**DEPARTMENT OF HEALTH CARE FINANCE**

| **HEATH CARE ACCOUNTABILITY ADMINISTRATION** | POLICY AND PROCEDURES |
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**SUBJECT:** Prior Authorization Process for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for the DC Medicaid Fee for Service (FFS) program

| **Effective Date:** | **Last Date Revised** |
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| June 15, 2009 | April 29, 2009 |

**Policy:**

The District of Columbia Department of Health Care Finance's (DHCF) Medicaid program covers durable medical equipment, prosthetics, orthotics, and supplies (DME/POS), that are required to aid or improve activities of daily living when equipment and supplies are prescribed by a physician or authorized prescriber (requesting provider) and are deemed medically necessary.

As stated in the DC Medicaid State Plan (Supplement 1 to Attachment 3.1A, Page 20B) prior authorization is required for:

- prosthetic devices not included within the DHCF fee schedule; and
- medical supplies and equipment in excess of specific limitations, i.e., cost, rental or lease equipment, certain procedure codes.

DHCF's DME/POS Provider Billing Manual further states that prior authorization is required for:

- durable medical equipment costing more than $500.00; and
- repair of purchased equipment that exceeds 75% of the purchase price of the equipment.

Equipment, supplies and repairs that require prior authorization are listed in the attached document entitled 'List of DC Medicaid Covered Durable Medical Equipment, Prosthetics Orthotics and Supplies (DME/POS)'.

DHCF contracts with a federally recognized Quality Improvement Organization (QIO) to verify the medical necessity for requested DME/POS. DHCF's QIO will execute the prior authorization process in advance of a DME/POS vendor (billing provider) supplying DME/POS for a Medicaid beneficiary in accordance with the DC Medicaid State Plan and DHCF's DME/POS Provider Billing Manual.

Prior authorization for DME/POS will be requested via a 719A Form. The 719A Form is the requesting provider's written prescription for DME/POS. Depending on the enrollment status of the Medicaid beneficiary, one of two (2) versions of the 719A Form will be utilized for:

- beneficiaries enrolled in the Intellectual and Developmental Disabilities (IDD) waiver [formerly the Mental Retardation Developmental Disability (MRDD) waiver]; or

- beneficiaries enrolled in any other FFS program.

Authorization of DME/POS is valid for a period of six (6) months.

This document describes the policies and procedures that DHCF and DHCF's QIO will follow in authorizing Medicaid payments for DME/POS.

**Purpose:**
To help ensure that beneficiaries receive DME/POS that best aid or improve activities of daily living and to make efficient use of Medicaid and beneficiary resources.

**Procedures**:

*I. Requesting (Prescribing) Provider Requests Approval:*

1. Every requesting provider is to complete fields 1A-F, 2A-E, 3, 4, 5, 6, 8, 10, 13, and 15A-B of the 719A Form by identifying the appropriate Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes for the DME/POS; in addition to providing the justification on the need for the DME/POS.
2. The requesting provider transmits (via mail, fax, or web portal (when available)) the 719A Form and clinical documentation that supports the requested services to the billing provider; or gives the 719A Form to the beneficiary for delivery to the billing provider.

*II. Billing Provider forwards 719A Form to QIO Prior Authorization Unit*

1. The billing provider receives the 719A Form via mail, fax, or web portal (when available) from the requesting provider; or via hand delivery from the beneficiary.
2. Every billing provider is to insert its business name and DC Medicaid ID number in the upper right corner of the 719A Form.
3. Every billing provider is to enter the HCPCS code with the appropriate modifier for the equipment or service being requested into field 7 of the 719A Form.
4. Every billing provider is to complete field 11 of the 719A Form by estimating the customary and usual charge for the requested service or equipment.
5. The billing provider transmits the request to the QIO Prior Authorization Unit via mail, fax, or web portal (when available).
6. 719A Forms submitted for beneficiaries in the IDD waiver program will be identified by a 'IDD' or 'DDA' stamp, or a handwritten 'DDA' on the 719A Form.

*III. QIO Prior Authorization Process*

*A Prior Authorization Process*

1. **Beneficiary and provider eligibility verification.** The QIO Prior Authorization Unit will implement the prior authorization process by verifying the:
    a. Beneficiary's Medicaid ID number (located in the MMIS Recipient Subsystem screen), including the beneficiary's active coverage period, as follows:
        - Date of services requested shall not exceed beneficiary's eligibility start and end dates;

- If the beneficiary's eligibility end date is '999999', he or she is eligible for services indefinitely; and
- Presence of appropriate Medicaid program eligibility codes.

b. Provider's status as a Medicaid provider (located in the MMIS Provider Subsystem screen):
   - Provider not enrolled in DC Medicaid program→ Not eligible to provide services;
   - Active Status (01)→Eligible to provide services; or
   - Inactive Status→ Not eligible to provide services.

c. Requesting provider signature and date on required documentation.

2. **Clinical review.** The QIO Prior Authorization Unit will review the 719A Form and supporting documentation for the:
   a. Presence of appropriate diagnosis and procedure codes; and
   b. Written justification and supporting documentation.

   If the 719A Form contains an imprecise HCPCS procedure code, such as a miscellaneous "99" code, the QIO Prior Authorization Unit will request that the billing provider resubmit the 719A Form using more precise HCPCS procedure code(s), if available. If a miscellaneous code continues to be used, the QIO will forward the PA request to DHCF's Utilization Management unit who will discuss the miscellaneous coding with the DME/POS vendor.

   The QIO will use medical criteria approved by DHCF to approve or deny payment.

3. **Data submission to MMIS.** If the request for DME/POS is approved, the QIO Prior Authorization Unit remotely and electronically enters approval data into the MMIS Prior Authorization Subsystem. Upon the entry of all necessary data, a prior 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's Medicaid ID number;
   d. billing provider's Medicaid ID number;
   e. approver's MMIS Approval ID Number;
   f. dates of service range;
   g. referring provider's (physician or authorized prescriber) Medicaid ID number;
   h. status → A (indicating approval);
   i. type of procedure → 1 (indicating purchase of item);
   j. procedure code(s);
   k. modifier → RR (indicating rental of equipment);
   l. diagnosis code;
   m. requested units for each procedure code requested by billing provider;
   n. estimated charge(s) submitted by billing provider;
   o. QIO's approved units;
   p. QIO's approved dollar amount; and

q. Comments provided by QIO.

3. **Pricing.** If the request for DME/POS is approved, the QIO will adhere to the guidance below when entering data into the 'Approved Amount' field of the MMIS Prior Authorization Subsystem.
   a. If the estimated charge of the DME/POS is equal to or greater than, the dollar amount included in the current DHCF fee schedule, the QIO will enter '00'.
   b. If the estimated charge of the DME/POS is less than the dollar amount included in the current DHCF fee schedule, the QIO will enter the estimated charge.
   c. If a HCPCS procedure code for DME/POS does not have a price on the current District Medicaid Fee Schedule, the 719A Form is forwarded to DHCF for manual pricing.

4. **Transmittal of approval to billing provider.** The QIO faxes to the billing provider notification that includes a prior authorization number, approved dates of service range, approved HCPCS or CPT codes, approved reimbursement total, and approved units.

***B. Timelines***

1. The QIO Prior Authorization Unit will return all incomplete 719A Forms to the requesting provider via fax immediately. No action will be taken by the QIO until a complete 719A Form is received.

2. Within five (5) business days of the receipt of a complete 719A Form for a beneficiary enrolled in either the IDD waiver or any other FFS program, the QIO Prior Authorization Unit will conduct a review of the information submitted, and fax to the billing provider all determinations, including information on appeal rights for denials.

3. If the requested DME/POS is not included in the current DC Medicaid fee schedule:

   a) For beneficiaries enrolled in the IDD waiver:
   - Within two (2) business days of the receipt of the complete IDD waiver 719A Form (identified by a handwritten or stamped 'IDD' or 'DDA'), the QIO will:
     - notify the billing provider, via fax, that their request has been forwarded to DHCF for review; and
     - contact DHCF, via phone, to present the beneficiary's clinical detail and other information that will help in the manual pricing of the requested DME/POS.
   - Within two (2) business days of the call between DHCF and the QIO, DHCF will fax a decision to the QIO that will include the price for the requested DME/POS.
   - The QIO will fax a prior authorization decision to the billing

provider within five (5) business days of the receipt of the original 719A Form.

b) For beneficiaries enrolled in all other FFS programs, except the IDD waiver:

- Within five (5) business days of the receipt of the 719A Form, the QIO Prior Authorization Unit will notify the billing provider that their request has been forwarded to DHCF for review; and will fax the complete 719A Form and supporting documentation to DHCF.
- Within five (5) business days of receipt of the 719A Form and supporting documentation from the QIO, DHCF will review the request, and fax a decision to the QIO.
- The QIO will fax a decision to the billing provider within ten (10) business days of the receipt of the original 719A Form.

**C. *Tracking***

The QIO will maintain a tracking log of all prior authorization requests and transactions, which includes the following:

a. beneficiary name and Medicaid ID number;
b. requesting physician name and Medicaid ID number;
c. billing provider name;
d. date of service;
e. the type of service requested;
f. date of determination; and
g. prior authorization number issued.

The tracking log will be updated monthly on the QIO's web portal, under 'Out Patient'.

***III. Billing Provider Submits Claim to ACS***

All DME/POS claims submitted to DHCF for payment must include the prior 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.

***IV. Appeals Process:***

A The billing provider may fax a request for reconsideration to the QIO Prior Authorization Unit.

B The QIO Prior 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 QIO Prior Authorization Unit electronically and remotely enters the approval data into the Prior Authorization Subsystem of the MMIS and QIO Web Portal.
    - If not approved, provide written notification of denied services including information on appeal rights.

*V. 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 billing provider and/or 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, the DHCF Contracting Officer's Technical Representative will respond.

**Attached Materials:**

List of DC Medicaid Covered Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DME/POS)

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| Responsible Approving Manager: | Date: 5/13/09 |
| DHCF Approval: | Date: 5/15/09 |