GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal # 19-21**

TO: Long Term Services and Supports Providers

FROM: Melisa Byrd MB
Senior Deputy Director/State Medicaid Director

DATE: September 17, 2019

SUBJECT: Revised Prescription Order Form (POF) for Long Term Services and Supports (LTSS)

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).

An updated version of the POF (version 9/1/19) was created to ease completion of the form, where previously both the Medicaid Provider ID number and National Provider Identifier (NPI) number were required fields. With this most recent revision, the required field of Medicaid Provider ID has been eliminated to reduce unnecessary redundancies. However, the National Provider Identifier (NPI) Number is retained in the revised POF as a required field (See Section 3 of the POF-Physician/APRN Information). DHCF has replaced version 9/12/18 on our website with the 9/1/19 form, effective October 1, 2019.

The accompanying revised form – which is being distributed with this transmittal – will be used to initiate the face-to-face assessment for the following LTSS: 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 facilities. 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.

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.

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

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE

PRESCRIPTION ORDER FORM (POF)

FOR LONG TERM CARE SERVICES AND SUPPORTS

This completed form must be uploaded to DC Care Connect or 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 ☐ Reassessment ☐ Initial assessment ☐ Change in patient condition

C.** Request Type: ☐ EPD Waiver ☐ State Plan LTSS

D. Retroactive Coverage Request Effective Date (Nursing Facilities Only): [ ]

E. **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: [ ]

F. Comments: [ ]

SECTION III: PHYSICIAN/APRN INFORMATION

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

B. **Telephone Number: [ ] C. **National Provider Identifier Number: [ ]

D. **Provider Address: [ ] E. **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: [ ]

Version: 9/1/2019