

**DISTRICT OF COLUMBIA  
BOARD OF ELECTIONS AND ETHICS**

**NOTICE OF PROPOSED RULEMAKING**

The District of Columbia Board of Elections and Ethics pursuant to the authority set forth in D.C. Code §1-1001.05(a)(14) hereby gives notice of proposed rulemaking action to adopt the following amendments to 3 DCMR Chapter 7, "Election Procedures".

The proposed amendments: 1) establish procedures for representatives of civic organizations who wish to observe at polling places and vote counts; 2) establish uniform terms for referencing voting equipment, and; 3) correct substantive and typographical errors in the chapter.

The Board gives notice of its intent to take final rulemaking action to adopt these amendments in not less than 30 days from the date of publication of this notice in the D.C. Register.

*Section 701 of Chapter 7 of 3 DCMR, "Election Procedures," shall be amended as follows:*

- 1) By deleting the word "referendum" in paragraph 701.3(b) and inserting the phrase "initiative, referendum," in its place.

*Section 705 of Chapter 7 of 3 DCMR, "Election Procedures," shall be amended as follows:*

- 1) By deleting the phrase "AND VOTE COUNTING WATCHERS" in the section title and inserting the phrase ", VOTE COUNTING WATCHERS, AND ELECTION OBSERVERS" in its place;
- 2) By adding a new subsection 705.2 to read as follows and redesignating current subsections 705.2 through 705.15 as subsections 705.3 through 705.16:

"705.2 A non-partisan or bipartisan organization not affiliated with a candidate or ballot measure that wishes to observe at polling places or counting places may petition the Board for credentials authorizing election observers at one or more polling places or counting places."

- 3) By inserting the phrase "or organization representative" after the word "candidate" and before the word "," in paragraph 705.4(a);
- 4) By inserting the phrase "or observer" after the word "watcher" and before the word "supervisor" in paragraph 705.4(b);
- 5) By inserting the phrase "organization," after the word "," and before the word "proponent" in paragraph 705.4(b);
- 6) By inserting the phrase "organization," after the word "," and before the word

- “proponent” in paragraph 705.4(c);
- 7) By inserting the phrase “or observer” after the word “watcher” and before the word “selected” in paragraph 705.4(d);
  - 8) By inserting the phrase “or observers” after the word “watchers” and before the word “and” in paragraph 705.4(d);
  - 9) By inserting the phrase “or observers” after the word “watchers” and before the word “to” in subsection 705.5;
  - 10) By inserting the phrase “or observers” after the word “watcher” and before the word “allowed” in subsection 705.6;
  - 11) By inserting the phrase “organization,” after the word “,” and before the word “proponent” in subsection 705.6;
  - 12) By inserting the phrase “or observers” after the word “watchers” and before the word “allowed” in subsection 705.7;
  - 13) By inserting the phrase “or requesting organizations” after the word “candidates” and before the word “;” in paragraph 705.7(a);
  - 14) By inserting the phrase “or observer” after the word “watcher” and before the word “,” in subsection 705.8;
  - 15) By inserting the phrase “or observer’s” after the word “watcher’s” and before the word “name” in subsection 705.8;
  - 16) By inserting the phrase “organization,” after the word “,” and before the word “proponent” in subsection 705.9;
  - 17) By inserting the phrase “or observer” after the word “watcher” and before the word “at” in subsection 705.10;
  - 18) By inserting the phrase “or observer” after the word “watcher” and before the word “may” in subsection 705.11;
  - 19) By inserting the phrase “or observer” after the word “watcher” and before the word “at” in subsection 705.11;
  - 20) By inserting the phrase “or observer” after the word “watcher” and before the word “shall” in subsection 705.12;
  - 21) By deleting the phrase “ballot box” in paragraph 705.12(a) and inserting the phrase “voting equipment” in its place;
  - 22) By inserting the phrase “or observer” after the word “watcher” and before the word “shall” in subsection 705.13;
  - 23) By inserting a new paragraph 705.13(e) to read as follows:

“705.13(e) Use any video or still cameras inside the polling place while the polls are open for voting, or use any video or still camera inside the counting center if such use is disruptive or interferes with the administration of the counting process.”
  - 24) By inserting the phrase “or observer” after the word “watcher” and before the word “who” in subsection 705.14;
  - 25) By inserting the phrase “or observer” after the word “watcher” and before the word “is” in subsection 705.15;
  - 26) By inserting the phrase “or observer’s” after the word “watcher’s” and before

- the word “credential” in subsection 705.15; and
- 27) By inserting the phrase “or observer” after the word “watcher” and before the word “may” in subsection 705.16.

*Section 706 of Chapter 7 of 3 DCMR, “Election Procedures,” shall be amended as follows:*

- 1) By inserting the phrase “AND OBSERVERS” after the word “WATCHERS” in the section title;
- 2) By deleting the word “,” in subsection 706.1 and inserting the phrase “or observers” in its place;
- 3) By inserting the phrase “or observers” after the word “watchers” and before the word “shall” in subsection 706.2;
- 4) By inserting the phrase “or observers” after the word “watchers” and before the word “shall” in subsection 706.3; and
- 5) By inserting the phrase “or observer” after the word “watcher” and before the word “has” in subsection 706.4.

*Section 710 of Chapter 7 of 3 DCMR, “Election Procedures,” shall be amended as follows:*

- 1) By deleting the word “address” in paragraph 710.4(g) and inserting the word “precinct” in its place; and
- 2) By inserting a new paragraph 710.4(l) to read as follows:

“710.4(l) Resides at a District of Columbia licensed nursing home or assisted living facility, or at a qualified retirement home.”

*Section 712 of Chapter 7 of 3 DCMR, “Election Procedures,” shall be amended as follows:*

- 1) By deleting the phrase “ballot box” in subsection 712.1 and inserting the phrase “optical scan voting equipment (“OSVE”)” in its place;
- 2) By deleting the phrase “ballot box” in paragraph 712.1(a) and inserting the word “OSVE” in its place;
- 3) By deleting the phrase “ballot box” in paragraph 712.1(b) and inserting the word “OSVE” in its place;
- 4) By deleting the phrase “ballot box” in paragraph 712.1(d) and inserting the word “OSVE” in its place;
- 5) By deleting the phrase “the following” in subsection 712.2 and inserting the word “that” in its place;
- 6) By deleting the word “box” each time it appears in subsection 712.2 and inserting the word “OSVE” in its place;
- 7) By deleting the phrase “Preservation of the secrecy of each voter’s ballot” in paragraph 712.2(c) and inserting the phrase “The secrecy of each voter’s ballot is preserved” in its place;

- 8) By deleting the phrase “deposit his or her official ballot in the ballot box” in subsection 712.3 and inserting the phrase “pass his or her voted paper ballot through the OSVE” in its place;
- 9) By deleting the phrase “ballot box” in subsection 712.4 and inserting the word “OSVE” in its place;
- 10) By deleting the phrase “ballot box(es) in subsection 712.5 and inserting the word “OSVE’s” in its place; and
- 11) By inserting the phrase “, cartridges,” after the word “ballots” and before the word “and” in subsection 712.5.

*Section 713 of Chapter 7 of 3 DCMR, “Election Procedures,” shall be amended as follows:*

- 1) By deleting the phrase “(Duly Registered Voters)” in subsection 713.3 and inserting the phrase “who have not been designated as inactive on the voter roll.”;
- 2) By deleting the phrase “, and in a primary election, the party on the Voter Card” in paragraph 713.10(b) and inserting the phrase “and party on the Voter Card in a primary election, and the name and ANC Single-Member District on the Voter Card in a general election”;
- 3) By deleting the phrase “optical scan voting equipment” in paragraph 713.10(c) and inserting the word “OSVE” in its place;
- 4) By deleting the phrase “optical scan voting equipment” in paragraph 713.10(d) and inserting the word “OSVE” in its place;
- 5) By deleting the phrase “optical scan voting machines” in subsection 713.11 and inserting the word “OSVE” in its place;
- 6) By deleting the phrase “optical scan machine” in subsection 713.12 and inserting the word “OSVE” in its place;
- 7) By deleting the phrase “direct recording electronic (DRE) in subsection 713.13 and inserting the word “DRE” in its place;
- 8) By deleting the phrase “optical scan voting equipment” in subsection 713.14 and inserting the word “OSVE” in its place; and
- 9) By deleting the phrase “optical scan voting equipment” in subsection 713.15 and inserting the word “OSVE” in its place.

