GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal # 18-29**

TO: Long Term Care Services and Supports Providers

FROM: Angelique Martin
Interim Medicaid Director

DATE: October 4, 2018

SUBJECT: **Revised Prescription Order Form (POF) for Long Term Care Services and Supports (LTCSS)**

The purpose of this transmittal is to inform you that the Department of Health Care Finance (DHCF) is revising its format for the Prescription Order Form (POF) to establish standards governing the assessment process for the level of need for beneficiaries who receive Long Term Services and Supports (LTSS).

A streamlined version of the POF (version 9/12/18) was created as part of DHCF's continuous quality improvement processes to more appropriately reflect the Long Term Care Assessment Rule (Chapter 9, Section 989) of the District of Columbia Municipal Regulations. DHCF subsequently replaced version 2/21/17 on our website with the 9/12/18 form. Effective January 1, 2019, the LTSS Assessment Contractor, Liberty Healthcare, will only accept the newer version.

The accompanying form – which is being distributed with this transmittal – will be used to initiate the face-to-face assessment for the following LTCSS: the Elderly and Persons with Physical Disabilities Waiver (EPD Waiver), Adult Day Health Program (ADHP) under the 1915(i) State Plan Option, Personal Care Aide (PCA) services available under the District's Medicaid State Plan and EPD Waiver, and nursing homes. The POF and subsequent assessment process is not applicable to Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities and Home and Community-Based Services for Individuals with Intellectual and Developmental Disabilities (IDD Waiver).

The POF is to be completed by Medicaid-enrolled physicians and advanced practice registered nurses (APRNs) as a requirement for receiving Medicaid-funded LTCSS. The fillable form is divided into three sections, and each section contains information that is ***required*** for processing.

This required information continues to be highlighted with a double asterisk on the form itself for easy identification. As clarification, a POF can only be used to initiate ***one*** assessment. Further, the physician/APRN signature is valid for twelve (12) months from the date of signature.

Please note that all referring providers must be enrolled as a DC Medicaid Provider as stated above. DHCF has a streamlined application process for ordering and referring providers, which can be obtained at www.dcpdms.com by clicking "create an account." Providers can then follow the instructions to set up an expedited enrollment package. Please note that providers who enroll as ordering/referring providers only will not receive payment for any claims submitted, and will not be part of the Medicaid-eligible Provider Directory. The new version of the POF is available on DHCF's website in the Provider Information and Forms section: http://dhcf.dc.gov/page/provider-information-and-forms.

Please feel free to refer to the LTSS rule posted on DHCF's website. Questions regarding this transmittal should be directed to Ieisha Gray, Director, Long Term Care Administration, by telephone at 202-442-5818 or email at Ieisha.Gray@dc.gov.

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE
PRESCRIPTION ORDER FORM (POF)
FOR LONG TERM CARE SERVICES AND SUPPORTS

This completed form must be faxed to Liberty Healthcare Corporation at 202-698-2075.

This Prescription Order Form (POF) is required by the District of Columbia's Department of Health Care Finance (DHCF) to authorize Medicaid-funded long term care services and supports. Prior to submission, the following items (indicated with a **) **must** be completed.

- Patient Medicaid Number (if available)
- Patient full name
- Patient date of birth
- Patient telephone number
- Provider name
- Provider telephone number
- Patient's chronic medical conditions
- Reason for referral to assessment
- Signature of ordering physician / APRN

Please note that all referring providers must be enrolled as a DC Medicaid Provider. DHCF has a streamlined application process for ordering/referring providers which can be accessed at www.dcpdms.com by clicking "Create an account." Providers can then follow the instructions to set up an expedited enrollment package. Please note that providers who enroll as ordering/referring providers only will not receive payment for any claims submitted and will not be part of the Medicaid-eligible providers' directory.

SECTION I: PATIENT INFORMATION

A. **Patient DC Medicaid Number (8 digits).
If the individual is new to DC Medicaid and does not yet have a Medicaid number, please note "N/A."

B. **Patient Name (Last, First):

C. **Date of Birth (MM/DD/YYYY):

D. **Telephone Number:

E. Secondary Telephone Number:

F. ** Current Address:

G. Permanent Address (if different than above):

H. Emergency Contact Name:

I. Telephone Number:

SECTION II. DETERMINING NEED FOR SERVICES

A. **This patient has the following chronic medical condition(s) / ICD-10 diagnosis(es):

B** Reason for referral to assessment: ☐ Hospital Discharge ☐ Reassessment ☐ Initial assessment ☐ Change in patient condition

C. **If "Change in patient condition" was checked in section B, please indicate how this patient's condition has changed significantly since his/her most recent assessment:

SECTION III: PHYSICIAN/APRN INFORMATION

A. **Provider Name (Last, First):

B. **DC Medicaid Provider Number:

C. **Telephone Number:

D. **National Provider Identifier (NPI) Number:

E. **Provider Address:

F. **Fax Number:

I have examined this patient and certify that long term care services and supports are medically necessary.

**Signature of Ordering Physician/APRN:

Date: