LOGISTICS

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Transforming Maternal Health (TMaH) Webinar:

Managed Care Plan (MCP) Essentials for Doulas, Part 2

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PRESENTED BY:
Zipatly Mendoza, MPH
Felicia Sears
April Edwards, MHA

Tuesday, September 8, 2026
11:30 AM–12:30 PM ET

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF). This project is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS). A total of $1,527,057.67, or 57 percent, of the project is financed with federal funds, and $1,147,478.36, or 43 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS or the U.S. Government.

DHCF Department of Health Care Finance

HMA

TODAY'S AGENDA

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- Welcome and Session Orientation
- Part 1 Recap and Resources
- Revenue Cycle Basics
- Appeals and Reconciliations
- Reminders and Next Steps

Image Source: Microsoft 365 Stock Photos

LEARNING OBJECTIVES

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Explain key stages of the revenue cycle process, from patient registration through final payment reconciliation.

Classify the difference between reconsiderations and appeals, including best practices to reduce denials and support clean claims.

Describe required documentation to support an appeal and MCP billing activities within their practices.

Identify top three denials and common steps missed within the revenue cycle process that impact reimbursement.

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Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A	N/A

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- Health Management Associates (HMA), #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. HMA maintains responsibility for this course. ACE provider approval period: 09/22/2025–09/22/2028. ***Social workers completing this course may receive 1 continuing education credit – review is still pending.***
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- The American Academy of Family Physicians (AAFP) has reviewed Integrated Care DC Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 05/12/2026 to 05/11/2027. Physicians should claim only the credit commensurate with the extent of their participation in the activity. ***This session is pending review for approval for 1 Online Only, Live AAFP Prescribed credit.***
  - **<u>If you would like to receive CME credit, the online evaluation will need to be completed</u>.**
  - You will receive a link to the evaluation shortly after this webinar.
- Certificates of completion will be emailed within 12 business days of course completion.

PART 1 RECAP AND RESOURCES

CREDENTIALING AND CLAIMS: KEY TAKEAWAYS

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1 MCP CREDENTIALING

Shared Credentialing Foundation

- Prepare core documentation, including National Provider Identifier (NPI), business and tax documents, doula certification, and liability insurance.
- Follow each MCP's submission process and contact pathway.
- Note that processes complete applications within 120 days.

AmeriHealth Caritas DC

- Relies heavily on Council for Affordable Quality Healthcare, Inc. (CAQH), with applicants authorizing AmeriHealth to access their information.
- Requires a Provider Intake Data Form and supporting documents submitted by email.
- Coordinates contracting through Provider Services alongside credentialing review.

MedStar Family Choice DC

- Uses a plan-specific Doula Data Request Form.
- Requires the form and supporting credentialing documents to be submitted through the MedStar pathway.
- Directs application status questions to Provider Relations.

2 CMS 1500 CLAIM SUBMISSION

- Organize the claim around patient, service, and provider information.
- Match demographics to the member's insurance card.
- Use current diagnosis and procedure codes, modifiers, units, and diagnosis pointers.
- Enter the individual rendering provider NPI separately from the billing provider or facility NPI.
- Note that accurate CMS 1500 completion supports clean claim submission.

IMPLEMENTATION RESOURCES

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CMS 1500 Form Guidance

Credentialing Checklist

Image Source: Microsoft 365 Stock Photos

DHCF PROVIDER INQUIRY FORM

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- The DHCF Provider Inquiry Form enables providers to escalate outstanding concerns related to provider relations activities and payments of the MCPs directly to DHCF.
  - The form can be used for concerns related to claims, credentialing, appeals and grievances, and utilization management.
- Inquiries are channeled to the appropriate MCP for review and resolution.
  - The inquiry is automatically escalated to DHCF's Health Care Delivery Management Administration after five (5) business days if the MCP fails to respond.
- For additional informational, please refer to the following transmittals:
  - Transmittal 23-43: Provider Network Communication Tool: Provider Inquiry Form
  - Transmittal 26-20: Updated Access Link - Provider Network Communication Tool: Provider Inquiry Form

REVENUE CYCLE BASICS

REVENUE CYCLE MANAGEMENT

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Revenue Cycle Flow (Revenue Cycle Management) is the process that tracks revenue from the initial customer interaction through payment collection. It is especially important in healthcare, but the concept applies to many industries.

Why Revenue Cycle Flow Is Important

- Ensures steady cash flow
- Improves financial performance
- Enhances operational efficiency
- Improves the patient experience
- Supports compliance
- Enables better decision-making

Key Benefits

- Faster revenue collection
- Reduced claim denials and billing errors
- Improved financial stability
- Better resource utilization
- Increased patient satisfaction

REVENUE CYCLE MANAGEMENT FLOW

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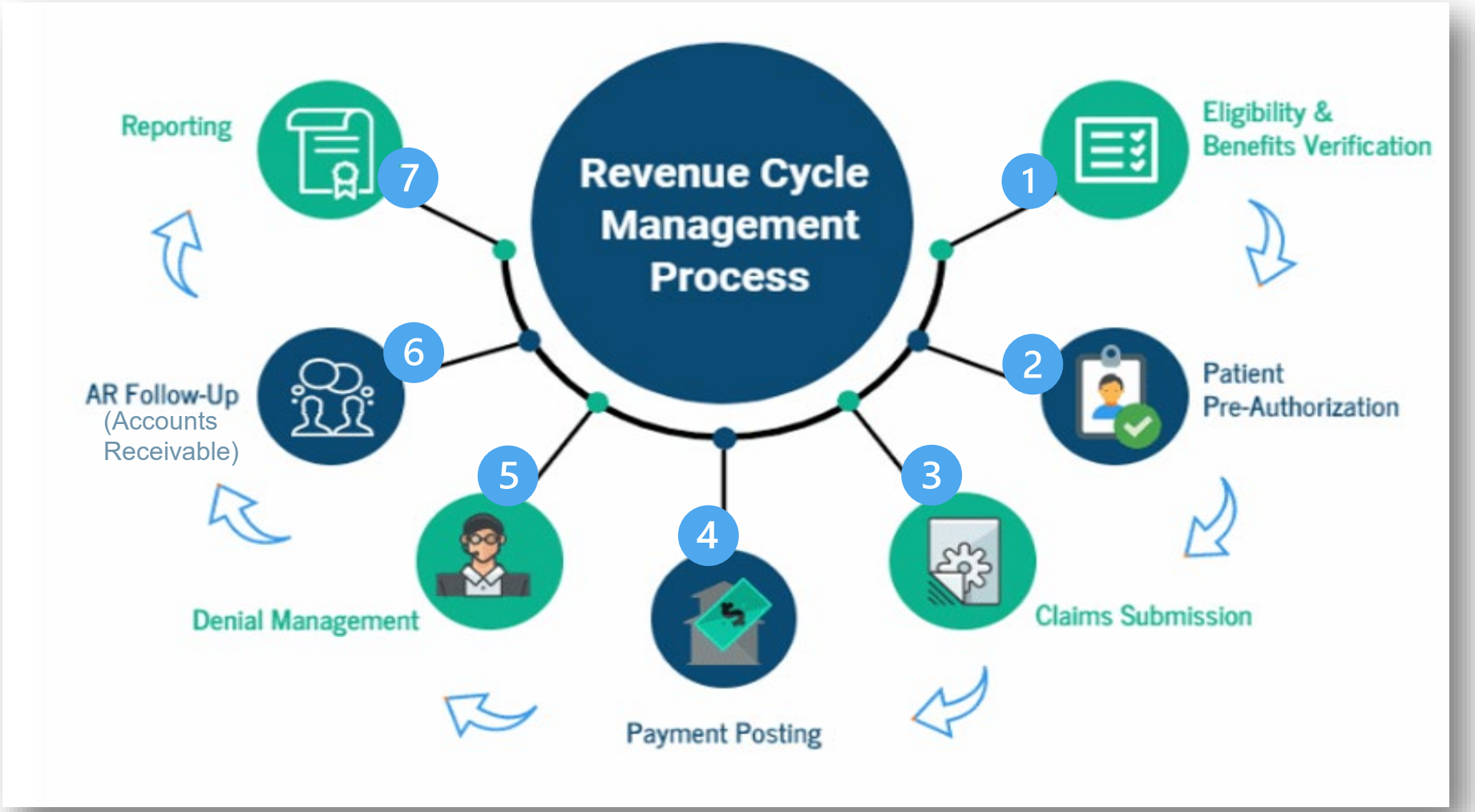

Image Source: US24 Solutions: Revenue Cycle Management. Available at: https://us24solutions.com/revenue-cycle-management/

REVENUE CYCLE DESCRIPTION

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1. **Eligibility and Benefits Verification:** Verify the patient's insurance coverage, eligibility status, policy benefits, deductible amounts, copayments, coinsurance, and coverage limitations before services are rendered. Accurate verification reduces claim denials, improves patient financial transparency, and helps ensure reimbursement for provided services.

2. **Prior Authorization:** Obtain approval from the insurance payer for procedures, treatments, diagnostic tests, or specialty services that require authorization. Completing this step in advance prevents delays in care, minimizes denied claims, and ensures compliance with payer requirements.

3. **Claims Submission:** Prepare and submit clean, accurate claims containing all required patient, provider, coding, and billing information. Timely claim submission helps accelerate reimbursement, reduce rework, and improve overall cash flow.

4. **Payment Posting:** Record payments received from insurance companies and patients, reconcile payment details against submitted claims, and identify any underpayments or adjustments. Accurate payment posting is critical for maintaining financial accuracy and tracking outstanding balances.

REVENUE CYCLE DESCRIPTION (CONT'D).

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5 **Denial Management:** Review denied or rejected claims, determine the root cause, correct errors, and resubmit claims when appropriate. Effective denial management helps recover lost revenue, identify process improvement opportunities, and reduce future denial rates. "***Impacts revenue***"

6 **Accounts Receivable (AR) Follow-Up:** Monitor unpaid claims and patient balances, follow up with insurance companies regarding outstanding payments, and resolve billing issues promptly. Consistent AR management reduces aging balances and improves collection performance.

7 **Reporting and Analytics:** Generate and review key performance indicators (KPIs) such as collection rates, denial rates, days in accounts receivable, claim acceptance rates, and reimbursement trends. Reporting provides insights into financial performance and supports strategic decision-making for continuous improvement.

REVENUE CYCLE MANAGEMENT BEST PRACTICES

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Best Practice: *Always verify eligibility, submit appropriate documentation, authorizations, and codes with your claim. Establish good billing practices to submit a* ***clean claim*** *and verify all the codes and authorizations before submitting a claim.*

Image Source: Microsoft 365 Stock Photos

Follow each step in the revenue cycle flow to ensure:

- ✓ Clean claims
- ✓ Claim accuracy
- ✓ Reduced errors
- ✓ Timely payment/reimbursement
- ✓ Reduced number of appeals
- ✓ Improve provider/payer relationships

3 CLAIMS SUBMISSION

SUBMISSION OF A CLEAN CLAIM

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Submitting a ***clean claim*** means sending a complete, accurate insurance claim that passes all electronic edits the first time so it can be processed without delays.

Pre-Submission Verification

- Verify Patient Data: Confirm the patient's name, birth date, address, and member ID match their insurance card.
- Check Provider Information: Ensure your NPI, tax ID, and practice address are correct.
- Confirm Coverage: Verify active insurance status and coordination of benefits before the appointment.
- Secure Prior Authorization: Obtain required pre-approvals and include the correct authorization numbers.

Coding and Documentation

- Use Correct Codes: Apply accurate ICD-10 diagnosis codes (without decimals) along with standard CPT or HCPCS procedure codes (*see the Doula Billing Manual Cheat Sheet for codes*).
- Add Modifiers: Include appropriate modifiers when required to clarify services.
- Attach Records: Provide necessary supporting documents like lab reports, operative notes, or clinical charts.

Source: 10 Tips for Clean Claims - AAPC Knowledge Center, Pre-Submission Clean Claims Checklist for Medical Billing Teams

SUBMISSION OF A CLEAN CLAIM (CONT'D.)

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Claims submission methods

- Providers can submit claims electronically or via mail; however, MCPs **encourage electronic submission**, which allows for quicker processing.
- MCPs typically use **clearinghouses** for electronic claims submission.
  - A clearinghouse is an intermediary that enables the exchange of data between the provider and the payer for billing and payment. It reviews for incorrect formatting and common errors in claims before they reach the payer.
  - Examples of clearinghouses used by MCPs (as of September 2026):
    - AmeriHealth → Availity and Optum/Change Healthcare
    - MedStar → Change Healthcare
    - HSCSN → Optum Relay Exchange
- Providers have the option to use other clearinghouses or practice management software (e.g., Doulado) that have the capability to transfer data electronically to the MCP's clearinghouse(s).

Timely filing

- Claims must be submitted to MCPs within 365 days of the date of service.
- MCPs will deny claims received after 365 days.

Source: (AmeriHealth Claims and Billing), (MedStar Family Choice DC | Providers | Electronic Claims Submission)

SUBMISSION OF A CLEAN CLAIM (CONT'D.)

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Tips for doulas to help ensure submission and timely processing of clean claims:

- ✓ Submit claim to the correct payer - check that the member's MCP enrollment was active for the date of service on the claim
- ✓ Include correct NPI/TIN
- ✓ Include correct CPT/HCPCS code and HD modifier
  - ✓ Check out the Doula Billing Manual Cheat Sheet for tips on codes
- ✓ Include correct postpartum units
- ✓ Submit the claim within 24 hours, or as soon as possible, following service to stay withing the timely filling requirements

Q&A SESSION

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- Are you actively billing?
- Do you have a biller or use a vendor?
- Where are you in the process?
- What successes have you experienced?
- What barriers are you facing?
- What questions do you have?

Image Source: Microsoft 365 Stock Photos

5 DENIAL MANAGEMENT

INTRODUCTION TO DENIAL MANAGEMENT

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- After reviewing the claims submission, the MCP will take one of the following actions:
  - Pay the claim in full
  - Reject the claim
  - Deny the full claim or part of the claim
- The next several slides review the steps doulas should take for each of these possible actions.

Image Source: Microsoft 365 Stock Photos

DENIAL MANAGEMENT DECISION TREE

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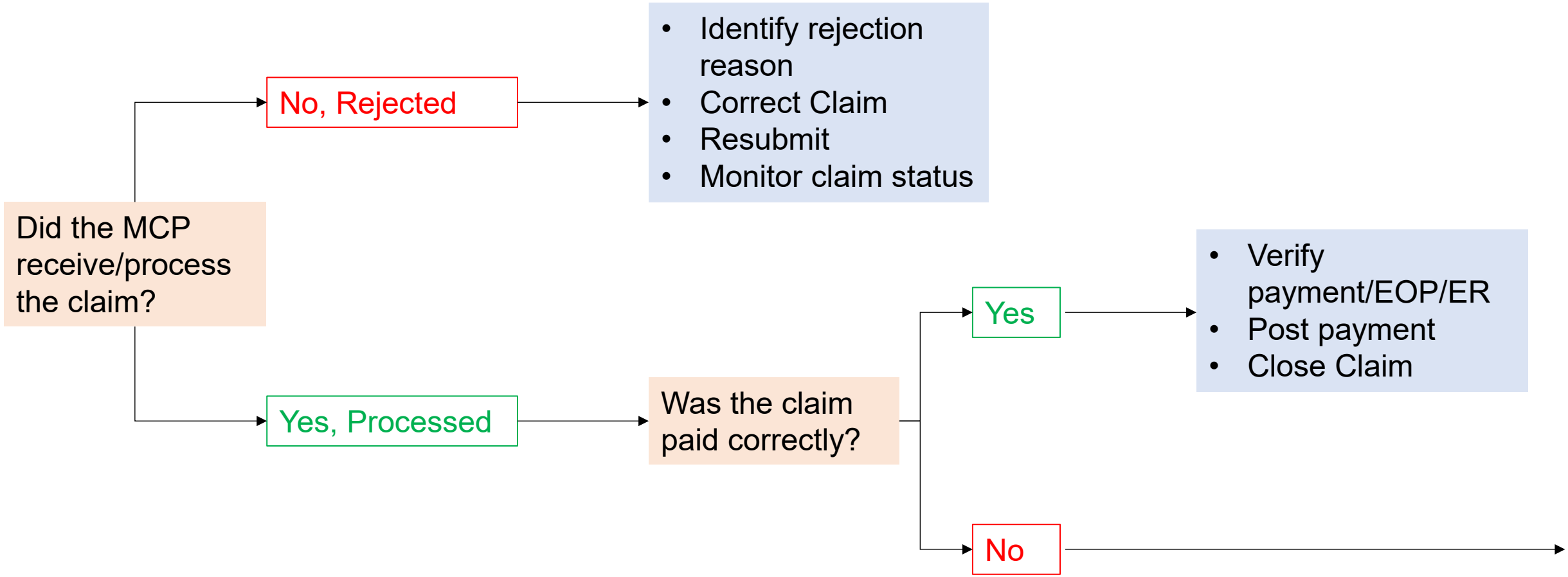

DENIAL MANAGEMENT DECISION TREE (CONT'D.)

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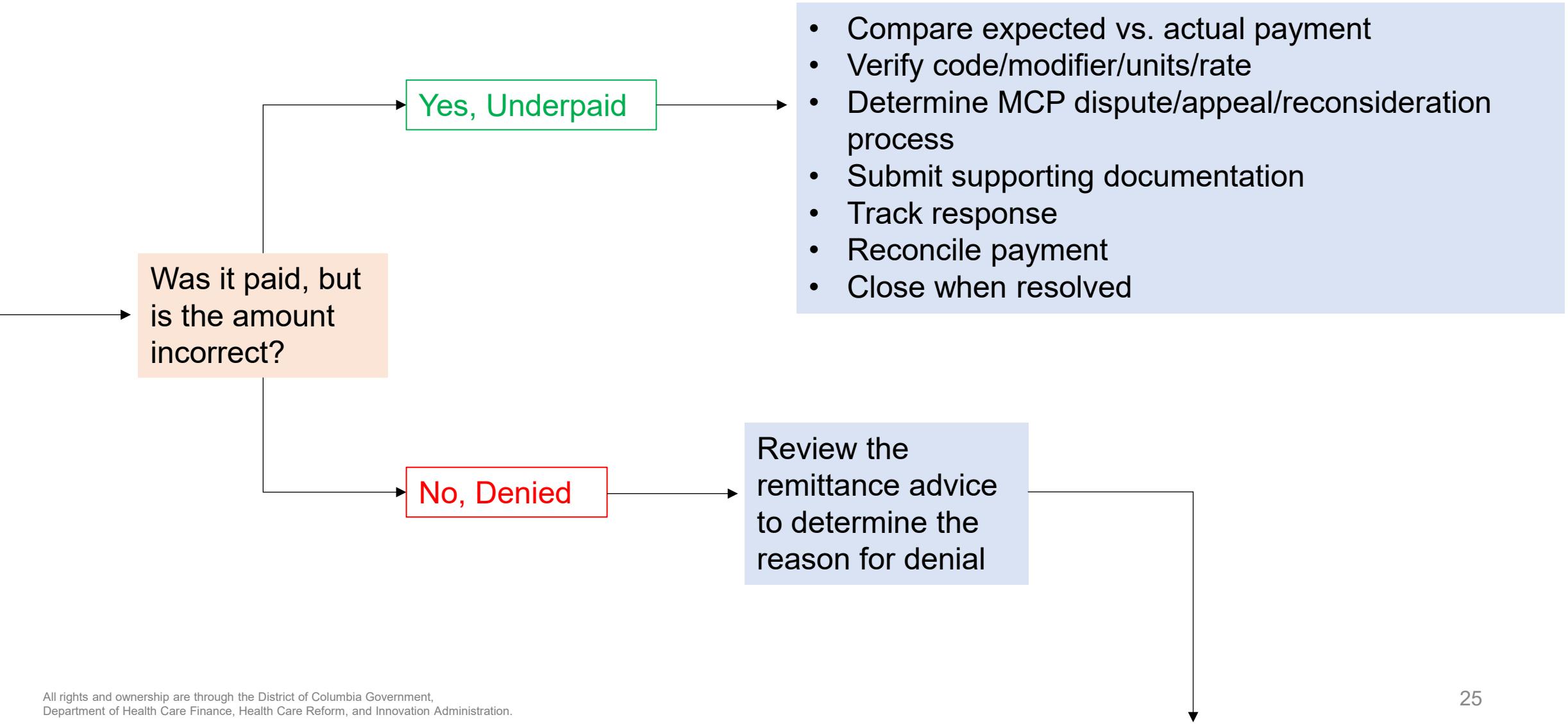

DENIAL MANAGEMENT DECISION TREE (CONT'D.)

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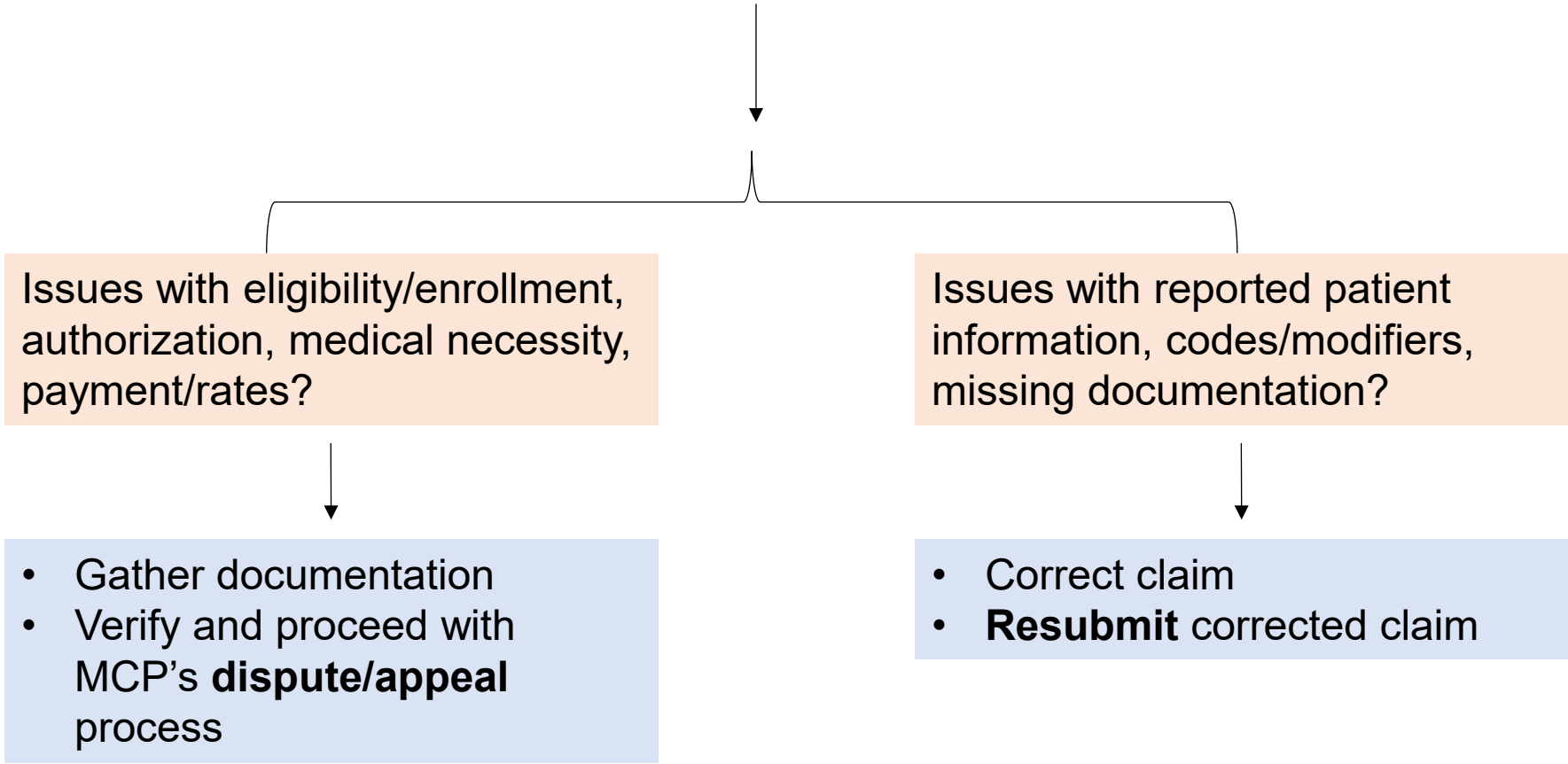

MCP CLAIM DISPUTE/APPEALS

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- Processes for claims disputes/appeals vary by MCP. For example:
  - **AmeriHealth** and **MedStar** have distinct processes for disputes versus appeals:
    - **Disputes** are used when a claim, or a portion of a claim, is denied for administrative reasons or underpaid.
    - **Appeals** are used when a claim is denied for medical necessity.
  - **HSCSN** uses an appeals process for all types of claims denials.
- The exact timeline for submitting disputes/appeals for depends on the MCP and denial type.
- Check out MCPs' provider manuals for information on claims disputes/appeals processes:
  - AmeriHealth Caritas DC
  - MedStar Family Choice
  - HSCSN

CLAIMS DOCUMENTATION

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Image Source: Microsoft 365 Stock Photos

Required/recommended documentation for submission includes:

- ✓ Provider name and NPI
- ✓ Tax ID
- ✓ MCP provider ID, if applicable
- ✓ Member name
- ✓ Member Medicaid ID
- ✓ Date of birth
- ✓ Claim number
- ✓ Date(s) of service
- ✓ CPT/HCPCS codes
- ✓ Modifiers
- ✓ Units
- ✓ Original claim
- ✓ EOP/ERA showing the denial
- ✓ Corrected claim, if applicable
- ✓ Authorization number/documentation, if applicable
- ✓ Clinical and supporting documentation
- ✓ Doula service documentation
- ✓ Proof of timely filing, if timely filing is the issue
- ✓ Clear written explanation of why the denial should be overturned
- ✓ Desired resolution (e.g., “Please reprocess and issue payment”)

KEY REMINDERS FOR DOULAS

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- Make sure that the claim reflects the correct 2026 DC Medicaid doula codes, modifiers, units, and rates.
  - DHCF increased the doula rates effective January 1, 2026.
- Do not wait to appeal.
  - Track the denial date, appeal deadline, submission date, acknowledgment date, and final determination.

Image Source: Microsoft 365 Stock Photos

Q&A SESSION

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- Have you filed any disputes/appeals?
- Where are you in the process?
- What successes have you experienced?
- What barriers are you facing?
- What questions do you have?

Image Source: Microsoft 365 Stock Photos

REMINDERS AND NEXT STEPS

TIMELINE FOR 2026

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May
Cross-Provider Journey Mapping (5/12/26)
1:1 TA

June
Improving Coordination Across Screening and Referral Workflows (6/9/26)
1:1 TA

July
Operational Sustainability for Maternal Health Services (7/14/26)
1:1 TA

August
MCP Essentials for Doulas, Part 1
(8/11/26)
1:1 TA

September
MCP Essentials for Doulas, Part 2
(9/8/26)
1:1 TA

We are here!

October
In-Person Workshop (10/20/26)
1:1 TA

November
Group Learning (11/10/26)
1:1 TA

December
Group Learning (12/8/26)
1:1 TA

MILESTONE 7 ACTIVITIES DUE DATE

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For doulas participating in the TMaH Incentive Program:

All Milestone 7 activities (Learning Collaborative participation) and required documentation must be completed and uploaded in D-TIPs by **December 15, 2026**, to receive the incentive payment of $15,000.

Image Source: Microsoft 365 Stock Photos

LOOKING AHEAD: NEXT STEPS

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Homework

- Identify one or two next topics from today's session that you would like to discuss in your next individual coaching session.

Collaboration and Support

- **Goal:** Complete all Learning Collaborative activities before **December 15, 2026.**
  - This pertains **only** to those participating in the TMaH Learning Collaborative (Milestone 7).

Coming Next!

- **In-Person Workshop:** Tuesday, October 20, 2026 (***SAVE THE DATE!***)
- **Session 6:** Tuesday, November 10, 2026, 11:30 AM–12:30 PM

WRAP UP AND NEXT STEPS

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- Please complete the online **evaluation by <u>September 18</u>!**
  - **<u>If you would like to receive CME or CE for Social Work credit, the evaluation will need to be completed</u>.** You may use the link in the chat box or scan the QR code to access the evaluation.
- The slides and a recording of the webinar will be emailed to registered participants and available soon on the Integrated Care DC website.
- For more information about Integrated Care DC, please visit: www.integratedcare.dc.gov

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APPENDIX

DOULA MCP CLAIM APPEAL ELEMENTS

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Identify Appeal Elements

- Start with the date shown on the MCP's **Explanation of Payment (EOP) / Electronic Remittance Advice (ERA), claim denial, or payment notice**.
- The doula should then identify:

- ✓ Claim number
- ✓ Member Medicaid ID
- ✓ Date(s) of service
- ✓ Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) code and modifier
- ✓ Amount billed
- ✓ Amount paid, if any
- ✓ Denial/remark code
- ✓ Reason for denial
- ✓ Authorization information, if applicable

Image Source: Microsoft 365 Stock Photos

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Step 1. Capture the Services Provided

» Start with the doula's own service records and, for every patient, track:

- ✓ Member ID/Name
- ✓ MCP
- ✓ Date of service
- ✓ CPT/HCPCS code
- ✓ Modifier
- ✓ Units
- ✓ Authorization, if applicable
- ✓ Amount billed
- ✓ Claim submission date
- ✓ Claim number

Image Source: Microsoft 365 Stock Photos

DOULA MCP RECONSIDERATION ROADMAP (CONT'D.)

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Step 2. Verify Member and Provider Eligibility

Before chasing payment, verify:

- **Member**
  - Was the patient Medicaid eligible on the date of service?
  - Was the patient enrolled with the MCP on that date?
- **Doula**
  - Was the doula enrolled/credentialed with Medicaid/MCP?
  - Was the correct NPI/TIN used?
  - Was the provider information active?
    - This prevents spending time appealing a claim that has an underlying eligibility or enrollment problem.

Image Source: Microsoft 365 Stock Photos

DOULA MCP RECONSIDERATION ROADMAP (CONT'D.)

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Step 3. Identify the Discrepancy

At this point, classify each claim into one of four buckets:

- **PAID CORRECTLY**
  No action required.
- **UNDERPAID**
  Claim paid, but payment doesn't match the applicable rate/units.
- **DENIED**
  Claim was received but payment was denied.
- **REJECTED/NOT PROCESSED**
  Claim could not be adjudicated and may need correction/resubmission.

Image Source: Microsoft 365 Stock Photos

This is where reconciliation becomes very important: A denied claim and a rejected claim are not necessarily handled the same way.

DOULA MCP RECONSIDERATION ROADMAP (CONT'D.)

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Step 4. Submit the Dispute/Appeal

- The dispute should clearly state: **"We are requesting review and reprocessing of the claim because the payment/denial does not reflect the applicable Medicaid doula reimbursement requirements."**
- Attach the reconsideration evidence.
  - Claims guidance requires administrative disputes or clinical claim appeals to be submitted in writing with relevant supporting documentation. It states that an acknowledgment is sent within five business days and a response within 30 calendar days.

Image Source: Microsoft 365 Stock Photos

DOULA MCP RECONSIDERATION ROADMAP (CONT'D.)

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Step 5. Close the Loop

- A reconciliation isn't complete simply because the appeal was submitted.
- You want to get to:

- Then verify the **new EOP/ERA**.
- If the MCP says, "Claim corrected and payment issued," the doula should still verify that the money actually posted and that the **correct amount** was paid.