*Section 716 of Chapter 7 of 3 DCMR, “Election Procedures,” shall be amended as follows:*

- 1) By deleting the word “and” in paragraph 716.1(e);
- 2) By deleting the phrase “Voter’s original signature.” in paragraph 716.1(f) and inserting the phrase “Voter’s date of birth; and” in its place; and
- 3) By adding a new paragraph 716.1(g) to read as follows:

“716.1(g) Voter’s original signature.”

*Section 718 of Chapter 7 of 3 DCMR, "Election Procedures," shall be amended as follows:*

- 1) By striking the phrase "in absentee" in subsection 718.2 and inserting the phrase "an absentee" in its place;
- 2) By deleting the phrase "Address to which the absentee ballot shall be delivered; and" in paragraph 718.2(d) and inserting the phrase "Voter's original signature." In its place;
- 3) By deleting paragraph 718.2(e) in its entirety.
- 4) By deleting the phrase "qualified applicant" in subsection 718.3 and inserting the phrase "applicant qualified" in its place; and
- 5) By deleting the phrase "be issued a ballot for the current residence address; provided, that the applicant provides identification which establishes identity and current residence address " in subsection 718.3 and inserting the phrase "shall vote a special ballot in accordance with section 721 of this chapter.";
- 6) By inserting the phrase "at the Board's office" after the word "person" and before the word "shall" in subsection 718.4;
- 7) By deleting the phrase "the absentee ballot in the office of the Board, and;" in paragraph 718.4(a) and inserting the phrase "an absentee ballot using the DRE voting equipment and an electronic voter card, which shall be returned to a Board official once voting is completed; or" in its place; and
- 8) By deleting the word "Place" in paragraph 718.4 (b) and inserting the phrase "Cast an absentee paper ballot, place" in its place.

*Section 720 of Chapter 7 of 3 DCMR, "Election Procedures," shall be amended as follows:*

- 1) By deleting the phrase "710.1(d)" in subsection 720.1 and inserting the phrase "710.5" in its place;
- 2) By deleting the phrase ", which must be an original signature" in paragraph 720.1(c) and inserting the word "." in its place;
- 3) By deleting the word "Office" each time it appears in subsection 720.3 and inserting the word "Program" in its place; and
- 4) By deleting the word "Office" in subsection 720.4 and inserting the word "Program" in its place.

*Section 721 of Chapter 7 of 3 DCMR, "Election Procedures," shall be amended as follows:*

- 1) By deleting the phrase "Corporation Counsel" in subsection 721.14 and inserting the phrase "Attorney General" in its place. 710.1(d)" in subsection 720.1 and inserting the phrase "710.5" in its place;
- 2) By deleting the phrase ", which must be an original signature" in paragraph 720.1(c) and inserting the word "." in its place;
- 3) By deleting the word "Office" each time it appears in subsection 720.3 and

- inserting the word “Program” in its place; and
- 4) By deleting the word “Office” in subsection 720.4 and inserting the word “Program” in its place.

*Section 722 of Chapter 7 of 3 DCMR, “Election Procedures,” shall be amended as follows:*

- 1) By deleting the phrase “shall during regular business hours maintain a telephone service by which any voter who has voted a special ballot may learn of the Board’s preliminary decision to count or reject his or her ballot along with the reasons(s) for each decision.” and inserting the phrase “enable any voter who has voted a special ballot to learn of the Board’s preliminary decision to count or reject his or her ballot along with the reasons(s) for each decision by accessing the either a dedicated section of the Board’s website or a telephone service which shall be maintained during regular business hours.” in its place.

*Section 723 of Chapter 7 of 3 DCMR, “Election Procedures,” shall be amended as follows:*

- 1) By deleting the phrase “ballot box” in paragraph 723.1(a) and inserting the phrase “OSVE” in its place;
- 2) By deleting the phrase “the ballot box” in paragraph 723.1(b) and inserting the phrase “the OSVE” in its place;
- 3) By deleting the phrase “automatic tabulating system’s” in paragraph 723.1(d) and inserting the phrase “OSVE’s” in its place;
- 4) By deleting the phrase “automatic tabulating system’s” in paragraph 723.1(f) and inserting the phrase “OSVE’s” in its place;
- 5) By inserting the phrase “and the DRE’s tabulation cartridge” after the word “pack” and before the word “into” in paragraph 723.1(f); and
- 6) By deleting the phrase “and the memory packs” in paragraph 723.4 and inserting the phrase “, OSVE memory packs, and DRE tabulation cartridges” in its place.

*Section 724 of Chapter 7 of 3 DCMR, “Election Procedures,” shall be amended as follows:*

- 1) By deleting the phrase “automatic tabulating system’s memory pack” in subsection 724.1 and insert the phrase “OSVE memory packs and DRE tabulation cartridges” in its place;
- 2) By deleting the phrase “and memory packs” in subsection 724.3 and inserting the phrase “, OSVE memory packs, and DRE tabulation cartridges” in its place; and
- 3) By deleting the word “Roster” in subsection 724.5 and inserting the word “Master” in its place.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments no later than thirty (30) days after the publication of this notice in the D.C. Register. Comments should be sent to Kenneth J. McGhie, General Counsel, D.C. Board of Elections and Ethics, 441 4th Street, NW, Suite 270N, Washington, DC 20001. Copies of the proposed rules may be obtained at cost from the Board at the same address between the hours of 9:00 a.m. and 4:45 p.m.

## DISTRICT DEPARTMENT OF THE ENVIRONMENT

## NOTICE OF PROPOSED RULEMAKING

**Green Building Editions Update of LEED<sup>®</sup> and Green Communities**

The Director of the District Department of the Environment (“DDOE”), pursuant to the authority set forth in the Green Building Act of 2006, effective March 8, 2007 (D.C. Law 16-234; D.C. Official Code § 6-1451.11(b)) (“GBA”); section 107(4) of the District Department of the Environment Establishment Act of 2005, effective February 15, 2006 (D.C. Law 16-51; D.C. Official Code § 8-151.07(4)); and Mayor’s Order 2007-206, dated September 21, 2007, hereby gives notice of the intent to amend Title 20 of the District of Columbia Municipal Regulations (“DCMR”), to update the U.S. Green Building Council’s (“USGBC”) Leadership in Energy and Environmental Design (“LEED<sup>®</sup>”) and Enterprise Community Partners’ Green Communities, to LEED<sup>®</sup> 2009 and Green Communities 2008. The amendments shall take effect in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

As required by section 12(b) of the GBA, prior to the issuance of a Notice of Final Rulemaking, this rulemaking will be submitted to the Council of the District of Columbia (“Council”) for a review period of up to forty-five (45) days. Simultaneously submitted to the Council will be the “Green Building Technical Corrections, Clarification, and Revision Emergency Amendment Act of 2009,” which repeals existing LEED<sup>®</sup> and Green Communities editions in the GBA.

Summary

“Green” or “sustainable” building is the practice of creating healthier and more resource-efficient models of construction, renovation, operation, maintenance, and demolition. Green buildings enhance the quality of air, water, land, and climate. They are constructed from environmentally preferable materials and are sited within a well-planned infrastructure that serves the community, economy, and ecosystems. Sustainable buildings also maximize energy efficiency, use rainwater and reuse grey-water, prevent pollution from storm water run-off, and are reused or recycled at the end of their useful lifecycle. Finally, green buildings provide a healthy and productive indoor environment.

The GBA has significantly reformed the way buildings are being built in the District. Nevertheless, the green building movement has not remained static, and with added experience and acceptance, “green” standards have appropriately become more and more exacting. Accordingly, the USGBC and Enterprise Community Partners, Inc. have updated their standards, and both entities are retiring existing standards. Consequently, the Director of DDOE (“Director”) has reviewed the most recent editions of both standards, and based on the changes described below, the Director recommends the adoption of the LEED<sup>®</sup> 2009 and Green Communities 2008.

In addition to the recommendation of the Director, the Green Building Advisory Council, which according to section 10(d) of the GBA, has the responsibility to advise the Mayor on the

“development, adoption, and revisions” of the District’s green building legislation, also endorses the updates of editions of green building standards recommended in this proposed regulation.

