# ATTACHMENT J-17.4

# OFFICE OF QUALITY MANAGEMENT OF PROGRAM INTEGRITY

# AUTHORIZATION PROCESS FOR NON-COSMETIC BOTOX INJECTIONS

**DEPARTMENT OF HEALTH CARE FINANCE**

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| **OFFICE of QUALITY MANAGEMENT/OFFICE OF PROGRAM INTEGRITY** | **POLICY AND PROCEDURES** |

**SUBJECT:** Retrospective Authorization Process for Non-Cosmetic Botox Injection Services for the DC Medicaid Fee-for-Service (FFS) program.

| **Effective Date:** | | **Last Date Revised** |
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| **2/02/2009** | | |

The District of Columbia Department of Health Care Finance (DHCF) Fee-for-Service Medicaid program covers Non-Cosmetic Botox Injection Services when prescribed by an actively-enrolled physician and it is a covered service in accordance with DC Medicaid State Plan.

DHCF contracts with a quality improvement organization (QIO) to verify the medical necessity justification for Non-Cosmetic Botox Injection Services, in addition to verifying that the aforementioned restrictions are followed. This document describes the policies and procedures DHCF's QIO will follow in reviewing retrospective requests for Non-Cosmetic Botox Injection Services.

**Purpose:**
To ensure that beneficiaries receive quality medical services and to make efficient use of beneficiary and DHCF resources.

**Policy:**
DHCF's QIO will execute the retrospective authorization process of a provider administering Non-Cosmetic Botox Injection Services for a Medicaid FFS beneficiary in accordance with the DC Medicaid State Plan.

Authorizations for Non-Cosmetic Botox Injection Services are valid for the date(s) of service listed on the approval letter forwarded to the providers, ***ONLY***.

**Procedures**:

***I. Provider Procedure:***

1. Every requesting provider is to complete fields 1-11, 13,15A and 15B of the 719A Form by indentifying the appropriate ICD-9 codes, Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System) (HCPCS) codes for the Non-Cosmetic Botox Injection Services, units of Botox, the charges, and billing information. Date(s) of service should be noted in field 13.
2. The requesting provider faxes the 719A Form and clinical documentation that supports the requested services, to the QIO Authorization Unit.
3. The requesting provider shall call the QIO Authorization Unit for all inquiries.

## *II. QIO Authorization Unit:*

### A. Retrospective Authorization Process

1. **Beneficiary and provider verification.** The QIO Authorization Unit will begin the authorization process by verifying the:
   a. Patient's eligibility for Medicaid (located in the MMIS Beneficiary Subsystem screen), including the patient's active coverage period, as follows:
      - Date of services requested shall not exceed beneficiary's eligibility end dates;
      - If the beneficiary's eligibility end date is 999999, they are eligible for services indefinitely.
      - If specific eligibility codes are present, the request for retrospective authorization will be denied.
   b. Provider's status as an enrolled Medicaid provider (located in the MMIS Provider Subsystem screen);
      - Active Status (01)→Eligible to provide services; or
      - Inactive Status→ Not eligible to provide services.
   c. Presence of appropriate diagnosis and procedure codes;
   d. Written justification and supporting documentation; and
   e. Requesting provider signature and date.

2. **Data submission to MMIS.** If the procedure is approved, the QIO Authorization Unit will remotely enter the approved data into the MMIS Authorization Subsystem. Upon the entry of all necessary data, an 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 (see list);
   I. unit number (for each procedure code requested); and
   J. estimated charge

### B Transmittal of approval to provider

The QIO Authorization Unit faxes to the requesting provider notification which includes a MMIS authorization number, the dates of service that are approved, approved HCPCS or CPT codes, and approved units.

### C Timelines

a. Within five (5) business days of the 719A Form, and supporting documentation, receipt date, the QIO Authorization Unit will conduct a

review of each complete 719A Form, and fax to the requesting provider all determinations. This will include information on appeal rights for denials.

b. If the requested service is not included within DHCF's list of covered services, the requesting provider will be notified that their request has been forwarded to DHCF for review. The QIO Authorization Unit will then fax the complete 719A Form and supporting documentation to DHCF. Within two (2) business days, DHCF will review and manually price the requested service, and fax a decision to the QIO Authorization Unit. Within seven (7) business days of the date the 719A Form was originally submitted by the requesting provider, the QIO Authorization Unit will fax a decision to the requesting provider. The QIO will use medical criteria approved by DHCF.

c. All incomplete 719A forms will be returned 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 QIO Authorization Unit.

d. Authorizations for Non-Cosmetic Botox Injection Services are valid for the date(s) of service listed on the approval letter forwarded to the providers, ***ONLY.***

e. If the requesting provider is not a DC Medicaid provider: The QIO will enter the request into the tracking system with the case number and refer the provider to DHCF to facilitate the provider enrollment process. Upon notification, DHCF has five (5) business days to facilitate the provider enrollment process and fax the temporary provider identification number to the QIO Authorization Unit. The QIO Authorization Unit faxes a letter that contains the retrospective authorization number for the requested service to the requesting provider.

f. In cases of emergency the provider may call the QIO Authorization Unit's manager.

D **Tracking**

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

***III. Facility Submits Claim to ACS***

The requesting provider must document the 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 Authorization Unit.
b) The 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 Authorization Unit remotely enters the approval data into the Authorization Subsystem of the MMIS and QIO Web Portal.
        - If not approved, QIO will provide written notification of denied services including information on appeal rights.

***V. Customer Service***

a) The QIO Authorization Unit will respond to provider and beneficiary inquiries regarding authorization requests.
b) If the QIO 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 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 (COTR) will respond.

**Revision History**

**Enclosed Materials:**

1. Department of Health Care Finance Action Transmittal _____ (Attachment A)

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| Official Approval: | Date: |
| Director Approval: | Date: |