DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, HEPATITIS, STD, & TB ADMINISTRATION

District of Columbia Department of Health Ryan White HIV/AIDS Program Policies and Procedures **Retroactive Medicaid Billing**		**Policies and Procedures** Implementing Office: HAHSTA Care and Treatment Division Ryan White HIV/AIDS Program (RWHAP) Training Required: No Originally Issued: December 13, 2023 Revised/Reviewed: January 29, 2025
Program Approval: Ebony Fortune Ryan White Program Manager	**Recipient Authorization:** Avemaria Smith Ryan White Recipient	**Effective Date:** *December 13, 2023* **Valid Through Date:** *February 28, 2027*

I. SUBJECT

Retroactive Medicaid Billing

II. PURPOSE

The purpose of this policy document is to provide guidance on ensuring Medicaid is back billed for services delivered during the retroactive Medicaid eligibility period defined under Title XIX of the Social Security Act, Section 1902 (a) (34).

III. Definitions and Acronyms

Adjustment – a transaction that changes any information on a claim that has been paid. An adjustment transaction credits a credit record, which reversed the original claim payment, and a debit record that replaces the original payment with a corrected amount, usually due to a billing or processing error.

Back-billing – a billing made to collect an expense incurred in a previous billing period.

Billing entity – a business whose only significant activity is invoicing and collecting payments for professional medical services on behalf of an Affiliated Medical Group or a Subsidiary and transfers all its revenue on a regular basis to such.

Claim – a submission requesting payment for specific services rendered to a recipient by the Billing provider.

Eligibility – having the necessary qualities or satisfying the necessary conditions.

Medicaid – the District of Columbia's medical assistance program, provided under a state plan which has been approved by the U.S. Department of Health and

	Human Services under Title XIX of the Social Security Act. **Payor of Last Resort** – an entity that pays after all other programs have been pursued for enrollment and payment. **Provider** – a person, business, or facility currently licensed under the law of any state and enrolled in Medicaid to practice medicine, osteopathy, dentistry, podiatry, optometry, or to provide other Medicaid approved services and has entered into an agreement with the District of Columbia's Medicaid program to provide such services. **Retroactive Medicaid Eligibility Period** – three months prior to the Medicaid application dates if the individual would have been eligible during that period had he or she applied.
IV. Procedures	Medicaid back-billing is an effective process for ensuring compliance with "payor of last resort" requirements. Pass-thru Entities, such as HAHSTA, and its subrecipients are required to ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service— (i) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or (ii) (ii) by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Service). HAHSTA and its subrecipients fulfill this mandate by coordinating eligibility screening by back-billing any grant-related funds used to pay for a client service for which the other payer is liable. HAHSTA and its subrecipients must have policies in place for service eligibility determination and back-billing for Medicaid eligible services during the client's retroactive Medicaid eligibility period. *Identify Eligibility* The eligibility screening process (including annual and semi-annual recertification) determines whether a client is eligible for Medicaid retroactively. The retroactive Medicaid eligibility period includes the three months before the Medicaid application date should the client be eligible during that period had he or she applied. Medicaid claims can be filed within 365 days after the service date in the District of Columbia. To receive reimbursement requires coordinated efforts between the service provider, the billing entity, and Medicaid.

	Methodology There are several methods to back-bill Medicaid for services provided to clients during the retroactive Medicaid eligibility period. Implementing an established service eligibility determination process for identifying Medicaid eligibility clients is crucial for Medicaid back-billing. Once the individual is identified as being Medicaid eligible, the client is notified to use their Medicaid for services received. Once identified, HAHSTA, the subrecipient, or the billing entity bill Medicaid for claims processed during the retroactive Medicaid coverage period. The claims can be adjusted to ensure Medicaid is the payer, reversed, and/or the actual charges can be credited back to the service provider. It is, if applicable, HAHSTA's, the subrecipients', or the billing entity's responsibility to ensure all systems are updated regularly to prevent future payment of claims against non-Medicaid funding resources. *Annual Review* During the Annual Comprehensive Site Visit, HAHSTA's Grants Management Specialist is responsible for reviewing the subrecipient's policies and procedures in place for service eligibility determination and Medicaid back billing, and the general ledger for the recorded adjustments made for any Medicaid back-billing during the annual review period. The subrecipient is responsible for ensuring it fully implements and follows the policies and procedures in place and provides recorded documentation to support its actions and transactions.
VI. Key Contacts	Ebony Fortune, MPH, Ryan White HIV/AIDS Program Manager, 202.671.4900 or ebony.fortune@dc.gov Janice Carroll, MBA, Supervisory Grants Management Specialist, 202.671.4900 or janice.carroll@dc.gov
VII. Related Documents, Forms and Tools	HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) 13-01, "Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by the Ryan White HIV/AIDS Program" HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) 21-02, "Clarifications on Ryan White HIV/AIDS Program Client Eligibility Determinations and Recertification Requirements" Title XIX of the Social Security Act, Section 1902 (a) (34).