# ATTACHMENT J-17.6

# PRIOR AUTHORIZATION PROCESS FOR GASTRIC BY-PASS SURGERY

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**
**Department of Health Care Finance**

| **Division of Clinician, Pharmacy, and Acute Provider Services** | POLICY AND PROCEDURES |
|---|---|
| **Subject:** Prior Authorization Process for Gastric Bypass surgery for the DC Medicaid Fee for Service (FFS) Program. | |

**Effective Date:**

**Last Date Revised**
September 10, 2008

The District of Columbia Department of Health Care Finance (DHCF) Fee-for-Service Medicaid Program covers Gastric Bypass surgery as deemed medically necessary by a physician.

DHCF also contracts with a Quality Improvement Organization (QIO) to verify the medical necessity for such procedures. This document describes the policies and procedures that DHCF and DHCF's QIO will follow in authorizing Medicaid payment for Gastric Bypass surgery.

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

**Policy:**
DHCF's QIO will execute the prior authorization process in advance of a provider performing Gastric Bypass surgery for a Medicaid beneficiary in accordance with the DC Medicaid State Plan.

**Procedures:**

***I. Provider Procedure:***

1. Every provider requesting Medicaid reimbursement for gastric bypass surgery is to complete fields 1-11, 13,15A and 15B of the 719A Form by identifying 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 completed 719A Form and supporting documentation to the QIO Prior Authorization Unit. Examples of supporting documentation may include the items listed on Attachment C:
3. The requesting provider shall call the QIO Prior Authorization Unit for all inquires.

***II. QIO Prior Authorization Unit Procedure:***

**Timelines**

a. Within five (5) business days of the 719A Form receipt date, the QIO Prior Authorization Unit will conduct a review of each completed 719A Form, and fax to the requesting provider all determinations, including information on appeal rights for denials, if the requested service is included within DHCF's list of covered services.

b. *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 Prior Authorization Unit. The QIO will use medical criteria approved by DHCF.

c. Authorization of a service is valid for a period of (60) days.

**Tracking**

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

**Prior Authorization Process**

1. **Beneficiary, facility, and provider verification**. The QIO Prior Authorization Unit will implement the prior 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 date;
      - If the beneficiary's eligibility end date is 999999, they are eligible for services indefinitely.
      - If specific eligibility codes are present, the request for prior 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. Facility's status as an enrolled Medicaid provider (located in the MMIS Provider Subsystem screen).
   d. Presence of appropriate diagnosis and procedure codes;
   e. Written justification and supporting documentation; and
   f. Requesting provider signature and date.

2. **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 for the provider and the facility. 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 Medicaid number;
D. Billing provider number:
E. Approver ID number;
F. Dates of service range;
G. Diagnosis codes;
H. Procedure code;
I. Unit number (for each procedure code requested);
J. Estimated charge.

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

***III. Submission of Claims to XeroX***

The hospital will be required to document the 10 digit authorization number provided by the QIO Prior Authorization Unit (which is obtained and generated from the MMIS system) in Box 63 (see highlight below) of the UB92 or UB04 as part of their claim submission. **The payment will be denied if an authorization number is not present on the UB92 or UB04.**

The requesting provider must document the prior authorization number provided by the QIO 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 the reviewer, other than the reviewer who performed the initial review, to perform the reconsideration review; and
   2. Issue the reconsideration decision twenty-one (21) business days of the reconsideration request.
      - If approved, the Prior Authorization Unit remotely and electronically enters the approval data into the Prior Authorization Subsystem of the MMIS and QIO web Portal.
      - If not approved, the Prior Authorization Unit provides written notification of denied services including information on appeal rights.

***V. Customer Service***

a) The QIO Prior Authorization Unit will respond to the provider and beneficiary inquiries regarding prior authorization requests.
b) If the QIO Prior Authorization Unit is unable to adequately answer provider and beneficiary inquires, 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 inquires, the DHCF Contract Administrator will respond.

| **Exceptions**<br>See list of Ineligible Recipient Program Codes |
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| **Revision of History** |
| **Enclosed Materials:**<br>1. Ineligible Recipient Programs Codes (Attachment A)<br>2. Medical Assistance Administration Action Transmittal ___(Attachment B)<br>3. Supporting Documentation (Attachment C) |
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| Official Approval: | Date: |
|---|---|
| Senior Deputy Director Approval: | Date: |