Comagine Health DME: Multiple Incontinent Supplies Prior Authorization Training

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October 7, 2026

Comagine Health

A national, nonprofit, health care consulting firm.

We work collaboratively with patients, providers, payers, and other stakeholders to reimagine, redesign and implement sustainable improvements in the health care system. Our services include:

- Care Management
- Health System Improvement
- Research and Evaluation
- HIT and Analytics



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Objective

- Overview of Comagine Health's Incontinent Supply review process
  - To provide clear understanding and improve efficiency, effectiveness, and clarity for providers
- Review DHCF 719A form completion
- Review required documents for Incontinent Supply
- Review Comagine Health Provider Portal (CHPP)
- Review Log-on Information
- View Dashboard Features
- Submitting an Incontinent Supply Authorization Request Demonstration
- Review Provider Resources – Quick Start Guides

Everyone will remain on mute during the presentation, and if you have questions feel free to put them in the chat. We will monitor chat throughout the presentation and answer questions at the end.

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DME Regulation

- Comagine Health will review for medical necessity and provide prior authorization for durable medical equipment, prosthetics, orthotics, and supplies (DME POS) to qualified Medicaid beneficiaries in accordance with the requirements of this section and the D.C. Medicaid DME POS Provider/Supplier Billing Manual.
- All providers/suppliers of DME POS shall be enrolled as such by DHCF in accordance with Provider and Supplier Screening and Enrollment regulations and policies and § 996 of Title 29 District of Columbia Municipal Regulations (DCMR).
- Comagine Health will review DME requests for medical necessity within five (5) business days.

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Required Documents

1. **DC Medicaid approved 719A form completed in its entirety to include:**
   a. Duration and number of units requested
   b. Diagnosis related to the need for the DME item
   c. The appropriate descriptions, HCPC code, and cost for prior authorization request
   d. Medical Justification for the incontinent supply must be documented on the 719A form justification section
   e. Documentation describing incontinence, contributing conditions, functional limitations, and skin integrity
   f. Signatures must be **handwritten or signed electronically**
2. **Supporting Clinical documents**

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Age-Based Eligibility & Clinical Need

- Diapers/briefs are medically necessary at age 5+ with a qualifying diagnosis.
- Under age 5, approval requires clear documentation of a condition making incontinence developmentally inappropriate.
- Chux/underpads may be approved at any age when medically necessary, including as a standalone item when T-code products are not used.

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Mixed Product Request

Starting October 15, 2026

- Mixed product requests can include briefs and under pads.
- Documentation should include reasons for the additional support such as:
  - History/high risk of skin breakdown (dermatitis, pressure injury)
  - Moisture-associated skin damage (MASD)
  - Inadequate control with a single product type

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DHCF 719A Prior Authorization Form

(Transmittal 23-37)

- The 719A is an open prescription for six (6) months.
- All 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.
- If a mistake is made on the 719A form, 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.
- 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.

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719A Form - Prescribing Provider

This is the DC Medicaid provider **(NP, PA, MD or DO)** who is completing the medical justification and signing the 719A form.

Prescribing Provider	
Provider Name **JOHN Doctor**	
Provider Number **08888888**	NPI **1888877777**
Address City, State, Zip **44333 Nursing Home Road, NE** **Washington DC XXXXX**	
Telephone Number **202- XXX-XXXX**	

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719A - Service Provider

This is the DC Medicaid DME provider who is ordering the product or service and whom the PA will be issued to.

The servicing provider should never alter, add and/or change any information designated for the prescribing provider.

Servicing Provider	
Provider Name **DME Provider**	
Provider Number**07777788**	NPI **1555566666**
Address City, State, Zip **12000 Brown Road, NE** **Washington DC XXXXX**	
Telephone Number **202-XXX-XXXX**	

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719A Form

All information on the 719A form must be completed, including the requested service **(DME)** and the beneficiary's location.

Other Health Insurance Coverage	Requested Service				Beneficiary Location	
	Surgery	☐	DME	X	Home	☐
	Medical	☐	Pharmacy	☐	ICF/MR	☐
	Dental	☐	Eyewear	☐	Nursing Home	X
	Hospice	☐	Other		Hospital	☐
Discharge Date:	Home Health: ☐ Skilled Nurse ☐PT ☐OT ☐SLP ☐HHA ☐Private Duty				Office	☐

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719A - Requested Service Data

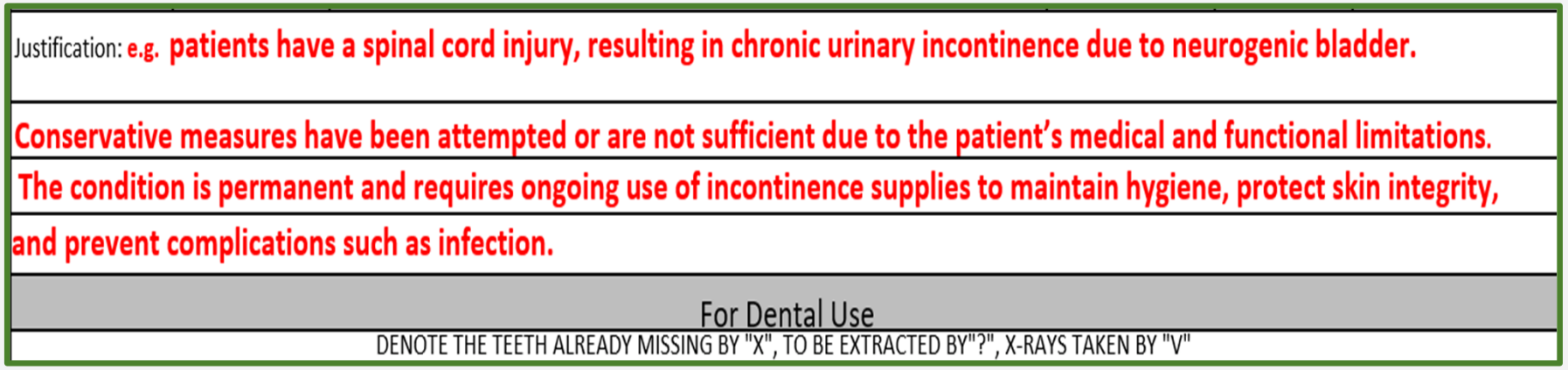
- The ICD10 diagnosis code must contain one of the following qualifying diagnosis codes: “F98.0, F98.1, N39.3, N39.41, N39.42, N39.43, N39.44,, N39.45, N39.46, N39.490, N39.491, N39.492, N39.498, R15.2, R15.9, R30.1, R39.2, R39.81, R39.89, R39.9”.
- Medical diagnoses causing or contributing to incontinence must be added to the 719A form.
- HCPCS code requiring prior authorization: T4521, T4522, T4523, T4524, T4529, T4530, T4535, T4539, T4543, A4554.
- The HCPC code must align with the service description on the DC Medicaid fee schedule.
- Incontinent supply should not exceed six (6) months.

Diagnosis Code	Procedure Code	Description of Services, DME and Supplies	Time Required	Frequency or Units	Estimated Charges
Use ICD-10	**T4521**	**Adult Size Brief**	**6 months**	**1260**	$2240.00
Code for Dx.	**A4554**	DISPOSABLE UNDERPADS, ALL SIZES, E.G., CHUX	**6 months**	**1800**	$2350.00
N39.41					
G82.22					

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719A - Medical Justification

- The medical justification for the service being requested is completed by the prescribing provider.
- The medical justification is not a diagnosis.
- The start date of the request, which cannot be earlier than the 719A form's signature date, should also be noted here.



Justification: e.g. patients have a spinal cord injury, resulting in chronic urinary incontinence due to neurogenic bladder.
Conservative measures have been attempted or are not sufficient due to the patient's medical and functional limitations.
The condition is permanent and requires ongoing use of incontinence supplies to maintain hygiene, protect skin integrity,
and prevent complications such as infection.
For Dental Use
DENOTE THE TEETH ALREADY MISSING BY "X", TO BE EXTRACTED BY"?", X-RAYS TAKEN BY "V"

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719A - Signature Requirement

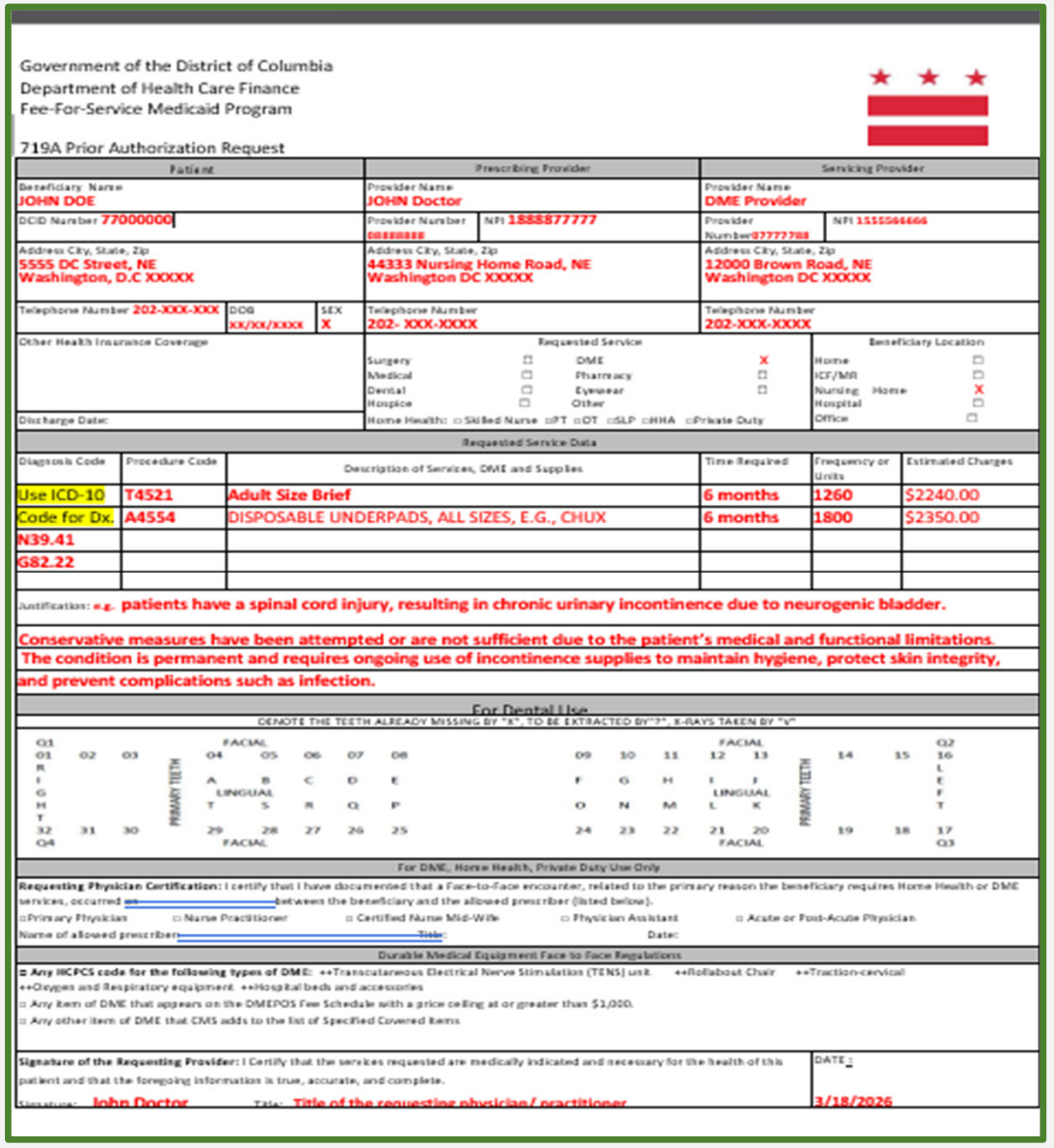
All 719A forms require the signature of the provider and the date of the request. These two elements MUST be on the 719A form. DC Medicaid will not accept stamped or typed signatures in this section - original or verifiable electronic signatures are required.

By signing and dating in the appropriate spaces, the provider certifies that they reviewed the form for accuracy and is responsible for the contents submitted. **Authorized prescriber signature dates are used as the initiation date for service.**

Signature of the Requesting Provider: I Certify that the services requested are medically indicated and necessary for the health of this patient and that the foregoing information is true, accurate, and complete. Signature: John Doctor Title: Title of the requesting physician/ practitioner	DATE: 3/18/2026

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- **719A Form**



Government of the District of Columbia
Department of Health Care Finance
Fee-For-Service Medicaid Program

719A Prior Authorization Request

Patient	Prescribing Provider	Servicing Provider
Beneficiary Name: JOHN DOE	Provider Name: JOHN Doctor	Provider Name: DME Provider
DCID Number: 77000000	Provider Number: 00888888 NPI: 1888877777	Provider Number: 07777788 NPI: 1555564666
Address City, State, Zip: 5555 DC Street, NE Washington, D.C XXXXX	Address City, State, Zip: 44333 Nursing Home Road, NE Washington DC XXXXX	Address City, State, Zip: 12000 Brown Road, NE Washington DC XXXXX
Telephone Number: 202-XXX-XXX DOB: XX/XX/XXXX SEX: X	Telephone Number: 202- XXX-XXXX	Telephone Number: 202-XXX-XXXX
Other Health Insurance Coverage:	Requested Service: Surgery ☐ DME X; Medical ☐ Pharmacy ☐; Dental ☐ Eyewear ☐; Hospice ☐ Other	Beneficiary Location: Home ☐; ICF/MR ☐; Nursing Home X; Hospital ☐; Office ☐
Discharge Date:	Home Health: ☐ Skilled Nurse ☐PT ☐OT ☐SLP ☐HHA ☐Private Duty	

Requested Service Data

Diagnosis Code	Procedure Code	Description of Services, DME and Supplies	Time Required	Frequency or Units	Estimated Charges
Use ICD-10	T4521	Adult Size Brief	6 months	1260	$2240.00
Code for Dx;	A4554	DISPOSABLE UNDERPADS, ALL SIZES, E.G., CHUX	6 months	1800	$2350.00
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Justification: e.g. patients have a spinal cord injury, resulting in chronic urinary incontinence due to neurogenic bladder.

Conservative measures have been attempted or are not sufficient due to the patient's medical and functional limitations.
The condition is permanent and requires ongoing use of incontinence supplies to maintain hygiene, protect skin integrity, and prevent complications such as infection.

For Dental Use

DENOTE THE TEETH ALREADY MISSING BY "X", TO BE EXTRACTED BY"?", X-RAYS TAKEN BY "√"

Q1				FACIAL								FACIAL				Q2			
01	02	03	PRIMARY TEETH	04	05	06	07	08	09	10	11	12	13	PRIMARY TEETH	14	15	16		
R																	L		
I				A	B	C	D	E	F	G	H	I	J				E		
G				LINGUAL								LINGUAL					F		
H				T	S	R	Q	P	O	N	M	L	K				T		
T																			
32	31	30		29	28	27	26	25	24	23	22	21	20		19	18	17		
Q4				FACIAL								FACIAL					Q3		

For DME, Home Health, Private Duty Use Only

Requesting Physician Certification: I certify that I have documented that a Face-to-Face encounter, related to the primary reason the beneficiary requires Home Health or DME services, occurred on _____ between the beneficiary and the allowed prescriber (listed below).

☐Primary Physician ☐ Nurse Practitioner ☐ Certified Nurse Mid-Wife ☐ Physician Assistant ☐ Acute or Post-Acute Physician

Name of allowed prescriber: _____ Title: _____ Date: _____

Durable Medical Equipment Face to Face Regulations

☐ **Any HCPCS code for the following types of DME:** ++Transcutaneous Electrical Nerve Stimulation (TENS) unit ++Rollabout Chair ++Traction-cervical ++Oxygen and Respiratory equipment ++Hospital beds and accessories

☐ Any item of DME that appears on the DMEPOS Fee Schedule with a price ceiling at or greater than $1,000.

☐ Any other item of DME that CMS adds to the list of Specified Covered Items

Signature of the Requesting Provider: I Certify that the services requested are medically indicated and necessary for the health of this patient and that the foregoing information is true, accurate, and complete.

Signature: John Doctor Title: Title of the requesting physician/ practitioner DATE: 3/18/2026

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DME Review Process

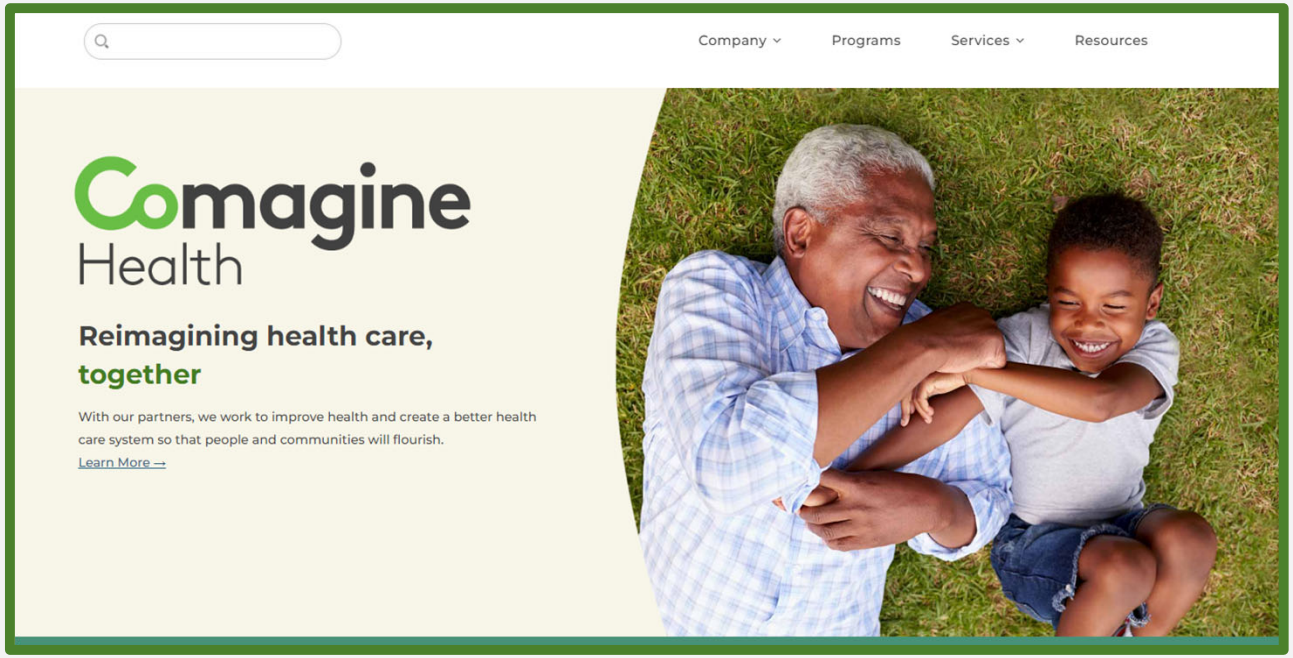
- **Overlapping dates –** If the dates associated with the request overlap with an existing Prior Authorization (PA), Comagine Health staff will automatically update the start date(s) associated with the new request to the day following the end date of the existing PA *(ex: PA 1 – ends 12/12/2024, PA 2 – will start 12/13/2024)*.
- **Request for Clarification -** If documents submitted do not meet quality check, an RFI (Request for Information/Clarification) for all missing, incomplete or lack of documentation will be issued.
  - Provider will have three (3) business days to return requested information to Comagine Health.
- **Technical Denial**- Comagine Health will issue a **Technical Denial** to the DME provider if requested information is not received within the requested timeframe.

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Comagine Health Provider Portal

Submit reviews within the Comagine Health Provider Portal (CHPP).

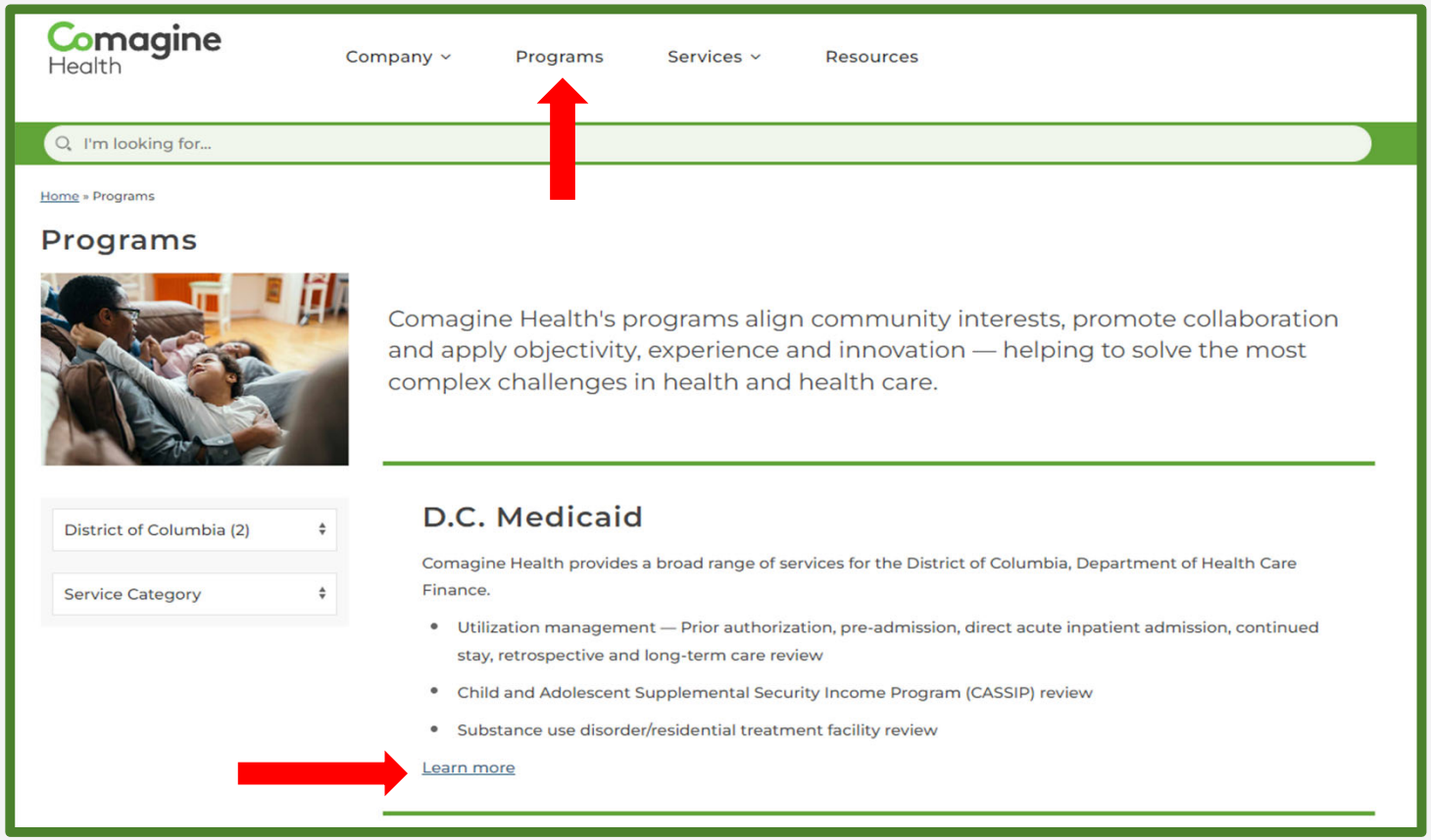
Go to Comagine Health's website - http:www.comagine.org



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Comagine Health Website

Click on **Programs**, find **D.C. Medicaid**, and select **Learn more.**



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Comagine Health Provider Website

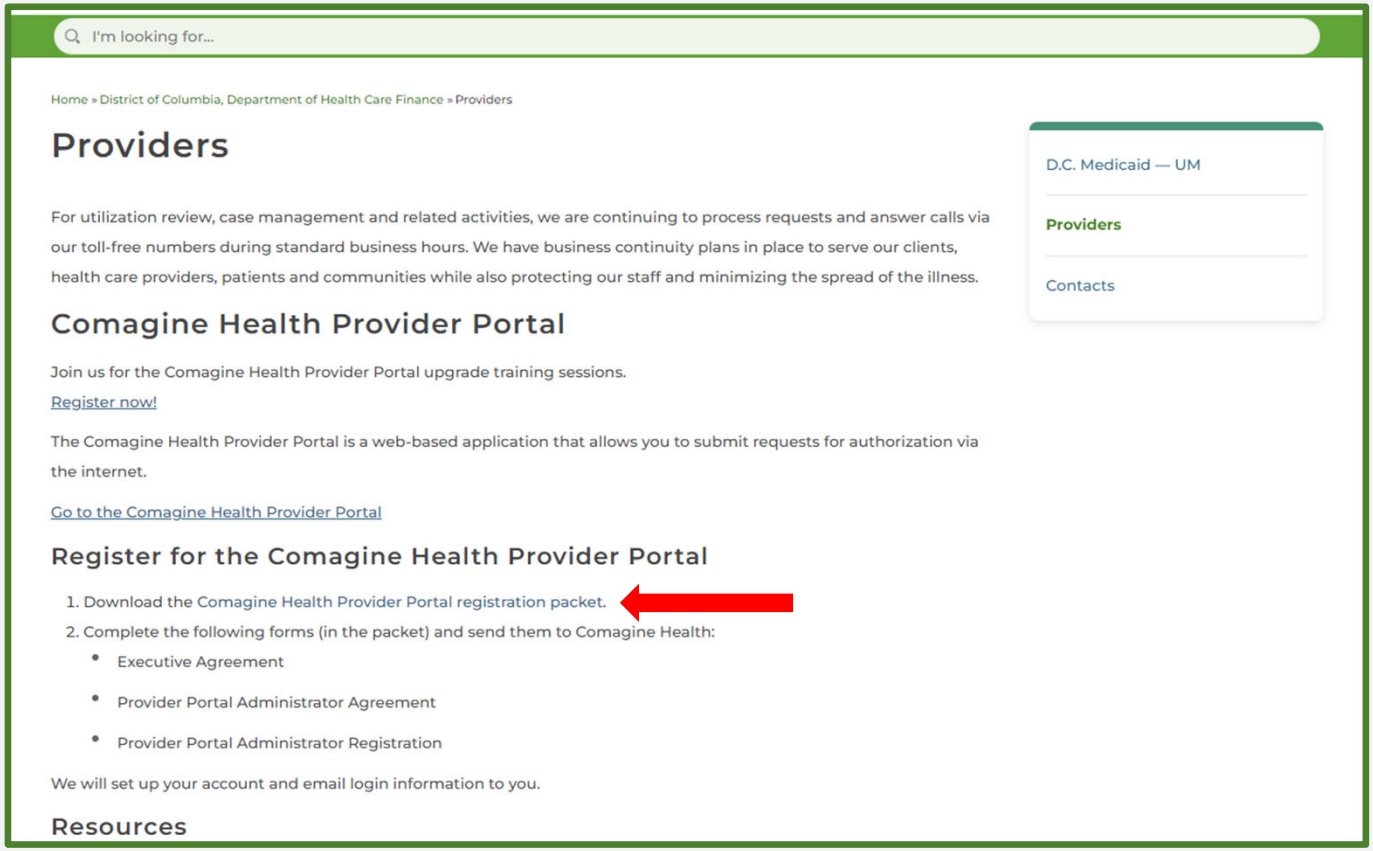
Select **Providers** on the right-side panel will display the Provider page. This page contains important trainings, provider resources, and more.



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CHPP Registration Packet

On the **Provider** page, under the **Comagine Health Provider Portal** section, you will find the link to download the CHPP registration packet.



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Submitting a Request for Portal Access

- **Submit via email:**
  - Email: dcmedicaid@comagine.org
- **Submit all completed forms:**
  - Executive Agreement
  - Provider Portal Administrator Agreement
  - Provider Portal Administrator Registration Form
  - Provider Portal User Agreement
  - Provider Portal User Registration Form

Once Comagine Health processes your registration packet, you will receive an email with your CHPP access information.

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Provider Portal Administrators

- Administrators have additional system access and system tasks to perform.
- Staff who need access to the CHPP are required to contact their Administrators.
- Provider Portal Administrators are responsible for:
  - Adding all User accounts
  - Managing all User accounts
  - Keeping the User account registration information
  - Resetting the passwords for User accounts
  - Deactivating User accounts

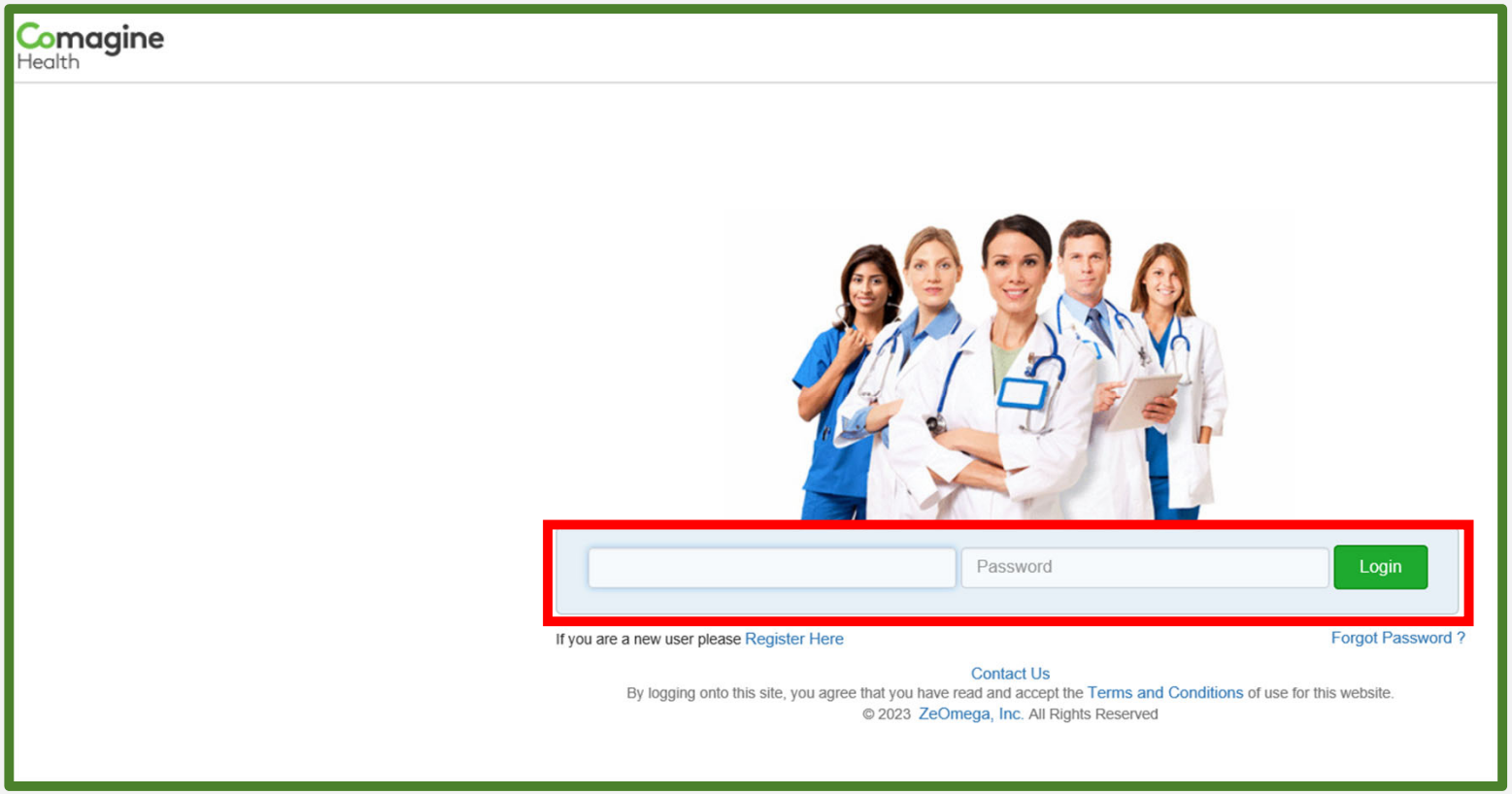
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- **Provider Portal Access**



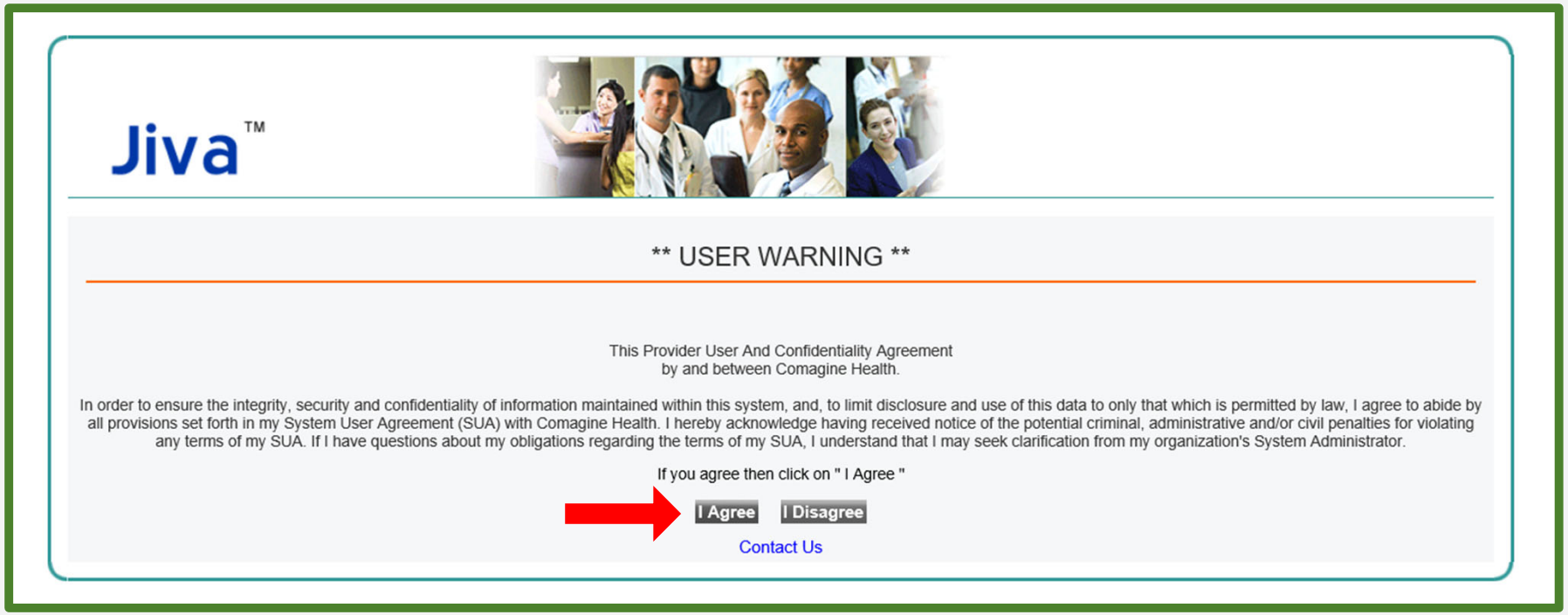
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How to Log Into the Provider Portal



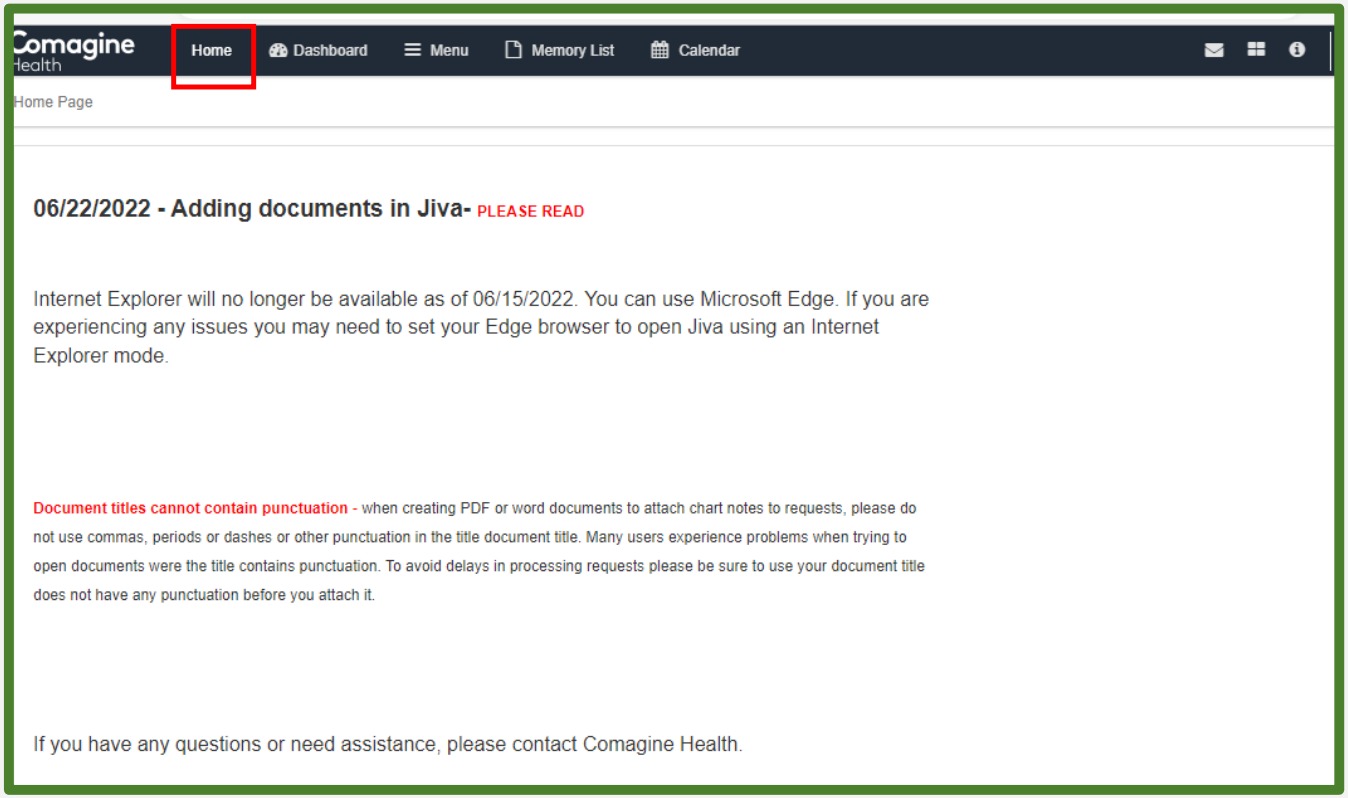
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Provider Portal Log In



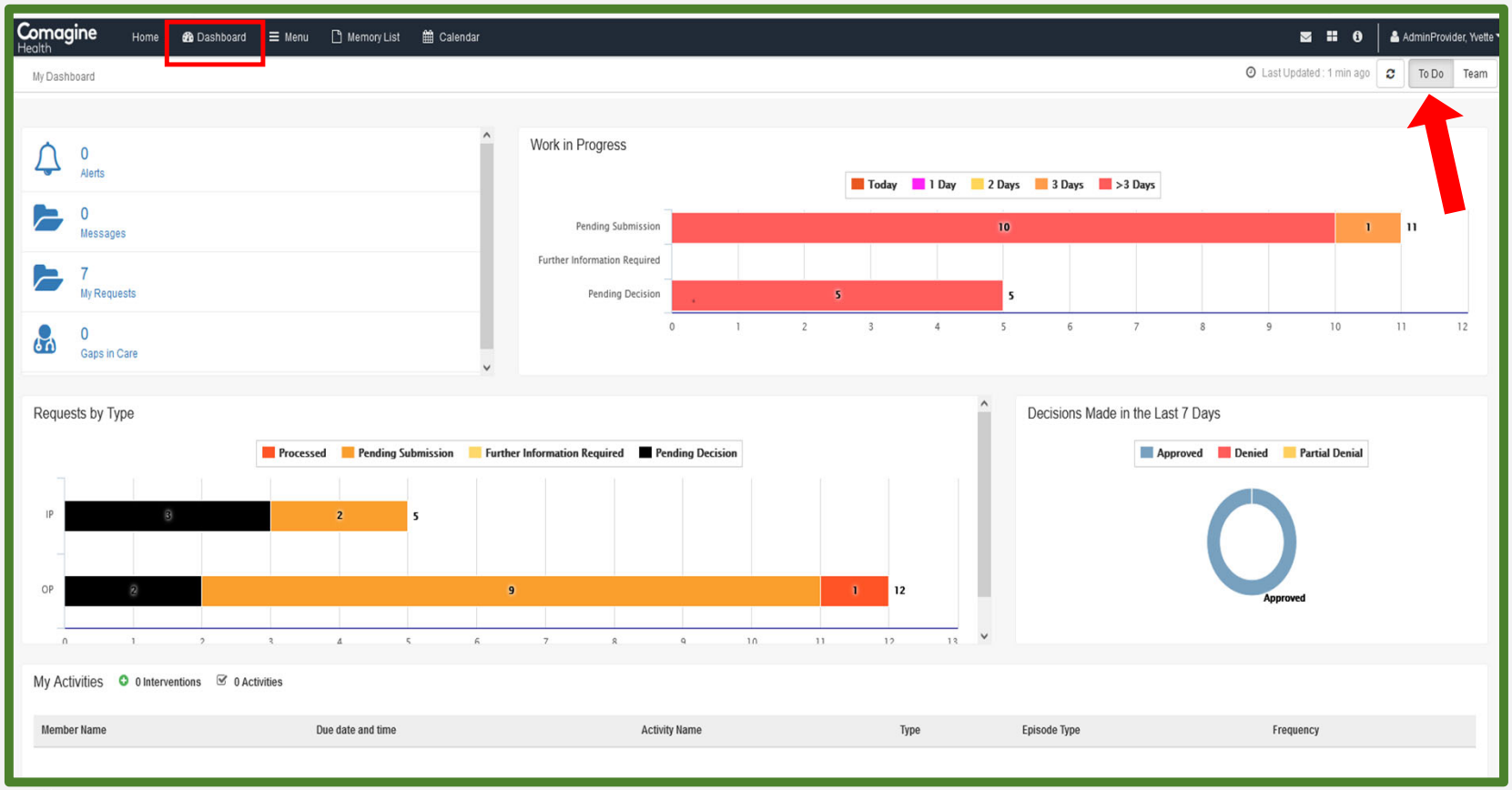
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Provider Home Page – View Posted Announcements



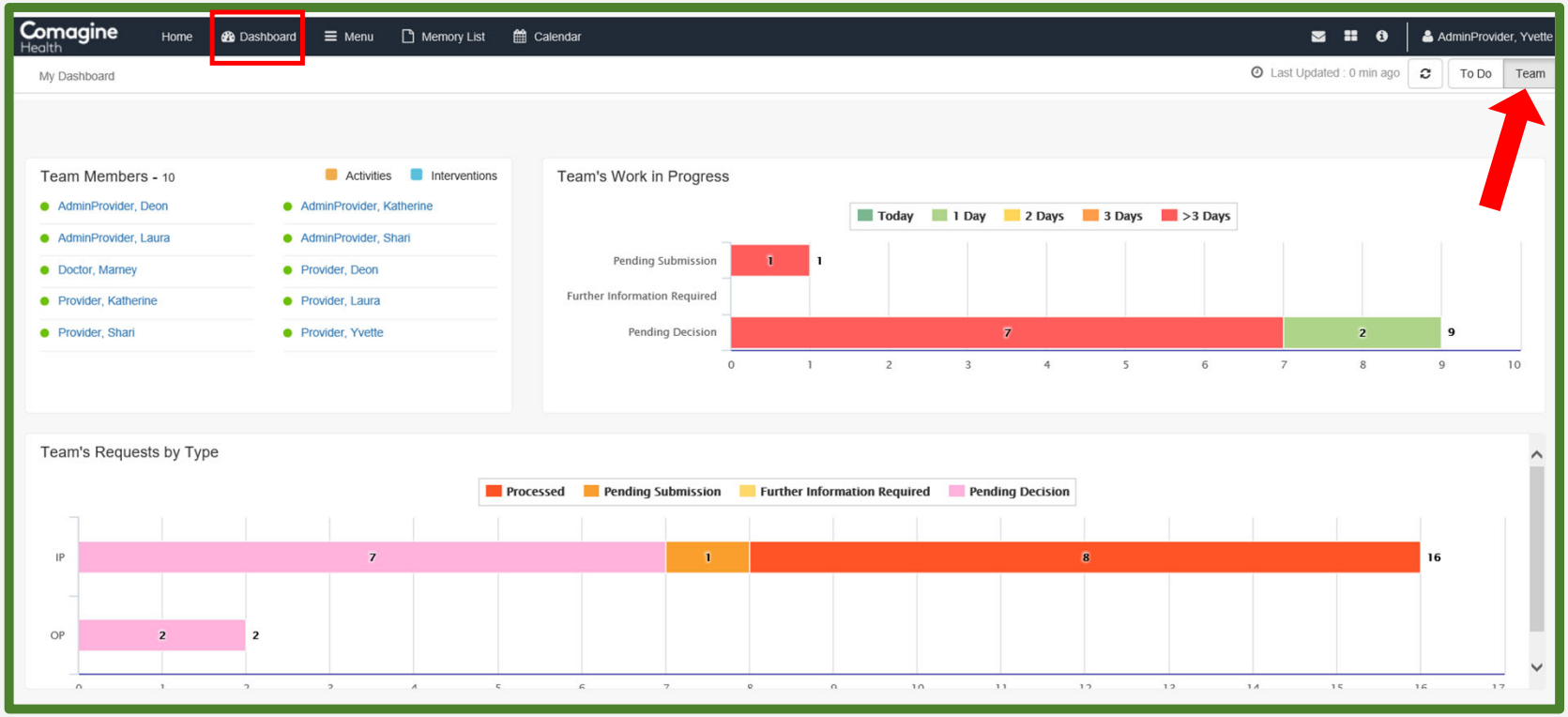
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Provider Dashboard - To Do



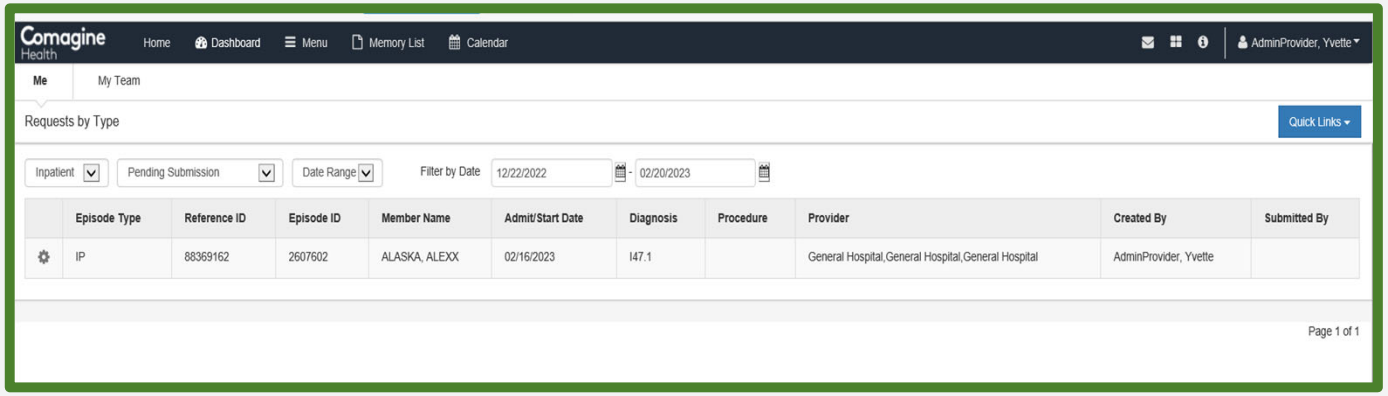
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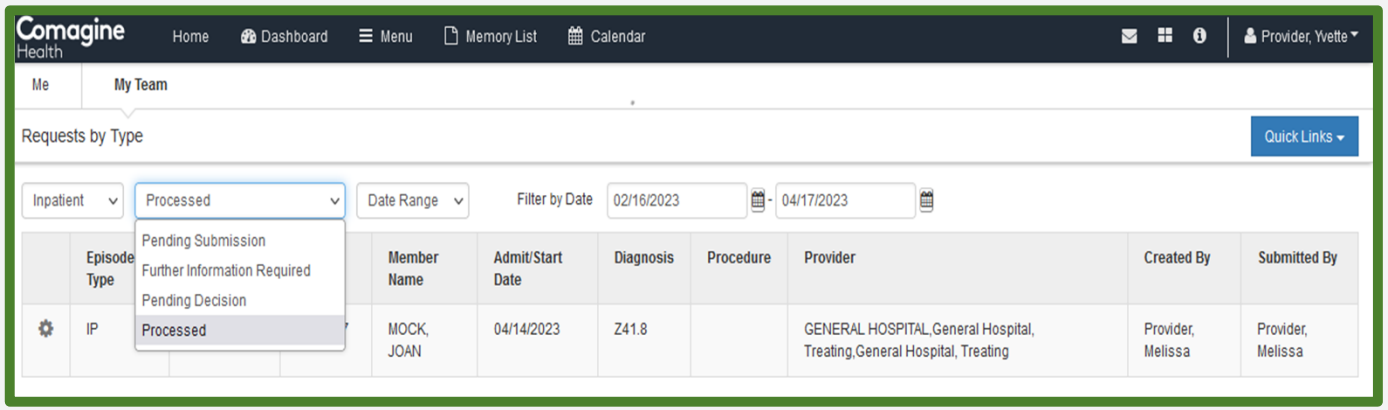
Provider Dashboard - Teams



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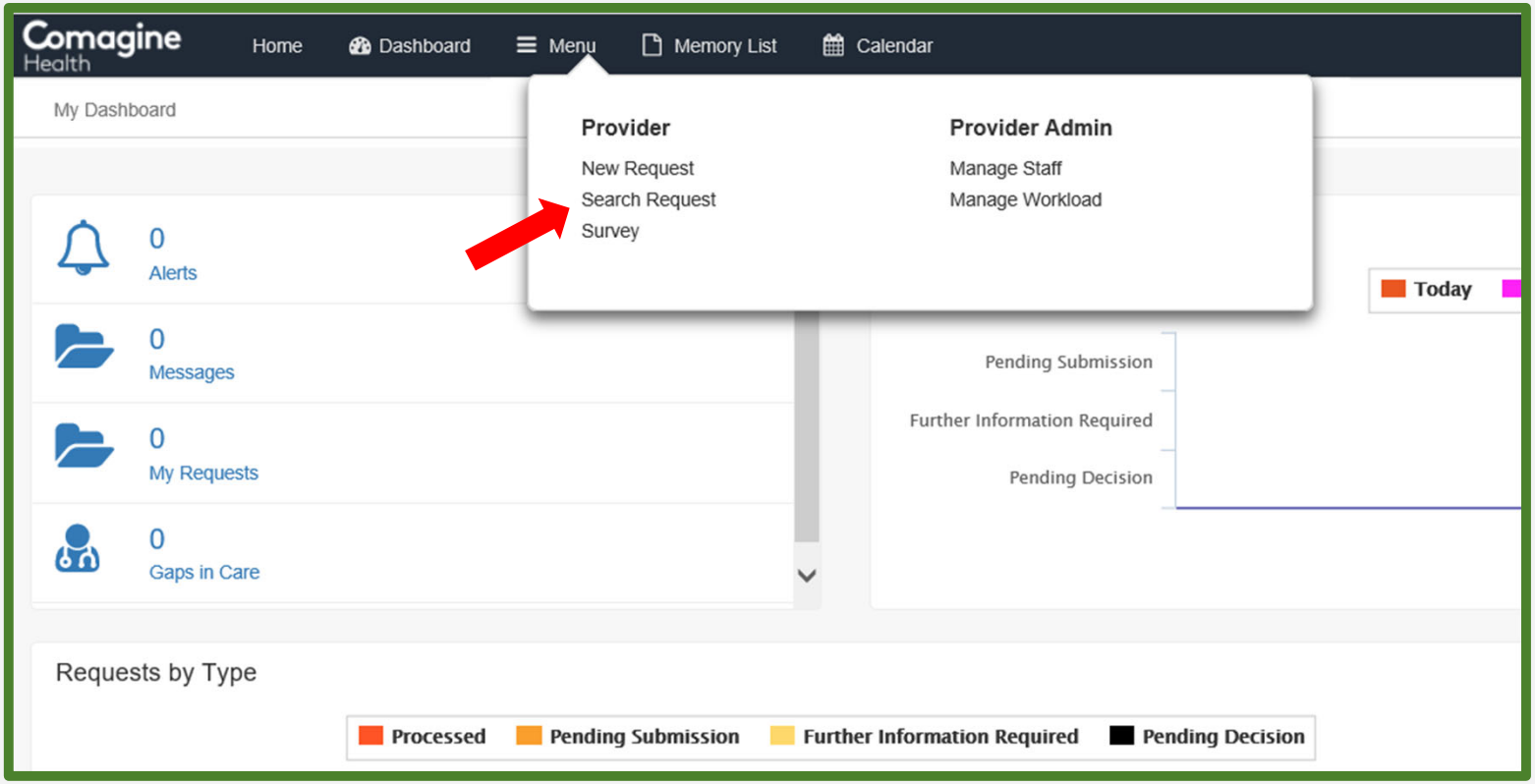
Provider Dashboard Links





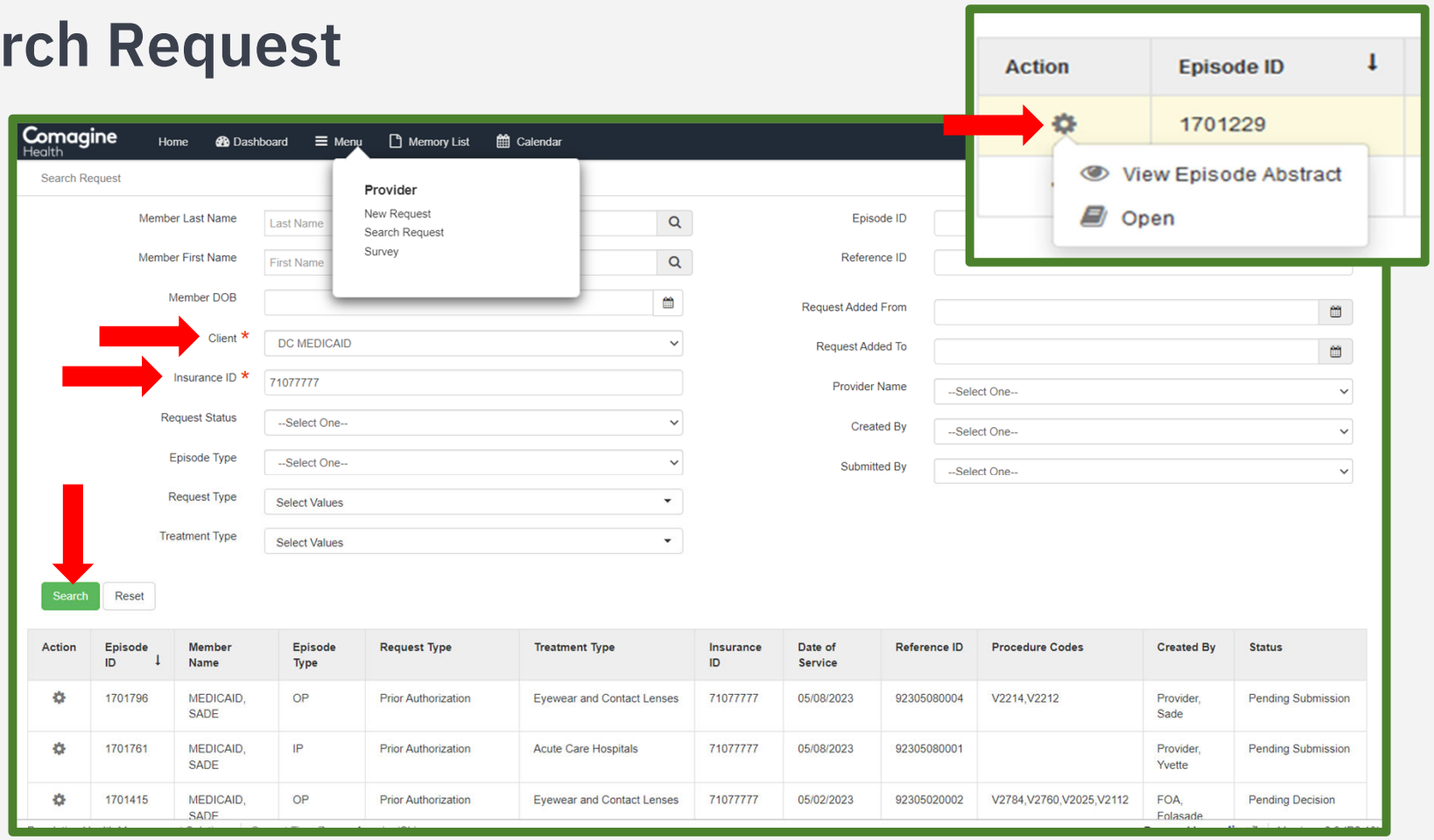
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How to Search or Submit a New Request



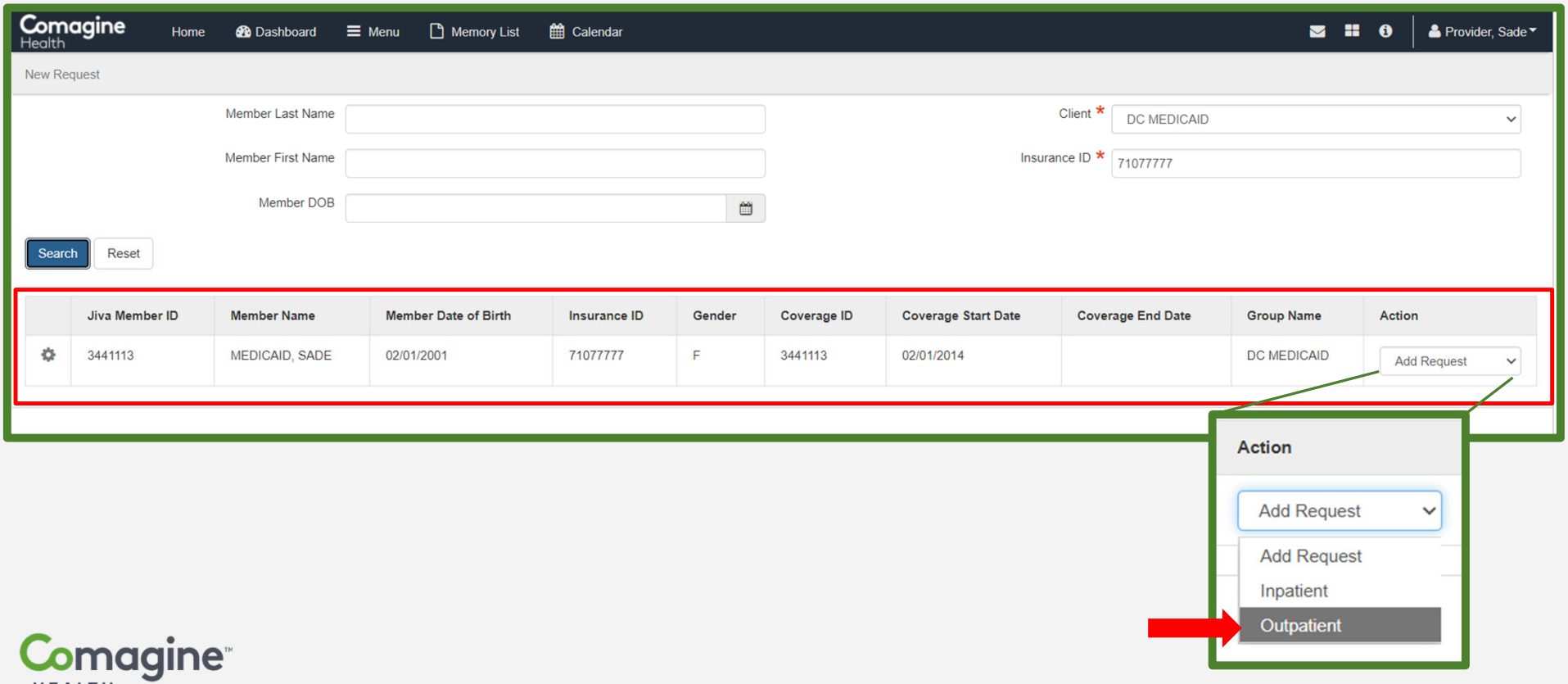
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Search Request



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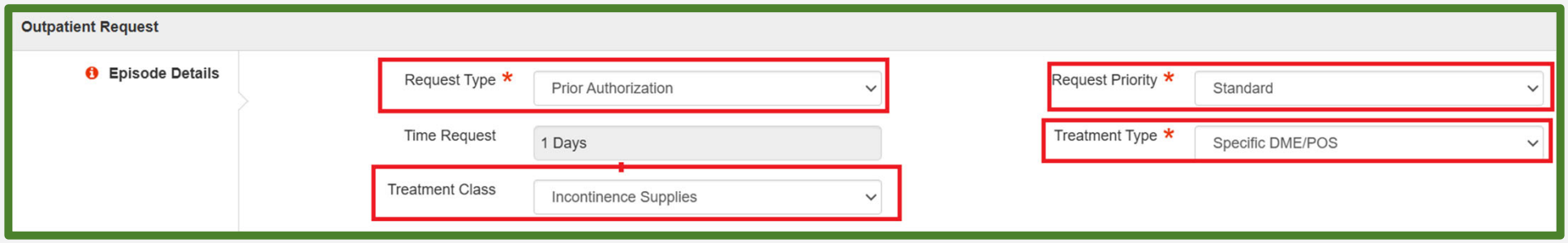
Submit a New Request



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Submit a New Request

- Fill out the **Episode Details** with the red asterisks, including the Treatment Class. For **Outpatient** requests, complete:
  - **A. Request Type***: Enter **Prior Authorization**.
  - **B. Time Request**: Does not need to be filled in, automatically populates to 1 day.
  - **C. Treatment Class**: Select **Incontinence Supplies** (this field MUST be completed even though an asterisk is not present).
  - **D. Request Priority***: Will auto-populate with **Standard**.
  - **E. Treatment Type***: Select **Specific DME POS**.

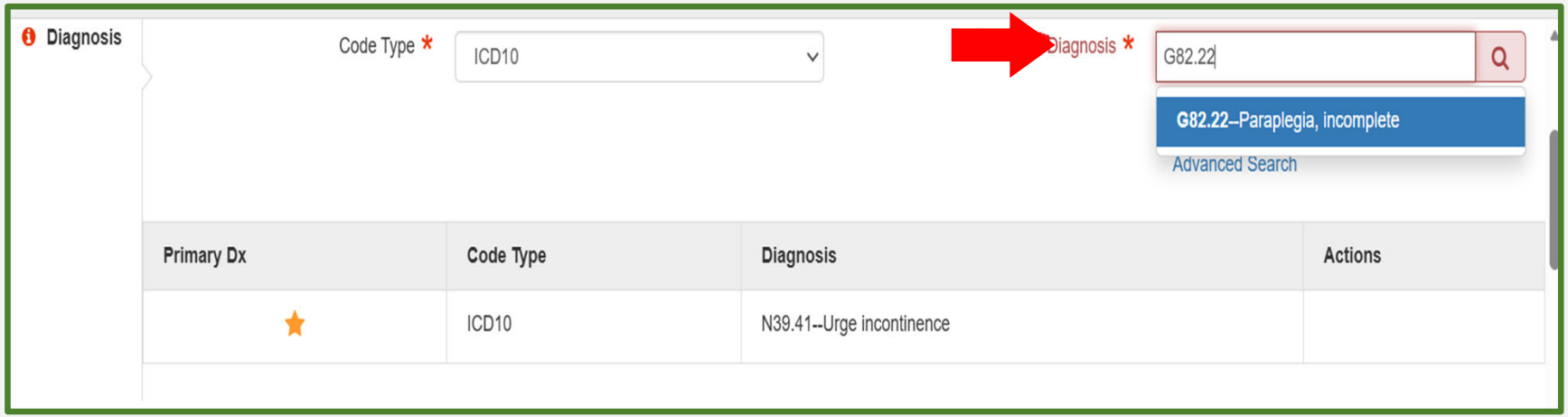


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Submit a New Request

Continued

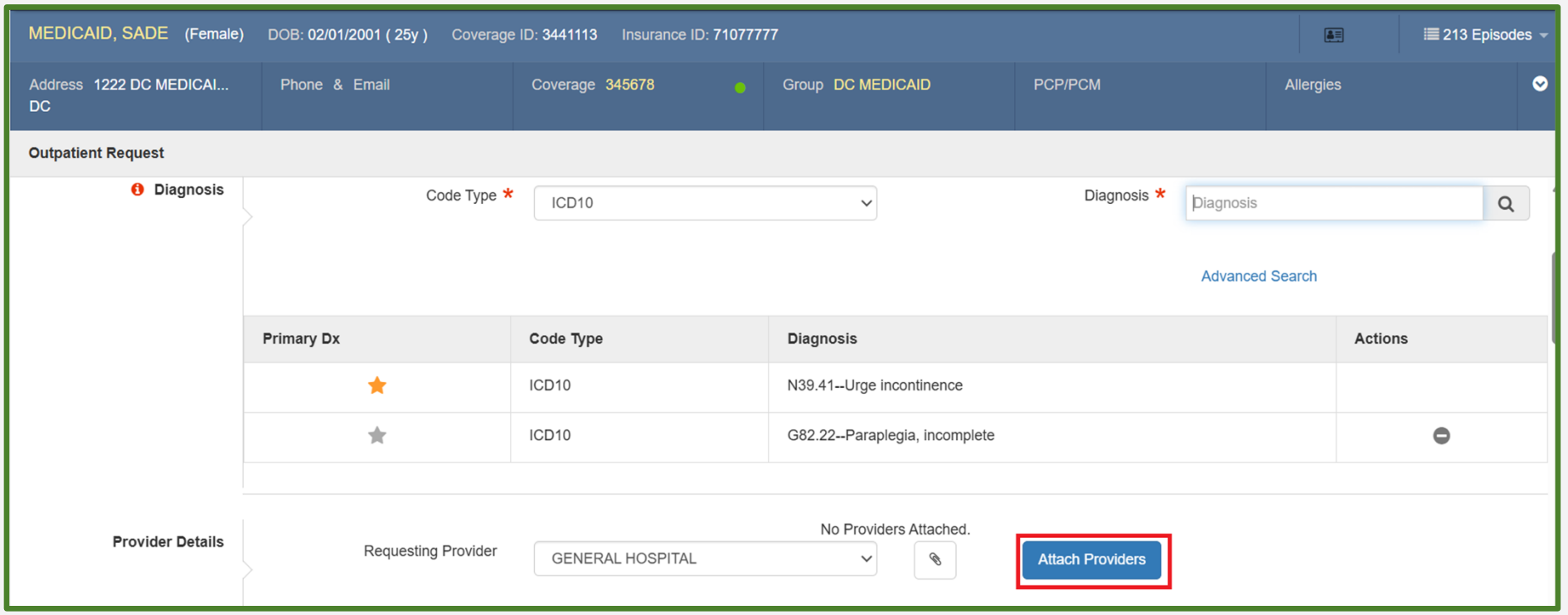
- Enter **Diagnosis**
- The ICD10 diagnosis code must contain one of the following qualifying diagnosis codes: F98.0, F98.1, N39.3, N39.41, N39.42, N39.43, N39.44, N39.45, N39.46, N39.490, N39.491, N39.492, N39.498, R15.2, R15.9, R30.1, R39.2, R39.81, R39.89, or R39.9.
- Include the medical diagnosis causing or contributing to incontinence.



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Submit a New Request

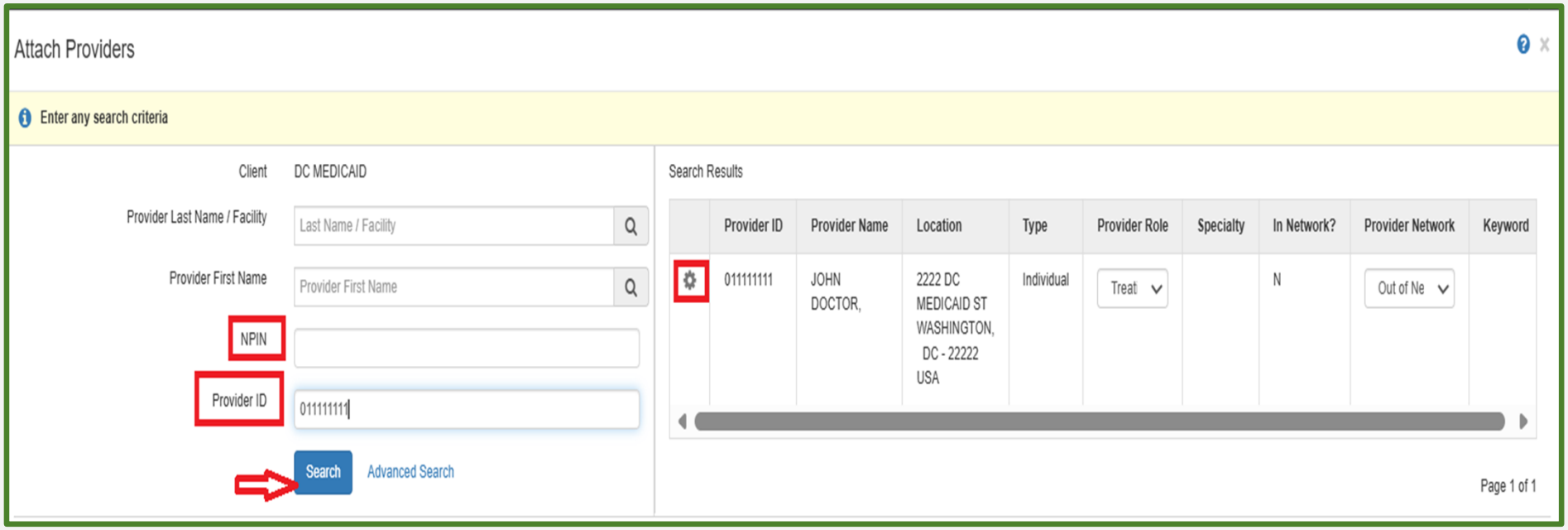
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Steps to Add Providers

Use **Search** or **Advanced Search** to find the correct providers.

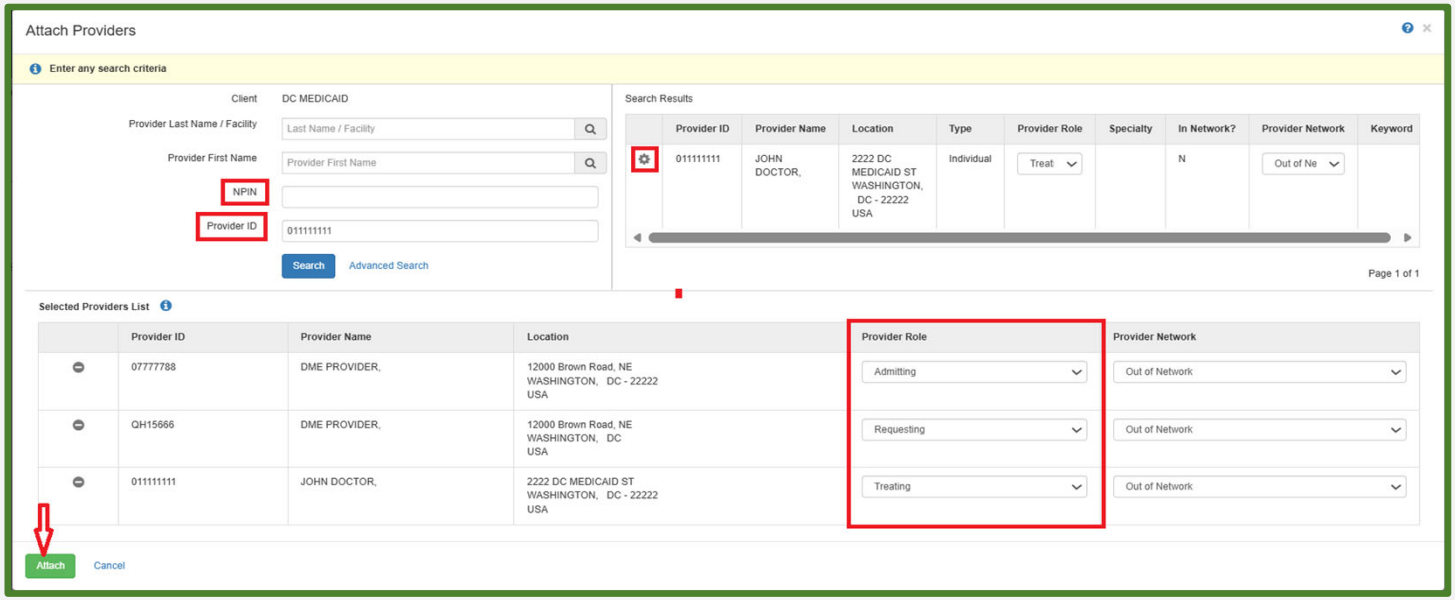


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Steps to Add Provider

Continued

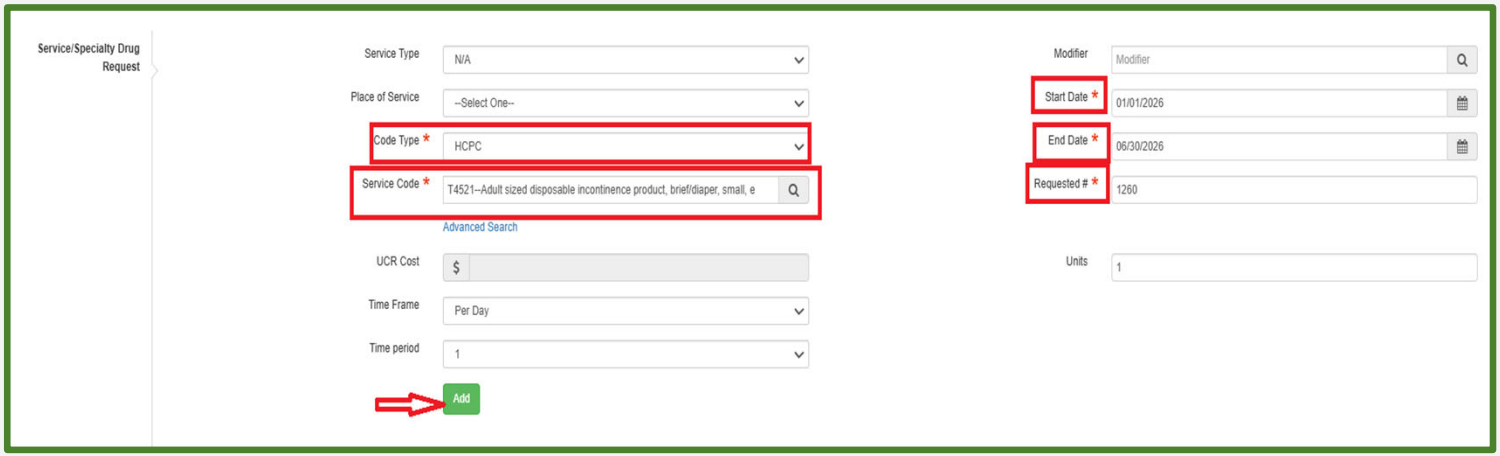
- **Admitting**, **Treating**, and **Requesting** providers must be attached
  - **Admitting**: DME Facility the PA is issued to (the Servicing Provider on 719A).
  - **Treating**: The treating provider (Prescribing Provider on the 719A).
  - **Requesting**: Ensure ID is selected; this allows access to the episode.



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Add a Service Request

- **Code Type***: Select appropriate code type (HCPC).
- **Service Code***: Enter code or search for code; select code by clicking from drop-down box.
- **Start Date***: Enter MM/DD/YYYY or select from calendar.
- **End Date***: Auto-populates and can be modified based on request days.
- **Requested #***: Enter the number of units you are requesting.
- **Units**: Auto-populates to 1 and can be adjusted, must match requested number.
- Click on the blue **Add** button.



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Assessments

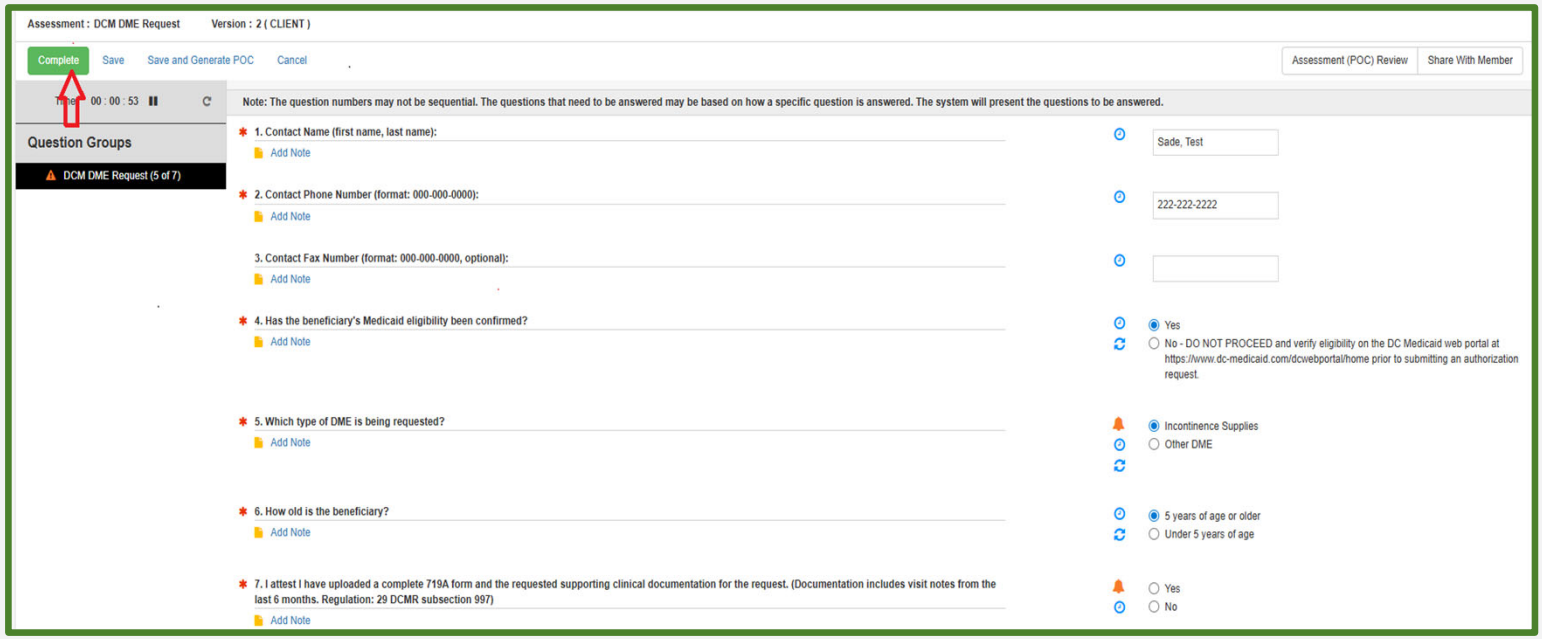
- Select the gear and click **Start** to complete the **DCM DME Request (mandatory to save and submit)**.



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DCM DME Request Assessment

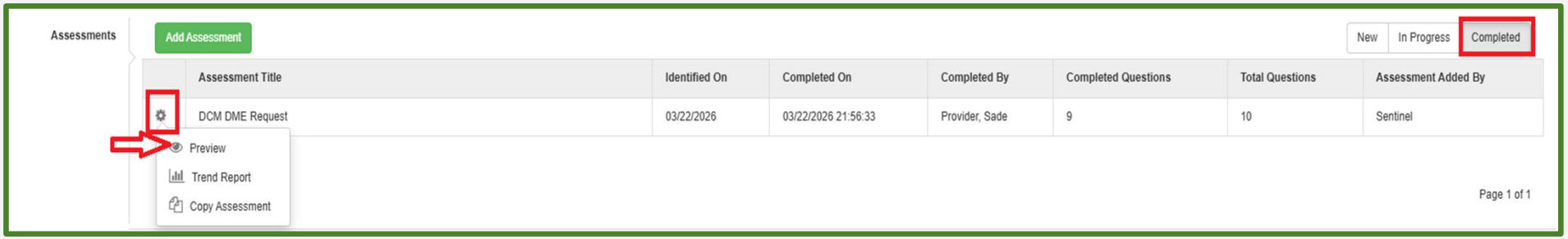
- Answer the assessment questions.
- Always select **Complete** when finished with an assessment and not just Save.



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Preview Assessment

- You can review the completed or in progress assessments by clicking on the gear and selecting Preview.
- The tab on the right-hand side also needs to be selected – either **completed** or **in progress**.



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Adding Documents

- Click on the **Add Documents** button.
- Please only use PDF or TIFF files; DOC files will not be accepted.

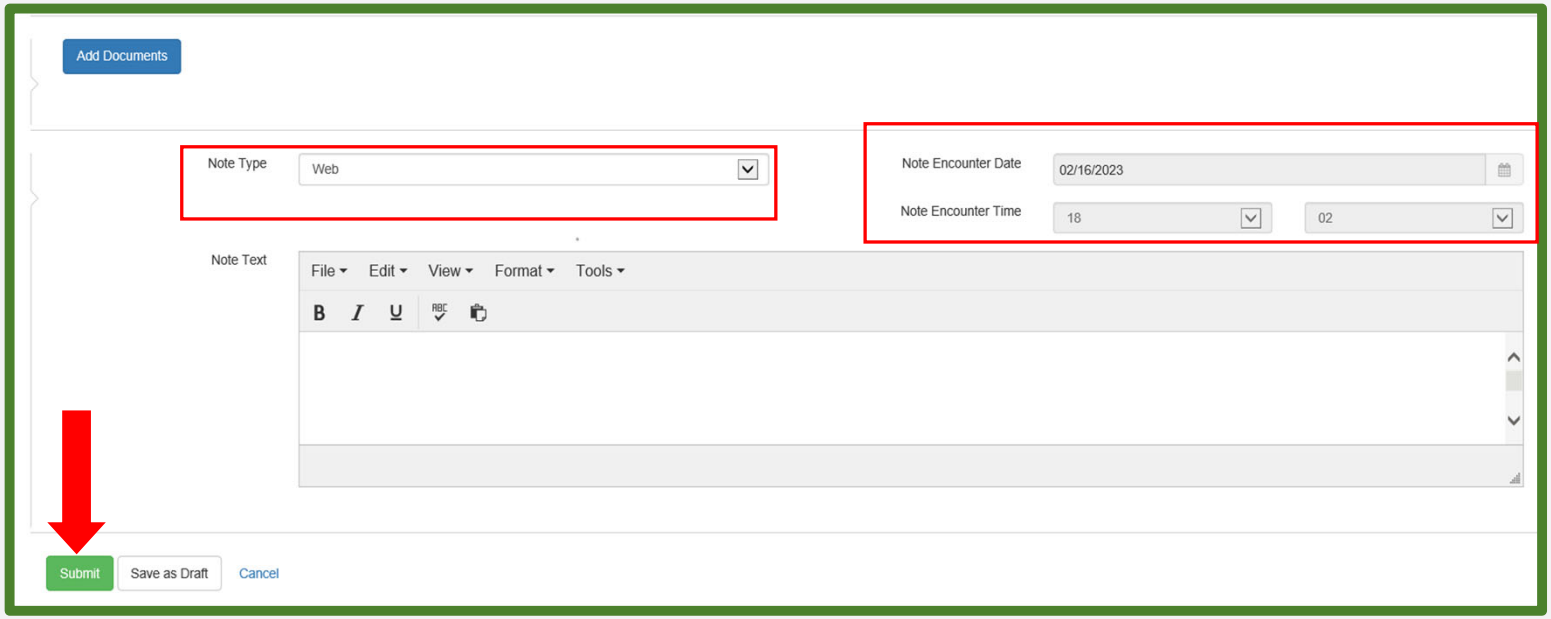


	Name	Type	Date Added	Added User	Description
⚙	719A		03/22/2026	Provider, Sade	
⚙	Clinical document		03/22/2026	Provider, Sade	

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Notes

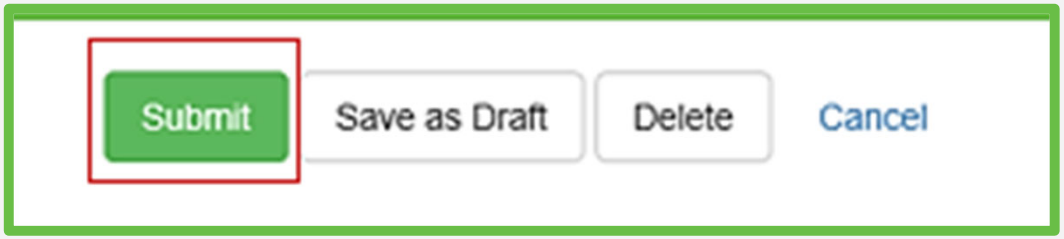
- Note Type: Auto Populates to **Web**.
- Note Text: Add notes according to the request (i.e., additional information submitted).
- Note Encounter Date: Auto Populates.
- Note Encounter Time: Auto-populates.



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Submit or Save as Draft

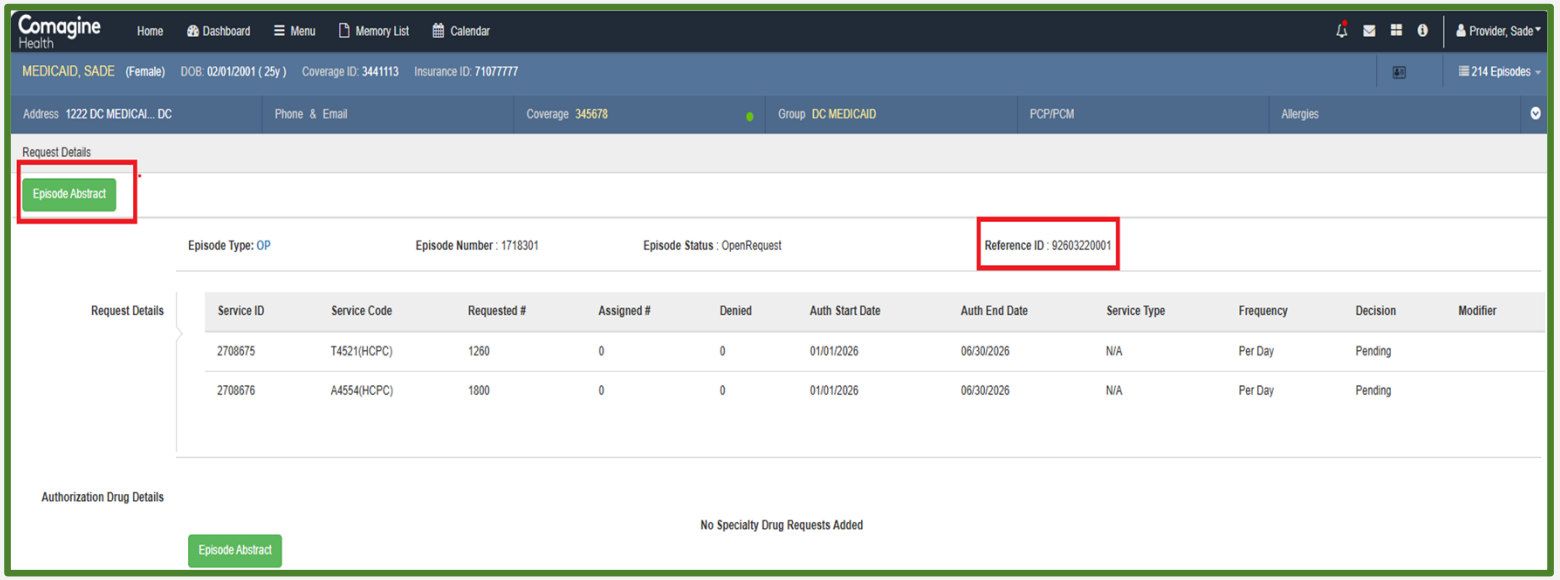
- **Submit**: Episode will be submitted to Comagine Health.
- **Save as Draft**: Episode will not submit to Comagine Health but will be saved for later submission and can be edited.
- **Delete**: The request will be deleted.



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Reference ID

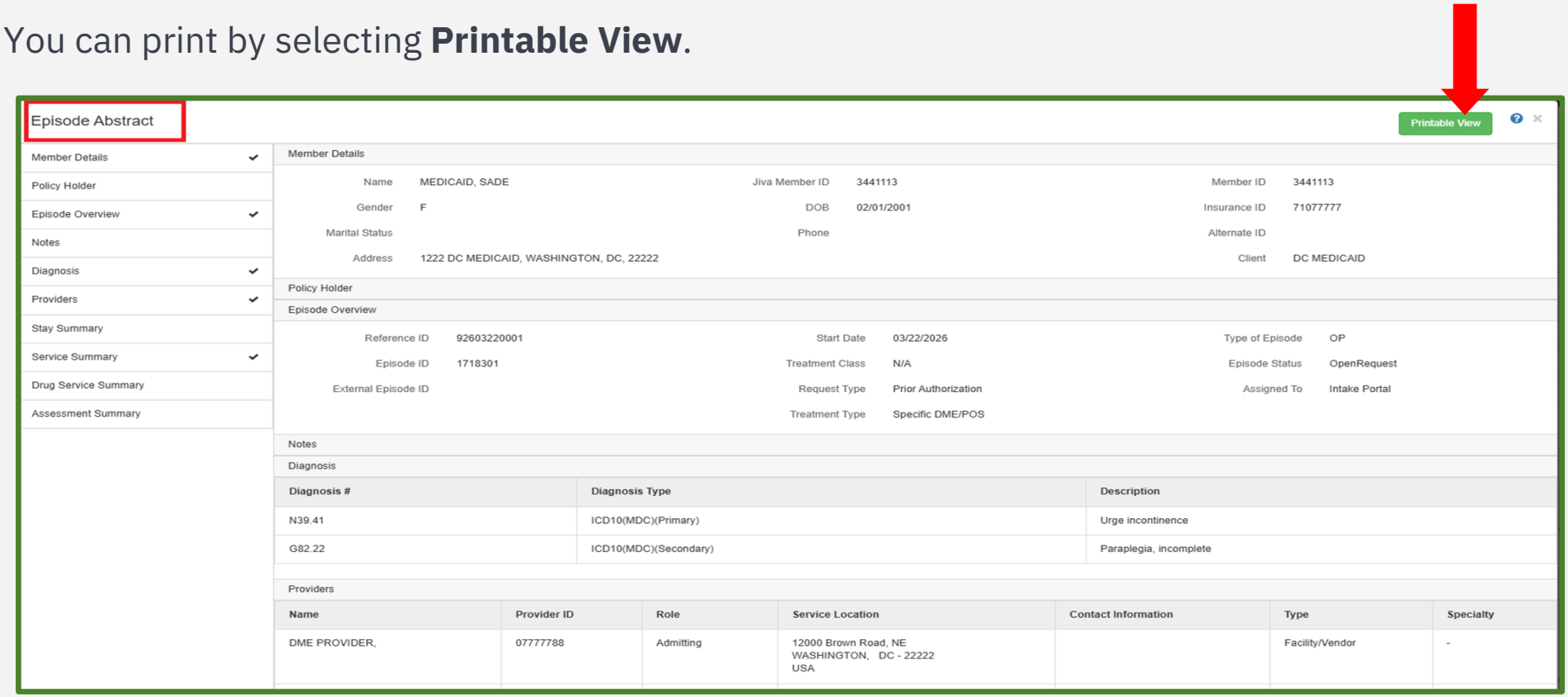
- Note of the CHPP Reference ID number for your records to locate the episode faster.
- The reference ID will become the prior authorization number on an approved request.
- Selecting **Episode Abstract** allows you to review what was submitted; however, you cannot edit from here.



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Abstract View

You can print by selecting **Printable View**.



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Provider Resources

- Comagine Health Provider Portal (CHPP) User Guide
- CHPP Administrator Guide
- CHPP Quick Start Guide – Incontinent Supply Review Authorizations
- CHPP Training Webinars (recording and slides)
- CHPP Registration Packet

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- Questions



Type your questions in the chat

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Who to Contact

- If there are errors messages with the CHPP
- Requests to create a new member in the CHPP
- Questions regarding Medical Necessity Denial or general questions

Comagine Health DC Office

Main #: 1-800-251-8890

Escalated questions or concerns: Ask for the QIO Director, Folasade Akinkuowo

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Thank you!

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