#### Discussion on the LEED® 2009 edition update

The USGBC’s most recent revision of LEED® maintains the existing foundations of several of its commercial and institutional rating systems, and incorporates them into a single rating system, LEED® 2009. The LEED® rating systems relevant to this proposed regulation include: LEED® for New Construction, LEED® for Commercial Interiors, LEED® for Core and Shell, and LEED® for Schools. In LEED® 2009, credits and prerequisites have been consolidated, aligned and updated to reflect their “most effective common denominator,” which provides a consistent set of prerequisites and credits across the spectrum of commercial and institutional project types.

The USGBC has made a significant change in the allocation of points compared with previous LEED® rating systems, and consequently, LEED® 2009 will award more points for strategies that have a greater impact on energy efficiency and carbon dioxide reductions. Overall, the changes increase the relative emphasis on the reduction of energy consumption and greenhouse gas emissions associated with building systems, transportation, the embodied energy of water, the embodied energy of materials, and where applicable, solid waste. LEED® 2009 also assigns greater point value to credits that reduce water-use within, and around buildings.

The USGBC used the U.S. Environmental Protection Agency (EPA) Translational Research at the Aging/Cancer Interface (“TRACI”) environmental impact categories as the basis for weighting each LEED® 2009 credit. TRACI was developed to assist with impact evaluation for life-cycle assessment, industrial ecology, process design, and pollution prevention. The USGBC also took into consideration weightings that compare impact categories with one another, and assign a relative weight to each, as developed by the National Institute of Standards and Technology.

To achieve the final credit weights, the USGBC evaluated each credit against a list of thirteen environmental impact categories, including climate change, indoor environmental quality, resource depletion and water intake, among others. The categories were prioritized by subject matter experts across the building and environmental sciences, and credits were assigned values based on the amount of environmental mitigation achieved by each credit. The result gives the most value to credits that have the greatest potential for making the most significant changes, and therefore correspondingly, earn the most points towards a LEED® 2009 rating.

The LEED® 2009 rating system also allows projects to earn a regional bonus point for building choices that support regional environmental priorities. For instance, in the Washington, D.C. area, bonus points may be earned for combined innovative strategies in four out of six areas: on-site habitat protection, stormwater quantity control, innovative water technologies, optimized energy performance, on-site renewables, and building reuse.

Discussion on the Green Communities 2008 edition update

Green Communities 2008 (“GC 2008”) reflects technical modifications resulting from improvements in other nationally recognized standards, such as EPA’s Energy Star and the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) standards. GC 2008 includes expanded technical resources embedded in the document, allowing developers to benefit from additional guidance and greater clarity on resources, materials and methods to satisfy its criteria. These clarifications improve and retain the effectiveness and rigor of the guidelines, and provide clearer guidance to developers and their project teams. Moreover, the updated GC 2008 explicitly references mandatory and optional criteria that would also qualify for credits under the recently released LEED® for Homes standard.

Conclusion

In conclusion, due to the changes described above, both LEED® 2009 and GC 2008 further advance the goals of the GBA to establish high-performance building standards that require the planning, design, construction, operation and maintenance of building projects that help to mitigate the environmental, economic, and social impacts of built structures in the District. The proposed language would update the regulations to specify that LEED® 2009 and Green Communities 2008, respectively, will henceforth apply. LEED® 2009 will replace the existing LEED® standard for schools, which is incorporated in LEED® 2009.

**TITLE 20 DCMR (ENVIRONMENT) is amended as follows:****Chapter 35 is amended as follows:**

Section 3501 is amended to read as follows:

**3501 CURRENT EDITIONS OF GREEN BUILDING STANDARDS**

**3501.1** The current edition of the LEED® standard is LEED® 2009.

**3501.2** The current edition of the Green Communities standard is Green Communities 2008.

**Comments on these proposed rules must be submitted, in writing, to Brendan Shane, Office of Policy & Sustainability, District Department of the Environment, 51 N Street, NE, 6<sup>th</sup> Floor, Washington, D.C. 20002, or via e-mail at [Brendan.Shane@dc.gov](mailto:Brendan.Shane@dc.gov), no later than thirty (30) days after the date of publication of this notice in the *D.C. Register*. Copies of the proposed rule may be obtained between the hours of 9:00 a.m. and 5:00 p.m. at the address listed above, or online at [www.ddoe.dc.gov](http://www.ddoe.dc.gov).**

## DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF PROPOSED RULEMAKING

The Director of the Department of Health Care Finance, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02) and the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code §7-771.05(6)), hereby gives notice of the intent to adopt the following new Chapter 90 of Title 29 of the District of Columbia Municipal Regulations (“DCMR”), entitled "Medical Necessity: General and Specific Standards." The proposed rulemaking establishes criteria for determining whether a service is medically necessary, a prerequisite for reimbursement by the Medicaid Program. Federal law requires State Plans for Medical Assistance (State Plans) to assure that care and services covered under the plan or early and periodic screening, diagnostic, and treatment services are medically necessary and provided in a manner consistent with the best interests of beneficiaries. Federal law also requires State Plans to assure methods and procedures pertaining to utilization of and payment for services care and services under the State Plan, as may be necessary to safeguard against unnecessary utilization of such care and services, and to assure that payments are consistent with efficiency, economy, and quality of care.

This rulemaking establishes a process for prospective, concurrent and retrospective reviews to ensure that services reimbursed by the Medicaid Program are both covered and medically necessary. The rules also clarify the relationship between the review procedures that will be used by the Department of Health Care Finance (DHCF) to make medical necessity determinations and reconsider its initial determinations and the process for requesting an appeal of any DHCF action involving the medical necessity of coverage. These rules also will enable DHCF to recover any payment for a service determined not to be medically necessary.

A notice of proposed rulemaking was published in the *D.C. Register* on August 29, 2008 (55 DCR 009330). Numerous comments were received and were taken into account in this notice of proposed rulemaking.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *DC Register*.

**Title 29 of the District of Columbia Municipal Regulations (Public Welfare) is amended by adding the following new Chapter 90 to read as follows:**

**9000            MEDICAL NECESSITY: GENERAL AND SPECIFIC STANDARDS**

- 9000.1 Subject to the provisions of this Chapter, these rules shall apply to the following medical assistance items and services:
- (a) Required and optional items and services covered under the District of Columbia State Plan for Medical Assistance (State Plan) pursuant to 42 U.S.C. Section 1396a(a)(10), and 42 U.S.C. Sections 1396d(a) and 1396d(r);
  - (b) Items and services described in 42 U.S.C. Section 1396d(r) (early and periodic diagnosis and treatment for individuals under age 21);
  - (c) Items and services provided under waivers of State Plan requirements authorized by Sections 1915 and 1115 of the Social Security Act and approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS); and
  - (d) Items and services set forth in §9000.1 through §9000.17 that are administered by managed care organizations under contracts with DHCF.
- 9000.2 These rules shall not apply to the following items and services:
- (a) Items and services furnished to members of the D.C. Healthcare Alliance;
  - (b) Medical necessity determinations involving transportation services;
  - (c) Items and services set forth in 9000.8 (clinical preventive treatments and services); and
  - (d) In the case of Medicaid beneficiaries who are participants in clinical research that satisfies the Medicare definition of a clinical investigational trial, payment will be made for the following covered items and services:
    - (i) items and services that are furnished as part of the investigational treatment;
    - (ii) covered items and services related to investigational treatment pre-care and aftercare;
    - (iii) covered items and services related to routine treatment for the condition that is the subject of the clinical trial; and
    - (iv) covered items and services for related conditions that could complicate the condition whose treatment is the subject of the clinical trial.

- 9000.3 The specific evidentiary criteria governing coverage requests by managed care enrollees for non-formulary prescribed drugs are set forth in section 9000.17. Coverage requests for prescribed drugs that are not identified in a preferred drug list are governed by the evidentiary criteria set forth in section 9000.16.
- 9000.4 A proposed or furnished treatment, item or service covered under the State Plan, or as an early and periodic screening diagnostic and treatment service (EPSDT) pursuant to 42 U.S.C. §§1396d(a)(4)(B) and 1396d(r), or pursuant to a waiver of otherwise applicable federal Medicaid requirements, shall be considered payable if the treatment, item or service is covered and medically necessary.
- 9000.5 A proposed or furnished treatment, item or service shall be considered medically necessary in the case of individuals under age twenty-one (21) if the treatment, item or service is covered under the State Plan or pursuant to 42 U.S.C. Sections 1396d(a)(4)(B) and 1396d(r), and if relevant medical evidence supports the conclusion that that the proposed or furnished treatment, item or service is:
- (a) Appropriate to the age, functional, and developmental status of the individual;
  - (b) Consistent with current and generally accepted standards of medical, developmental health, behavioral, or dental practice; and
  - (c) Likely to assist in achieving one or more of the following:
    - (i) Promoting growth and development;
    - (ii) Preventing, correcting, or ameliorating a physical, mental, developmental, behavioral, genetic or congenital condition, injury, or disability that can affect a child's healthy growth and development; or
    - (iii) Achieving, maintaining, or restoring health and functional capabilities without regard to whether the underlying condition is congenital or a developmental anomaly.
  - (d) In the case of individuals who have been determined to be qualified individuals with a disability pursuant to the Americans with Disabilities Act, 42 U.S.C. Section 12101 et seq., or qualified handicapped persons under Section 504 of the Rehabilitation Act of 1973, DHCF also shall consider whether the proposed item, treatment or service is to be furnished in the most community-

integrated setting desired by the individual and appropriate to the individual's specific needs.

9000.6 A proposed or furnished treatment, item, or service shall be considered medically necessary in the case of a Medicaid beneficiary age twenty-one (21) or older, if it is covered under the State Plan and if relevant medical evidence supports the conclusion that the treatment, item or service is:

- (a) Appropriate to the individual's physical, mental, developmental, psychological, and functional health;
- (b) Consistent with current and generally accepted standards of medical, behavioral, or dental practice; and
- (c) Clinically appropriate in terms of type, frequency, extent, setting and duration, and likely to assist in:
  - (i) preventing, diagnosing or treating an illness, condition or disability; or
  - (ii) achieving, maintaining, or regaining maximum functional capacity in performing Activities of Daily Living (e.g., bathing, dressing, toileting, or eating) or Instrumental Activities of Daily Living (e.g., grocery shopping, laundry).
- (d) In the case of individuals who have been determined to be qualified individuals with a disability pursuant to the Americans with Disabilities Act, 42 U.S.C. Section 12101 et seq., or qualified handicapped persons under Section 504 of the Rehabilitation Act of 1973, DHCF also shall consider whether the proposed item, treatment or service should be furnished in the most community-integrated setting desired by the individual and appropriate to the individual's specific needs.

9000.7 In the case of an agency that has entered into a formal agreement with DHCF and is acting pursuant to an express and written delegation of authority by DHCF to make determinations of medical necessity, covered items and services that are specified by such agency in a written plan of treatment shall be presumed medically necessary by DHCF without additional review, in the absence of relevant evidence to the contrary.

9000.8 When covered under the State Plan, the following preventive treatments, items and services shall be considered medically necessary:

- (a) Family planning services and supplies, as defined under 42 U.S.C. §1396d(a)(4)(C), including routine examinations to determine overall reproductive health in accordance with professional guidelines; all recommended immunizations (including HPV vaccine and vaccine to prevent cervical cancer); and pap smears and other routine tests to detect conditions that could affect reproductive health;
- (b) Periodic and inter-periodic EPSDT screening and related services furnished to individuals under age twenty-one (21) as described in 42 U.S.C. §1396d( r), which fall within the following service categories:
  - (1) Comprehensive health examinations to ascertain physical and mental health;
  - (2) Laboratory tests (including blood lead level tests to assess a child's blood lead levels);
  - (3) Developmental assessments;
  - (4) Anticipatory guidance;
  - (5) Nutritional assessments;
  - (6) Dental, vision and hearing assessments;
  - (7) Immunizations recommended by the Advisory Committee on Immunization Practices;
  - (8) HIV screening for children in the care and custody of the District's Child and Family Services Agency (CFSA); and
  - (9) Medical examinations required by CFSA for children in their care and custody.
- (c) Clinical preventive services furnished to individuals ages twenty-one (21) and older in accordance with recommended guidelines of the U.S. Clinical Preventive Services Task Force or Advisory Committee on Immunization Practices or any other governmental or professional standards used by DHCF. These services include:
  - (1) Routine mammography screening;
  - (2) Routine colorectal cancer screening;

- (3) Routine and as-indicated screening, in accordance with guidelines issued by the U.S. Clinical Preventive Services Task Force or other authoritative governmental body, for serious and chronic physical or mental health conditions including but not limited to mental illness, substance abuse, sexually transmitted diseases, HIV/AIDS, and other conditions and health risks;
- (4) Semi-annual dental care to prevent disease and maintain oral health;
- (5) Routine hearing exams;
- (6) Routine vision exams;
- (7) Pregnancy-related care, as defined pursuant to 42 U.S.C. §1396a(a)(10), including prenatal, delivery and postpartum care up to sixty (60) days following childbirth;
- (8) Immunizations recommended by the Advisory Committee on Immunization Practice;
- (9) Well women's care as described in guidelines issued by the Centers for Disease Control and Prevention; and
- (10) Health assessments of new managed care enrollees.

9000.9 Evidence regarding the cost of various treatment alternatives that are determined to be equally effective for an individual's condition based on a review of relevant medical evidence described in §9000.10 shall be considered relevant to, but not dispositive of, any medical necessity coverage determination.

9000.10 Medical evidence may be furnished as part of the initial determination or a reconsideration. Medical evidence shall consist of one or more of the following evidentiary categories:

- (a) Written and oral clinical judgments furnished by any medical or health care professional caring for the Medicaid beneficiary;
- (b) The beneficiary's medical record;
- (c) Written and oral information furnished by a public agency with the authority to provide or arrange for medical treatment, health care, and other services to be furnished to the beneficiary;

- (d) The Medicaid beneficiary, or when appropriate, the beneficiary's family, guardian or caregiver or anyone designated by the beneficiary for whom the beneficiary executes an appropriate release authorization pursuant to the requirements set forth in the Health Insurance Portability and Accountability Act, regarding the beneficiary's health and functional status, symptoms, and the need for the requested services to enable the beneficiary to prevent or ameliorate physical or mental health conditions, gain health benefits, improve or maintain functional capacity, or avert deterioration in health or functional status from particular interventions and treatments;
- (e) Scientifically conducted studies and research, including randomized controlled clinical trials, that either directly or indirectly demonstrate the effect of the intervention on health outcomes or observational studies that demonstrate a casual relationship between the intervention and the desired health outcome;
- (f) The results of government-conducted or sponsored research and government-issued treatment guidelines;
- (g) Written treatment guidelines issued by professional societies, peer-review and quality improvement organizations, organizations and entities that specialize in the development of treatment guidelines for use in health care administration; or
- (h) Objective evidence obtained from government sources, peer review literature, or other impartial and reliable sources, regarding the cost of health care treatment alternatives under consideration, including estimated and actual costs associated with the provision of covered medical and health care in both institutional and community settings.

9000.11 Any review undertaken by the DHCF regarding payment for items and services under these rules, including reviews of transfers or discharges of residents from Medicaid-financed institutional facility placements, or eligibility for institutional care following preadmission screening and annual resident review, shall at a minimum take into account the evidence described in §9000.10 (a) through (c) and §9000.10(d) if available.

9000.12 A medical necessity coverage determination may be retrospective, prospective, or concurrent.

- 9000.13 Required classes of items and services covered under the State Plan, if provided in or after the third month before the month in which the beneficiary makes application for assistance, are as follows:
- (a) Inpatient hospital services (other than services in an institution for mental diseases);
  - (b) Outpatient hospital services;
  - (c) Rural health clinic services and any other ambulatory services which are offered by a rural health clinic and which are otherwise included in the State Plan;
  - (d) Federally qualified health center services and any other ambulatory services offered by a federally qualified health center and which are otherwise included in the State Plan;
  - (e) Other laboratory and x-ray services;
  - (f) Nursing facility services (other than services in an institution for mental diseases) for individuals twenty-one (21) years of age or older;
  - (g) Early and periodic screening, diagnostic, and treatment services as defined in 42 U.S.C. §1396d(r) for individuals who are eligible under the State Plan and under the age of twenty-one (21);
  - (h) Family planning services and supplies to individuals of childbearing age (including minors who can be considered sexually active) who are eligible under the State Plan and who desire such services and supplies;
  - (i) Physician services furnished by a physician, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere;
  - (j) Medical and surgical services provided by a dentist, to the extent that such services may be performed under state law by either a doctor of medicine or a doctor of dental surgery or dental medicine and would be a physician's service if furnished by a physician;
  - (k) Services furnished by a nurse midwife which the nurse midwife is legally authorized to furnish under state law, whether or not the nurse midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

- (l) Services furnished by a pediatric nurse practitioner or certified family nurse practitioner, which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under state law, whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider; and
- (m) Home health care services for individuals entitled to nursing facility care, including medical supplies, equipment, and appliances suitable for use in a home.

9000.14

Optional classes of items and services covered under the State Plan in the case of beneficiaries ages twenty-one (21) and older, if provided in or after the third month before the month in which the beneficiary makes application for assistance, are as follows:

- (a) Medical and surgical services furnished by a dentist;
- (b) Podiatrists' services;
- (c) Optometrists' services;
- (d) Private duty nursing services;
- (e) Clinic services;
- (f) Dental services;
- (g) Physical therapy and related services;
- (h) Occupational therapy;
- (i) Services for individuals with speech, hearing and language disorders provided by or under the supervision of a speech pathologist or audiologist;
- (j) Prescribed drugs;
- (k) Dentures;
- (l) Prosthetic devices;
- (m) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist;
- (n) Diagnostic services;

- (o) Screening services;
- (p) Preventive services;
- (q) Rehabilitative services;
- (r) Services for individuals age sixty-five (65) or older in institutions for mental diseases to include inpatient hospital services;
- (s) Skilled nursing services and intermediate care facility services for the mentally retarded (other than in an institution for mental diseases);
- (t) Intermediate care facility (ICF) services other than such services in an institution for mental disease;
- (u) Inpatient psychiatric facility services for individuals under twenty-two (22) years of age;
- (v) Hospice care;
- (w) Special tuberculosis related services;
- (x) Extended services for pregnant women;
- (y) Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period;
- (z) Skilled nursing facility services for patients under twenty-one (21) years of age;
- (aa) Emergency hospital services; and
- (bb) Personal care services when furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, that are:
  - (i) authorized for the individual by a physician in accordance with a plan of treatment or otherwise authorized for the individual in accordance with a service plan approved by DHCF;
  - (ii) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and
  - (iii) furnished in a home or other location.

- 9000.15 Additional classes of items and services that are covered for individuals under age twenty-one (21) pursuant to 42 U.S.C. §§1396d(a)(4)(B) and 1396d(r) are as follows:
- (a) The classes of items and services enumerated in 9000.13;
  - (b) The classes of items and services enumerated in 9000.14;
  - (c) Ambulatory services offered by certain health centers to pregnant women or individuals under eighteen (18) years of age;
  - (d) The following classes of items and services that fall within definition of “medical assistance” under 42 U.S.C. Section 1396d(a) but that are not covered as optional services for individuals ages twenty-one (21) and older under the State Plan:
    - (i) Case management services as defined in 42 U.S.C. Section 1396n(g)(2);
    - (ii) Respiratory care services;
    - (iii) Primary care case management services; and
    - (iv) Primary and secondary medical strategies and treatment and secondary medical strategies and treatment and services who have Sickle Cell Disease, subject to the requirements set forth in 42 U.S.C. §1396d(x).
- 9000.16 Prescribed outpatient drugs that are not enumerated on the preferred drug list maintained by DHCF may be covered in accordance with the requirements governing medical necessity set forth in §9000.5 and §9000.6, when supported by medical evidence pursuant to §9000.10.
- 9000.17 Prescribed outpatient drugs that are not listed in a formulary administered by a managed care organization, and outpatient formulary drugs prescribed for off-label use, shall be considered medically necessary, pursuant to §9000.5 or §9000.6, under the following circumstances:
- (a) When the request is made by the prescribing physician that complies with the form and in a manner specified by DHCF;
  - (b) When the request is supported by the classes of medical evidence described in §9000.10 (a), (b), and (e)-(g); and
  - (c) When the prescribing physician provides written certification, in a form and manner specified by DHCF, of compliance with the

requirements governing off-label use of medications set forth in D.C. Official Code § 48-841.03.

**9001 RETROSPECTIVE COVERAGE DETERMINATIONS**

- 9001.1 Except for the preventive treatments, items and services set forth in 9000.8, and items and services that that have been explicitly pre-authorized as part of patient treatment, DHCF may conduct a retrospective coverage determination of any treatment, item or service, including procedures related to the diagnosis of a condition for which payment has been made by DHCF.
- 9001.2 DHCF shall mail a written notice of intent to conduct a retrospective coverage determination to the beneficiary, the beneficiary's representative (if known) and the provider whose treatments or services are under review.
- 9001.3 The written notice of intent mailed to the beneficiary shall include all of the following information:
- (a) An explanation of the retrospective coverage determination to be undertaken, including the process that will be used by DHCF in conducting the review;
  - (b) A description of the items, treatments and services to be reviewed;
  - (c) The date(s) on which such items, treatments and services occurred;
  - (d) The name of the provider whose items, treatment or services to be reviewed;
  - (e) The legal authority on which such a review is based; and
  - (f) A specific list of the information sought from the provider whose services or treatments are under review.
- 9001.4 In conducting the retrospective review, DHCF shall consider all relevant medical evidence submitted by the beneficiary, the beneficiary's representative (if known), the provider whose treatment or services are under review, and any public or private agency that is involved in the management or oversight of the beneficiary's treatment.
- 9001.5 Within one hundred and twenty (120) calendar days after receipt of all requested information obtained from the beneficiary and the provider whose treatments or services are under review, including but not limited to the beneficiary's medical records, DHCF will mail a notice of intended

action to the beneficiary, or the beneficiary's representative (if known), regarding the results of the retrospective coverage determination. DHCF retains the power to issue the notice of intended action, if requested information is not furnished. Copies of the notice also shall be mailed to the following individuals and entities:

- (a) The provider whose treatments, items, or services were the subject of the retrospective review;
- (b) The beneficiary's primary care provider, if known; and
- (c) Any public or private agency involved in the management or oversight of the beneficiary's care.

9001.6 The notice of intent issued pursuant to §9001.5 shall include the following:

- (a) A statement of what action DHCF intends to take and the date of intended action, which shall be no fewer than 45 days from the date on which the notice is mailed;
- (b) The specific regulations, rules and policies that support the decision regarding whether the treatment is considered medically necessary or whether there was an adverse determination;
- (c) An explanation of the beneficiary's right to request a reconsideration (either orally or in writing), which shall be made no later than fifteen (15) days from the date on which the notice of intended action is mailed;
- (d) An explanation of the process that the beneficiary can use to secure copies of all medical evidence on which DHCF relied (which shall be furnished to the beneficiary at no cost no later than seven (7) calendar days following the date of the request);
- (e) An explanation of the beneficiary's right to have assistance continued if the request for a reconsideration or hearing as specified in subsection (f) of this section is made before the date on which the action will occur;
- (f) An explanation of the beneficiary's right to request a hearing by submitting a written or oral request to the Office of Administrative Hearings within ninety (90) calendar days from the date that the notice described in §9001.5 is mailed;

- (g) An explanation that the beneficiary has the right to be represented by legal counsel or by a lay person who is not an employee of the District at the hearing; that the beneficiary may bring witnesses on his or her behalf to the hearing; that transportation for the beneficiary and his or her witnesses will be provided; and that legal services are available to the beneficiary; and
- (h) In the event of a notice of intent to pursue recovery of payment for medical assistance items and services, an explanation that the beneficiary has no responsibility either to:
  - i. Repay DHCF for any treatment or services found to be medically unnecessary; or
  - ii. Pay the treating provider whose medical assistance payments are the subject of recovery.

9001.7 Within fifteen (15) calendar days of the date on which the notice of intended action described in §9001.5 is mailed, the beneficiary or beneficiary's representative may submit an oral or written request for reconsideration by DHCF of its initial determination.

9001.8 The beneficiary, the beneficiary's representative, a provider acting on the beneficiary's behalf, or a public or private agency responsible for planning and managing the beneficiary's treatment may provide additional written information to DHCF for review. The reconsideration of the initial determination shall be completed no later than twenty-one (21) calendar days from the date on which DHCF receives any additional information from the beneficiary, which shall be no later than seven (7) days from the date on which the beneficiary submits an oral or written request for reconsideration by DHCF. Either party may request an extension of time not to exceed fourteen (14) days for completion of the reconsideration.

9001.9 DHCF shall mail written notice of the results of its reconsideration to the beneficiary, the beneficiary's representative, the provider whose treatment or services are under review, and any public or private agency involved in the beneficiary's treatment or management. The written notice of the results of the reconsideration shall contain all of the following information:

- (a) An explanation of the action that DHCF intends to take and the date on which such intended action will commence;
- (b) An explanation of the results of the reconsideration, including an explanation of the evidence in support of the decision;
- (c) The specific laws that support the decision;

- (d) An explanation that the treatment or services subject to the reconsideration will not be reduced or terminated if an administrative hearing described in D.C. Official Code §4-210.01 et seq. is requested prior to the date of action;
- (e) An explanation of the beneficiary's right to request a hearing by submitting a written or an oral request to the Office of Administrative Hearings within ninety (90) calendar days from the date that the notice is mailed;
- (f) An explanation that the beneficiary has the right to be represented by legal counsel or by a lay person who is not an employee of the District at the hearing; that the beneficiary may bring witnesses on his or her behalf to the hearing; that transportation for the beneficiary and his or her witnesses to the hearing will be provided; and that legal services are available to the beneficiary; and
- (g) In the event of a notice of intent to pursue recovery of payment for medical assistance items and services, an explanation that the beneficiary has no responsibility either to:
  - i. Repay DHCF for any treatment or services found to be medically unnecessary; or
  - ii. Pay the treating provider whose medical assistance payments are the subject of recovery.

9001.10 A reconsideration of a retrospective coverage determination shall be conducted by an individual who:

- (a) Possesses professional credentials, skills, and training relevant to the beneficiary's condition and the course of treatment under review; and
- (b) Is someone other than the individual who made the initial adverse determination and who is not a subordinate of such individual.

9001.11 As part of the reconsideration process, the beneficiary or beneficiary's representative shall have the right to:

- (a) Submit additional relevant medical evidence, including a second opinion;
- (b) Request an in-person or telephonic meeting with the individual conducting the reconsideration; and

- (c) Access to copies of all medical evidence examined as part of the reconsideration process.

- 9001.12 All notices issued to beneficiaries or beneficiaries' representatives shall comply with the requirements set forth in the Language Access Act of 2004, approved June 19, 2004 (D.C. Law 15-167; D.C. Official Code § 1-1932 et seq.), and shall be provided in alternative formats and large typeface to accommodate individuals with disabilities.
- 9001.13 The beneficiary or beneficiary's representative may request a hearing by submitting a written or oral request to the Office of Administrative Hearings within ninety (90) calendar days from the date that the notice of intended action described in §9001.5 or the reconsideration notice described in §9001.9 is mailed.
- 9001.14 If DHCF fails to comply with the timeframes set forth in §§ 9001.5 or 9001.8, the services shall be deemed medically necessary and approved.
- 9001.15 If the beneficiary fails to timely request a reconsideration as set forth in section §9001.7 or a hearing as set forth in § 9001.13, the decision issued by DHCF shall become effective.

## **9002 PROSPECTIVE COVERAGE DETERMINATION**

- 9002.1 Subject to updates contained on the DHCF website, the following treatments, items and services shall be prior-authorized by DHCF and subject to the procedures governing prospective coverage determinations set forth in this section:
- (a) Inpatient hospital admissions other than admissions undertaken to stabilize an individual under 42 U.S.C. §1395dd (related to emergency screening and stabilization services for persons with emergency medical conditions who come to a hospital's emergency department);
  - (b) Pet Scans;
  - (c) Gastric By-Pass Surgery;
  - (d) Hearing Aid and Speech Services;
  - (e) Sleep Studies;
  - (f) Mammoplasty;

- (g) Out-of-state specialty hospital admissions for children and adolescents;
  - (h) Botox treatments;
  - (i) Penile Implants;
  - (j) Various extended home health care services;
  - (k) Organ transplants;
  - (l) Ventilator care;
  - (m) Out-of-state dialysis;
  - (n) Various eye glasses and contact lenses;
  - (o) Various durable medical equipment services, prosthetics and orthotics;
  - (p) Various dental services, excluding preventive treatment, items and services as described in §9000.5;
  - (q) Out-of State nursing home care;
  - (r) Prescribed drugs other than those listed on a preferred drug list or a prescription drug formulary administered by a managed care organization;
  - (s) Out-of-state care in an intermediate care facility for persons with mental retardation; and
  - (t) Out-of-state residential treatment centers for children and adolescents.
- 9002.2 A request for a prospective coverage determination may be made by the Medicaid beneficiary or beneficiary's representative, the beneficiary's primary care physician, or the health care professional or provider who has prescribed or will be furnishing the services or treatment.
- 9002.3 The request shall be made orally or in writing and in a form and manner prescribed by DHCF. The written request shall also indicate whether the request is an expedited request.
- 9002.4 The request for a prospective coverage determination shall be accompanied by the relevant medical evidence in support of the request.

Copies of all relevant medical evidence submitted to DHCF shall be made available to the beneficiary or beneficiary's representative at no cost.

- 9002.5 An oral request for an expedited prospective coverage determination may be made by the prescribing or treating health care professional or provider or the beneficiary's primary care physician. An oral request shall be followed by a written request within twenty-four (24) hours.
- 9002.6 The written request for an expedited coverage determination shall be consistent with the requirements set forth in §§ 9002.3 and 9002.4 and shall be submitted to DHCF within twenty-four (24) hours of the oral request. Upon request, DHCF may grant an extension of up to twenty-four (24) hours to file the written request unless reasonable evidence indicates that to do so would jeopardize the health and safety of the beneficiary.
- 9002.7 Within one (1) business day after receipt of an expedited request as described in §9002.5 and §9002.6, DHCF shall respond orally. DHCF shall issue a written notice of intended action within 24 hours of conveying the oral response and may take up to an additional (24) hours to respond in writing unless reasonable evidence indicates that to do so would jeopardize the health and safety of the beneficiary.
- 9002.8 The notice issued pursuant to § 9002.7 shall include a description of the results of the review, including a statement indicating whether the treatment is authorized or whether there was an adverse determination and shall comply with the requirements set forth in §9001.6 (b),(c),(d),(f) and (g).. The notice shall be issued to the Medicaid beneficiary or beneficiary's representative and copies sent to the prescribing or treating health care professional or health care provider who sought prior authorization.
- 9002.9 Where a request for prior authorization is not expedited, DHCF shall issue a notice of intended action conforming to §9002.8 within twenty (20) calendar days of the oral or written request. The notice shall be mailed to the Medicaid beneficiary or beneficiary's representative and copies sent to the prescribing or treating health care professional or health care provider who made the request.
- 9002.10 Where the notice of intended action involves a denial of an expedited request for prior authorization, the beneficiary or beneficiary's representative, health care professional or provider may request an expedited reconsideration of the denial not later than twenty-four (24) hours after receipt of the determination.
- 9002.11 Within twenty-four (24) hours of receipt of an expedited reconsideration request, DHCF shall respond orally and issue a written notice of the

results of the reconsideration. The written notice shall comply with the requirements set forth in §9001.9. The notice shall be issued to the Medicaid beneficiary or beneficiary's representative and copies sent to the prescribing or treating health care professional or health care provider. DHCF or the beneficiary may request an additional twenty-four (24) extension of the deadlines set forth in this section, but in no event shall the reconsideration request jeopardize the health and safety of the beneficiary.

