GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director

Transmittal # 18-22

TO: District of Columbia Medicaid Providers

FROM: Angelique Martin
Interim Medicaid Director

DATE: July 19, 2018

SUBJECT: **REVISED: Policy and Procedure: Prior Authorization Process for Organ Transplants**

The purpose of this transmittal is to provide an update to the DC Medicaid policies for organ transplantation for Medicaid Fee-For-Service (FFS) and Managed Care Organization (MCO) enrollees. On July 1, 2018, the procedure for requesting and obtaining a prior authorization will shift to the Medicaid Quality Improvement Organization (QIO), currently Qualis Health.

The District of Columbia State Plan (§1.A.4 of supp. 1 to att.3.1a p.1) and District rulemaking (§937 of Title 29 of the DCMR) state that the DC Medicaid Program will cover hospital and physician expenses for the following organ transplantation procedures when the requested transplant meets the transplant requirements outlined in the rule (and noted below), and the physician(s) and hospital are enrolled in DC Medicaid and are Medicare-certified to provide the requested transplant.

- Liver transplantation;
- Heart transplantation;
- Lung transplantation;
- Kidney transplantation;
- Allogeneic stem cell transplantation; and
- Autologous hematopoietic stem cell transplantation.

The QIO will use DHCF clinical guidelines and standards for determining approval for all transplant requests. Providers must submit prior authorizations to the QIO at least ten (10) days in advance of the procedure for approval. The following documentation must be submitted by the DC Medicaid provider when requesting transplant services:

1. A completed **Transplant Prior Authorization Form** (see attached)
2. A completed **Organ Transplantation Request Checklist** (see attached)
3. Supporting clinical documentation which should include:
    a. Letter of medical necessity for the transplant (not the listing letter);

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b. Medical Records including: 1) summary course of illness and 2) a complete history and physical exam within the last 12 months;
c. Lab assessments and radiograph studies, including CXR and those specific to the organ requested; and
d. If applicable, a letter to support the need to have a transplant performed outside the District of Columbia Medical Service Area (DCMSA)

Transplant Requirements

1. The recipient is or has been diagnosed and recommended by his/her physician(s) for an organ or stem cell transplantation as the medically necessary treatment for the patient's survival;
2. There is reasonable expectation by the physician that the recipient possesses sufficient mental capacity and awareness to undergo the mental and physical rigors of post-transplantation rehabilitation, with adherence to the long-term medical regimen that may be required;
3. There is a reasonable expectation that the recipient shall recover sufficiently to resume physical and social activities of daily living;
4. Alternative medical and surgical therapies that might be expected to yield both short and long term survival have been tried or considered and determined not sufficient to prevent progressive deterioration and death; and
5. The recipient is diagnosed as having no other system disease, major organ disease or condition likely to complicate, limit, or preclude expected recuperation after transplantation.

All Transplant requests must be faxed to Qualis Health at **(800)731-2314**. In order to provide an approval within the ten (10) day timeframe, all documentation listed above must be submitted at the time of the request.

Claim Submission

A paper claim will continue to be submitted to DHCF by first class mail or hand-delivered directly to DHCF. The submitted original claim should include the following:

1. The PA approval number must be included for reimbursement.
2. Clinical information must include: discharge summary, operative report, and backroom organ prep reports.

The address for claim submission is:

District of Columbia Department of Health Care Finance
Division of Clinicians, Pharmacy, and Acute Provider Services
Attn: Transplant Claim Submission
441 4th Street, NW
Suite 900 South
Washington, DC 20001

If you have any questions about this transmittal, please contact Cavella Bishop, Program Manager, Division of Clinician, Pharmacy, and Acute Provider Services via telephone at (202) 724-8936, or via email at cavella.bishop@dc.gov or Qualis Health via telephone at (800) 251-8890.

cc: Medical Society of the District of Columbia
DC Hospital Association
DC Primary Care Association
DC Health Care Association
DC Home Care Association
DC Behavioral Health Association
DC Coalition of Disability Service Providers

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ORGAN TRANSPLANTATION REQUEST CHECKLIST

Transplant Coordinator:_______________________________________**Phone:**______________________

Recipient Name: ____ **DCID#:** ___________________________

Transplant Related Diagnosis: ____

CHECKLIST: Please notate inclusion of the following:

- ☐ Letter of medical necessity
  - ☐ The recipient is or has been diagnosed and recommended by his/her physician(s) for an organ or stem cell transplantation as the medically necessary treatment for the patient's survival;
  - ☐ There is reasonable expectation by the physician that the recipient possesses sufficient mental capacity and awareness to undergo the mental and physical rigors of post-transplantation rehabilitation, with adherence to the long-term medical regimen that may be required;
  - ☐ There is a reasonable expectation that the recipient shall recover sufficiently to resume physical and social activities of daily living;
  - ☐ Alternative medical and surgical therapies that might be expected to yield both short and long term survival have been tried or considered and determined not sufficient to prevent progressive deterioration and death; and
  - ☐ The recipient is diagnosed as having no other system disease, major organ disease or condition likely to complicate, limit, or preclude expected recuperation after transplantation.
- ☐ Cancer screening (Age-appropriate for colon, cervical, breast and prostate)
- ☐ History and physical exam, including social and family history
- ☐ Complete labs including CBC, Chemistry profile including liver-related indices
- ☐ Radiographic studies specific to organ request
- ☐ Psychosocial evaluation
- ☐ MELD score, if applicable
- ☐ Hemoglobin A1C, if applicable
- ☐ Tuberculin Skin Test or IGRA
- ☐ HIV Status and viral load within the last 3 months, if applicable*
- ☐ Hepatitis C and viral load within the last 3 months, if applicable

This beneficiary:
Is a smoker ☐Yes ☐No
Has active or a history of substance use ☐ Yes ☐No
Has active or a history of alcohol abuse ☐ Yes ☐No

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Transplant Prior Authorization Form

SECTION A: BENEFICIARY

Last Name: First Name:	Date of Birth:	Medicaid ID #:	Telephone:

Address:	Guardian Name (if applicable):

Transplant related diagnosis

SECTION B: MANAGED CARE ORGANIZATION (MCO)

Name:	MCO Medicaid #:	MCO coordinator name

Coordinator Email address:	Coordinator phone number

SECTION C: FACILITY

Facility Name and Treatment Center DCID #:

Street Address:	City:	State:	ZIP code:

SECTION D: REQUESTING PHYSICIAN

Last Name:	First:	Medicaid #:	NPI #:

Transplant Type: ☐ Kidney ☐ Liver ☐ Lung ☐ Heart ☐ Allogeneic Bone Marrow ☐ Autologous Bone Marrow

☐ Small Bowel ☐ Other, specify ____________________

Will Beneficiary Require Transportation? ☐ Yes ☐ No	Recommended Mode: ☐ Ground Ambulance ☐ Air Ambulance ☐ Private Ground ☐ Commercial Air ☐ Other:

I certify that the information is correct and that contact has been made with the rendering physician/facility. I also certify that if the request is to a physician and/or facility outside of the DC Medical Service Area (DCMSA), that the service cannot be provided within the DCMSA.

Signature of Referring Physician: Date:

Transplant facilities must be Medicare-certified to be eligible for Medicaid reimbursement CMS 42 CFR 482.74

SECTION D: INSTRUCTIONS

All transplant prior authorization requests require at least 10 days advance notice

In determining approval, Qualis will use DHCFclinical guidelines and standards for the condition. **DHCF reserves the right to make recommendations to a certified center that has provided transplant services to Medicaid beneficiaries in the past**. Services considered experimental and/or investigational or sponsored under a research program are not covered by DC Medicaid and must be disclosed by the requesting physician. In addition, a copy of the beneficiary's medical records within the prior year relating to the transplant must be included.

When submitting a completed Transplant Prior Authorization form:

1. The requesting District of Columbia (DC) Medicaid provider must complete all fields of the form.

2. Submission of this form MUST be accompanied by the ***completed*** Organ Transplantation Request Checklist. Incomplete checklists will be returned along with the application and will result in processing delays.

3. Referring Providers must provide sufficient information to allow Qualis to make a decision. Supporting clinical documentation should include:

   - ☑ Letter of medical necessity for the transplant (Not the listing letter)
   - ☑ Medical records including: 1. summary of course of illness, 2. a complete history and physical exam, including social and family history conducted within the past 12 months
   - ☑ Lab assessments and radiographic studies including CXR and those specific to organ request
   - ☑ If, applicable, a letter to support need to have transplant performed outside the District of Columbia Medical Service Area (DCMSA)

4. Providers seeking reimbursement for services must be enrolled D.C. Medicaid providers

5. If the transplant service is available in-state and this case is being referred outside the District of Columbia Medical Service Area (DCMSA), Referring Providers must provide justification.

NOTE: Authorization is not an authorization for payment. Payments are made subject to the beneficiary's eligibility and benefits on the day of service and continued eligibility throughout the period of hospitalization and follow-up treatment.

Fax this form, checklist, and supporting documentation to: Qualis Health (800)731-2314