ATTACHMENT J-17.3

OFFICE OF CHRONIC & LONG-TERM CARE

PRIOR AUTHORIZATION OF EXTENDED PERSONAL CARE AIDE (PCA) SERVICES

THE GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH CARE FINANCE

OFFICE OF CHRONIC & LONG-TERM CARE	POLICY AND PROCEDURES

SUBJECT: Prior Authorization Process for the Extended PCA Services Provided Under the State Plan

Effective Date:	**Last Date Revised**
7/12/10	7/12/10

Policy:
The District of Columbia Department of Health Care Finance's (DHCF) Medicaid program covers personal care aide (PCA) services under its state plan to:

- "Provide necessary hands-on personal care assistance with the activities of daily living in order to maintain a patient in the home in a clean, sanitary and safe condition; and
- To encourage home-based care as a preferred and cost-effective alternative to institutional care." (29 DCMR § 5000.2)

Per DHCF Transmittal No. 10-04, reimbursement for personal care services shall not exceed one thousand and forty (1,040) hours each calendar year, unless prior authorized by DHCF.

If a DC Medicaid beneficiary requires a continuation of PCA services that exceed the annual limit of 1040 hours, a home health agency must request authorization to be reimbursed for hours over the annual limit ***before*** the limit is exhausted. DHCF will not grant retroactive prior authorizations.

Prior authorization of extended PCA services is valid up to 90 days from the date issued.

If additional extensions of PCA services are needed, the home health agency must submit subsequent prior authorization extension requests before the current prior authorization end date is reached.

The annual limit of PCA services is tracked for each beneficiary; therefore the accumulation of hours continues if a beneficiary changes providers. District of Columbia law requires home health agencies to maintain patient records that are complete, accurate and contain up-to-date information relevant to each patient's care and treatment (29 DCMR §5009.3). In cases in which a beneficiary transitions from one home health agency to another, the new agency should contact the old agency to request the total number of hours of PCA services provided to that beneficiary during the current calendar year. The former provider is expected to supply accurate information to the new agency.

DHCF contracts with a federally recognized Quality Improvement Organization (QIO) to verify that DC Medicaid and District requirements are met by providers requesting prior authorization for extended PCA services. DHCF's QIO will execute the prior authorization

process in advance of a home health agency delivering extended PCA services to a Medicaid beneficiary, in accordance with Medicaid rules and requirements set forth in this document.

Prior authorization for extended home health services will be requested via submission of a complete prior authorization request package to the DC Medicaid web portal. A complete package includes:

- DC Medicaid Request for Prior Approval for Extended Home Health/PCA Services, and
- The beneficairy's Plan of Care (CMS Form 485).

Both forms must be signed by the beneficiary's attending physician within 28-days prior to submission. Copies of both forms are attached to this document.

Additionally, if a beneficiary transitions to another home health agency during a time period when he/she is receiving extended PCA services from the initial home health agency that were previously authorized by DHCF, the agency requesting the new prior authorization must also include the DHCF Home Health Beneficiary Transition Form in the prior authorization request package.

This document describes the policies and procedures that home health agencies will follow in requesting prior authorization for extended PCA services and that DHCF and DHCF's QIO will follow in authorizing Medicaid payments for state plan PCA services that exceed the annual limit of 1,040 hours.

PURPOSE:

To help ensure that beneficiaries receive personal care services that best aid with activities of daily living and to make efficient use of Medicaid and beneficiary resources.

PRIOR AUTHORIZATION PROCEDURES:

I. Home health agency procedures for requesting prior authorization for extended PCA hours

(Each home health agency shall provide PCA services consistent with the service frequency and duration specified in a beneficiary's plan of care. Guidance on the frequency of patient health assessments and plan of care updates, in addition to patient rights, physician referrals and home health agency reimbursement is provided in 29 DCMR § 5000-5099.)

Each home health agency shall:

A. Track the total number of hours of PCA services each patient receives during the calendar year.
B. Submit a prior authorization request for extended PCA services, via the DC Medicaid web portal, before a patient reaches their annual 1,040 hour limit for PCA services. A complete prior authorization request includes:
   a. Request for Prior Approval for Extended Home Health/PCA Services (Attachment A)
   b. Plan of Care (CMS Form 485) (Attachment B)
C. Ensure that both submitted forms are signed by beneficiary's attending physician within 30 days before the prior authorization request is submitted.
D. Ensure frequency and duration information included on both forms are

consistent.

E. Ensure that the beneficiary's CMS Form 485 expires after the requested PA is set to end.

II. QIO Procedures

A. Prior Authorization Review and Determination

In reviewing and responding to requests for prior authorization of extended PCA services, the QIO shall:

1. ***Identify all pending home health agency prior authorization requests.*** The QIO Prior Authorization Unit shall initiate the prior authorization process by running a report in Omnicaid that lists all pending requests for prior authorization of extended PCA services submitted by home health agencies.

2. ***Review each pending prior authorization request for extended PCA services.*** The QIO Prior Authorization Unit shall review each request in the order submitted; beginning with the oldest to most recent request. The date and order of a submitted prior authorization request is determined by the prior authorization request number, as described below:
   a. The first two numbers indicate the year;
   b. The next two numbers indicate the month;
   c. The next two numbers indicate the date; and
   d. The final string of numbers indicates the order the request was submitted compared to others submitted that day.

   For example, a prior authorization number of 10051300045 is the 45th prior authorization request submitted on May 13, 2010.

3. ***Verify the beneficiary's Medicaid eligibility.*** The QIO Prior Authorization Unit will check a beneficiary's eligibility for state plan PCA services through the DHCF Omnicaid system. Within the Omnicaid system, the Unit will:
   a. Access the Control Panel and click on 'Recipient', then 'Detail'.
   b. Check eligibility information in both the 'Summary' tab and the 'Eligibility' tab.
   c. Contact DHCF's Program Analyst responsible for the Elderly Persons with Disabilities (EPD) waiver program if the beneficiary has an **853** program code (either with or without a suffix) to determine if an identical prior authorization request was submitted for the same beneficiary under the EPD program.
      i. If an identical prior authorization request was submitted under the EPD program and the EPD PA will be approved before extended state plan services would start, skip to *Step 11* to deny the request.
      ii. If the prior authorization request was not previously submitted under the EPD waiver or extended state plan services would start before an EPD waiver PA would be approved, proceed to *Step 3.*

d. If the beneficiary has a program code that allows him or her to receive long-term care services, proceed to Step 6.
e. If the beneficiary has a program code where the extension request should be denied (Attachment E) **do not** review or approve the request. Skip to *Step 11* to deny the request.

4. ***In Omnicaid, identify any previously submitted prior authorization request with identical PCA services and dates, or PCA prior authorizations with services with dates that overlap the request under review.***
   a. Review steps
      i. Go to the Control Panel, and select '*Prior Authorization*' and '*Maintenance*';
      ii. Select '*Recipient ID*' for the '*Search By*' criteria; and
      iii. Enter the beneficiary's Medicaid ID under 'Search For'.
   b. If there are no prior authorization requests in Omnicaid for identical PCA services that overlap with the request under review, proceed to *Step 5*.
   c. If a previously submitted prior authorization request for same PCA services with overlapping dates of service is present in Omnicaid, the QIO shall:
      i. Contact the home health agency, via phone, to request that agency fax a completed DHCF Home Health Agency Patient Transfer Form (Attachment D), within five (5) business days.
      ii. If the QIO Prior Authorization Unit does not receive the DHCF Home Health Agency Patient Transfer Form within two (2) business days, proceed to *Step 11* to deny the request.
      iii. If the QIO Prior Authorization Unit receives the DHCF Home Health Agency Patient Transfer form within two (2) business days, the Unit shall:
         a) Review the DHCF Home Health Agency Patient Transfer Form to ensure completeness.
         b) If the DHCF Home Health Agency Patient Transfer Form is incomplete, proceed to *Step 11* to deny request.
         c) If the DHCF Home Health Agency Patient Transfer Form is complete and approved, end the prior authorization approval number connected to the initial home health agency on the day preceding the start date requested under the new agency's prior authorization request.

