: Claims Department**
P.O. Box 29055
Washington, DC 20017

HSCSN asks that Providers do not submit a duplicate claim for at least **forty-five (45) days** after submitting the original claim. Duplicate claims can delay payment and cause denials to happen.

HSCSN is a Medicaid Health Plan and as such is always the payer of last resort. If the enrollee has other insurance coverage, submit claims to the other carrier first. All claims for enrollees who have other insurance coverage will be denied if submitted without the primary insurance EOB physically attached to the claim.

## Electronic Submission of Claims

To submit claims electronically to HSCSN, you must use Change Healthcare as a clearinghouse, or your practice management system must be able to connect to Change Healthcare clearinghouse.

### What is the advantage of Electronic Claims Submission?

- Claims can be tracked electronically
- Improved patient collections
- Rapid and accurate payment processing

To connect to Change Healthcare for electronic claims submission, please visit Change Healthcare at https://www.changehealthcare.com/providers and follow the steps for Enroll New Customer. If you choose to use your practice management system to connect and have questions, please contact your practice management system. To submit claims, you will need the **HSCSN Payor ID 37290**.

## Claims Status Inquiry and Direct Claims Entry

HSCSN's Change Healthcare Provider Portal (ConnectCenter) is a web-based solution that simplifies the everyday tasks of practices by integrating claim status inquiry transactions. Providers may log in to the secure portal to check claims status, check eligibility, or submit claims directly. The HSCSN Provider Portal can be accessed at **https://physician.connectcenter.changehealthcare.com/#/site/home?payer=214707**.

These features of the HSCSN Provider Web Portal provide you with:

- Secure, personalized web portal access
- Electronic claim inquiries and tracking
- Direct claims entry system at no cost
-

For instructions on how to use the Provider Portal, please contact Change Healthcare's Customer Care at 800-527-8133.

**Note:** If you are currently using a practice management system that provides you the ability to submit claims electronically to Change Healthcare, 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.
If you are **unable to access the Internet**, you may call HSCSN's Customer Care Department at (202) 467-2737 to check the status of a claim.

## Timely Submission and Processing of Claims

### DC Code § 31-3132

In accordance with D.C. Code § 31-3132, HSCSN shall accept in-network/participating and out-of-network/non-participating Provider initial claims for covered or authorized services no later than three hundred and sixty-five (365) days from the date of service. Claims received more than three hundred and sixty-five (365) days after the date of service will be denied due to timely filing rules. Providers can appeal timely filing denials. For further information on appeals, please see the Claims Appeal section.

### The Social Security Act and 42 CFR § 447.45

HSCSN is held to a minimum standard to 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.

### Prompt Payment Act of 2002

HSCSN is contractually bound to meet the following prompt payment guidelines according to the provision of the D.C. Prompt Payment Act of 2002:

- Pay or deny ninety percent (90%) of all clean claims within thirty (30) days of receipt and ninety-nine percent (99%) of clean claims within ninety (90) days of receipt.

**Note**: A clean claim is defined as having no deficit or impropriety, including any lack of reasonably

required substantiating documentation or information which may prevent timely payment. If a clean claim is not paid within thirty (30) days of receipt, and HSCSN fails to notify the provider within said thirty (30) days of any missing information required to pay the claim, HSCSN will pay interest according to the Prompt Payment Act of 2002 which states the following:

- One and a half percent (1.5%) from the 31st day through the 60th day.
- Two percent (2%) from the 61st day through the 120th day; and,
- Two- and one-half percent (2.5%) after the 120th day

## Enrollees Held Harmless

Under the requirements of the Social Security Act, all payments from HSCSN to providers must be accepted as payment in full for services rendered. HSCSN Enrollees or designees **may not** be balanced billed for medically necessary, covered, or authorized services **under any circumstances**. All providers are encouraged to use the claims appeals process to resolve any outstanding claims payment concerns.

## Important Billing Notice for HSCSN Providers Who Service HSCSN Enrollees Over 18 Years of Age

To be eligible for enrollment with HSCSN, children and young adults must be under 26 years of age and must be eligible to receive Supplemental Security Income (SSI) disability benefits.

Providers who service the entire age range of the HSCSN membership should use the appropriate age-based billing codes. Use of inappropriate billing codes will cause denials.

## Coordination of Benefits

HSCSN is a health plan contracted with the Medicaid Program of the District of Columbia. All Medicaid products in the United States are required by federal mandates to always be the payer of last resort when the enrollee has other insurance coverage. When a beneficiary has insurance from another source, Medicare, or a Commercial policy, the provider must bill this source first before submitting a claim to HSCSN. Once the provider receives an Explanation of Benefits (EOB) or Explanation of Medicare Benefits (EOMB) from the primary payer, the provider should file the claim with HSCSN. The provider must attach a copy of the EOB or EOMB to the original claim for submission to HSCSN. HSCSN will pay up to the amount that is contracted. The provider will not receive payment for more than the charge, the contracted amount, or the non-par fee schedule when combining the payments of other payers. For multiple claims, please ensure that each claim has a copy of the correct corresponding EOB or EOMB attached. Claims for enrollees with a primary source of insurance billed without a copy of the correct corresponding EOB or EOMB will be denied per federal regulations. All claims submitted via the Coordination of Benefits rule must be submitted within 180 days of the date of the primary insurance carrier's payment. Any claims with the corresponding EOB or EOMB received after 180 days of the primary carrier's payment date will be denied due to timely filing regulations. **All COB Claims must be received by HSCSN**

**within three hundred and sixty-five (365) days of the date of service, regardless of the EOB or EOMB processing date.**

## Claims Appeals

Claim payments or denials can be appealed in writing ***within ninety (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 incorrect. 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 must include the documentation that supports your case for reconsideration. This may involve sending proof of timely submission.

Examples of claims appeals are:

- Payment amount was less than expected based on a Single Case Agreement. A letter stating the issue should be sent along with a copy of the Single Case Agreement stating the correct payment.
- Claim was denied as not authorized, but authorization was obtained. A letter stating the issue should be sent along with a copy of the authorization.
- Claims were denied for lack of required documentation such as medical records, nursing notes, or manufacturer's invoice. This information must also be submitted within 90 days with a letter of explanation.

Claims Appeals should be sent to:
**Health Services for Children with Special Needs (HSCSN)**
**Attn: Claims Appeals**
**P.O. Box 29055**
**Washington, DC 20017**

## Second and Third Level Claim Appeals

Providers have the right to a second (2nd) level and a third (3rd) level claim appeal once the original appeal is denied. Providers should submit their 2nd or 3rd level appeal with all the information from the first (1st) level appeal along with any new or additional documentation to support the 2nd or 3rd level appeal. All 2nd or 3rd Level Appeals should be sent to:

Health Services for Children with Special Needs (HSCSN)
Attn: (insert level here) Level Claim Appeal

P.O. Box 29055
Washington, DC 20017

Please ensure to clearly mark on the attention line whether the appeal is a 2nd Level Claim Appeal or 3rd Level Claim Appeal. **Please note, all 2nd Level Claim Appeals must be submitted within forty- five (45) days of the decision of the 1st Level Claim Appeal. All 3rd Level Claim Appeals must be submitted within thirty (30) days of the decision of the 2nd Level Claim Appeal. All 3rd Level Claim Appeal decisions are final.**

### Appeals for Federally Qualified Healthcare Centers

HSCSN follows the following appeals process for all participating Federally Qualified Health Centers (FQHCs):

1. All first-level appeals must be submitted within 90 business days of the denial or payment.
2. Providers must submit a written request for an appeal with the specific reason for the appeal and the appropriate supporting documentation (including a copy of the claim and Explanation of Benefits [EOB]).
3. HSCSN will send an acknowledgment letter within five business (5) days of receiving an appeal.
4. Second-level appeals must be sent in writing within thirty (30) calendar days of receiving HSCSN's response letter.
5. HSCSN will send an acknowledgement letter within five (5) business days of receiving an appeal.
6. FQHCs will receive a response letter regarding an appeal within thirty (30) calendar days of HSCSN receiving the appeal.
7. If the claims denial is overturned, the provider will receive payment within thirty (30) calendar days of the decision.

All FQHC Appeals should be sent to:

**Health Services for Children with Special Needs (HSCSN)**
**Attn: Claims Appeals**
**P.O. Box 29055**
**Washington, DC 20017**

## Appeal of Adverse Benefit Determinations

An Adverse Benefit Determination means any of the following per 42 C.F.R. § 438.400:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirement for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services promptly as defined by the District; or
- The failure of the HSCSN to act within the timeframes for the resolution and notification of Grievances and Appeals; and
- The denial of an enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

HSCSN categorizes the reasons for adverse benefit determinations as Administrative, Medical Necessity (lack of medical necessity), or Non-Covered Service (not a benefit). Providers have the following rights:

- To discuss an adverse benefit determination with the medical director who made the decision. Call the Executive Assistant for Medical Affairs at 202-974-4692 to request peer-to-peer discussion within three (3) business days of an adverse benefit determination.
- To request and obtain a copy of the medical necessity criteria/policy used in making the decision.
- To obtain an explanation of the appeals process, including timeframes for an appeal resolution.
- With consent of the enrollee, to appeal the adverse benefit determination by submitting written comments, documents, or any relevant information.

The HSCSN enrollee, provider, or other representative acting on behalf of the enrollee may submit an appeal for any adverse benefit determination issued by HSCSN with the expressed consent of the enrollee. **Note: the appeal needs to be submitted within 60 calendar days of the notice of adverse benefit determination.**

HSCSN provides the HSCSN enrollee, the enrollee's designee (including the legal representative of a deceased HSCSN enrollee's estate), provider, and/ or the facility the opportunity to appeal an adverse benefit determination through a verbal or written request. **Note: An enrollee may file a grievance and request an appeal with HSCSN.**

Oral inquiries seeking to appeal an adverse benefit determination are treated as appeals. Details of the verbal appeal will be logged in a dated memo in the HSCSN enrollee's electronic record in the HSCSN IT System. Verbal inquiries seeking to appeal an action are treated as appeals to establish the earliest possible filing date for the appeal. Any ambiguous communication will be treated as a grievance and forwarded to the Risk Management Department.

The HSCSN enrollee, the enrollee's designee and/or the facility or provider may file a verbal appeal by calling the Grievance and Appeal Hotline at (202) 495-7582 or the HSCSN Customer

Care Department at (202) 467-2737, seven (7) days a week, 24 hours a day. Impartial assistance at all stages in the appeal process, including provision of interpreter/translator services and toll-free numbers that have adequate TTY/TDD capabilities and interpreter capabilities are free of charge to HSCSN enrollees. HSCSN enrollees and/or their designees should send their written appeal request to:

Health Services for Children with Special Needs, Inc. (HSCSN)
Utilization Management Department - Appeals
1101 Vermont Avenue, NW, Ste 12
Washington, DC 20005

Written acknowledgement of the receipt of an appeal is issued to the requestor within two (2) business days of receipt.

## Standard Appeals Process

HSCSN enrollees, HSCSN enrollee's designees (or the legal representative of a deceased enrollee's estate), providers, provider groups and facilities have the right to request an appeal of pre-service, post-service, and adverse benefit determinations via the standard (non-urgent) appeals process. All standard appeals are accepted either verbally or in writing. At the time of the request, standard appeals will be referred to the Denial/Appeals Coordinator, who will log the data into the HSCSN enrollee's file as well as into the appeal tracking log.

The HSCSN enrollee, their designee, or provider requesting the appeal will receive written notification of appeal receipt. Written acknowledgement of the receipt of an appeal is issued to the requestor within two (2) business days of receipt of the appeal request.

The Director of Utilization Management will be notified and will initiate a referral for review to the Appeals Committee. As part of the standard appeal process, the ordering provider, facility, HSCSN enrollee, or HSCSN enrollee's designee will have the opportunity to submit written comments, documents, records, and other information relating to the case. The Appeals Committee will take all such information into account during the standard appeal process without regard to whether such information was submitted or considered in the initial consideration of the case. Information may be exchanged by telephone or fax transmittal. **Please note: the need for a full Appeals Committee review may be eliminated if the Clinical Reviewer who rendered the original non-determination reviews new or additional information submitted and is able to overturn a non-certification based on the new or additional information.** If the Clinical Reviewer cannot overturn the non-certification, the appeal review is referred for a same/similar specialty peer review.

