GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director and Medicaid Director **Transmittal 23-37**

TO: District of Columbia Medicaid Providers

FROM: Melisa Byrd
Senior Deputy Director and Medicaid Director

DATE: **August 22, 2023**

SUBJECT: **CLARIFICATION: Policy and Procedure regarding the District of Columbia (DC) Medicaid 719A Prescription Order Form**

Purpose
The purpose of this transmittal is to clarify the process and requirements regarding the 719A prescription order form. The 719A form is the DC prescription order form that is a required document used to obtain medical, surgical, and dental services for the Fee-for-Service (FFS) Medicaid beneficiary. The 719A is required for any service that the Department of Health Care Finance (DHCF) has indicated on the fee schedule or in policy as needing prior authorization (PA). The purpose of prior authorization is to validate that the service or item being requested is medically necessary and that it meets DC Medicaid criteria for coverage. There are several details related to the 719A that require clarification:

- The 719A is an open prescription for 6 months.
- All of the information in the patient, prescribing provider, and servicing provider sections must be completed in its entirety. None of the boxes should be left blank.
- The 719A should be completed accurately to prevent processing delays or the risk of having the form returned.
- All 719A forms require the signature of the provider and the date of the request. These two elements MUST be on the 719A form. DC Medicaid will not accept stamped or typed signatures in this section - original signatures are required. By signing and dating in the appropriate spaces, the provider certifies that he or she has reviewed the form for accuracy and is responsible for the contents submitted. Authorized prescriber signature dates are used as the initiation date for service.
- If a mistake is made on the 719A, the provider should draw a line through the incorrect information, initial and date any corrections made on the form. Whiteout should never be used to correct a mistake.

- The servicing provider should never alter, add and/or change any information designated for the prescribing provider.
- Any alterations made by the servicing provider after the 719A form has been signed by the prescribing provider could lead to denial of claims, action seeking monetary sanctions against the servicing provider, and possible criminal charges.
- A Prior Authorization (PA) does not guarantee payment. A PA only authorizes those services and/or equipment that may be provided.

Durable Medical Equipment/Prosthetics, Orthotics, Medical Supplies (DME/POS)

- Payment is contingent on passing all edits contained within the claim's payment process, the beneficiary's continued Medicaid eligibility, and the ongoing medical necessity for the service being provided. Authorizations are specific to a beneficiary, a provider, a service code, an established quantity, and for specific dates of service. If prior authorization is required, authorization shall be received prior to the delivery of the DME/POS service or item. DME/POS prior authorizations are valid for six (6) months, except for capped rental items.
- Do not submit claims for a procedure requiring prior authorization without first obtaining the PA number. If you submit a claim for a procedure code that requires a PA, your claim will be denied if the PA number is not provided. Please consult the fee schedule at www.dc-medicaid.com, to verify if the procedure code requires prior authorization. Once the PA request has been approved, you will receive a PA letter containing the prior authorization number to enter on your claim.
- If granted, a prior authorization is valid for six (6) months from the date of the physician or authorized provider's (requesting provider) signature or proposed delivery date.
- A service may occur after the authorized prescriber's signature, BUT a service cannot be authorized prior to the authorized prescriber's date of signature without his written documentation of the date of service within the six (6) month window allowed within the medical justification field.
- Use miscellaneous codes ONLY when a more precise and appropriate Healthcare Common Procedure Coding System (HCPCS) code is not available. When using a miscellaneous code, include the manufacturer's quote, invoice, or paid receipt with the 719A form, in addition to the required clinical documentation.
- If a prescribing clinician or DME/POS provider/supplier receives a discount for an item ordered for use by a D.C. Medicaid beneficiary, the prescribing clinician and/or DME/POS provider/supplier shall subtract the amount of the discount from the amount for which reimbursement is sought prior to submitting the claim to DHCF. Failure to comply with the requirements of this paragraph may result in denied claims, recoupment of any overpayments, temporary suspension of payments, or termination of the Medicaid Provider Agreement.
- A DME/POS provider/supplier shall be required to provide original documentation reflecting all discounts that apply to the cost of any item provided to a Medicaid beneficiary.
- In the case where a beneficiary walks into a DME provider office pharmacy for a product that does not require prior authorization (e.g., a pack of protective underwear, a blood pressure cuff, or compression stockings), a written prescription from a prescribing provider is sufficient.

- In the event that a DMEPOS provider/supplier goes out-of-business, another enrolled DMEPOS provider/supplier that is capable of providing continuous DMEPOS services/items to a beneficiary shall complete a new Form 719A, include a reference to the original prior authorization number on Form 719A, and submit the form to DHCF, or its designee. The new DMEPOS provider/supplier shall not provide any new item to a beneficiary until DHCF, or its designee, has provided a new prior authorization number.
- A DME/POS provider/supplier shall be required to produce proof of delivery (POD) for all items that are provided to a Medicaid beneficiary. POD may include:
    - Receipts that are signed by the beneficiary who requires DME/POS, or his or her legal representative; or
    - Delivery confirmation.

Prior to or at the time of delivery of DME, the DMEPOS provider/supplier shall perform an on-site evaluation of the beneficiary's home, if applicable, to verify that the beneficiary can adequately maneuver the item that is provided considering the physical layout, doorway widths and thresholds, and surfaces. There shall be a written report of this evaluation, and the provider/supplier shall make it available upon DHCF's request. Documentation required under this section shall also be subject to the record keeping requirements of 29 DCMR § 996.9.

Contact
If you have questions, please contact Cavella Bishop, Program Manager, Health Care Delivery Management Administration, Department of Health Care Finance (DHCF) at cavella.bishop@dc.gov or (202) 724-8936.

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