5. ***Verify that the prior authorization request package is complete.*** Within the DC Medicaid web portal, the QIO Prior Authorization Unit shall:
   a. Click on 'Go To', then
   b. Click on 'EDMS' to retrieve the required documents:
      i. DHCF Request for Prior Approval for Home Health/Personal Care Services
      ii. Plan of Treatment (Form CMS-485).
   c. If required documents are attached, proceed to Step 4 below.
   d. If the required documents are not attached, contact the Project Manager, Health Care Operations Administration, Department of Health Care Finance. They will investigate the issue and notify the QIO when the issue

has been resolved.

6. ***Verify that the prior authorization request package contains required and consistent information.*** The QIO shall check the following information on the required forms:

   a. CMS Form 485: The dates indicated in #3 *'Certification Period'* cover the entire time period of the prior authorization period being requested.
   b. Signature date of beneficiary's attending physician included on both forms is within 30 days prior to submitting the prior authorization request package.
   c. The number of hours and days per week of PCA services being requested must be identical on CMS Form 485 and the DHCF Request for Prior Approval for Home Health/Personal Care Services;
   d. If all of the above are present, proceed to *Step 7.*
   e. If any of the requirements listed above are not met, skip to *Step 11* and deny the PA request

7. ***Review information entered into Omnicaid for the prior authorization request for accuracy.*** To confirm that information contained in the prior authorization request is accurate, the QIO Prior Authorization Unit will:
   a. Return to the Omnicaid screen containing the request information. (To do this, minimize the Control Panel and the Recipient information).
      i. Select the 'Detail' tab;
      ii. Confirm that the begin date and end date match the start and end dates listed in the header tab;
      iii. Confirm that under '*Service Type'*, '*P-Proc Code'* appears;
      iv. Confirm that under 'Service', '*T1019*' appears;
      v. Use the PCA PA calculator (Attachment C) to enter approved units, approved amount, and approved rate amount;
      vi. Confirm that under Procedure Modifiers, under Mod 1 U6 appears (no other modifier codes should be appear anywhere else); and
      vii. Change the status of the request to '*Approved*'.
   b. Check under the 'Header' tab to ensure the Begin Date matches the Effective Date
   c. Check the 'Detail' tab to ensure the *'Expiration Date'* matches the *'End Date'* .

8. ***Complete the review and approval of the prior authorization request.*** The QIO Prior Authorization Unit will click the 'Verify' button on the menu bar and then click the 'Save' button.

9. ***Enter approved prior authorization request into Omnicaid's 'State Plan Personal Care Aid Prior Authorization Log'.***

10. ***Enter details of approved PCA prior authorization request into the QIO tracking system.***

11. ***As appropriate, deny the prior authorization request.*** To deny a PA request in Omnicaid, the QIO Prior Authorization Unit shall:

a. Select *'Deny'* from the options listed under *'Status'*
b. Under the 'Notes' tab select 'Letter' and include one or more of the following reasons the prior authorization request was denied.
   i. *'The home health agency that submitted the request did not submit the required documents. A complete packet must be submitted for DHCF to review an extension request.'*
   ii. *'The home health agency submitted documents that were missing the attending physician's signature. Documents must be signed by the attending physician in order for DHCF to review an extension request.'*
   iii. *'The end date listed on the Plan of Treatment submitted by the home health agency ends before the extension request end date. The Plan of Treatment must end after the extension request end date in order for DHCF to review an extension request.'*
   iv. *'The documentation provided by the home health agency includes conflicting information about the amount of personal care aide services that are required. All documentation submitted must include consistent information about personal care aide services required for DHCF to review an extension request.'*
   v. *'The home health agency requested an extension of personal care aide services when authorization was not required.'*
   vi. *Based on the program code, the patient is not eligible for personal care aide services.*
c. Enter a *'Y'* for both the provider and beneficiary on the *'Header'* tab so both receive a denial letter.
d. Click save.
e. Enter details of denied PCA prior authorization request into the QIO tracking system, including reason for the denial.

B. Data Collection

The QIO Prior Authorization Unit shall collect and store information specific to the prior authorization request, (such as PCA dates of service requested for prior approval), as well as beneficiary and home health agency information, including:

- Recipient's name, Ward number, Medicaid ID number, date of birth, and sex;
- Scheduled date of extended PCA services;
- Frequency/duration of services for treatment/diagnosis;
- Primary diagnosis, secondary diagnosis, tertiary diagnosis (if applicable);
- Clinical information sufficient to support the appropriateness and level of service proposed, if applicable;
- Contact person for detailed clinical information;
- Recipient's primary care physician name, address, telephone/fax number, provider number (if available), and type physician; and
- Home health agency name, address, telephone/fax number, and provider

number.

C. Timelines

The QIO shall:

1. Daily, review pending PCA prior authorization requests by running a report, within the DC Medicaid web portal, that lists all pending requests submitted by home health agencies.
2. Within five (5) business days from date of prior authorization request receipt, review each PA request submitted into Omnicaid.
3. Monthly, produce three reports that summarize PCA prior authorization activities for the month. (See the next section for the fields to be included in each report.)

D. Tracking

1. The QIO Prior Authorization Unit will generate three reports monthly from their tracking system.
    a. **Report One:** Details of each PCA prior authorization request, by 'Approved' and 'Denied', including the following fields:
        i. Name, age, sex, date of birth of the beneficiary
        ii. Medicaid number of the beneficiary;
        iii. Ward in which beneficiary resides/ receives services;
        iv. Name of the home health agency;
        v. The type and units of service(s) requested;
        vi. If approved, the type and units of service(s) authorized;
        vii. If denied, the reason(s) for the denial;
        viii. Effective date and expiration date for prior authorization certification; and
        ix. The prior authorization number issued.
    b. **Report Two:** Instances of PCA prior authorization requests that are duplicates of previous requests submitted under the PCA state plan benefit or/ and under the EPD program; and
    c. **Report Three:** PCA prior authorization requests that included the DHCF Home Health Beneficiary Transition Form
2. The data reports shall be uploaded to the QIO's web portal on a monthly basis.

III. Home health agency submits claim for extended PCA hours

The home health agency must document the prior authorization number provided by the QIO in 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.** See Provider Billing Manual from ACS, DHCF's fiscal intermediary, for further instructions.

IV. Appeals Process

A home health agency may appeal the QIO decision to deny a request for extended PCA services, by following the steps below:

A. The home health agency may fax a request for reconsideration to the QIO Prior Authorization Unit.

B. The QIO 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.
      i. If approved, the QIO Prior Authorization Unit will:
         - Enter the approval data into Omnicaid;
         - Update the QIO tracking system; and
         - Update the QIO Web Portal.
      ii. If not approved, provide written notification of denied services including information on appeal rights via the District of Columbia fair hearing process.
      iii. Mail the beneficiary a letter of denial to beneficiary ineligible for the services.

VII. Customer Service:

1. The QIO staff shall respond to provider and beneficiary inquiries regarding prior authorization requests.
2. If the QIO staff is unable to adequately answer provider and beneficiary inquiries, the QIO Director of DC Medicaid Programs will respond.
3. If neither the QIO staff, nor the QIO Director of DC Medicaid Programs, is able to adequately answer provider or beneficiary inquiries, the COTR will be notified. Subsequently, a DHCF Office of Chronic & Long-Term Care staff member will respond.

REVISION HISTORY: This is the first iteration of the prior authorization policy for extended state plan PCA services assumed by Delmarva – July 12, 2010.

ENCLOSED MATERIALS:
1. Request for Prior Approval for Extended Home Health/PCA Services (Attachment A)
2. Plan of Treatment (Form CMS-485) (Attachment B)
3. PCA PA calculator (Attachment C)
4. DHCF Home Health Beneficiary Transition Form (Attachment D)
5. PCA Program Codes to Deny (Attachment E)
6. Provider denial letter
7. Beneficiary denial letter

Official Approval:	Date:
Deputy Director Approval:	Date: