District of Columbia | Wellpoint District of Columbia, Inc. | Medicaid

Provider orientation

DCWP-CD-084411-25-SRS84411 | July 2025

Wellpoint
District of Columbia

Agenda

- Welcome
- Introduction to provider resources
- Claims and billing
- Pre-service processing, rejected, and denied claims
- Grievances and appeals
- Population health, enrollee benefits, and services
- Health homes
- Additional resources

Additional resources at the conclusion of the presentation.

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Department of Health Care Finance (DHCF)

The Department of Health Care Finance is the state agency responsible for implementing and administering the Medicaid program: District of Columbia Healthy Families Program (DCHFP) and the Children's Health Insurance Program (CHIP).

The Department of Health Care Finance is also responsible for administering:

- District of Columbia Healthcare Alliance Program
- Immigrant Children's Program (ICP)

You can find more information about DC DHCF on their website https://dhcf.dc.gov.

Single system of care

- The District of Columbia Department of Health Care Finance (DHCF) contracted with us to provide comprehensive healthcare services, including physical and behavioral health.
- This initiative creates a single system of care to promote efficient, coordinated, and high-quality healthcare delivery and establishes accountability in healthcare coordination.

Provider communications

We have many easy-to-use options to communicate important information to care providers. Most information is available electronically, but you may also receive mailings and faxes concerning specific billing and patient concerns.

We communicate through:

- Provider websites
- Provider manuals
- Monthly provider newsletters
- Fax blasts about program and process changes
- Provider network representatives

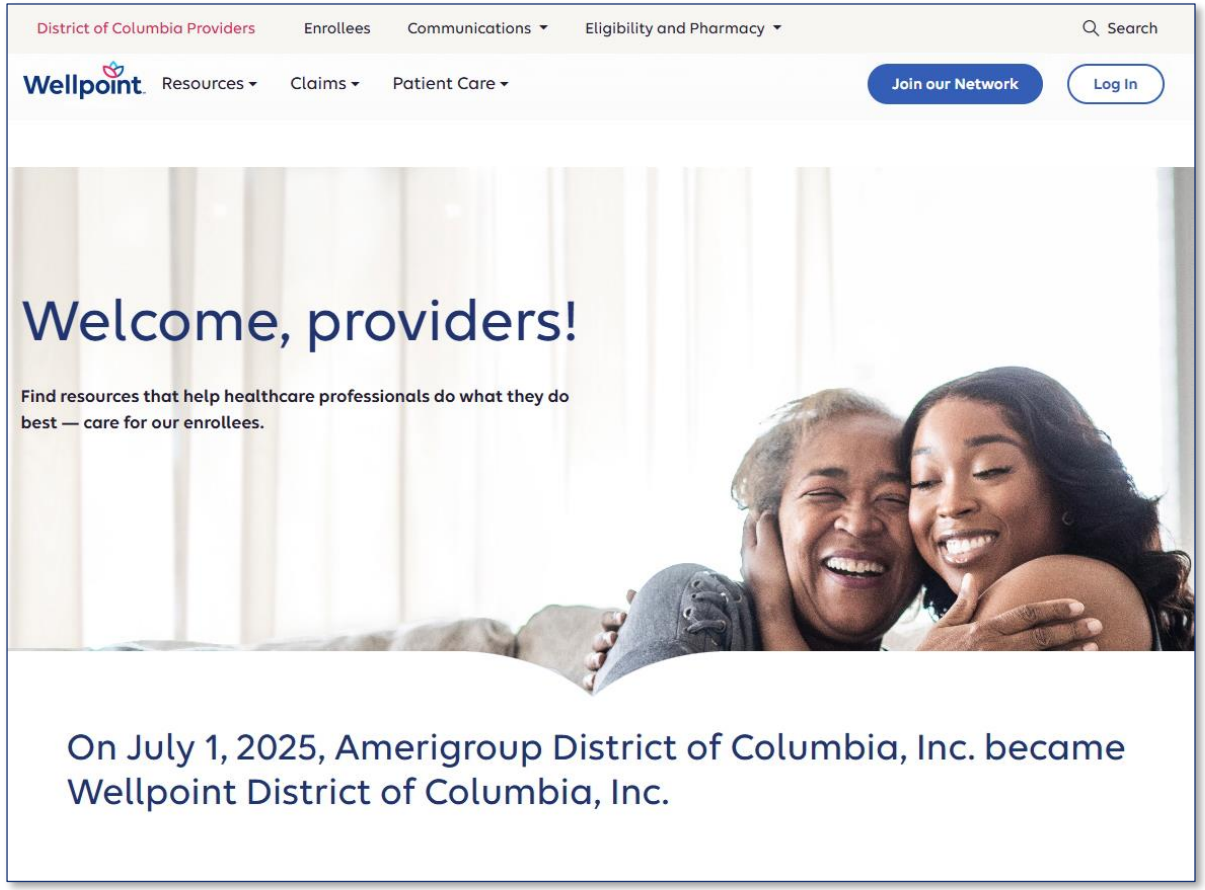
Provider website

Resource topics:

- Medical Policies, UM guidelines, and manuals
- DCHFP enrollment information
- Health education/case management
- Digital provider newsletters
- Referral directory/look-up tool
- Orientations and CME trainings
- Cultural and Linguistic Services (CLAS) resources
- Contact us options

Availity Essentials multi-payer secure platform:

- Eligibility and benefits
- Provider online reporting: access assigned enrollee data/panel listings
- Claims submission and claims status
- Provider enrollment: network participation requests
- Authorization request and inquiry
- Provider data maintenance: provider data updates



Provider trainings

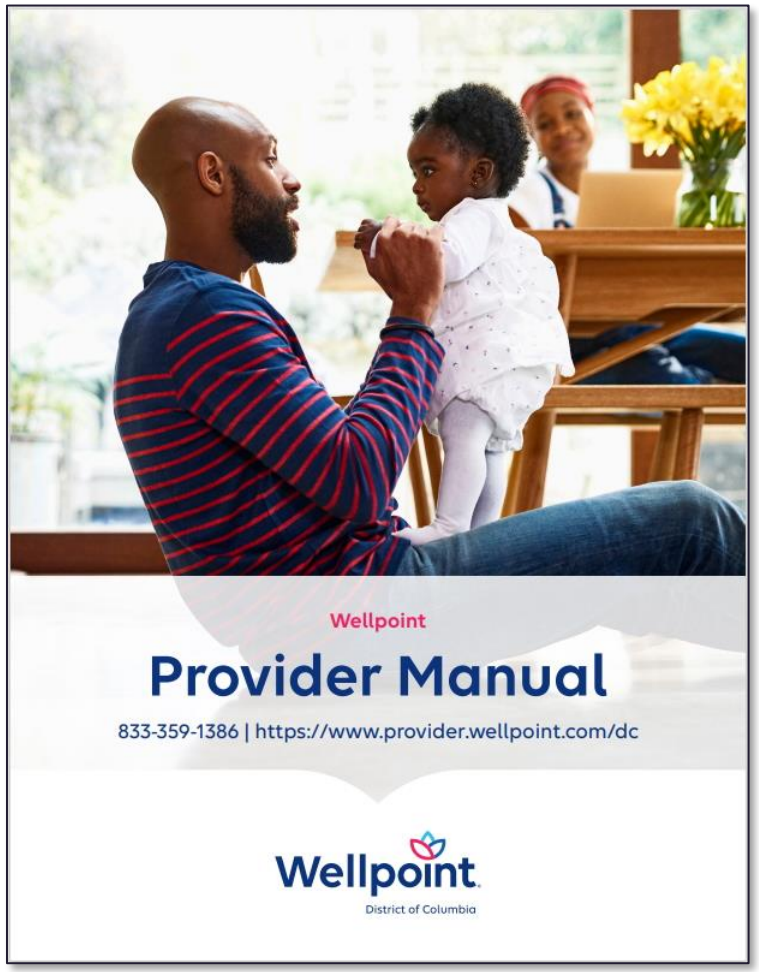
Access to specialized education and training:

- ICD codes
- Cultural competency
- HIPAA
- Quality
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Individuals with Disabilities Education Act (IDEA)
- HealthCheck
- Additional courses and learning resources specifically designed to meet the training needs of our care providers

Provider manual

The provider manual is a key support resource for:

- Preauthorization requirements.
- An overview of covered services.
- Enrollee eligibility verification process.
- Enrollee benefits.
- Access and availability standards.
- The grievances and appeals process.



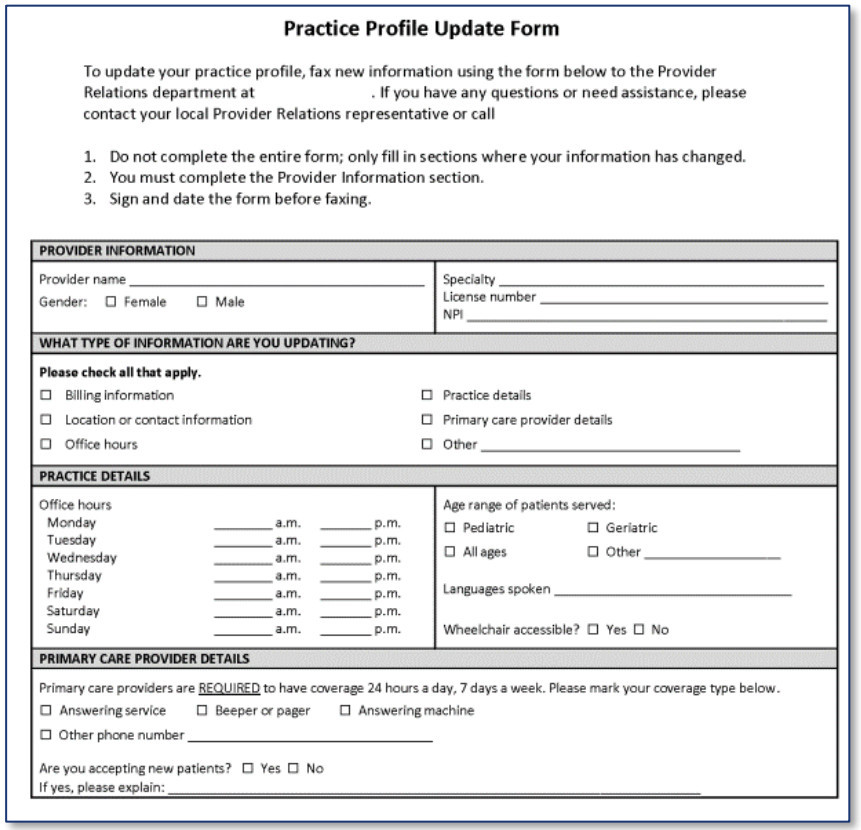
Practice update

Digital resource through Availity Essentials (https://Availity.com)

Applicable changes include the following:

- Change in practice name
- Adding or updating site, billing/remit, email address, phone, or fax number
- Change to tax ID (newly signed contract required)
- Change to provider name
- Adding or removing a provider
- Adding NPI, Medicare, or Medicaid numbers
- Initiating the Council for Affordable Quality Healthcare (CAQH) numbers for new providers

Paper: Submit information changes to us at https://www.provider.wellpoint.com/dc.



Practice Profile Update Form

To update your practice profile, fax new information using the form below to the Provider Relations department at . If you have any questions or need assistance, please contact your local Provider Relations representative or call

1. Do not complete the entire form; only fill in sections where your information has changed.
2. You must complete the Provider Information section.
3. Sign and date the form before faxing.

PROVIDER INFORMATION

Provider name _____
Gender: ☐ Female ☐ Male

Specialty _____
License number _____
NPI _____

WHAT TYPE OF INFORMATION ARE YOU UPDATING?

Please check all that apply.

☐ Billing information
☐ Location or contact information
☐ Office hours
☐ Practice details
☐ Primary care provider details
☐ Other _____

PRACTICE DETAILS

Office hours

Monday	_____ a.m.	_____ p.m.
Tuesday	_____ a.m.	_____ p.m.
Wednesday	_____ a.m.	_____ p.m.
Thursday	_____ a.m.	_____ p.m.
Friday	_____ a.m.	_____ p.m.
Saturday	_____ a.m.	_____ p.m.
Sunday	_____ a.m.	_____ p.m.

Age range of patients served:
☐ Pediatric ☐ Geriatric
☐ All ages ☐ Other _____

Languages spoken _____

Wheelchair accessible? ☐ Yes ☐ No

PRIMARY CARE PROVIDER DETAILS

Primary care providers are REQUIRED to have coverage 24 hours a day, 7 days a week. Please mark your coverage type below.
☐ Answering service ☐ Beeper or pager ☐ Answering machine
☐ Other phone number _____

Are you accepting new patients? ☐ Yes ☐ No
If yes, please explain: _____

Cultural competency

We are dedicated to providing high-quality, effective, compassionate care. Delivering healthcare to a diverse enrollee population presents many challenges, but we're here to help.

We offer:

- Translation of enrollee materials in multiple languages.
- Telephone and on-site interpreter services through our enrollee services line and local vendors.
- Cultural competency training tips and CME training on our provider website through our Training Academy.
- Guides and resources based on the culturally and linguistically appropriate service (CLAS) standards, and local vendors.

Key contact information

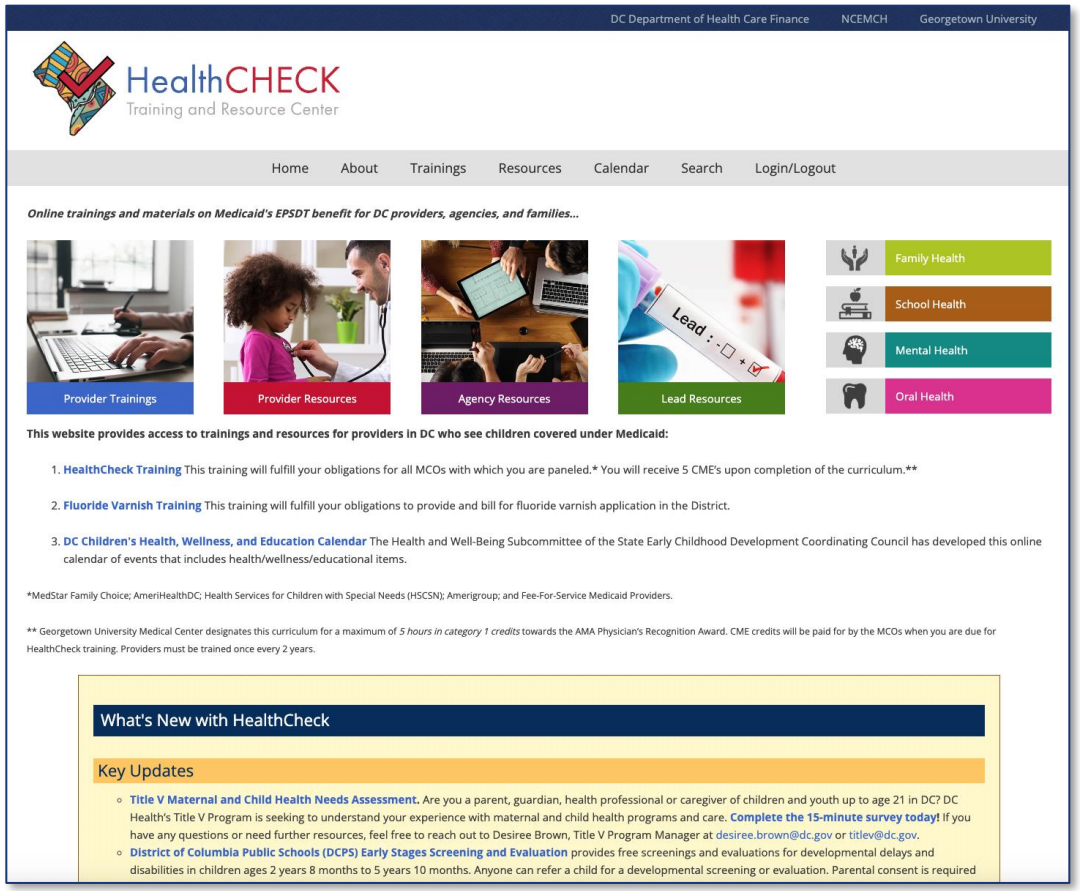
Provider services:	833-359-1386	**Member services:**	833-359-1384 (TTY711)
Website:	https://www.provider.wellpoint.com/dc		
Physical health prior authorization (PA):	Web: Availity Essentials (https://Availity.com)	Pharmacy PA	Phone: **800-454-3730** Fax: **844-487-9292** Medical injectable: **844-487-9294**
	Phone: **800-454-3730**	Behavioral health PA:	Should be submitted electronically using our preferred method via https://Availity.com
Medical authorization fax numbers	Inpatient requests: **844-495-4419** Outpatient requests: **844-495-4421**	Behavioral health authorization request fax numbers	Inpatient requests: **844-445-6647** Outpatient requests: **844-451-2829**
Paper claim submission:	Claims Wellpoint District of Columbia, Inc. P.O. Box 61010 Virginia Beach, VA 23466-1010		
Electronic claim submission:	Availity Essentials EDI gateway: • 837 — institutional claims • 837 — professional claims • 837 — dental claims • 835 — electronic remittance advice • 276/277 — claims status: Batch • 270/271 — eligibility request: Batch	Payer IDs Change Healthcare: 27514 Availity Essentials: 26375	

Required Medicaid ID number

- To get reimbursed for Medicaid, care providers must have a Medicaid number.
- If a potential provider does not have a Medicaid number assigned, we'll work with the provider and the District of Columbia to complete the necessary paperwork and assist the provider with obtaining one.
- You may register for a Medicaid number at dc-Medicaid.com.

HealthCheck/EPSDT training

- HealthCheck care providers must complete the web-based HealthCheck before joining our network and at least every two years thereafter.
- Compliance with HealthCheck training is also a requirement for recredentialing.
- The HealthCheck Training and Resource Center is located at dchealthcheck.net. The HealthCheck provider training module satisfies the EPSDT and IDEA provider training requirements for HealthCheck care providers.



Verifying enrollee eligibility

Always confirm an enrollee's eligibility and PCP of record before providing services:

- Resources for determining the enrollee's specific benefit plan and coverage include the following:
  - Availity Essentials — Eligibility and benefits: (https://Availity.com)
  - Enrollee services: **800-600-444**, Monday to Friday, 8:30 a.m. to 7 p.m. ET
- Real-time enrollee enrollment and eligibility verification for all District of Columbia Medicaid programs is available 24 hours a day, 7 days a week:
  - IVR system: **202-906-8319**
  - Website: dc-medicaid.com/dcwebportal

Claim submission (ERA and EFT)

We require the use of Availity Essentials (https://Availity.com) to submit electronic claims:

- Acknowledges receipt of claims electronically through various reporting options
- Improves claims tracking and inquiry
- Reduces adjudication turnaround time
- Improved auto-adjudication of claims, leading to faster claims payment
- Faster delivery of remittance advice via the electronic 835 transaction (ERA)

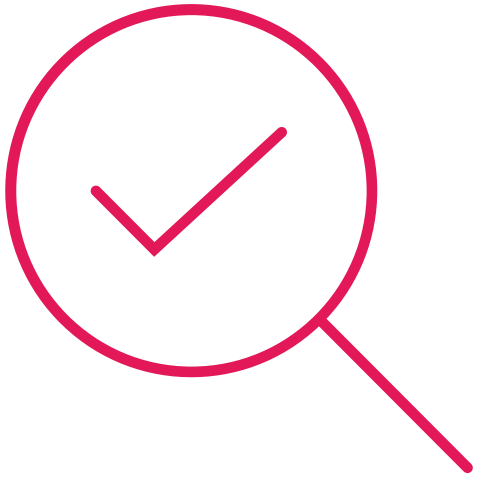
Use EnrollSafe to register and manage EFT account changes:
https://enrollsafe.payeehub.org

Laboratory services

Testing sites must have a Clinical Laboratory Improvement Act/Amendments (CLIA) certificate or a waiver.

Notification or precertification is not required if lab work is performed:

- In a physician's office.
- In a participating hospital outpatient department (for stat services).
- By one of our preferred lab vendors (LabCorp and Quest).

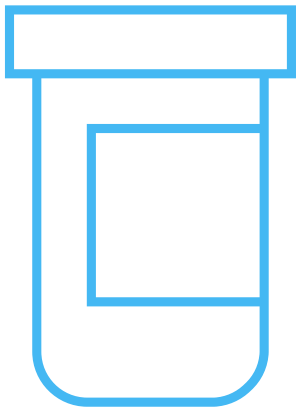


Pharmacy program

The Preferred Drug List (PDL) and formulary are available on our website.

Prior authorization is required for:

- Nonformulary drug requests.
- Brand name medications when generics are available.
- High-cost injectables and specialty drugs.
- Any other drugs identified in the formulary as needing prior authorization.



Note: This list is not all-inclusive and is subject to change.

Balance billing

Medicaid care providers are prohibited from balance billing enrollees. Be sure to submit notification and prior authorization request through Availity Essentials (https://Availity.com) before providing non-covered services.

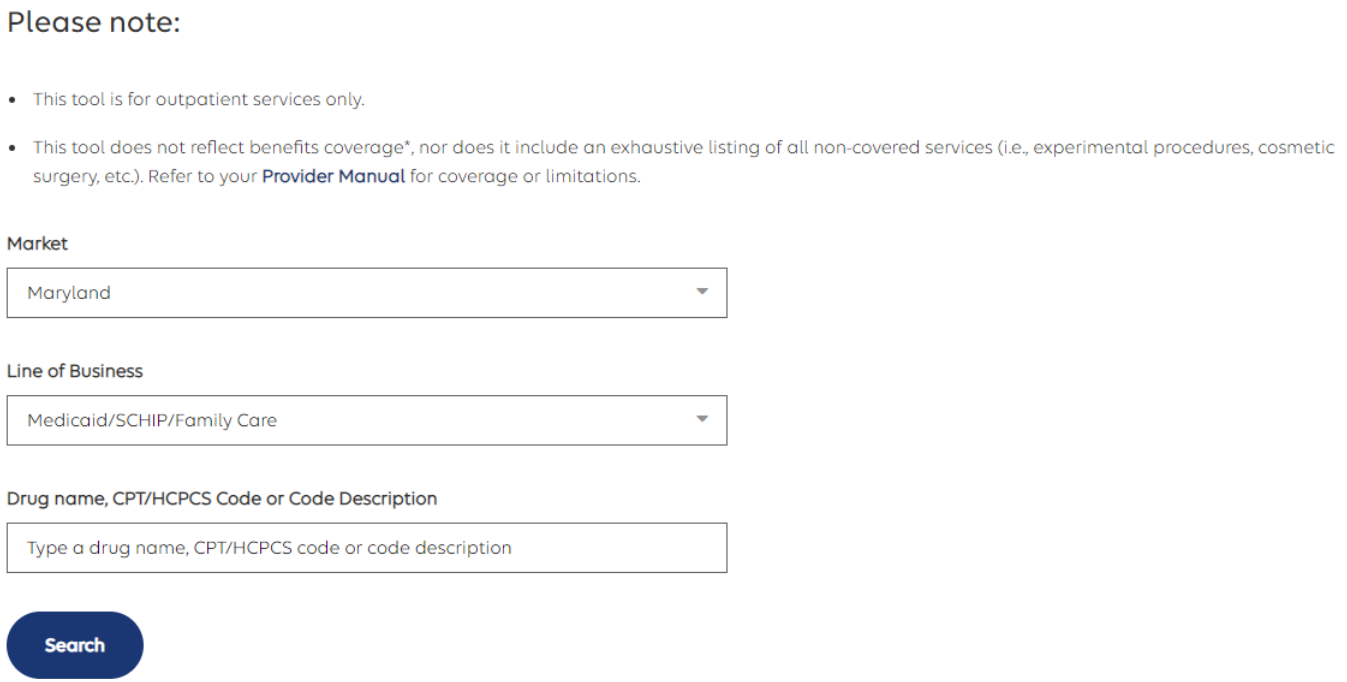
For a list of services requiring prior authorization, please refer to the prior authorization lookup tool online at https://provider.wellpoint.com/dc > **Resources** > **Prior Authorization Requirements**.

Prior authorization lookup tool

Look-up precertification requests via provider website:

Search by Market, Line of Business, or Drug name, CPT®/HCPCS code, or Code Description.

Check the status of your request on Availity Essentials (https://Availity.com).



Medically necessary

Federal and District law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy, and must be considered first when determining eligibility for coverage:

- We use medical policies or UM guidelines to determine whether services are considered to be:
  - Investigational/experimental.
  - Medically necessary.
  - Cosmetic or reconstructive.
- A list of specific medical policies and clinical UM guidelines is posted and maintained at https://provider.wellpoint.com/dc.
- We use evidence-based guidelines (McKesson InterQual criteria) to determine the medical necessity of acute inpatient care and skilled nursing care.

Prior authorization denials/appeals

- If authorization is not granted before the service is provided to the enrollee, either the enrollee or the provider, on behalf of the enrollee, can submit an appeal. When submitted by a provider, this appeal type requires the enrollee's written consent.
- You can file an appeal within 60 calendar days from the notice of denial or adverse benefit determination.
- Appeals are reviewed and resolved within 30 calendar days. A 14-day extension may be approved if additional time is needed.
- Appeals requiring expedited review will be reviewed and resolved within 72 hours of receipt. Expedited appeals are allowed if it is determined that taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.
- Appeals that require an expedited review should only be submitted electronically, as outlined on the next slide. Do not mail an expedited appeal request.
- There is one level of appeal for a denied authorization. If the enrollee or provider filing on behalf of the enrollee disagrees with the appeal decision, they may request a hearing with the District of Columbia. The appeal denial notification letter will include instructions on filing a request, and is also available in the enrollee and provider handbooks.

Submitting pre-service appeals

- Care providers can submit appeals on the enrollee's behalf by logging into Availity Essentials (https://Availity.com). Locate the case on your dashboard or through **Check Case Status**. Select the **Appeal** button from the **Case Overview** screen. The enrollee's consent can be attached to the request for appeal.
- Appeal forms can also be downloaded from https://provider.wellpoint.com/dc and submitted in the following ways:
  - By email to MedicaidDCGA@amerigroup.com
  - By fax to **866-516-4806**
  - By calling Provider Services at **833-359-1386** and requesting that an appeal be created
  - Non-expedited appeals can be mailed to:

    Wellpoint District of Columbia, Inc.
    Member Appeals
    P.O. Box 62429
    Virginia Beach, VA 23466-2429
- Enrollees can also submit an appeal online via a secure website or mobile application for new enrollees.

Provider post service/retrospective appeals

- If services have been rendered to the enrollee, care providers should file the claim along with medical records and an explanation of any extenuating circumstances for not submitting the prior authorization, and a medical necessity review will be completed:
  - If a provider is dissatisfied with the outcome of an initial medical necessity review as part of the claim submission, they can file an appeal.
- Claims not eligible for reimbursement because of a medical necessity review previously were not eligible for reimbursement. The preauthorization request can also be appealed to request another review of the medical rationale for providing the service.
- If the appeal decision results in a claim adjustment, the payment and Explanation of Payment will be sent separately from the appeal decision.
- Provider authorization/UM appeals can be submitted in the following ways:
  - Digitally using Interactive Care Reviewer accessed through Availity Essentials at https://Availity.com
  - Fax directly to the appeals department at **866-587-3316**
- Appeals must be submitted within 60 calendar days from the initial date; they are not eligible for reimbursement. We will send the provider a written acknowledgment of the appeal within two business days of receipt.
- We will respond to appeals associated with a claim not eligible for reimbursement within 30 days.

Submitting post service appeals

- Care providers can submit a claim (no authorization requested) reconsideration through Availity Essentials (https://Availity.com) by selecting claim payment appeal, and the initial medical necessity review will be completed:
  - Select the **Dispute** button in **Claim Status** to initiate and navigate to the appeals tool to add documents and complete.
- Care providers who do not agree with a medical necessity decision can file an appeal for a second review of the case.
- Care providers can request a medical necessity appeal by logging into Availity Essentials (https://Availity.com) and accessing the **Authorization in ICR** — select appeal decision.
- Appeal forms can also be downloaded from https://provider.wellpoint.com/dc and submitted in the following ways:
  - By email to MedicaidDCGA@amerigroup.com
  - By fax to **866-516-4806**
  - By calling Provider Services at **833-359-1386**, requesting that an appeal be created
  - By mailing to:

    Wellpoint District of Columbia, Inc.
    Member Appeals
    P.O. Box 62429
    Virginia Beach, VA 23466-2429

Grievances

- Submit requests and inquire on medical and behavioral health pre-authorizations by accessing Availity Essentials (https://Availity.com).
- Submit appeals of not eligible for reimbursement authorizations by locating the case on your dashboard or selecting **Check Case Status**. Then select the **Appeal** button from the **Case Overview** screen. Add additional documents needed for the appeal, including an enrollee consent form.
- The status of your appeal can be found within Availity Essentials (https://Availity.com). Select the appeal case number provided on the appeal acknowledgment letter.

Rejected versus denied claims

There are two notice types you may receive in response to your claims submission:

Rejected	Denied
Does not enter the adjudication system due to missing or incorrect information. Please review electronic response reports for rejections.	Goes through the adjudication process but is denied for payment.

You can find claims status information at https://Availity.com or by calling Provider Services at **833-359-1386**.

Provider claims payment/dispute process

Care providers may access a timely claims/payment dispute resolution process.

- A claims/payment dispute is a claim or any portion of a claim that is not eligible for reimbursement for any reason or is underpaid. We must receive payment disputes within 90 business days of the Explanation of Payment (EOP) paid date.
- The provider must submit a written request including:
  - An explanation of the issue in dispute.
  - The reason for the dispute and all supporting documentation (medical records).
  - The EOP.
  - A copy of the claim.

To submit a payment dispute:

- The preferred method is through Availity Essentials at https://Availity.com, or
- Complete the Payment Dispute Form located online at https://www.provider.wellpoint.com/dc and mail it to:

  Wellpoint District of Columbia, Inc.
  Payment Dispute Unit
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Condition care

Health promotions services:

800-964-2112 ext. 44120

Case management enrollee referrals:

833-346-1663

Disease management enrollee referrals:

888-830-4300

Patient- and family-centered care

Patient- and family-centered care is an innovative approach to the planning, delivering, and evaluating healthcare grounded in a mutually beneficial partnership among enrollees, families, and care providers.

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Enrollee benefits and services

- Coordination of care where applicable
- Initial health assessments
- Physician office visits — inpatient and outpatient services
- Durable medical equipment and supplies
- Emergency services
- Case management and utilization management where applicable
- Pharmacy benefits through CarelonRx, Inc.

New enrollees also receive a welcome letter, enrollee handbook, and provider directory.

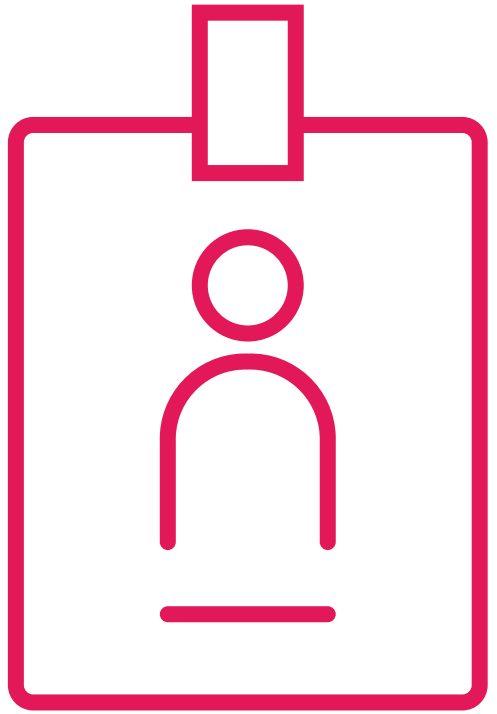
Detailed benefits and services information is available in the provider manual at https://provider.wellpoint.com/dc.

PCP selection

Enrollees:

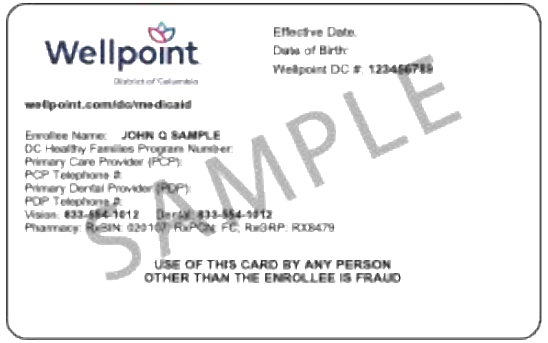
- Must select an in-network PCP.
- Can change their PCP at any time (must call enrollee services or complete PCP change form).
- Can see an in-network specialist without a referral.

Note: A PCP is only paid if they are the PCP of record.



Enrollee card template guidelines

DC Healthy Families Program



Immigrant Children's Program

DC Healthcare Alliance Program

Access and availability

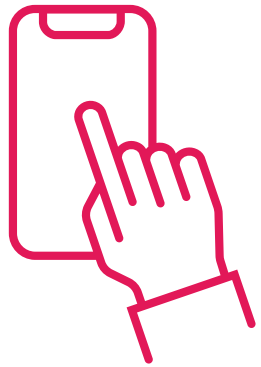
Measure	Standard
PCP/pediatrician provider access standards	
Appointment availability	Routine care visit must be available within 30 calendar days of request.
	Urgent care visit must be available within 24 hours of request.
	Enrollees must have access to talk to a medical professional via phone within 30 minutes of request.
	Initial EPSDT screenings must be offered within 60 days of the enrollee's enrollment with us or earlier if needed (in other words, to comply with the periodicity schedule. A more rapid assessment may be required if a request results from an emergency medical condition).
	All initial EPSDT screenings must be completed within three months of enrollment with us unless the enrollee is up-to-date with the periodicity schedule.
	All EPSDT screenings, tests, and immunizations must be completed within 30 days of their due dates for children under two years of age and within 60 days of their due dates for children two years and older.
	Periodic EPSDT screening exams must take place with 30 days of request.
	IDEA multidisciplinary assessments must be completed within 30 days of request. Needed treatments shall begin within 25 days of receipt of a completed and signed Individualized Family Service Plan Assessment.
Geo access	Two providers within 30 minutes or five miles of an enrollee's home
	One provider per 500 enrollees
Specialty provider access standards	
Appointment availability	Routine care visit must be available within 30 calendar days of request.
	Prenatal/post partum/family planning care visit must be available within two weeks or 10 business days.
Geo access	One provider within 30 minutes or five miles of an enrollee's home.
	One provider per 3,500 enrollees

Access and availability (cont.)

Measure	Standard
Behavioral health access standards	
Appointment availability	Services for the assessment and stabilization of psychiatric crises must be available 24/7
	Phone-based assessment must be provided within 15 minutes of request
	When medically necessary, intervention or face-to-face assessment must ben provided within 90 minutes of completion of the phone assessment
	Initial routine care visit must be within two weeks or 10 business days of request
	Follow-up Care visits must be within 30 calendar days
	Nonlife-threatening emergency visit within six hours
Geo access	One provider within 30 minutes or five miles of an enrollee's home
	One provider per 15,000 enrollees
Hospital access standards	
Geo access	One location within 30 minutes or five miles of an enrollee's home
	One location per 3,500 enrollees
Laboratory access standards	
Geo access	One location within 30 minutes or five miles of an enrollee's home
Pharmacy access standards	
Geo access	Two locations within two miles of an enrollee's home
	One provider available 24 hours a day/7 days a week
	One provider providing home delivery within four hours
	One provider offering mail-order service
Dental access standards	
Geo access	One dental provider per 750 pediatric enrollees
	One dental provider with fully open patient panel per 750 enrollees
	One pediatric dental provider within 30 minutes or five miles of a pediatric enrollee's home
	One dental provider within 30 minutes or five miles of an enrollee's home

24-hour Nurse HelpLine

- Enrollees can speak to a registered nurse who can answer their questions and help them decide how to treat any health problems.
- Our nurses can help an enrollee decide where to go if care is needed.
- The phone number is located on the back of our enrollee ID cards.
- Enrollees can call Nurse HelpLine for health advice seven days a week, 365 days a year. When an enrollee uses this service, a report is faxed to the Wellpoint DC office within 24 hours of receipt of the call.



Nurse HelpLine

866-864-2544 (TTY 711)

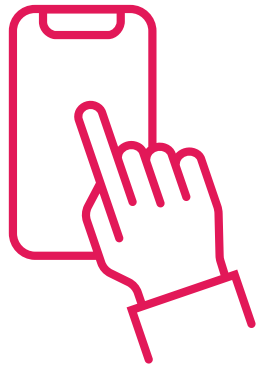
866-864-2545 (Spanish)

Benefit partners

Contact name	Contact information
AVESIS (vision and dental services)	Provider Services: **833-554-1013** Enrollee Services: **833-554-1012** Claims Department: P.O. Box 38300 Phoenix, AZ 85069
CarelonRx (pharmacy services)	General phone: **833-235-2029** Prior authorization (PA) phone: **800-454-3730** Retail PA fax: **844-487-9292** Medical injectable PA fax: **844-487-9294**

Interpreter and translation services

- We offer interpreter services, telephonic translations, and in-person translations in about 170 languages. Our interpreters are formally trained and fluent in communicating in the enrollee's primary, non-English language.
  - We recommend arranging services for in-person translation at least 24 hours before the appointment.
- Interpreters who provide communication for deaf or hard-of-hearing enrollees should be offered to enrollees who need these services.
  - Enrollees should call the AT&T Relay Service at **TTY 711** at least five days before the scheduled appointment. We will then set up and pay for a person who knows sign language to help during the office visit.



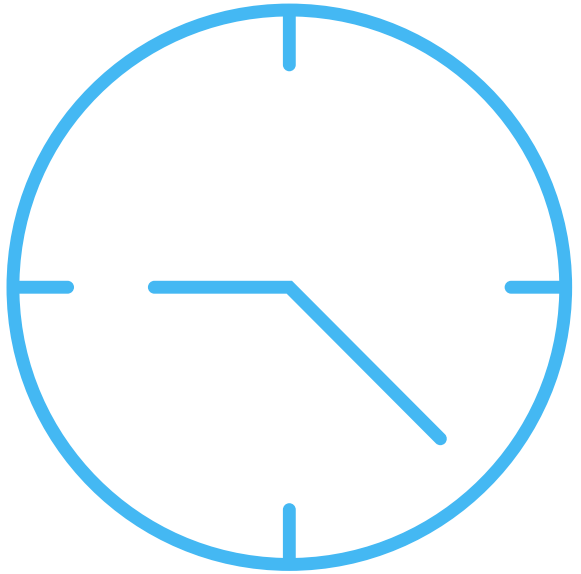
Enrollee Services

800-600-4441

MTM nonemergency transportation services

Enrollees can call the MTM Call Center to schedule trips, change trip details (time/date/additional passengers), and cancel their rides.

- MTM Call Center: **888-828-1183**
  Monday to Friday, 7 a.m. to 10 p.m. ET
  Saturday, 7 a.m. to 6:30 p.m. ET
  tphelpdesk@mtm-inc.net



Value-added services

Expanded programs and services provide opportunities to help care for the whole person and better address the specific needs of each population segment.

For staying healthy	• $50 in over-the-counter medicines • Weight Watchers® vouchers to help eligible enrollees lose weight • Baby & Toddler Essentials up to $200 • DCHFP app to find doctors, access enrollee ID cards, and send them to a physician if needed
For getting better	• Digital mental health toolkit — a mental health and well-being app • Call to get health advice from a nurse day or night • Disease management programs to help enrollees with special health conditions set goals and manage their health
For living healthy	• Free memberships for children ages 6 to 18 at the Boys & Girls Clubs of Greater Washington (District of Columbia locations) • General education development (GED) test vouchers for qualified enrollees 18 and up • Enrollees will be able to select asthma and allergy relief products from a catalog

Behavioral health

- Our mission is to coordinate enrollees' physical and behavioral health (BH) care, offering a continuum of targeted interventions, education, and enhanced access to care to ensure improved outcomes and quality of life for Wellpoint DC enrollees.
- BH services include a robust array of mental health and substance use disorder services.
- We collaborate with healthcare providers, community mental health centers (CMHCs), the D.C. Department of Behavioral Health (DBH), substance use disorder providers, and various community agencies and resources to successfully meet the needs of enrollees with mental health (MH) and substance use disorders (SUDs).
- For resources to support patients with BH needs or to learn opportunities to identify these needs, please visit: https://tinyurl.com/4zmu9k2p.

Integration of behavioral health and physical health

- Integrated physical health/behavioral health case management training for all case managers
- Integrated quality management committee and medical advisory group
- One integrated IT system for both physical and behavioral health — health insights platform (HIP)
- Behavioral case management, including enrollees with co-occurring disorders

My Health GPS Program benefit

MyHealth GPS Program is designated as a Health Home under the authority of Section 1945 of the Social Security Act, aimed as District Medicaid enrollees with three or more qualifying chronic conditions. It is part of the District of Columbia's Medicaid initiatives that emphasize personalized, person-centered case management and care coordination. The program seeks to address the unmet care management needs of enrollees who have experienced preventable use of emergency services, avoidable emergency department visits, hospital admissions, potentially preventable readmissions and poor health outcomes. My Health GPS services will be provided by an interdisciplinary team within the primary care setting, facilitation patient-centered and population-focused care for these enrollees

My Health GPS health home benefit

Enrollees are eligible for My Health GPS if they have three or more of the following chronic health conditions:

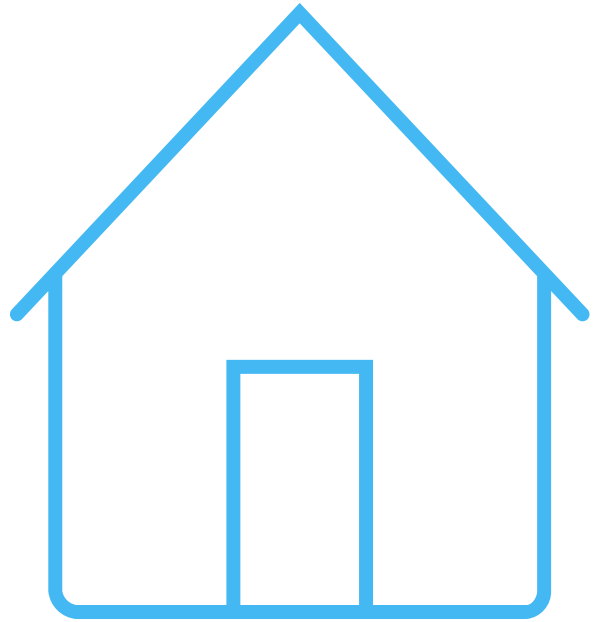
- Mental health conditions (depression, personality disorder)
- Substance use disorder
- Diabetes
- Chronic renal failure (on dialysis)
- Hyperlipidemia
- Heart disease (congestive heart failure)
- Hypertension
- Sickle cell anemia
- Asthma
- Chronic obstructive pulmonary disease
- Cerebrovascular disease
- Morbid obesity
- Hepatitis
- HIV
- Malignancies
- Paralysis
- Peripheral atherosclerosis

Health home benefits

Core health home services include:

- Comprehensive care management.
- Care coordination.
- Transitions in care.
- Support for individual and family enrollees.
- The facilitation of referrals to community services and supports.
- Health promotion and self-care.

The district identifies eligible enrollees and assigns them to a health home provider. To refer an enrollee to a health home, call the DC Access HELPLINE at **888-7WE-HELP** (**888-793-4357**).



Office of the Healthcare Ombudsman and Bill of Rights

The District of Columbia's Office of the Healthcare Ombudsman and Bill of Rights:

- Advises enrollees and helps them understand healthcare rights and responsibilities.
- Helps enrollees solve problems with healthcare coverage, healthcare access, and healthcare bill issues.
- Advocates for enrollees until their healthcare needs are addressed and fixed.
- Guides enrollees towards the appropriate private and government agencies when needed.
- Helps enrollees with appeals processes.
- Tracks healthcare problems and reports patterns to help fix what is causing the problem.

Fraud, waste, and abuse

Please help us prevent fraud, waste, and abuse, and tell us if you suspect it:

- Verify an enrollee's identity.
- Ensure services are medically necessary.
- Document medical records completely.
- Bill accurately.

Reporting fraud, waste, and abuse is required. If you suspect or witness it, please tell us immediately:

- Visit the provider website and complete the Report Waste, Fraud, and Abuse form.
- Call the SIU Hotline at **866-847-8247** or fill out the form at https://fighthealthcarefraud.com
- Call the External Anonymous Compliance Hotline at **877-725-2702**
- Email corpinvest@amerigroup.com or obe@amerigroup.com
- Contact the Department of Health Care Finance:
  Division of Program Integrity
  441 4th Street NW, Washington, DC 20001
  Phone: **202-698-2000**
  Fraud Hotline: **877-632-2873**

Provider roles and responsibilities

- Provide preventive health screenings if you're a DCHFP PCP.
- Provide culturally competent care, with no discrimination whatsoever, complying with ADA standards.
- Maintain and support access standards (for example, wheelchair accessibility).
- Notify us of changes, such as billing address, name, full panel, and the like.
- Encourage advance directives, educating enrollees on their importance.
- Comply with HIPAA requirements and recordkeeping standards in all transactions, including medical records.
- Promote preventive care services to all enrollees.
- Identify behavioral health needs and participate in collaborative care.

Key enrollee responsibilities

Our enrollees have the responsibility to:

- Present their health plan ID card each time they receive medical care.
- Make or change appointments and get to them on time.
- Call their physician if they cannot make it to their appointment or will not be on time.
- Use the emergency room only for true emergencies.
- Pay for any services that Medicaid does not cover.
- Treat their physician and other healthcare care providers with respect.
- Tell us, their physician, and other healthcare care providers what they need to know to treat them.
- Follow the treatment plans that the enrollee, the physician, and other healthcare providers agree on.

Note: This is not a complete list; refer to your provider manual for a full listing and additional details.

HIPAA compliance

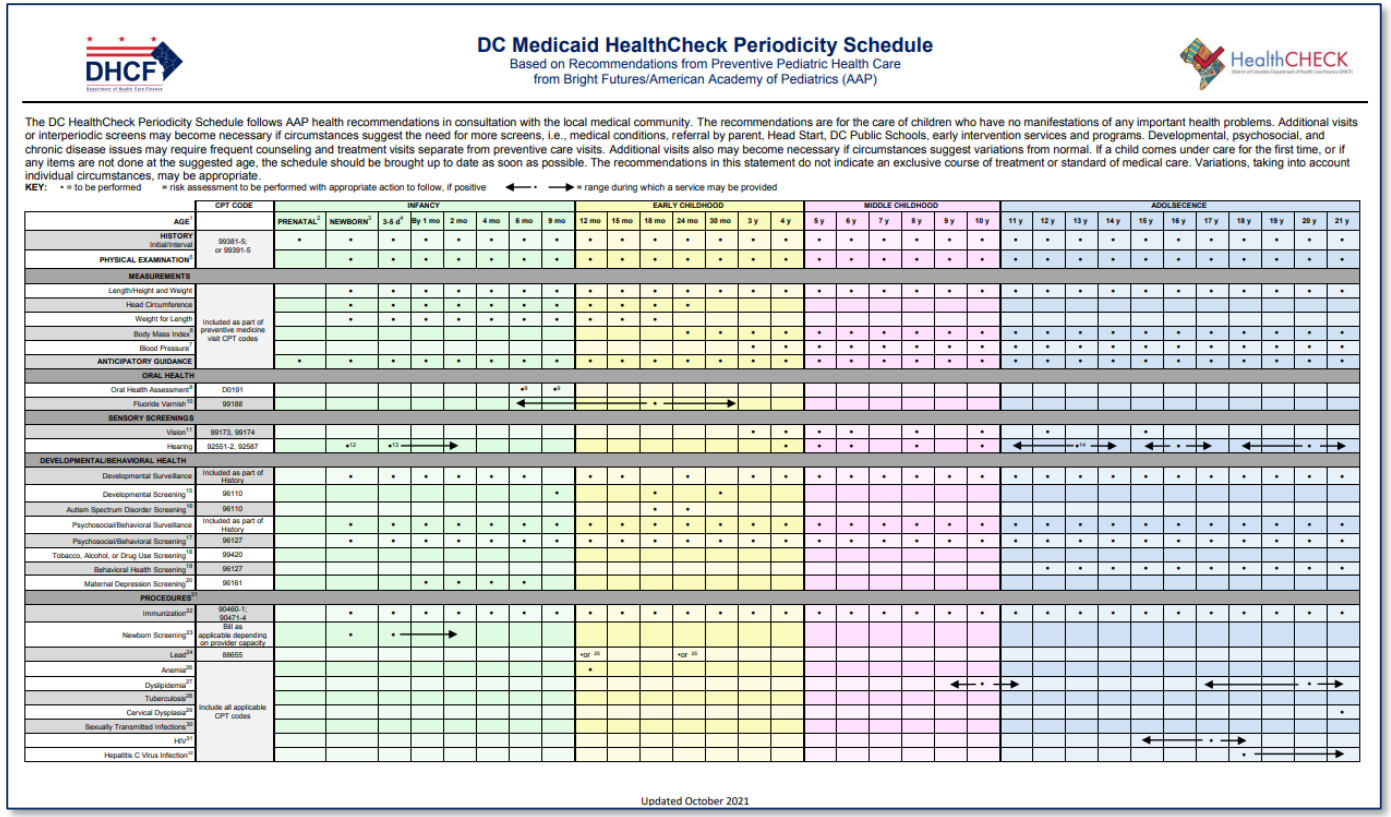
- HIPAA was signed into law in August 1996. This legislation improves the portability and continuity of health benefits, ensures greater accountability in healthcare fraud, and simplifies health insurance administration.
- We strive to ensure our organization and our contracted, participating care providers conduct business in a manner that safeguards enrollee information per HIPAA privacy regulations.

Individuals with Disability Education Act

- Individuals with Disability Education Act (IDEA) is a law that ensures that services to children with disabilities are provided throughout the nation. IDEA governs how states and public agencies provide early intervention, special education, and related services to more than 6.5 million eligible infants, toddlers, children, and youth with disabilities.
- Infants and toddlers with disabilities (birth through age two) and their families receive early intervention services under IDEA Part C. Children and youth (ages 3 to 21) receive special education and related services under IDEA Part B.
- PCPs evaluate the child to determine the need for services.
- If a child needs IDEA services, the PCP refers to the District's Early Intervention Program.
- Website: https://tinyurl.com/y92v4yde

Early and periodic screening, diagnostic, and treatment (EPSDT)

PCPs are responsible for providing EPSDT services to enrollees from birth to age 21 in compliance with the District of Columbia Periodicity Schedule and Salazar v. the District of Columbia Et Al.



DHCF

DC Medicaid HealthCheck Periodicity Schedule

Based on Recommendations from Preventive Pediatric Health Care from Bright Futures/American Academy of Pediatrics (AAP)

HealthCHECK

The DC HealthCheck Periodicity Schedule follows AAP health recommendations in consultation with the local medical community. The recommendations are for the care of children who have no manifestations of any important health problems. Additional visits or interperiodic screens may become necessary if circumstances suggest the need for more screens, i.e., medical conditions, referral by parent, Head Start, DC Public Schools, early intervention services and programs. Developmental, psychosocial, and chronic disease issues may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal. If a child comes under care for the first time, or if any items are not done at the suggested age, the schedule should be brought up to date as soon as possible. The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

KEY: • = to be performed = risk assessment to be performed with appropriate action to follow, if positive ←• = range during which a service may be provided

	CPT CODE	INFANCY							EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLSECENCE										
AGE[1]		PRENATAL[2]	NEWBORN[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	99381-5; or 99391-5	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION[2]			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																																	
Length/Height and Weight	Included as part of preventive medicine visit CPT codes		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference			•	•	•	•	•	•	•	•	•	•	•																				
Weight for Length			•	•	•	•	•	•	•	•	•	•																					
Body Mass Index[5]													•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure[6]															•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ANTICIPATORY GUIDANCE		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ORAL HEALTH																																	
Oral Health Assessment[7]	D0191							•8	•9																								
Fluoride Varnish[10]	99188							←	→			•	→																				
SENSORY SCREENINGS																																	
Vision[11]	99173, 99174														•	•	•	•		•		•		•			•						
Hearing	92551-2, 92587		•12	•13 →												•	•	•		•		•	←•14 →			←• →				←• →		
DEVELOPMENTAL/BEHAVIORAL HEALTH																																	
Developmental Surveillance	Included as part of History		•	•	•	•	•	•		•	•		•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Developmental Screening[15]	96110								•				•		•																		
Autism Spectrum Disorder Screening[16]	96110											•	•																				
Psychosocial/Behavioral Surveillance	Included as part of History		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Psychosocial/Behavioral Screening[17]	96127		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol, or Drug Use Screening[18]	99420																																
Behavioral Health Screening[19]	96127																							•	•	•	•	•	•	•	•	•	•
Maternal Depression Screening[20]	96161				•	•	•	•																									
PROCEDURES																																	
Immunization[22]	90460-1; 90471-4		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Newborn Screening[23]	Bill as applicable depending on provider capacity		•	• →																													
Lead[24]	88655									•or 25			•or 25																				
Anemia[26]	Include all applicable CPT codes									•																							
Dyslipidemia[27]																					← • →							←• →				
Tuberculosis[28]																																	
Cervical Dysplasia[29]																																	•
Sexually Transmitted Infections[30]																																	
HIV[31]																											← • →						
Hepatitis C Virus Infection[32]																														•→			

Updated October 2021

CarelonRx, Inc. is a separate company providing utilization review services on behalf of the health plan.

Coverage provided by Wellpoint District of Columbia, Inc.

DCWP-CD-084411-25-SRS84411 | July 2025