Before, during, or for a limited time following an appeal resolution the ordering provider, facility, HSCSN enrollee, or HSCSN enrollee's designee may view the HSCSN appeal file inclusive of

medical records, and any other documents considered during the appeal.

Upon completion of the standard appeal process, a written notification of the appeal decision will be issued within thirty (30) days after receipt of the appeal request. The standard appeal timeframe, for verbal requests, starts on the date when a call comes in. For written requests, it is the date the written request is received by HSCSN.

## Expedited Appeal Process

HSCSN enrollees have the right to an Expedited Appeal process when there is a risk to life, limb, unborn child, deteriorating condition, extreme pain, or could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. At the time of the request, expedited appeals will be referred to the Denial/Appeals Coordinator, who will log the data into the enrollee's file, as well as into the appeal-tracking log. An HSCSN enrollee, their designee or provider may request that the appeal be expedited if the enrollee, their designee, or provider feels that taking the time for a standard appeal resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. HSCSN will not apply punitive action against a provider who requests an expedited resolution or supports an HSCSN enrollee's appeal.

The HSCSN enrollee, their designee, or provider requesting the appeal will receive written notification of appeal receipt. Written acknowledgement of the receipt of an appeal is issued to the requestor within two (2) calendar days of receipt of the appeal request. Any medical information, as well as any supporting documentation and written comments can be faxed to the Utilization Management Department to the attention of the Denial/Appeals Coordinator at (202) 721-7190 or mailed/hand delivered to:

Health Services for Children with Special Needs, Inc. (HSCSN)
Utilization Management Department, Expedited Appeal
1101 Vermont Avenue, NW, Ste 12
Washington, DC 20005

The Director of Utilization Management is notified and initiates a referral for review to the Appeals Committee. If the request does not meet HSCSN criteria for an expedited appeal: risk to life, limb, unborn child, deteriorating condition, extreme pain, or could seriously jeopardize the HSCSN enrollee's life or health or ability to attain, maintain, or regain maximum function the requestor will be notified verbally/telephonically that the health plan will process their request in the standard appeal time frame. HSCSN will make reasonable efforts to give the HSCSN enrollee prompt oral notice of the denial for an expedited review, and follow up within two (2) calendar days with a written notice.

As part of the appeal process, the ordering provider, facility, or HSCSN enrollee/their designee (or legal representative of a deceased HSCSN enrollee's estate) will have the opportunity to

submit written comments, documents, records, and other information relating to the case. The requestor is provided the opportunity to present evidence and allegations of fact or law, in person as well as in writing. The requestor is informed of the limited time available for presenting evidence in the case of expedited appeals. The peer reviewer will take all such information into account during the expedited appeal process, without regard to whether such information was submitted or considered in the initial consideration of the case. Information may be exchanged by telephone or fax transmittal. Reasonable efforts will be made to provide written and oral notification of the upheld, in whole or part, and/or overturned adverse benefit determinations will be issued to the ordering Provider, Facility, and Enrollee/Their designee (or legal representative of a deceased enrollee's estate) and the date it was completed. HSCSN will provide prompt oral notice of any appeal resolution delay.

The expedited appeal will be completed as expeditiously as the HSCSN enrollee's health condition requires, but within 72 (seventy-two) hours from the date/time the appeal request was received unless an extension of up to 14 days is requested by HSCSN and approved by the Department of Health Care Finance. The expedited appeal timeframe, for verbal or written requests, starts on the date the request is received by the Denial/Appeals Coordinator. The timeframe of an appeal may be extended by no more than fourteen (14) calendar days, if:

- Requested by DHCF; or
- The enrollee requests the extension; or
- HSCSN shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's best interest.

## Appeal Resolution Timelines and Extensions

The time of an appeal may be extended by no more than fourteen (14) calendar days, if approved by DHCF. For extended timeframes, additional information may be required. If HSCSN extends the timeframe of an appeal for which an extension was not requested by the HSCSN enrollee or the enrollee's designee, a notice will be given in writing as to the reason for the delay.

Reasonable efforts will be made to provide written and oral notification of the upheld, in whole or part, and/or overturned adverse benefit determinations will be issued to the ordering Provider, Facility, HSCSN enrollee, or their designee, or legal representative of a deceased enrollee's estate) and the date it was completed. HSCSN will provide prompt oral notice of any appeal resolution delay. Enrollees will receive written notice within two (2) business days of the reason for any extension not requested by the enrollee. The following items will be included in any written appeal resolution provided:

- The reason for the appeal decision including the HSCSN enrollee's right to file a Fair Hearing if the enrollee disagrees with the decision. Sufficient details to allow the practitioner, facility or HSCSN enrollee to understand the reason for the decision using easily, understood language;

- A statement that the clinical rationale (as determined by using clinical review criteria) usedin making the appeal decision will be provided, in writing upon request;
- A statement that reasonable access to and copies of all documents relevant to the appeal will be provided, free of charge upon request including titles, qualifications etc. of those involved in the appeal review;
- Information about requesting a Fair Hearing and their right to request and receive benefits while the Fair Hearing is pending and how to make the request.

## Reviewing Appeals Records

Before, during, or for a limited time following an appeal resolution, the ordering provider, facility, HSCSN enrollee, their designee (or legal representative of a deceased enrollee's estate) may view the HSCSN appeal file inclusive of medical records, and any other documents considered during the appeal.

## Continuation of Benefits

For benefits to continue during the appeal, the following conditions must be met:

- An appeal must be requested no later than 10 calendar days after the Notice of Adverse Benefit Determination (Denial Letter) was mailed OR on or before the first day that services are scheduled to be reduced, suspended, or terminated, whichever is later;
- The appeal involves the termination, suspension, or reduction of previously authorized services;
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The enrollee timely files for continuation of benefits.

## Fair Hearing Process

An HSCSN enrollee and/or their designee may seek a Fair Hearing with the District of Columbia Office of Administrative Hearings after exhausting the HSCSN appeals process and within 120 days from the date of notice of the HSCSN appeal resolution.

HSCSN Enrollees have the right to self-representation or to be represented by a family caregiver, legal counsel, or other representative during a Fair Hearing. HSCSN enrollees expressing dissatisfaction with a District's Agency denial of a request to transfer plans or disenroll are ensured access to a Fair Hearing.

To request a Fair Hearing, contact the following agency:

District of Columbia Office of Administrative Hearings Clerk of the Court
441 4th Street, NW, Suite 450 North
Washington, DC 20001

(202) 442-9094

If an enrollee/caregiver needs assistance filing a request for a Fair Hearing with the District of Columbia Office of Administrative Hearings, you may contact HSCSN's Grievance and Appeal Hotline at (202) 495-7582. You may also request assistance by sending a written request to:

Health Services for Children with Special Needs, Inc. (HSCSN)
Attn: Risk Management
1101 Vermont Avenue, NW, Ste 12
Washington, DC 20005

In accordance with 42 C.F.R. § 438.424(a), if HSCSN or the District Office of Administrative Hearings reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, HSCSN will authorize the disputed services as expeditiously as the HSCSN enrollee's health condition requires and no later than 72 hours from the date it receives notice reversing the determination.

In accordance with 42 C.F.R. § 438.424(b), if HSCSN or the District Office of Administrative Hearings reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, HSCSN will pay for those services.

## Health Care Acquired Conditions

The Patient Protection and Affordable Care Act of 2010 included provisions prohibiting Federal Financial Participation (FFP) to States for payments for **health care acquired conditions** (HCACs) and other provider preventable conditions or **Never Events**.

HSCSN shall does not reimburse providers for procedures relating to the following health care acquired conditions when any of the following conditions are not present upon admission in any inpatient setting, but subsequently acquired in that setting. For a list of the specific conditions please visit: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions. **Note: There are no exempt providers, HSCSN reviews claims for all hospitals paid on a DRG and a Non-DRG Basis.**

## Present on Admission (POA) Indicator and the Effect on Payment

| Present on admission indicator | Indicator Description | Effect on payment |
|---|---|---|

| | | |
|---|---|---|
| Y | Diagnosis was present at the time of inpatient admission | HSCSN will pay for those selected HACs that are coded as “Y” for the POA Indicator |
| N | Diagnosis was not present at time of inpatient admission | HSCSN will **not** pay for those selected HACs that are coded as “N” for the POA Indicator |
| U | Documentation insufficient to determine if the condition was present at the time of inpatient admission | HSCSN will **not** pay for those selected HACs that are coded as “U” for the POA Indicator |
| W | Provider unable to clinically determine whether the condition was present at the time of inpatient admission | HSCSN will pay for those selected HACs that are coded as “W” for the POA Indicator |
| I | Unreported /Not used. Exempt from POA reporting. (This code is equivalent to a blank on the UB- 04, however, it was determined that blanks are undesirable when submitting this data via an electronic claim). | Does not affect payment. All POA indicator options coded as “1” are exempt from the HAC payment provision |

## Additional Claims Education and Training

Reimbursement policies serve as a reference and guide to assist providers with accurate claims submissions for covered services. Services must meet authorization and medical necessity guidelines appropriate to the procedures and diagnoses. Covered services do not guarantee reimbursement unless specific criteria are met. Providers must follow proper billing and submission guidelines, including using industry standard compliant codes on all claims submissions. Services should be billed with ICD-10 Codes, Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. All services billed are required to be fully supported in the medical record of the HSCSN enrollee receiving services. These policies and guidelines apply to both participating and non- participating providers and facilities.

### Top 10 Reasons Claims are denied

Here are some of the top 10 reasons why claims are denied. If you follow the instructions provided by the NUCC and CMS as well as ensuring that all data is accurate and concise, provider

claims will stand the chance to be deemed as clean and accepted on first submission. Note: you should always check eligibility before any service is rendered and ensure that you have accurate authorization for any service that is rendered. Your Provider Relations Representative is available to help you navigate the HSCSN system, do not hesitate to contact them at (202) 495-7526.

1. Duplicate claim
2. Timely filing
3. Invalid diagnosis
4. Invalid age
5. Invalid gender
6. Non-covered procedure
7. Bilateral procedure
8. Exceeds authorization
9. Not authorized
10. Medical Records requested

## Claims Tips

### Do submit claims electronically

Handwritten and photocopied claims may be rejected. Please submit the current version of CMS 1500 and UB-04 claim form electronically. Change Healthcare is our clearinghouse provider and the HSCSN Payor ID is 37290.

### Do give complete information on the HSCSN Enrollee

Please provide complete information for items such as the name, date of birth, and gender. Verify that this information matches the HSCSN enrollee's insurance card. Always confirm the correct spelling of the first and last name of the HSCSN enrollee. **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 payee.

### 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 claim form to the HSCSN enrollee or designee to complete.**

### Do include the complete diagnosis

If the HSCSN enrollee has more than one diagnosis, please be sure to report all relevant diagnoses on the claim. **For the diagnosis code, include all required digits.**

### Do list each date of service for each procedure code

For individual services on different dates, such as office visits, services must be billed on separate claim lines. We cannot accept dates of service combined together under "from" and "through" dates. Each date of service must be shown separately. For spanning services, such as DME rentals, it is permissible to use "from" and "through" date fields for consecutive dates, such as: FROM THROUGH #DAYS/UNITS 9/1/19 - 9/2/19.Claims Definitions

## National Provider Identifier (NPI)

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

All individual HIPAA covered health care 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 transaction, 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 for a practitioner or provider group can be obtained online through the National Plan and Provider Enumeration System (NPPES) at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

## International Classification of Diseases 10th Clinical Modification (ICD-10-CM)

ICD-10-CM codes have been required since October 1, 2015. The sixth ($6^{th}$) and seventh ($7^{th}$) digits, for ICD-10-CM is mandatory for reporting information documented in the patient records.

## Current Procedural Terminology (CPT®)

Current Procedural Terminology (CPT) is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. Procedures and services submitted to HSCSN must be linked to the ICD-10 diagnosis 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 claims processing, while improper use of CPT modifiers may result in claims delays or claims denials.

## Healthcare Common Procedure Coding System (HCPCS)

The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products, and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs.

## Place of Service Codes (POS)

Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. The Centers for Medicare & Medicaid Services (CMS) maintains POS codes used throughout the health care industry. Place of services codes are required on all CMS 1500 claims forms submitted to HSCSN.

01 Pharmacy

02 Telehealth

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

10 Unassigned

11 Office

12 Home

13 Assisted Living Facility

14 Group Home

15 Mobile Unit

16 Temporary Lodging

17 Walk-in Retail Health Clinic

18 Residential Facility

19 Off Campus Outpatient Hospital

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

27 - 30 Unassigned

31 Skilled Nursing Facility

32 Nursing Facility

33 Custodial Care Facility

34 Hospice

35 - 40 Unassigned

41 Ambulance – Land

42 Ambulance – Air or Water

43 - 48 Unassigned

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 – Individuals with Intellectual Capabilities

55 Residential Substance Abuse Treatment

Facility

56 Psychiatric Residential Treatment Center

57 Non-Residential Substance Abuse Facility

58 - 59 Unassigned

60 Mass Immunization Center

61 Comprehensive Inpatient Rehab Facility

62 Comprehensive Outpatient Rehab Facility

63 - 64 Unassigned

65 End-stage Renal Disease Treatment Facility

66 – 70 Unassigned

71 Public Health Clinic

72 Rural Health Clinic

73 – 80 Unassigned

81 Independent Lab

82 – 98 Unassigned

99 Other Place of Service

***Note: Providers should use the specific place of service the services happened at all times. POS 99 should only be used when the specific location is not listed above.***

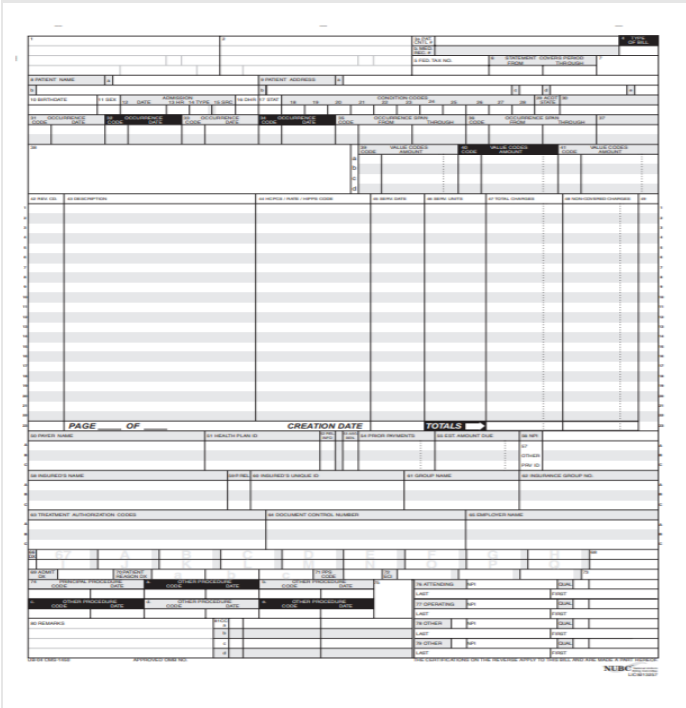
## CMS 1500 Form

The insurance claim form used to report professional and technical services is known as the CMS-1500 form. 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.

For a thorough education and how to obtain the CMS 1500, please visit the National Uniform Claim Committee Website and/or click here. For more information see http://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2019_07-v7.pdf

## UB-04

The UB-04 should be completed by hospital, long-term care, hospice, and dialysis providers billing for patient services. For detailed education and instructions on how to complete a UB-04, please visit CMS website for guidance and regulations or click here. (https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1450



**For more information visit www.hscsnhealthplan.org.**

**For reasonable accommodations please call (202) 467-2737.**

If you do not speak and/or read English, please call 202-467-2737 between 7:00 a.m. and 5:30 p.m. A representative will assist you. **English.**

Si no habla o lee inglés, llame al 202-467-2737 entre las 7:00 a.m. y las 5:30 p.m. Un representante se complacerá en asistirle. **Spanish.**

የእንግሊዝኛ ቋንቋ መናገርና ማንበብ የማይችሉ ከሆነ ከጧቱ 7:00 ሰዓት እስከ ቀኑ 5:30 ባለው ጊዜ በስልክ ቁጥር 202-467-2737 በመደወል እርዳታ ማግኘት ይችላሉ። **Amharic.**

Nếu bạn không nói và/hoặc đọc tiếng Anh, xin gọi 202-467-2737 từ 7 giờ 00 sáng đến 5 giờ 30 chiều. Sẽ có người đại diện giúp bạn. **Vietnamese.**

如果您不能講和/或不能閱讀英語，請在上午 7:00 到下午 5:30 之間給 (202) 467-2737 打電話，我們會有代表幫助您。**Traditional Chinese.**

영어로 대화를 못하시거나 영어를 읽지 못하시는 경우, 오전 7시 00분에서 오후 5시 30분 사이에 (202) 467-2737번으로 전화해 주시기 바랍니다. 담당 직원이 도와드립니다. **Korean.**

Si vous ne parlez pas ou lisez l'anglais, s'il vous plaît appeller 202-467-2737 entre 7:00 du matin et 5:30 du soir. Un représentant vous aidera. **French.**

Kung hindi ka nagsasalita ng Ingles o hindi marunong magbasa ng Ingles, tumawag sa 202-467-2737 mula 7:00 hanggang 17:30. Tutulungan ka ng isang kinatawan. **Tagalog.**

Если вы не говорите по-английски или не читаете по-английски, звоните по номеру 202-467-2737 с 7:00 до 17:30. Представитель поможет вам. **Russian.**

Se você não fala inglês ou lê inglês, ligue para 202-467-2737 entre as 7:00 e 17:30. Um representante irá ajudá-lo. **Portuguese.**

Se non parli inglese o non leggi inglese, chiama 202-467-2737 dalle 7:00 alle 17:30. Un rappresentante ti aiuterà. **Italian.**

আপন যিদ ইংরেজী না বেলন বা ইংরিজ না পেড়ন, 202-467-2737 কল কর 7:00 থেক 17:30 পযর। একজন প্রতিনধ আপনাকে সাহাযয কেরব। **Bengali.**

Wenn Sie kein Englisch sprechen oder kein Englisch lesen, rufen Sie die Nummer 202-467-2737 von 7:00 bis 17:30 an. Ein Vertreter wird Ihnen helfen. **German.**

หากคุณไม่พูดภาษาอังกฤษหรือไม่อ่านภาษาอังกฤษโทร 202-467-2737 ตั้งแต่ 7:00 ถึง 17:30 น. ตัวแทนจะช่วยคุณ **Thai.**

英語を話さないか、英語を読まない場合は、7:00ー17:30 に202-467-2737に電話してください。担当者がお手伝いします。**Japanese.**

Ọ bụrụ na ị naghị asụ ma ọ bụ agụ oyibo, biko kpọọ 202-467-2737 ihe dịka oge elekere asaa nke ụtụtụ (7:00 a.m) ruo na elekere ise na ọkara nke mgbede (5:30 p.m). Onye nnọchiteanya ga enyere gị aka. **Igbo**

Tí ó bá jẹ́ pé o kìí sọ pẹ̀lú/àbí ka èdè Gẹ̀ẹ́sì, jọ̀wọ́ pe 202-467-2737 láárín aago méje òwúrọ̀ sí márún àbọ̀ ìrọ̀lẹ́ (7am-5:30pm). Aṣojú kan yóò ràn ọ́ lọ́wọ́. **Yoruba**

THE HSC HEALTH CARE SYSTEM

# Health Services for Children with Special Needs, Inc.

You can call us 24 hours a day, 7 days a week. Our office hours are Monday through Friday, 8:00 a.m. to 5:30 p.m. We have two locations, listed below. To visit either location, please contact Customer Care Services at (202) 467-2737 or 1 (866) 937-4549 for directions or more information. Please call your Care Manager if you would like to set up a day and time to meet.

**Health Services for Children with Special Needs, Inc. (HSCSN)**
**1101 Vermont Avenue NW, 12th Floor**
Washington, D.C. 20005
The nearest Metro station is McPherson Square,
3 blocks from our office.

**3400 Martin Luther King Jr. Avenue SE**
**Washington, D.C. 20032**
The nearest Metro station is Congress

For more information visit www.hscsnhealthplan.org

For reasonable accommodations please call (202) 467-2737.

DHCF Department of Health Care Finance | WE ARE WASHINGTON DC GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.

HSCSN complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.