- 9002.12 Where the notice of intended action involves a non-expedited request for prior authorization the beneficiary or beneficiary's representative may submit a written request for reconsideration within thirty (30) calendar days of the date on which the initial notice of intended action is mailed. DHCF shall complete its reconsideration within twenty-one (21) calendar days of the date on which the request is made and shall comply with the procedural and notice requirements set forth in Sections 9002.11.
- 9002.13 A beneficiary may request a hearing following the results of the reconsideration of either an expedited or non-expedited request for prior authorization.
- 9002.14 In the case of a hearing that is sought following the reconsideration of a non-expedited or expedited prior authorization request, the beneficiary or beneficiary's representative may orally request a hearing or submit a written request to the Office of Administrative Hearings within ninety (90) calendar days from the date that the notice of reconsideration is mailed. The written request for a hearing shall include a copy of written reconsideration by DHCF.
- .9002.15 Each notice issued to a beneficiary shall comply with the requirements set forth in the Language Access Act of 2004, approved June 19, 2004 (D.C. Law 15-167; D.C. Official Code § 1-1932 et seq.) and shall be provided in alternative formats and large typeface to accommodate individuals with disabilities.

### **9003 CONCURRENT COVERAGE DETERMINATION**

- 9003.1 DHCF may conduct a concurrent coverage determination of any treatment, item or service including procedures related to the diagnosis of a condition for which payment will be sought from DHCF.
- 9003.2 DHCF may conduct a concurrent coverage determination on the following services, items and treatments, which shall be subject to the procedures set forth in this section:
- (a) Acute inpatient and general hospital services;

- (b) Nursing facility services;
  - (c) Extended home health services; and
  - (d) Out-of-state specialty hospital services for children and adolescents.
- 9003.3 DHCF shall consider all relevant medical evidence submitted by the treating health care professional or provider when making a concurrent coverage determination.
- 9003.4 DHCF shall issue a written notice which shall include a description of the review and indicate whether the services are medically necessary and covered or whether an adverse determination has been made. The notice shall indicate the date on which action shall take place.
- 9003.5 The written notice shall comply with the requirements set forth in §9001.6. The written notice shall be issued to the beneficiary or the beneficiary's representative with copies to the treating health care professional or provider.
- 9003.6 The beneficiary or beneficiary's representative may submit a request for reconsideration of the adverse determination within fifteen (15) calendar days of receipt of the notice issued pursuant to §9003.4.
- 9003.7 A reconsideration shall be conducted pursuant to the requirements set forth in §§ 9001.10 and 9001.11.
- 9003.8 Within twenty-one (21) calendar days of receipt of the request for reconsideration, DHCF shall issue a written notice of the results of the reconsideration. If an adverse determination has been made, the notice shall comply with the requirements set forth in §9001.9. The written notice shall be issued to the beneficiary or beneficiary's representative with copies of the treating health care professional or provider.
- 9003.9 The beneficiary or beneficiary's representative may orally request a hearing or submit a written request to the Office of Administrative Hearings within ninety (90) calendar days from the date of mailing of the notice described in §9003.8. The written request shall include a copy of the adverse determination. .
- 9003.10 Services shall not be terminated or reduced if the beneficiary requests a reconsideration or administrative hearing before the date of action referenced in §9003.4.

9003.11 Each notice issued to a beneficiary shall comply with the requirements set forth in the Language Access Act of 2004, approved June 19, 2004 (D.C. Law 15-167; D.C. Official Code § 1-1932 et seq.) and shall be provided in alternative formats and large typeface to accommodate individuals with disabilities.

**9004 PROVIDER APPEALS**

9004.1 Except for preventive treatments, items and services and treatments that have been expressly pre-authorized or concurrently authorized, DHCF may conduct a retrospective coverage determination of any treatment, item or service, including procedures related to the diagnosis of a conditions for which payment has been made by DHCF and reimbursement is sought by DHCF from the provider.

9004.2 DHCF shall issue a written notice to conduct a retrospective coverage determination to the beneficiary and the provider. DHCF shall have one hundred and twenty (120) days from the date that information sought from the provider is furnished to complete the retrospective review.

9004.3 The written notice issued to the provider shall include the following information:

- (a) An explanation of the retrospective coverage determination, including the procedures that will be used by DHCF in conducting the review;
- (b) The beneficiary's name and Medicaid identification number of the person whose treatment or services are subject to review;
- (c) A description of the items, treatments and services to be reviewed and the specific information that the provider must submit;
- (d) The date(s) on which such items, treatments and services occurred; and
- (e) A request for copies of the beneficiary's medical record, including the time frame for responding to the request, if required.

9004.4 DHCF shall consider all relevant medical evidence submitted by the treating health care professional or provider.

9004.5 If DHCF proposes to seek reimbursement from a provider because the service is not medically necessary or a covered service, within ninety (90) calendar days after receipt of all requested information, DHCF shall send a

written notice of intent seeking reimbursement from the provider. The notice shall include the following:

- (a) The basis for the proposed action;
- (b) The amount of the overpayment;
- (c) The specific action DHCF intends to take;
- (d) The provider's right to dispute the allegations, and to submit relevant medical evidence to support his or her position; and
- (e) Specific reference to the particular sections of the rules or regulations, statutes, transmittals or provider manuals in support of the proposed action.

9004.6 Within thirty (30) calendar days of the date on the notice set forth in §9004.5, the provider may submit relevant medical evidence and written argument against the proposed action.

9004.7 For good cause shown, DHCF may extend the thirty (30) day period prescribed in §9004.6.

9004.8 If DHCF decides to seek reimbursement after the provider has filed a response under §9004.7, then DHCF shall send written notice of the final decision to the provider at least thirty (30) calendar days before the date of intended action. The notice shall include the following:

- (a) The basis for the final action, including the evidence on which DHCF relies, the amount of the overpayment and the specific action DHCF intends to take;
- (b) Specific reference to the particular sections of the rules or regulations, statutes, transmittals, or provider manuals; and
- (c) The provider's right to request a hearing by filing a notice of appeal with the Office of Administrative Hearings.

9004.9 If the provider files a notice of appeal within thirty (30) calendar days of the date of the notice prescribed pursuant to §9004.8, then the proposed action shall be stayed pending a decision by the Office of Administrative Hearings.

9004.10 A copy of the notice prescribed in §9004.5 and 9004.8 shall also be sent to the Medicaid beneficiary and the beneficiary's primary care physician, if known.

**9005            APPLICABILITY OF MEDICAL NECESSITY COVERAGE  
DETERMINATION PROCEDURES TO MANAGED CARE  
ARRANGEMENTS**

9005.1        The procedures described in sections 9001-9004 (other than those related to prior authorization of prescribed drugs not included in a formulary administered by an managed care organization (MCO) under 9002.1) shall not apply to items or services enumerated in a contract with a MCO.

9005.2        DHCF shall review each request for a hearing filed by a managed care enrollee before the Office of Administrative Hearings. DHCF retains the right to reverse or modify the MCO's final adverse determination during the hearing or appeal process.

**9006            NURSING FACILITY ADMISSIONS AND CONTINUED STAY**

9006.1        Each Medicaid beneficiary seeking admission for placement in a nursing facility or the receipt of services available under the Home and Community-based Waiver for Persons who are Elderly and Individuals with Physical Disabilities shall meet all of the following requirements:

- (a)        In the case of beneficiaries who seek admission for placement in a nursing facility, the Form-1728 and Level I Pre-Admission Screen Resident Review (PASRR) screening form shall be completed, appropriately signed and submitted to DHCF's Quality Improvement Organization (QIO) for review;
- (b)        The Medicaid beneficiary shall require extensive assistance or total dependence or supervision or limited assistance in at least two (2) of the five (5) activities of daily living listed on Form-1728; and
- (c)        The Medicaid beneficiary shall require extensive assistance or total dependence or supervision or limited assistance in at least three (3) of the five (5) instrumental activities of daily living listed on Form-1728.

9006.2        In addition to the requirements set forth in §9006.1, each Medicaid beneficiary seeking admission for placement in a nursing facility shall have a negative Level I PASRR screening or have a positive Level I PASRR screening with clearance for nursing facility placement by the Department of Disabilities Services or the Department of Mental Health.

9006.3        Following the initial admission review, a continued stay review shall be conducted by the QIO every ninety (90) days to determine whether the

continued stay in a facility is medically necessary. The elements of a continued stay review shall include, but are not limited to:

- (a) Appropriateness of level of care;
- (b) Minimum Data Set (MDS) validation;
- (c) Annual PASRR screening if due; and
- (d) Referral for community placement opportunities.

**9099.99****DEFINITIONS**

**Adverse determination** - a decision or finding that an individual does not require the level of services provided by a nursing facility; does not need an item or service covered under the State Plan; or a decision to deny, terminate, or reduce the amount, duration, or scope of, an item or service covered under the State Plan.

**Beneficiary** – any individual who has been designated as eligible to receive or who receives any item or service under the D.C. Medicaid program.

**Concurrent coverage determination** - a determination made regarding whether a treatment, item or service is medically necessary and covered at the time of, or during, a proposed course of treatment.

**EPSDT** - early and periodic screening, diagnosis, and treatment services for individuals under the age of twenty-one (21) as defined in 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r).

**Expedited request** -- an expedited request is a request that a coverage determination be made quickly because in the opinion of the treating medical or health care professional or health care provider such action is necessary to:

- (a) Avert jeopardy to the life or health of the beneficiary;
- (b) Avoid a beneficiary's failure to regain or maintain proper functioning; or
- (c) Prevent or manage severe pain.

**Individual Habilitation Plan** - that term as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of

1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.3).

**Individual Support Plan** - the successor plan to the Individual Habilitation Plan as defined in the court-approved Joy Evans Exit Plan.

**Individualized Support Plan** - a plan of action formalized with the beneficiary/representative and one or more health care professionals based upon the nature of the beneficiary's illness and identified needs. The plan includes the beneficiary's health care and supportive needs, and the approaches recommended for meeting those needs. Modifications are made to the plan, as required, to ensure the optimal outcomes for the beneficiaries.

**Investigational** - items and services that otherwise would be considered as falling within one or more classes of items and services covered under the State Plan but are excluded, because they are furnished as part of the research protocol within a clinical investigational trial that meets Medicare-applicable standards, as specified in the Decision Memorandum for the Clinical Trial Policy issued by the Centers for Medicare and Medicaid Services on July 9, 2007.

**DHCF** - the Department of Health Care Finance or its authorized agent.

**Managed Care Organizations** - entities defined in 42 U.S.C. §§ 1396b(m)(1)(A) and 1396u-2(a)(1)(B)

**Medicaid beneficiary or beneficiary** - an individual enrolled in the District of Columbia Medicaid program.

**Minimum Data Set (MDS)** - the resident assessment instrument and data used to classify nursing facility residents into groups based on each resident's needs and functional, mental and psychosocial characteristics.

**Prospective Coverage Determination** - a prior authorization determination made regarding whether the proposed treatment or service is medical necessary and covered in advance of treatment.

**Relevant Medical Evidence** - information that falls within one or more of the evidentiary categories listed in §9000.10 and that relates to the physical, mental, or developmental health condition of a particular beneficiary or to a particular course of furnished or recommended treatment.

**Retrospective Coverage Determination** - a decision or finding regarding whether a furnished treatment or service is covered and medical necessary following the provision of the treatment or service.

Comments on the proposed rules shall be submitted in writing to Julie Hudman, Director, Department of Health Care Finance, 825 North Capitol Street, N.E., 5<sup>th</sup> Floor, Washington, DC 20002, within thirty (30) days from the date of publication of this notice in the *DC Register*. Copies of the proposed rules may be obtained from the same address.

## PUBLIC SERVICE COMMISSION OF THE DISTRICT OF COLUMBIA

NOTICE OF PROPOSED RULEMAKINGFormal Case No. 988, In the Matter of the Development of Universal Service Standards and a Universal Service Trust Fund for the District of Columbia

The Public Service Commission of the District of Columbia ("Commission"), pursuant to its authority under D.C. Official Code § 34-802 and D.C. Code § 34-2003 (2001 Ed.), hereby gives notice of its intent to amend Chapter 28 of Title 15 of the District of Columbia Municipal Regulations ("DCMR"). This chapter governs the operation of the District of Columbia Universal Service Trust Fund ("DC USTF") for telecommunications services.

**CHAPTER 28 UNIVERSAL SERVICE****2803 DISTRICT OF COLUMBIA UNIVERSAL SERVICE TRUST FUND**

2803.1 Funds from the DC USTF will be used to support the enumerated services listed in 2802.1 as follows:

To reimburse eligible telecommunications carriers ("ETCs") ~~local exchange carriers~~ for the reasonable investments and expenses not recovered from the federal universal service low-income fund. The amount to be reimbursed shall ~~be calculated for each eligible telecommunications carrier ("ETC") to be no more than the remainder of the ETC's retail tariffed rate less funding from the Federal Universal Service Low Income Fund less the tariffed lifeline rate for each eligible customer subscribing to the ETC's lifeline \$6.50 for each eligible customer.~~ For ETCs that have a universal service program for low-income seniors, the amount to be reimbursed shall be no more than \$8.50.

**2805 SIZING THE DISTRICT OF COLUMBIA UNIVERSAL SERVICE TRUST FUND**

2805.2 The Fund Administrator shall submit to the Commission:

- (a) An income statement of the Fund's activity based on the proceeding calendar year by April 15; and
- (b) A proposed budget for the Fund for the upcoming calendar year by September 30~~October 31~~.

2805.3 ~~The Commission shall issue a Notice of Proposed Rulemaking on the Fund Administrator's report to be published in the D.C. Register. Interested~~

~~persons may file comments within thirty (30) days after publication, and reply comments within forty five (45) days of publication.~~

- 2805.34 On or before November 30 of each year, the Commission shall establish a budget for the upcoming year after ~~notice and~~ receipt of comments on the Fund Administrator's ~~report~~ proposed budget.

**2809 UNIVERSAL SERVICE FUND AUDIT**

- 2809.5 If the result of the audit reveals evidence of fraud or mismanagement, such results will be forwarded to the Office of the Inspector General and the District of Columbia Office of the Attorney General ~~Corporation Counsel~~ for further review.

**2812 REPORTING REQUIREMENTS FOR LOCAL EXCHANGE CARRIERS**

- 2812.1 ~~By October 31~~ By July 31 of each year, ~~ETCs~~ each LEC shall submit to the Fund Administrator a report containing ~~the~~ total jurisdictional revenue for ~~each~~ its local exchange service provided in the District of Columbia based on the 12-month period beginning on ~~July~~ January 1 of the proceeding year and ending on ~~June~~ December 31 of ~~that~~ the preceding year (e.g. ~~July~~ January 2XXX – ~~June~~ December 2XXX).

**2813 REPORTING REQUIREMENTS FOR THE DC USTF ADMINISTRATOR**

- 2813.1 On a quarterly basis, the Fund Administrator shall submit to the Commission a report including:
- (a) A statement of collections and distributions from the universal service fund for each local exchange carrier;
  - (b) A statement detailing the purpose for which the universal service funds were used (i.e. to support an enumerated service listed in § 2804.1 or for verification of lifeline eligibility); and
  - (c) A record of total cost of universal service fund administration.
- 2813.2 On September 30 ~~October 31~~ every year after the establishment of the DC USTF, the Fund Administrator shall submit to the Commission a report that includes a proposed budget for the upcoming year.

**2814 CONTRIBUTIONS TO THE DC USTF**

- 2814.1 The amount of contribution required from each LEC shall be based on total revenues for local exchange services of the local exchange carrier as a

percentage of all the LEC's total retail revenues for local exchange service provided in the District of Columbia, for the previous 12-month period ending ~~September 30~~ December 31.

**2820 DISTRICT OF COLUMBIA LIFELINE SERVICE PROGRAM**

2820.5 When ~~the District of Columbia Energy Office~~ or the entity responsible for certifying Lifeline customers notifies an ETC that ~~the~~ a customer no longer qualifies for Lifeline service, the Lifeline rate for that customer will revert to the serving ETC's standard tariffed retail rate.

All persons interested in commenting on the subject matter of this proposed rulemaking action may submit written comments and reply comments no later than thirty (30) and forty-five (45) days, respectively, after publication of this notice in the *D.C. Register*, with Dorothy Wideman, Commission Secretary, Public Service Commission of the District of Columbia, 1333 H Street, NW, West Tower, Suite 200, Washington, DC 20005. Copies of the proposed rules may be obtained by visiting the Commission's website at [www.dcpsc.org](http://www.dcpsc.org) or at cost, by contacting the Commission Secretary at the above address.