ATTACHMENT J-17.2

OFFICE OF UTILIZATION MANAGEMENT

PRIOR AUTHORIZATRION FOR SELECTED OUTPATIENT SURGERIES

DEPARTMENT OF HEALTH CARE FINANCE

OFFICE of UTILIZATION MANAGEMENT	POLICY AND PROCEDURES

SUBJECT: Revised Prior Authorization for Selected Outpatient Surgeries in the DC Medicaid Fee-for-Service (FFS) program

Effective Date:		**Last Date Revised** 1/12/09

Policy: The District of Columbia Department of Health Care Finance's (DHCF) Fee-for-Service Medicaid program covers selected outpatient surgeries that meet medical necessity criteria.

Prior authorization is required for certain outpatient surgical procedures, such as:

- Reduction mammoplasty
- Intestinal bypass for morbid obesity
- Cosmetic procedures

Covered outpatient procedures are those surgical and other medical procedures that:

- Are commonly performed on an inpatient basis in hospitals, but may be safely performed in an outpatient facility;
- Are not of a type that are commonly performed, or that may be safely performed, in physician's offices;
- Are limited to those requiring a dedicated operating room (or suite), and generally requiring a post-operative recovery room or short-term convalescent room;
- Generally, do not require a total of 90 minutes operating time or 4 hours recovery time; and
- If required, use local or regional anesthesia; or general anesthesia lasting less than or equal to 90 minutes. [42CFR416.65]

DHCF contracts with a quality improvement organization (QIO) to verify the medical necessity for such procedures, and that the restrictions described above are followed. DHCF's QIO will execute the prior authorization process in advance of a provider conducting outpatient surgical procedures for Medicaid beneficiaries in accordance with the DC Medicaid State Plan.

This document describes the policies and procedures that DHCF and DHCF's QIO will follow in authorizing Medicaid payments for Mammoplasty. Authorization for mammoplasty is valid for a period of six (6) months.

Purpose:
To help ensure that beneficiaries receive quality medical services and to make efficient use of beneficiary and Department of Health Care Finance (DHCF) resources.

Procedures:

I. Provider Actions:

1. Every requesting provider is to complete fields 1-11, 13,15A and 15B of DHCF's 719A Form by indentifying the appropriate ICD-9 and Current Procedural Terminology (CPT) codes for the services, the estimated charges and billing information.
2. The requesting provider faxes the 719A Form and supporting documentation to the QIO Prior Authorization Unit. Supporting documentation for determining the medical necessity for mammoplasty is described in Attachment A.
3. The requesting provider shall call the QIO Prior Authorization Unit for all inquiries.

II. QIO Prior Authorization Unit Processes:

A. Procedure

1. **Beneficiary and provider verification.** The QIO Prior Authorization Unit will implement the prior authorization process by verifying the:
   a. Patient's beneficiary number for Medicaid (located in the MMIS Recipient Subsystem screen), including the patient's active coverage period, as follows:
      - Date of services requested shall not exceed beneficiary's eligibility start and end dates;
      - If the beneficiary's eligibility end date is 999999, he or she is eligible for services indefinitely.
      - Presence of appropriate program codes.
   b. Provider's status as an Medicaid provider (located in the MMIS Provider Subsystem screen);
      - Provider not enrolled in DC Medicaid program→ Not eligible to provide services.
      - Active Status (01)→Eligible to provide services; or
      - Inactive Status→ Not eligible to provide services.
   c. Requesting provider signature and date on required documentation.

2. **Clinical review.** The QIO will review the 719A Form and supporting documentation for the:
   a. Presence of appropriate diagnosis and procedure codes; and
   b. Written justification and supporting documentation.

   If the 719F Form contains an imprecise procedure code: e.g., such as a miscellaneous "99" code, the QIO will request the provider to resubmit the 719A Form using more precise procedure codes.

   The QIO will use medical criteria approved by DHCF.

