ATTACHMENT J - 17.7

OFFICE OF DISABILITIES AND AGING PRIOR AUTHORIZATION PROCESS FOR THE ELDERLY AND INDIVIDUALS WITH PHYSICIAL DISABILITIES (EPD) WAIVER

DEPARTMENT OF HEALTH CARE FINANCE

OFFICE ON DISABILITIES AND AGING	POLICY AND PROCEDURES

SUBJECT: Revised Prior Authorization Process for the Elderly and Individuals with Physical Disabilities (EPD) Waiver

Effective Date: **Last Date Revised** 12/29/08

The District of Columbia Department of Health Care Finance (DHCF) Medicaid program provides home-based services to those persons deemed eligible.

DHCF also contracts with a quality improvement organization (QIO) to verify the functional appropriateness of such services. This document describes the policies and procedures that DHCF and DHCF's QIO will follow in authorizing Medicaid payments for home-based services to Medicaid recipients enrolled in the Elderly and Individuals with Physical Disabilities (EPD) Waiver.

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

Policy:
DHCF's QIO Prior Authorization Unit will execute the prior authorization process in advance of a provider delivering home-based services to Medicaid beneficiaries in accordance with the DC Medicaid State Plan and EPD waiver rules as prescribed by District law.

Authorization of a service is valid for a period of up to one year.

Procedures:

I. Provider Procedure

The requesting case management provider will upload the following information into CaseNet:

a. Form 30-AW (New) or 1209-W (Re-certifications);
b. Referral for Medicaid Level of Care (form 1728) with physician's signature;
c. Level of Care eligibility approval from DHCF's QIO;
d. Client Health History form with case manager's signature;
e. Waiver Beneficiary Freedom of Choice form with identified case management agency of choice, beneficiary signature, and case manager

signature;
f. Clients' Bill of Rights and Responsibilities form with beneficiary signature and case manager signature;
g. Individualized Services Plan (ISP) with signature of case manager;
h. Risk Assessment form with signature of case manager and a registered nurse (in the case of re-certifications); and
i. Medicaid application (only required for new admissions who are not currently Medicaid beneficiaries).

II. DHCF Procedure

DHCF will:

1. Download the following documents from CaseNET, and forward to the Income Maintenance Administration (IMA) to determine eligibility:
   a. Form 30-AW (New)or 1209-W (Re-certifications);
   b. Referral for Medicaid Level of Care (form 1728) with physician's signature;
   c. Level of Care eligibility approval from DHCF's QIO; and
   d. Medicaid application (if applicable).
2. Mail the beneficiary a letter of denial, in cases where IMA determines a beneficiary ineligible for the EPD waiver.
3. Check the CaseNET system to confirm that CaseNET has extracted all cases coded as eligible based on an 853 program code in the MMIS system.
4. Task the DC QIO to review request for functional assessment and level of care appropriateness and issue prior authorization.
5. Notify the DC QIO Contracting Officer's Technical Representative (COTR), via email of provider concerns as a result of this revised prior authorization process.

III. Income Maintenance Administration (IMA) Procedure:

IMA has up to 45 days to determine eligibility according to 42CFR435.911.
In cases of ineligibility, IMA (in addition to DHCF) will send the beneficiary a letter of denial.

IV. QIO Prior Authorization Unit Procedure:

A. The QIO Prior Authorization Unit will:
   1. Check CaseNET for list of beneficiaries with the 853 program code report each day.
   2. Within five (5) business days of DHCF's task notification, review request for functional assessment and level of care appropriateness using the following documents:
      a. Individualized Services Plan;
      b. Client Health History form; and
      c. Risk Assessment form.
   3. Make a determination using criteria approved by DHCF (See Attachment A).
   4. If approved, remotely and electronically enter the QIO Prior Authorization Unit Approval status→A (indicating approval) and the approved data into the MMIS

Prior Authorization Subsystem. The data entry process includes populating the following fields in the MMIS:

a. Provider letter status→Y (mail letter to provider);
b. Beneficiary number;
c. Billing provider number;
d. Approver ID number;
e. Dates of service range;
f. Diagnosis code;
g. CPT/HCPCS code(s);
h. Unit number (for each procedure code requested); and
i. Requested and approved charge.

Upon the entry of all necessary data, a prior authorization (PA) number is generated for the provider in the MMIS. CaseNET will extract PA numbers from the MMIS and feed them into the PA section of the CaseNET display.

5. Notify the DC QIO Contracting Officer's Technical Representative (COTR), via email, of provider concerns as a result of this revised prior authorization process.

B. Timelines

a. Upon receipt of the task notification from DHCF, the QIO Prior Authorization Unit will conduct a review within five (5) business days.
b. Once a determination is made by the QIO, CaseNET will automatically notify both DHCF and the provider agency case manager of the determination, including the PA number for all waiver service approvals and appeal rights for any waiver service denials. information on appeal rights for denials, if the requested service is not included within DHCF's list of covered services.

C. Tracking

a. The QIO maintains a tracking log of all prior authorization requests and transactions, which includes the following:
   i) Name and identification number of the recipient;
   ii) Name of the case manager or supports broker and the provider agency;
   iii) The origin and date of the prior authorization request;
   iv) The type of service(s) requested and units of service;
   v) Effective date and expiration date for prior authorization certification; and
   vi) The prior authorization number issued.
b. The tracking log will be updated monthly on the QIO's web portal, under 'Waivers.'

V. Submission of Claim to ACS

The requesting provider 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.**

VI. Appeals Process:

a) If an individual is denied services or admittance to the EPD Waiver, the individual has the right to request a fair hearing.

b) The QIO Prior Authorization Unit will send a denial letter to the individual which includes information on how to access the fair hearing process.

VII. 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, DHCF's Office on Disabilities and Aging Representative will respond.

Revision History

Enclosed Materials:

1. Determination Criteria for Service Hours (Attachment A)
2. Department of Health Care Finance Action Transmittal _____ (Attachment B)

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

Determination Criteria for Service hours

Medicaid beneficiary may exhibit the following characteristics or behavior for approval of service hours:

Range 1-3 Hours

- Alert
- Oriented to person, place, time
- Require assistance with ADL
- Require assistance with IADL
- Require assistance with meal preparation
- Require assistance with accompaniment to medical appointment

Range 4-8 Hours

- Alert
- Oriented to person, place, time
- Able to walk independently
- Impaired mobility slight but able to walk
- Use of assistive device e.g., cane, walker, wheelchair if needed
- Able to verbalize needs
- Dialysis patient
- Medical appointment
- Require assistance with meal preparation
- Require assistance with light housekeeping

Range 9-12 Hours

- Alert/appears lethargic (may experience periods of lethargy)
- Oriented to person, place, (not time)
- Up out of bed (OOB) with assistance
- Cognitive impairment (confusion at periods)
- Impaired mobility, not bedbound
- Not able to walk independently
- Needs assistive devices i.e. cane walker, wheelchair
- Affected use of one arm and/or one leg
- Lives alone/working caregiver
- Incontinent of bowel and bladder regarding impaired mobility
- Impaired skin conditions requiring changing in positions in chair and/or bed
- Retires early
- Dialysis patient
- Medical appointments
- Medication reminder
- Fall Risk as assessed and mitigated
- Require meal preparation
- Require assistance with feeding
- Require light housekeeping

Range 13-16 hours

- Alteration in physiological functioning that impedes performance of activities of daily living and independent activities of daily living by the participant.
- Alteration in bowel elimination resultant in incontinence coupled with mobility limitation.
- Chronic alteration in urine elimination resultant in urinary incontinence coupled with immobility limitation.
- Alteration in respiratory muscles functioning resultant in an inability to sustain positioning.
- Alteration in the circulation of the participant resultant in an inability to move/propel self independently.
- Participant is bedbound
- Participant lives with an elderly spouse/family member who may have impaired physiological functioning.
- Functional diagnosis/limitations as determined by the ICD-9 code.