

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




Office of the Senior Deputy Director

**REVISED VERSION**

**Transmittal No. 14-33**

To: DC Medicaid Providers

From: Claudia Schlosberg, JD   
Acting Senior Deputy Director and State Medicaid Director

Date: **DEC 1 2014**

Subject: Organ Transplantation Coverage for DC Medicaid Fee-For-Service and Managed Care Enrollees – Update On Coverage Policies and Clarification of Prior Authorization Procedures

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The purpose of this Transmittal is to provide an update to the DC Medicaid coverage policies for organ transplantation for Medicaid Fee-For-Service and Managed Care Enrollees. On **November 18, 2014**, the Centers for Medicare and Medicaid Services (CMS) approved coverage of Lung Transplantation and Autologous Hematopoietic Stem Cell Transplantation within the District of Columbia Medicaid State Plan. This Transmittal confirms the procedures for requesting and obtaining prior authorization for organ transplant services.

**Coverage Policy**

The District of Columbia (DC) Medicaid State Plan (at Attachment 3.1-E: “Standards for the Coverage of Organ Transplant Services”) states that the DC Medicaid Program will cover hospital and physician expenses for the following organ transplantation procedures when the physician(s) and hospital have received prior approval from the State Medicaid Agency:

- (a) Liver transplantation;
- (b) Heart transplantation;
- (c) **Lung transplantation;**
- (d) Kidney transplantation;
- (e) Allogeneic stem cell transplantation; and
- (f) **Autologous hematopoietic stem cell transplantation**

Further, the DC Medicaid Program will reimburse for transplantation services only if 1) the recipient has been determined eligible for benefits under the DC Medicaid Program prior to performance of the transplantation procedure and continues to be eligible throughout the period of hospitalization and follow-up treatment; and 2) the following criteria are met:

- (a) The recipient shall be diagnosed and recommended by his/her physician(s) for an organ transplantation as the medically reasonable and necessary treatment for the patient's survival;
- (b) There is a reasonable expectation 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;
- (c) There is a reasonable expectation that the recipient shall recover sufficiently to resume physical and social activities of daily living;
- (d) Alternative medical and surgical therapies that might be expected to yield both short and long term survival must have been tried or considered and will not prevent progressive deterioration and death; and,
- (e) The recipient shall be diagnosed as having no other systemic disease, major organ disease, or condition considered likely to complicate, limit or preclude expected recuperation and rehabilitation after transplantation.

All transplantation procedures shall be prior authorized by the Department of Health Care Finance, or its designee, and performed in accordance with the clinical standards established under the State Plan for Medical Assistance consistent with 42 C.F.R § 441.35.

### **Managed Care Exclusions**

Inpatient transplantation surgery is excluded from coverage for managed care enrollees by the Managed Care Organization (MCO). The MCO shall only cover:

- a) Costs up to the time of the transplant surgery
- b) Costs after discharge from the hospital stay during which the transplant surgery occurred.

A request for Prior Authorization of organ transplants must be submitted to the DHCF Medical Director for review and approval. Approved transplantation services are covered and reimbursed through the DC Medicaid Fee-For-Service (FFS) Program.

### **The DC Healthcare Alliance**

Organ transplantation is not covered for Alliance enrollees.

### **Dual Eligibles including Qualified Medicare Beneficiaries (QMBs)**

Medicare may authorize payment for organ transplantation not currently covered by D.C. Medicaid. For non-QMB dual eligibles, Medicaid is not obligated to pay if the Medicare service is not covered by Medicaid; or if the beneficiary received the services from a Medicare provider who is not enrolled as a Medicaid provider.

For QMB dual eligibles, Medicaid must pay all cost-sharing (premiums, deductibles, co-insurance and copayments) related to Medicare Part A and B. For Medicare Part B covered

services, Medicaid pays the coinsurance and deductible up to the point where the payment from Medicare and Medicaid is the amount the provider would receive if Medicaid was primary.

### **Procedures to Request Prior Authorization of Organ Transplantation**

1. At least ten (10) days prior to the transplant, the requesting DC Medicaid Provider shall submit to the Medical Director of the Department of Health Care Finance (DHCF):
  - a. A completed, signed and dated Transplant Prior Authorization Request Form (sample attached);
  - b. Documentation needed to complete prior authorization review including;
  - c. Letter of Medical Necessity for the transplant signed by Transplant Program Director/Transplant Surgeon, including the following:
    - i. Organ transplant-related diagnosis(es);
    - ii. Summary of course of illness;
    - iii. Current medications;
    - iv. Smoking, alcohol and drug abuse history
    - v. Medical records, including physical examination, medical history, and family history
    - vi. Laboratory assessments including serologies
2. If applicable, Letter of Support for the need to have the transplant performed outside of the District of Columbia Service Area (DCMSA).
3. The DHCF Medical Director shall:
  - a. Receive requests for organ transplantation and date stamp each request.
  - b. Determine if the requested organ transplantation is or is not a Medicaid covered service pursuant to the Medicaid State Plan.
  - c. If the requested organ transplantation is not a covered service, the DHCF Medical Director notifies in writing the referring DC Medicaid Provider that the requested organ transplantation is not a covered service.
  - d. If the requested organ transplantation is a covered service, the DHCF Medical Director shall look up the beneficiary in the DHCF MMIS system and confirm that the beneficiary is enrolled in the DC Medicaid program.
  - e. If the beneficiary is not eligible for DHCF Medicaid, the DHCF Medical Director shall notify in writing the requesting provider that the beneficiary is not eligible for DCHF Medicaid.
  - f. If the beneficiary is eligible for DHCF Medicaid, the DHCF Medical Director shall determine if the beneficiary is in enrolled in the DHCF Fee-For-Service program or a DC Medicaid MCO.
  - g. If the beneficiary is enrolled in the DHCF Fee-For-Service program, the DHCF Medical Director shall proceed with the review of the request.

- h. If the beneficiary is enrolled in a DC Medicaid MCO, the DHCF Medical Director shall:
  - i. Notify the MCO's Medical Director that DHCF has received a request for transplant services for the MCO's member;
  - ii. Request that the MCO submit a letter of medical necessity affirming that the MCO will cover: a) costs up to the time of the transplant surgery, and b) costs after discharge from the hospital stay during which the transplant surgery occurred, and
  - iii. Proceed with the review of the request.
- i. Review the Request for Organ Transplantation and submitted required documentation for its completeness.
- j. If the Request and Required Documentation is incomplete, the DHCF Medical Director notifies in writing the referring DC Medicaid Provider that the request is incomplete, the reason(s) why it is incomplete, and instructs the referring DC Medicaid Provider to submit the incomplete/missing documents/information.
- k. If the Request and Required Documentation is complete, the DHCF Medical Director attaches and prepares a Transplant Request Checklist (sample attached) to the full Request for Transplantation package and conducts a medical review.

4. Medical Review

- a. The DHCF Medical Director shall review the medical evidence (and determine if the requested organ transplantation meets criteria for coverage as stated in the DC Medicaid state plan.
- b. If the DHCF Medical Director determines that the requested organ transplant is coverable, s/he shall prepare a Letter of Approval for the DHCF Director's signature.
- c. If the DHCF Medical Director determines that the requested organ transplant is not coverable by the DC Medicaid program, s/he shall make a recommendation for a second clinical review to the DHCF Deputy Director of Medicaid.
- d. If the DHCF Deputy Director of Medicaid approves the recommendation, s/he shall direct that the case records be sent to the DHCF Utilization Management contractor for second clinical review.
- e. If the DHCF Deputy Director of Medicaid disapproves the recommendation for second clinical review, s/he shall determine what additional actions are to be completed.

5. DHCF Senior Officials' Review and Decision - Upon completion of the coverage review process and receipt of the final coverage recommendation, the DHCF Medical Director shall prepare a DHCF Decision/Information Form, attach this form to the entire case record and

forward the entire case record to the following approving DHCF Senior Officials for review and decision:

- a. Senior Deputy Director for Medicaid
- b. Director of the DHCF

6. Notification of Requesting Provider of DHCF Determination

- a. After the DHCF Director has reviewed and made a coverage determination for the requested organ transplant, s/he shall forward the determination to the DHCF Office of the Director Special Assistant for processing:
- b. If the DHCF Director has made a determination to approve the requested organ transplant and signed the Letter of Approval, the DHCF Office of the Director Special Assistant shall mail the Letter of Approval to the requesting provider, provide courtesy copies of the Letter of Approval to the DHCF Deputy Director for Medicaid, the DHCF Deputy Director of Medicaid, the DHCF Director of the Health Care Operations Administration, and the DHCF Medical Director.
- c. If the DHCF Director has made a determination to disapprove or request additional information for the requested organ transplant, the DHCF Office of the Director Special Assistant shall forward the determination and case record to the DHCF Medical Director.
- d. If the DHCF Director has made a determination to disapprove the requested organ transplant, the DHCF Medical Director shall notify the beneficiary in writing that the requested organ transplant is being denied, the reason it is being denied, the beneficiary's right to a fair hearing at the D.C. Office of Administrative Hearings, the time frame for requesting a hearing, the method by which they may obtain an evidentiary hearing, and that they may represent themselves or use legal counsel, a relative, a friend, or other spokesman.

7. Issuance of the Prior Authorization (PA) for Approval of the Requested Organ Transplant

- a. Upon receipt of a courtesy copy of the signed Letter of Approval from the DHCF Office of the Director Special Assistant, the DHCF Medical Director shall notify the DHCF Utilization Management contractor to issue a PA number in the DHCF MMIS for the approved organ transplant.
- b. The DHCF Utilization Management contractor shall issue a PA number in the DHCF MMIS and contact the requesting provider to provide the PA number for the approved organ transplant.

8. Organ Transplant Claims Receipt and Processing

- a. The PA approval number must be included on all claims submitted for reimbursement.
- b. Submission of original claims forms with the clinical information (discharge summary, operative report(s) and backroom organ prep report(s), must be submitted by first class mail or hand-delivered to the DHCF Medical Director at the address below. Copies and facsimiles will not be accepted.

c. Address for claims submissions:

District of Columbia Department of Health Care Finance  
Office of the Medical Director  
Attn: Transplant Prior Authorization  
441 4<sup>th</sup> Street, N.W.  
Suite 900 South  
Washington, DC 20001

If you have any questions about this transmittal or organ transplantation coverage or policy, please contact Lisa Truitt at (202) 442-9109 or the DHCF Medical Director at (202) 442-9077.

Attachments

## ATTACHMENT A

### INSTRUCTIONS FOR SUBMITTING REQUEST/PRIOR AUTHORIZATION FORM

The Department of Health Care Finance (DHCF) reserves the right to make recommendations to a certified center that has provided transplant services to Medicaid beneficiaries in the past. You must identify any services that are considered experimental and/or investigational or sponsored under a research program, as these services are not covered by DC Medicaid. In addition, a copy of the beneficiary's medical records relating to the transplant, for up to the past year must be included.

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

In determining whether to provide Prior Authorization, DHCF may use guidelines that include clinical standards, protocols, or criteria regarding the treatment of specific conditions.

When submitting a completed Transplant Prior Authorization form:

1. The referring District of Columbia (DC) Medicaid provider must complete the form.
2. All fields on the form must be completed.
3. Include supporting clinical documentation (e.g., clinical notes, diagnostic studies, lab results).
4. **This 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.**
5. Providers seeking reimbursement for services must be approved D.C. Medicaid providers.
6. **You must provide sufficient information to allow us to make a decision regarding your request.**
7. If the transplant service is available in-state and this case is being referred outside the District of Columbia Medical Service Area (DCMSA), you must indicate why.
8. Requests may be faxed to (202) 442-6723 or mailed to:

District of Columbia Health Care Finance Administration  
Office of the Medical Director  
Attn: Transplant Prior Authorization  
441 4<sup>th</sup> Street, NW  
9<sup>th</sup> Floor, Suite 900 South  
Washington, DC 20001



### Transplant Prior Authorization Request Form

Omissions, generalities, and illegibility will result in the form being returned for completion or clarification. Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

NAME OF BENEFICIARY: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
DC MEDICAID ID#: \_\_\_\_\_  
NAME OF GUARDIAN (if applicable): \_\_\_\_\_  
CONTACT TELEPHONE NUMBER: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_  
NPI: \_\_\_\_\_  
DC MEDICAID #: \_\_\_\_\_  
TYPE OF TRANSPLANT: \_\_\_\_\_  
Is the patient receiving a \_\_\_\_\_ living organ or a \_\_\_\_\_ cadaveric organ?  
EXPECTED DATE OF SERVICE: \_\_\_\_\_  
EXPECTED DATE OF RETURN: \_\_\_\_\_  
WILL THE BENEFICIARY REQUIRE TRANSPORTATION? YES \_\_\_\_\_ NO \_\_\_\_\_  
RECOMMENDED MODE OF  
TRANSPORTATION: \_\_\_\_\_

Medicaid patients, as well as their escort, may be provided transportation when necessary. Prior approval is mandatory in order to make the necessary travel arrangements. Contact the DHCF Office of the Ombudsman at 1 (877) 685-6391 or (202) 442-5988 to make travel arrangements.

#### RENDERING PHYSICIANS/FACILITY

PATIENT REFERRED TO: \_\_\_\_\_  
NAME OF FACILITY AND/OR PHYSICIAN (S)  
ADDRESS: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_  
NAME OF CONTACT PERSON/COORDINATOR: \_\_\_\_\_

#### REQUIRED DOCUMENTATION

- ☐ Letter of Medical Necessity for the transplant, including the following: summary of course of illness, current medications, smoking, alcohol, and drug abuse history
- ☐ Medical records, including physical exam, medical history, and family history
- ☐ Laboratory assessments including serologies
- ☐ Letter to support the need to have the transplant performed outside of the District of Columbia Medical Service Area (SCMSA) – If applicable.



**PLEASE ANSWER THE FOLLOWING QUESTIONS**

	Yes	No
Does the patient have any unresolved psychosocial concerns or history of non-compliance with medical management?		
Has the patient had active alcohol, tobacco, or substance abuse within the past 6 months?		
Does the patient have any serious health conditions that create an inability to tolerate transplant surgery or post-transplant care?		
Does the patient have any uncontrolled/untreatable infections or disease?		

**If the answer is "Yes" to any of the above questions, please explain and provide medical documentation.**

I certify that the above information is correct and that contact has been made with the Rendering Facility/Physician. I also certify that if the request is to a provider and/or facility outside of the DCMSA, that the service is not available and cannot be provided within the DCMSA.

\_\_\_\_\_  
SIGNATURE OF REFERRING PHYSICIAN

\_\_\_\_\_  
DATE