3. **Data submission to MMIS.** If the procedure is approved, the QIO Prior Authorization Unit remotely and electronically enters the approved data into the MMIS Prior Authorization Subsystem. Upon the entry of all necessary data, a prior authorization number is generated. The data entry process includes

populating the following fields:

A. approval status-→A (indicating approval);
B. provider letter status-→Y (mail letter to provider);
C. beneficiary number;
D. billing provider number;
E. approver ID number;
F. dates of service range;
G. diagnosis code;
H. procedure code(s);
I. unit number (for each procedure code requested);
J. estimated charge; and
K. approved amount.

4. **Pricing.** If the requested procedure is approved, the QIO Prior Authorization Unit will adhere to the guidance below when entering data into the 'Approved Amount' field of the MMIS Prior Authorization Subsystem.
    1. If the estimated charge of the requested procedure is equal to, or greater than, the dollar amount included in the current DHCF fee schedule, the QIO will enter '00'.
    2. If the estimated charge of the requested procedure is lesser than the dollar amount included in the current DHCF fee schedule, the QIO will enter the estimated charge.
    3. If the estimated charge for the requested procedure has no price included in the current DHCF fee schedule, the 719A Form is forwarded to DHCF for review.

5. **Transmittal of approval to provider.** The QIO's Prior Authorization Unit faxes to the requesting provider the 719A Form that includes a prior authorization number, approved dates of service range, approved HCPCS or CPT codes, and approved units.

B. Timelines

1. The QIO Prior Authorization Unit will return all incomplete 719F Forms to the requesting provider via fax immediately. The requestor will have two (2) business days to complete the form and fax it back to the Prior Authorization Unit.

2. Within five (5) business days of the receipt of the 719A Form, the QIO Prior Authorization Unit will conduct a review of each complete 719A Form, and fax to the requesting provider all determinations, including information on appeal rights for requests that are denied.

3. If the procedure code is not included in DHCF/s current fee schedule, the QIO Prior Authorization Unit will fax a decision to the requesting provider within ten (10) business days of the receipt of the original 719A Form. Processing will include:
    - Within five (5) business days of the receipt of the 719A Form, the QIO Prior Authorization Unit will notify the requesting provider that their request has been forwarded to DHCF for review; and then fax the

complete 719A Form and supporting documentation to DHCF.

- Within five (5) business days of receipt of the 719A Form and supporting documentation form the QIO Prior Authorization Unit, DHCF will review the request, and fax a decision to the QIO Prior Authorization Unit.

- The QIO Prior Authorization unit will fax a decision to the requesting provider.

C. Tracking

The QIO will maintain a tracking log of all prior authorization requests and transactions, which includes the beneficiary and requesting physician names and identification numbers, billing provider name, date of service, the type of service requested, date of determination, and the prior authorization number issued. The tracking log will be updated monthly on the QIO's web portal, under 'Out Patient'.

III. Facility Submits Claim to ACS

The requesting provider must document the prior authorization number provided by the QIO (which is obtained and generated from the MMIS system) in Box 23 of the CMS 1500 as part of their claim submission. The payment will be denied if an authorization number is not present on the CMS 1500.

IV. Appeals Process:

A The requesting provider may fax a request for reconsideration to the QIO Prior Authorization Unit.

B The Prior Authorization Unit will:

1. Arrange for a reviewer, other than the reviewer who performed the initial review, to perform the reconsideration review; and
2. Issue the reconsideration decision within twenty-one (21) business days of the reconsideration request.
    - If approved, the Prior Authorization Unit electronically remotely enters the approval data into the Prior Authorization Subsystem of the MMIS and QIO Web Portal.
    - If not approved, provide written notification of denied services including information on appeal rights.

V. Customer Service

a) The QIO Prior Authorization Unit will respond to provider and beneficiary inquiries regarding prior authorization requests.
b) If the QIO Prior Authorization Unit is unable to adequately answer provider and beneficiary inquiries, the QIO Director of DC Medicaid Programs will respond.
c) If neither the QIO Prior Authorization Unit, nor the QIO Director of DC Medicaid Programs, is able to adequately answer provider or beneficiary inquiries, the DHCF Contracting Officer's Technical Representative will respond.

Revision History

Enclosed Materials: 1. Supporting Documentation (Attachment A)

Official Approval:	Date:
Senior Deputy Director Approval:	Date: