

FFS Prior Authorization DCH User Manual

Version 2.1



Revision History

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1.0 Document Purpose and Scope

This manual provides user instructions for Department of Community Health (DCH) personnel who have access to the Alliant/GMCF Prior Authorization (PA) systems as part of the Medicaid Medical Management Contract (MMC). The manual is divided into two sections that correspond to the following DCH PA activities for Fee-for-Service (FFS) Medicaid.

- **User Acceptance Testing (UAT):** DCH enters FFS PA requests in the UAT PA system as part of prior authorization user acceptance testing. This manual includes entry instructions for all PA request types that are entered in the Alliant/GMCF PA system.
- **Find and View Production PA Data:** DCH users have rights to find and view PA data/decisions in the Production PA system as part of DCH contract monitoring activities.

2.0 UAT Prior Authorization System

2.1 Screen Layout Overview

Each PA web request page is identified by the request type at the top of the page. All information is entered on one page with required data fields noted by an asterisk or highlighted box. Each PA request template provides navigational and functional links including: [Review Request](#), [Edit Request](#), [Submit Request](#) or [Enter a New PA Request](#).

The following examples provide an illustration of the PA entry screens layout.

Screen
Title →

Hospital Admissions and Outpatient Procedures (Form PA-81/100)

Please verify the member name and date of birth represents the member you wish to inquire on. If so, please proceed with this request. If not, please select the "Back to Request Authorization Login Screen" link and re-enter the correct information. If you need assistance, please select the "Contact Us" link in the upper right-hand corner of this page or call the Customer Interaction Center (CIC) at (404)298-1228 or (800)766-4456.

Please provide the required information for this transaction request on the following pages. When you have completed entering the data for this transaction, select the "Review Request" link on the next page to view the information entered.

Member Information						
Member ID	Last Name	First Name	MI	Suffix	DOB	Gender
			M		08/19/1947	M

Service Provider Information			
Provider ID	Name and Address	Phone	Taxonomy (Specialty)
			- Disproportionate Share Hospital - Hospital, Regular General - Swingbed Hospital - Presumptive Eligibility

Reference Provider Information			
Physician ID	Name and Address	Phone	Taxonomy (Specialty)
			- Cardiovascular Disease

Contact Information	
Address	Phone

Request Information	
* Admit Date: <input type="text"/>	* Admission Type: <input type="text"/>
Discharge Date: <input type="text"/> <input type="checkbox"/> Still in Facility	
* Place of Service: <input type="radio"/> InPatient <input type="radio"/> OutPatient	* Release of Info Code: <input type="text"/>

Diagnosis				
ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	Admission
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

Procedures								
CPT Code	CPT Description	From Date	To Date	Units	Mod 1	Mod 2	Mod 3	Mod 4
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Comments / Message

Patient Transfer Information	
Is patient being transferred TO your facility?	<input type="radio"/> Yes <input type="radio"/> No
Is patient being transferred FROM your facility?	<input type="radio"/> Yes <input type="radio"/> No

Supporting Information
Please provide a brief synopsis of the patient's presenting clinical situation and, if inpatient, describe the initial 24-48 hours of treatment in the following boxes.
* Clinical Data to Support Request : Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission
<input type="text"/>
* Admitting Treatment Plan : Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments.
<input type="text"/>

Does this member have retro eligibility for the submitted dates of service ? Yes No

Highlighted Required
Fields →

Review Request



Navigational
Link

Figure 1

Hospital Admissions and Outpatient Procedures (Form PA-81/100)



Screen Title

Please verify the member name and date of birth represents the member you wish to inquire on. If so, please proceed with this request. If not, please select the "Back to Request Authorization Login Screen" link and re-enter the correct information. If you need assistance, please select the "Contact Us" link in the upper right-hand corner of this page or call the Customer Interaction Center (CIC) at (404)296-1228 or (800)766-4456.

Please provide the required information for this transaction request on the following pages. When you have completed entering the data for this transaction, select the "Review Request" link on the next page to view the information entered. Please review the prior authorization information you have entered. If it is correct, you may print this page for your files or records by pressing the Print button on your web browser before you click the Submit button.

If you wish to make any changes, use the "Edit Request Data" link at the bottom or the Back arrow on your web browser to return to the previous page.

Once you submit the PA request, you will receive a prior approval number and a status. Once the review of this case has been completed and a decision rendered, you will be notified of the review outcome.

Member Information						
Member ID	Last Name	First Name	MI	Suffix	DOB	Gender
				M	08/19/1947	M

Service Provider Information			
Provider ID	Name and Address	Phone	Taxonomy (Specialty)
			- Disproportionate Share Hospital - Hospital, Regular General - Swingbed Hospital - Presumptive Eligibility

Reference Provider Information			
Physician ID	Name and Address	Phone	Taxonomy (Specialty)
			- Cardiovascular Disease

Contact Information	

Request Information			
Admission Date:	04/22/2010	Admission Type:	Emergency
Discharge Date:		Still in Facility:	Yes
Place of Service:	InPatient Hospital	Release of Info Code:	InformedConsent

Select the patient's current location :

Did patient fail to improve enough to safely discharge after 24-36 hours of hospital level care?

* Diagnosis				
ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	Admission
255	ADRENAL GLAND DISORDERS	04/22/2010	Yes	No

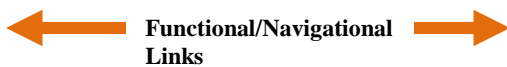
Procedures								
CPT Code	CPT Description	From Date	To Date	Units	Mod 1	Mod 2	Mod 3	Mod 4

Comments / Messages

Patient Transfer Information	
Is patient being transferred TO your facility?	<input type="text" value="No"/>
Is patient being transferred FROM your facility?	<input type="text" value="No"/>

Supporting Information	
* Clinical Data to Support Request: <i>(Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission)</i>	
test	
* Admitting Treatment Plan: <i>(Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments)</i>	
test	

Does this member have retro eligibility for the submitted dates of service ?



Functional/Navigational Links

Figure 2

2.2 UAT System Access

DCH personnel involved in *User Acceptance Testing* access the UAT application via the **UAT Web Portal**. DCH personnel log into the UAT portal using test portal IDs associated with a specific provider for the purpose of entering PA requests applicable to the provider’s category of service.

Access Instructions:

1. Enter a user ID and password on the portal login window.
2. Click **Sign In** and then select **UAT Web Portal**.

Georgia Medicaid Home

██████████ Welcome to Georgia Medicaid (NON-PROD)

Applications

Application	Description
MEUPS Account Management	Manages contact information, password, and authorizations for applications.
UAT Web Portal	Georgia Web Portal User Acceptance Test

Figure 3

3. On the UAT *Secure Home* page, click the **Prior Authorization** link.
4. Then, click **Submit/View**.

The screenshot shows the Georgia Department of Community Health Web Portal. The user is logged in as a provider. The navigation menu includes 'Home', 'Contact Information', 'Member Information', 'Provider Information', 'Provider Enrollment', 'Nurse Aide', 'EDI', 'Pharmacy', 'Account', 'Providers', 'Training', 'Claims', 'Eligibility', 'Presumptive Activations', 'Health Check', 'Prior Authorization', 'Reports', and 'Trade Files'. The 'Prior Authorization' menu is open, showing 'Submit/View' and 'Provider' options. The 'Provider' option is selected, showing a table of provider information. The table has columns for Name, Medicaid Provider ID, National Provider ID, Provider Type, Address 1, Address 2, City, State, and Zip. The 'Messages' section at the bottom shows '*** No rows found ***'.

Figure 4

5. The next page displays a list of the PA request types applicable to the login provider's category of service (COS). (Refer to Appendix A for a crosswalk of request type to allowable COS).

The figure below shows the PA type list for a hospital provider.

New Request for Prior Authorization

[Hospital OutPatient Therapy](#)
[Intermediate Care Facility for Mentally Retarded \(Form Number : DMA-6\)](#)
[Intermediate Care Facility for Mentally Retarded - Pediatric \(Form Number : DMA6A\)](#)
[Medications PA Facility Setting](#)
[Nursing Home \(Form Number: DMA-6\)](#)
[Pediatric Admission to Nursing Home \(Form DMA-6A\)](#)
[Hospital Admissions and Outpatient Procedures \(Form Number: GMCF form PA81/100\)](#)
[In-State Transplants \(Form Number: PA-81\)](#)
[Out-of-State Services \(Form Number: GMCF FAX OOS\)](#)
[Radiology-Facility Setting](#)

Figure 5

6. To enter a request, click the applicable request type.
7. On the next page that displays, the requesting provider ID (provider associated with the portal credentials) is auto populated.
8. Enter the member's Medicaid ID.
9. If the PA type selected is a hospital based PA, then the Reference Provider ID for the other provider involved in the case may be required. If prompted, enter the Reference Provider ID. (Refer to Appendix A to find which PA request types require entry of a Reference ID.)

2.3 Authorization Request Web Entry

The online request forms for all PA types are similar in format and design. Each template includes a data entry page and review page. Here are some general guidelines for entering request data. (Instructions for submitting specific PA types start on page 15).

Provider Contact Information

The system populates the requesting provider contact information on the PA form if the contact information is available in the provider file. If the required contact information is missing, the information must be entered manually.

Auto Formatting of Data

Numbers entered in phone, fax, or Social Security boxes are automatically formatted by the system.

Date Lookup and Entry

Dates may be entered on request forms via a calendar popup or entered manually. Follow these steps to insert a date using the calendar:

1. Click in a date box to open the calendar. When the calendar opens, the current month and year display. In the following figure, the 'ICD-9 Date' box was clicked.

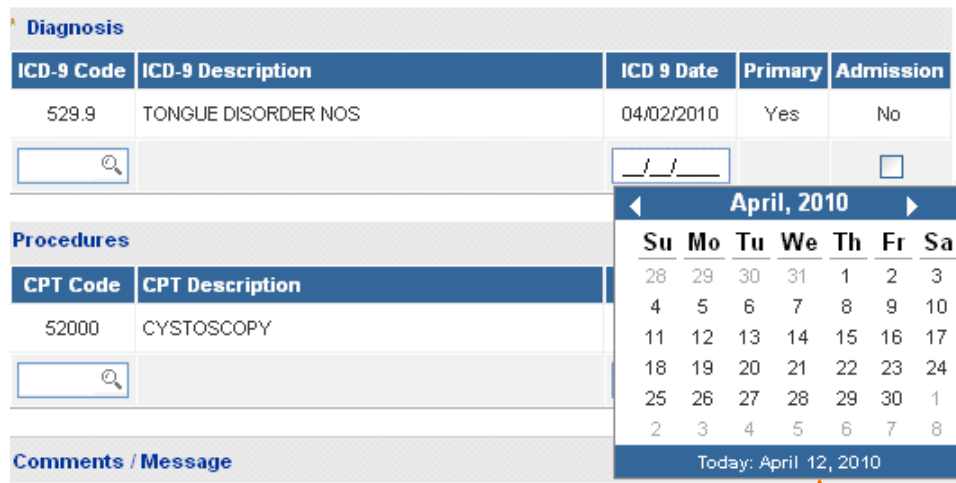


Figure 6

2. To insert the current date, click the date at the bottom of the calendar. To insert a different day for the current month, click the applicable day in the calendar.

- To select a different month for the current year, use the back and forth arrows at the top of the calendar to advance or go back - **OR** - Click the year at the top of the calendar.



Figure 7

- If the year is clicked, a list of months for the year displays. Click a month to view the calendar for that month.



Figure 8

OR

- Don't select a month, but click the year again, and other years display.

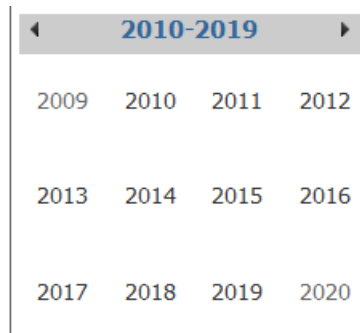



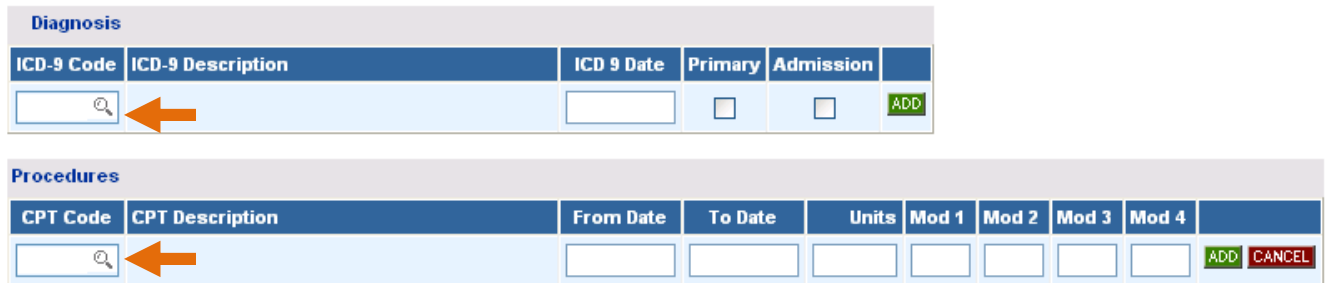
Figure 9

- Select a year or use the arrows to advance or go back in years, and then select the year. Select a month and then day.

Diagnosis and Procedure Lookup

This function allows the user to find a diagnosis or procedure code by a description, and then select the appropriate code for insertion in the diagnosis or procedure code box on the request template.

1. To initiate a search, click the magnifying glass icon  in the diagnosis or procedure code box. This action opens a search page.



Diagnosis

ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	Admission	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="button" value="ADD"/>

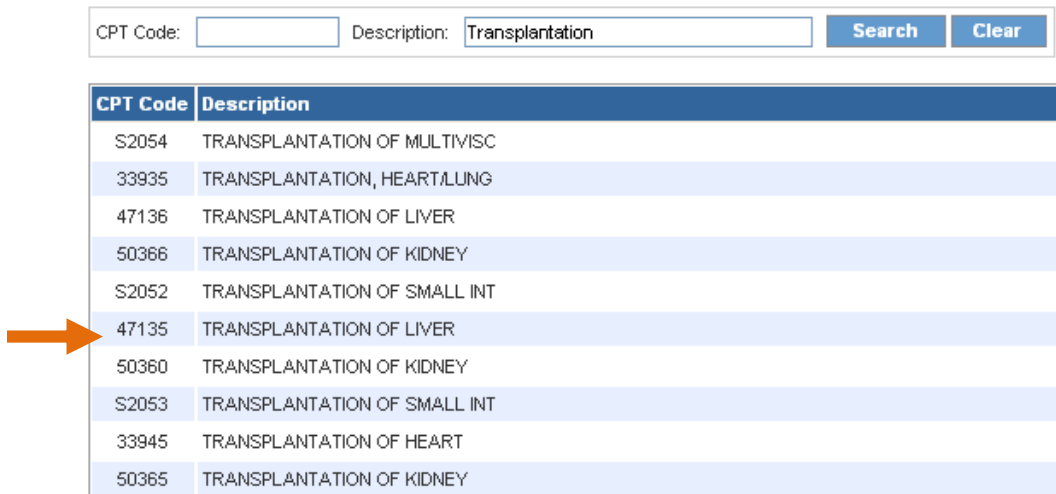
Procedures

CPT Code	CPT Description	From Date	To Date	Units	Mod 1	Mod 2	Mod 3	Mod 4	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="ADD"/> <input type="button" value="CANCEL"/>

Figure 10

2. On the search page, enter all or part of the first word of the description, and then click **Search**. A list of codes matching the description displays.

Procedure Search

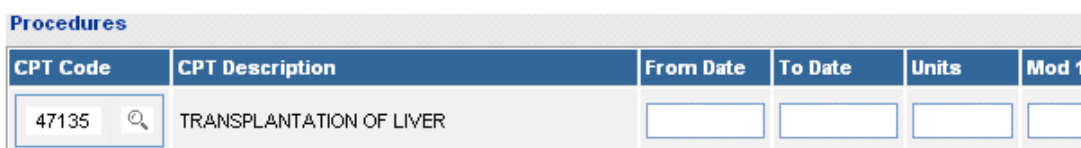


CPT Code: Description:

CPT Code	Description
S2054	TRANSPLANTATION OF MULTIVISC
33935	TRANSPLANTATION, HEART/LUNG
47136	TRANSPLANTATION OF LIVER
50366	TRANSPLANTATION OF KIDNEY
S2052	TRANSPLANTATION OF SMALL INT
47135	TRANSPLANTATION OF LIVER
50360	TRANSPLANTATION OF KIDNEY
S2053	TRANSPLANTATION OF SMALL INT
33945	TRANSPLANTATION OF HEART
50365	TRANSPLANTATION OF KIDNEY

Figure 11

3. Click on a code and the system inserts the code in the appropriate code box on the request form.



Procedures

CPT Code	CPT Description	From Date	To Date	Units	Mod 1
47135 	TRANSPLANTATION OF LIVER	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Figure 12

Add or Modify Data Entered in a Table

Diagnosis code information, procedure code information or any data entered in a table format on the request form maybe added, edited or deleted **when a new PA request is being entered**. The following table provides a description of the functions available on initial PA entry:

Function	Description
ADD	Click to add information entered.
EDIT	Click to modify the following diagnosis/procedure information added to a table: <ul style="list-style-type: none"> ✓ ICD Diagnosis code, ICD-9 date, primary and admission indicators. ✓ Procedure from and to dates, units, and modifiers. <p>A procedure code cannot be edited. To change a procedure code, first click <i>Delete</i> to delete the procedure code, and then enter and add a new procedure code.</p>
SAVE	Click to save the information that is edited.
DELETE	Click to delete all information ALREADY ADDED to a row of a table.
CANCEL	Click to remove all data entered on a row of a table BEFORE the data is added or saved.

Table 1

The following instructions describe how to add/edit diagnosis code information; but the process used to add/edit procedure code information is basically the same.

Add Information:

1. Enter the diagnosis code, the diagnosis date, select primary and admission if applicable, and then click **ADD**.

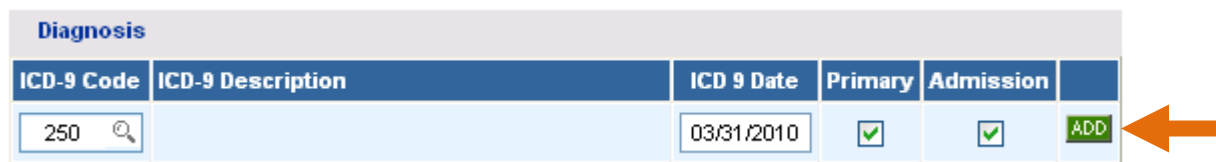


Figure 13

2. When **ADD** is clicked, the diagnosis information is added to the Diagnosis Table; and a new blank diagnosis line displays, which allows the entry of another diagnosis. The **EDIT** and **DELETE** functions also display.

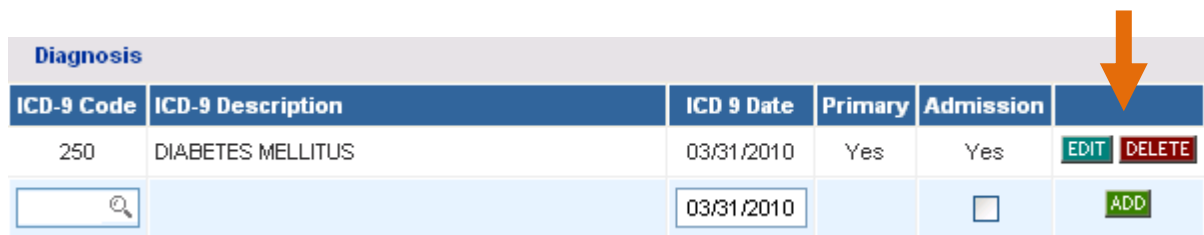


Figure 14

Edit Information:

1. To edit diagnosis information already added, click **EDIT** at the end of the diagnosis line. When edit is clicked, the diagnosis information displays in an editable format.

Diagnosis						
ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	Admission		
250	DIABETES MELLITUS	03/31/2010	Yes	Yes	EDIT	DELETE
<input type="text" value="250"/> <input type="button" value="🔍"/>	DIABETES MELLITUS	<input type="text" value="03/31/2010"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	SAVE	CANCEL

Figure 15



2. Modify the information that needs to be corrected. In the figure below, the ICD-9 date was changed to 3/31/2009.

Diagnosis						
ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	Admission		
250	DIABETES MELLITUS	03/31/2010	Yes	Yes	EDIT	DELETE
<input type="text" value="250"/> <input type="button" value="🔍"/>	DIABETES MELLITUS	<input type="text" value="03/31/2009"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	SAVE	CANCEL

Figure 16

3. Click **SAVE**. The new data is saved to the original diagnosis line.

Diagnosis						
ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	Admission		
250	DIABETES MELLITUS	03/31/2009	Yes	Yes	EDIT	DELETE
<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	ADD	

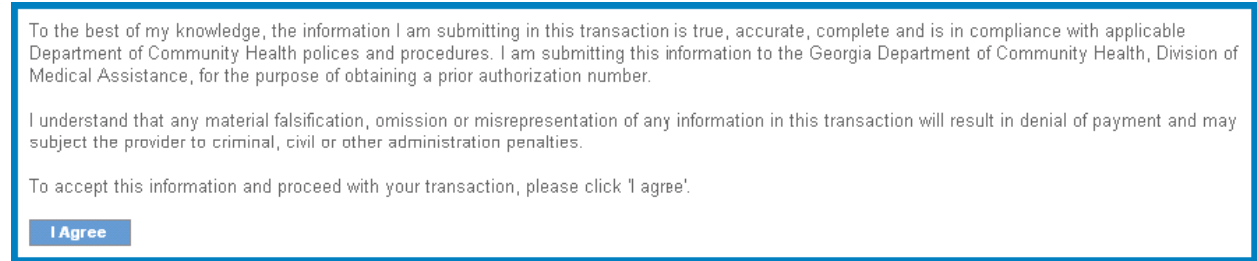
Figure 17

Additional Information Questions

For some request types, additional clinical questions are loaded to the request template when certain data is entered, such as: specific diagnosis codes, specific procedure codes, place of service, admission type and/or current location. Responses to the additional questions are required in order to submit the PA.

Attestation Statement

Each PA request form accessed via the web also includes a mandatory *Attestation Statement*, which specifies that all information submitted is true, accurate, complete and in compliance with all Department of Community Health policies and procedures. The user entering the request must select *I Agree* in order to submit the request.



To the best of my knowledge, the information I am submitting in this transaction is true, accurate, complete and is in compliance with applicable Department of Community Health policies and procedures. I am submitting this information to the Georgia Department of Community Health, Division of Medical Assistance, for the purpose of obtaining a prior authorization number.

I understand that any material falsification, omission or misrepresentation of any information in this transaction will result in denial of payment and may subject the provider to criminal, civil or other administration penalties.

To accept this information and proceed with your transaction, please click 'I agree'.

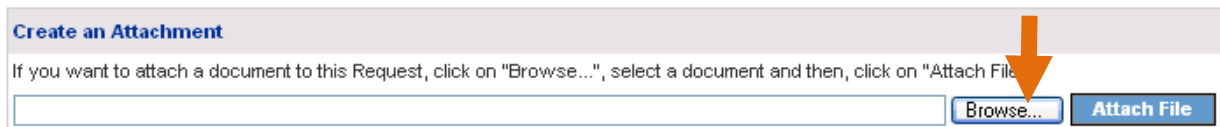
Figure 18

Attach Documentation

Documents may be attached to a PA upon PA submission (some PA type restrictions apply). The following file types may be attached: TXT, DOC, DOCX, PDF, TIF, TIFF, JPG, and JPEG. Each file cannot be more than 20 MB in size. For certain request types, required documentation is represented as 'checklist' type items that can be associated with one or more files attached.

Attach a file upon PA submission:

1. Complete the request form and click **Submit Request**.
2. On the next page that displays, go to '*Create an Attachment*'.
3. Click **Browse** in the attachment panel to open the file directory.



Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

Figure 19

4. Find the file that is to be attached. Select the file by double clicking the file, or highlight the file and then click **Open**.

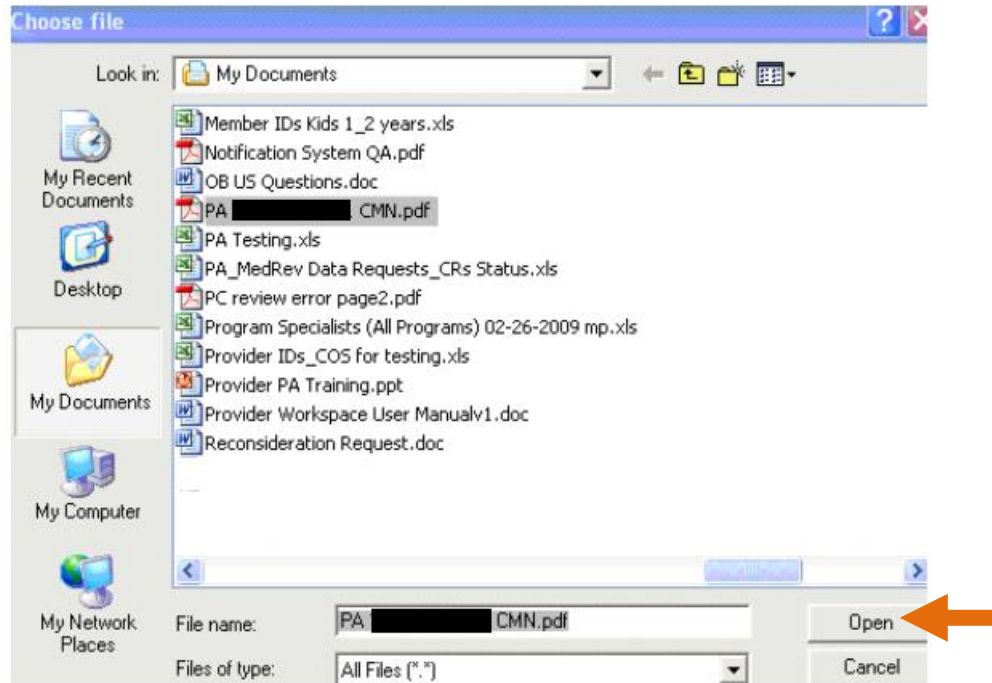


Figure 20

5. The selected file displays in the attachment panel.



Figure 21

6. Click the **Attach File** button.

7. The 'File uploaded successfully' message displays when the file is attached; and a link to the attachment displays in the **Attached Files** table.

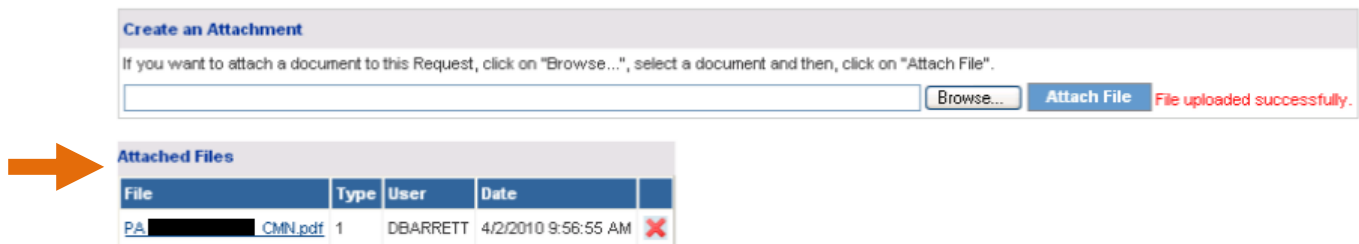


Figure 22

8. For some request types, document type checkboxes are included in the attachment panel. The purpose of a document type checkbox is to associate the actual file attached with the

specific additional information required by policy. The next figure shows the checkboxes for a Durable Medical Equipment request for oxygen services. Each procedure code on this request requires a Certificate of Medical Necessity; and procedures, E0431 and E1390, also require a copy of testing results.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)

Codes	Documents
E0431	<input type="checkbox"/> Certificate of Medical Necessity (CMN) <input type="checkbox"/> Copy of Testing Results
E0445	<input type="checkbox"/> Certificate of Medical Necessity (CMN)
E1390	<input type="checkbox"/> Certificate of Medical Necessity (CMN) <input type="checkbox"/> Copy of Testing Results

Figure 23

9. To attach a file or files to this request, first determine if one file with all the required information is to be attached, or individual files are to be attached.
10. **If one file is to be attached and that file includes all the required information**, click all the checkboxes and then attach the one file. Attaching one file for all required documents is the preferred attachment method. The attached file is added to the **Attached Files** table and associated with each document type.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

File uploaded successfully.

Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)

Codes	Documents
E0431	<input type="checkbox"/> Certificate of Medical Necessity (CMN) <input type="checkbox"/> Copy of Testing Results
E0445	<input type="checkbox"/> Certificate of Medical Necessity (CMN)
E1390	<input type="checkbox"/> Certificate of Medical Necessity (CMN) <input type="checkbox"/> Copy of Testing Results

Attached Files

File	Type	Code	Document Name	User	Date	
John Doe CMN and Testing Results.pdf	4	E0431	Certificate of Medical Necessity (CMN)	DBARRETT	4/2/2010 11:50:24 AM	✘
John Doe CMN and Testing Results.pdf	4	E0431	Copy of Testing Results	DBARRETT	4/2/2010 11:50:24 AM	✘
John Doe CMN and Testing Results.pdf	4	E0445	Certificate of Medical Necessity (CMN)	DBARRETT	4/2/2010 11:50:24 AM	✘
John Doe CMN and Testing Results.pdf	4	E1390	Certificate of Medical Necessity (CMN)	DBARRETT	4/2/2010 11:50:24 AM	✘
John Doe CMN and Testing Results.pdf	4	E1390	Copy of Testing Results	DBARRETT	4/2/2010 11:50:24 AM	✘

Figure 24

11. When multiple files are to be attached and each file relates to a different required document, first select the applicable checkbox for the first file to be attached, and then attach the file. To attach additional files, repeat the same process. Select the check box or checkboxes and then attach the file.

12. Checkboxes not selected continue to display in red, indicating that the required document has not been attached.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

Browse...
Attach File

File uploaded successfully.

Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)

Codes	Documents
B4088	<input type="checkbox"/> Certificate of Medical Necessity (CMN)
B9998	<input type="checkbox"/> Certificate of Medical Necessity (CMN)

Attached Files

File	Type	Code	Document Name	User	Date	
John Smith B4088 CMN.pdf	4	B4088	Certificate of Medical Necessity (CMN)	DBARRETT	4/2/2010 12:12:18 PM	✖

Figure 25

2.3.1 Hospital Admissions and In-State Transplant Requests	
Program	Authorization Period
Precertification	90 days
Precertification-Instate Transplants	One year
Description	
<p>Precertification requests for inpatient and outpatient hospital services are entered on the <i>Hospital Admissions and Outpatient Procedures</i> request template; and requests for in-state transplant services are entered on the <i>In-State Transplants</i> request template. The request templates for both PA types are basically the same. However, additional information questions may be pulled into a hospital precertification request depending on data entered for one or more of the following: diagnosis, procedure code, place of service, and patient’s current location (inpatient admissions only). Response to the additional information questions is required for PA submission. There are no additional information questions for <i>In-State Transplant</i> requests.</p>	

2.3.1.1 Inpatient Hospital Admission

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Hospital Admissions and Outpatient Procedures** from the list of review types.
4. On the *New Request for Prior Authorization* page, click the **Fee for Service** button to indicate that this request is for a member in Fee for Service Medicaid.

Figure 26

- The provider ID associated with the user who logged into the portal (requesting provider) displays in the appropriate Provider ID box. In the preceding screen shot, the facility was the requesting provider.
- Enter the 'Member Medicaid ID'.
- Enter the Reference number for the other provider associated with the request. The Reference number always starts with REF. If the hospital is the requestor, enter the REF # for the medical practitioner. If the medical practitioner is the requestor, enter the REF # for the facility.

Hospital Admissions and Outpatient Procedures (Form Number: GMCF form PA81/100)

To find a Member or Provider click the next to the ID box

Fee For Service or CMO PA ? Fee for Service
 Amerigroup Community Care
 Peach State Health Plan
 Wellcare Health Plans Inc.

Member Medicaid ID:

Facility Provider ID :

Medical Practitioner Reference ID :

Fictitious member/provider IDs.

Figure 27

- Click **Submit** to open the request template.
- At the top of the request template, the member and provider information is system populated based on the Member ID and Provider IDs entered.

Contact Information:

The system pulls in the provider's contact information.

- The contact name, email, phone, and fax are required. If missing, this information must be entered manually.

Contact Information

* Contact Name: * Contact Email:

Contact Phone: Ext.

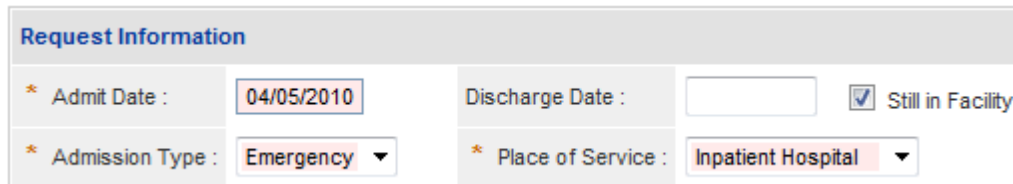
* Contact Fax:

Figure 28

Request Information:

This section captures the hospital Admit Date, Admission Type, Discharge Date/Still in Facility, and Place of Service.

11. Enter the 'Admit Date' in the box provided. If the admission date is more than 90 days greater than the request date, the request will be auto-withdrawn/denied, since hospital admission requests should be submitted within 90 days of the planned admission date.
12. Select the 'Admission Type' (Elective, Emergency or Urgent) from the drop list.
13. If the admission date entered is prior to the request date, enter a 'Discharge Date' or check 'Still in Facility'.
14. Select 'Inpatient' from the drop list for 'Place of Service'.



The screenshot shows a form titled "Request Information" with the following fields and values:

- * Admit Date : 04/05/2010
- Discharge Date : (empty)
- Still in Facility
- * Admission Type : Emergency (dropdown)
- * Place of Service : Inpatient Hospital (dropdown)

Figure 29

15. When 'Inpatient' is selected as the place of service and 'Emergency' or 'Urgent' selected as the type of admission, the system pulls in the following questions:



The screenshot shows two questions:

- Select the patient's current location : (dropdown menu)
- Did patient fail to improve enough to safely discharge after 24-36 hours of hospital level care? Yes No Unknown

Figure 30

16. Select the patient's 'Current Location' in the hospital from the drop list (Critical Care, General Acute Care Medical, Surgical Floor, or Telemetry Unit/Intermediate Critical Care).
17. Indicate whether or not the patient failed to improve enough to discharge after 24-36 hours of hospital care by clicking 'Yes', 'No' or 'Unknown'.



The screenshot shows the same two questions as Figure 30, but with the following changes:

- Select the patient's current location : General Acute Care Medical (dropdown menu)
- Did patient fail to improve enough to safely discharge after 24-36 hours of hospital level care? Yes No Unknown

Figure 31

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (auto-populated), diagnosis date, primary diagnosis indicator, admission diagnosis indicator, and diagnosis type (ICD9 or ICD10) for each diagnosis code entered.

18. Enter the diagnosis code in the ‘Diag Code’ box; or search for the diagnosis and the system will insert the diagnosis code. If diagnosis code includes a decimal point, enter the code with the decimal point.
19. Enter the date that the diagnosis was established in the ‘Date’ box. If not known, enter the admission date.
20. Denote the diagnosis entered as ‘Primary’, and indicate if this diagnosis is the admission diagnosis by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to ‘Primary’.
21. Click **Add** to add the diagnosis code to the request.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
789.00	ABDMNAL PAIN UNSPCF SITE	01/01/2014	Yes	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	01/01/2014	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 32

22. Follow the same process to add other diagnosis codes, as applicable. **Remember to click Add after each line of diagnosis information is entered.**

Procedures Table:

The **Procedures Table** captures CPT Code, CPT code description (auto-populated), procedure ‘From Date’ and ‘To Date’, units requested, and modifiers (if applicable).

Procedures									
CPT Code	CPT Description	From Date	To Date	Units	Mod 1	Mod 2	Mod 3	Mod 4	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 33

23. For inpatient hospital admissions, a procedure code is not required. However, when a procedure is requested that requires *prior authorization*, follow this process: Enter the CPT code, procedure ‘From Date’; procedure ‘To Date’, and requested unit(s). (For specific instructions on adding procedures, refer to Section 2.3.1.2.).

24. After entering the procedure information, click **Add** to add the information to the request.

Note: If the procedure ‘From Date’ is more than ninety (90) days in the future, this message displays when **Add** is clicked: “You have indicated a procedure <<CPT code>> with a date that is more than 90 days in the future. Please check your dates and make sure the date is correct before proceeding.” The date must be corrected in order to submit the request.

Patient Transfer:

This section captures the reasons for patient transfer to or from a facility.

The screenshot shows a form titled "Patient Transfer Information". It contains two questions, each with two radio button options: "Yes" and "No".

- Question 1: "Is patient being transferred **TO** your facility?" with radio buttons for "Yes" and "No".
- Question 2: "Is patient being transferred **FROM** your facility?" with radio buttons for "Yes" and "No".

Figure 34

25. Respond to each transfer question by clicking ‘Yes’ or ‘No’.

26. If ‘Yes’ is selected for either transfer question, additional **required** transfer questions display.

The screenshot shows a form titled "Patient Transfer Information : (select all that apply and explain in clinical)". It contains a list of checkboxes for reasons for transfer:

- a. Higher level of care facility. (Explain in Clinical)
- b. MD Specialist/Specialty Unit not available at original facility. (Explain in Clinical)
- c. Back transfer to lower level of care facility. (select all that apply)
 - 1. Higher level of care is no longer warranted.
 - 2. Level of care continues to meet inpatient confinement.
 - 3. Transfer back does not compromise patient care.
 - 4. Transfer back is not to alleviate bed overcrowding at sending facility.
- d. Patient/family/physician convenience. (Explain in Clinical)
- e. No beds available at original facility. (Explain in Clinical)

Figure 35

27. Check all the boxes that apply to the transfer. If ‘c’ is checked, then 1, or 2, or 3 or 4 must be checked.

Patient Transfer Information	Patient Transfer Information : (select all that apply and explain in clinical)
Is patient being transferred TO your facility? <input checked="" type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> a. Higher level of care facility. (Explain in Clinical)
Is patient being transferred FROM your facility? <input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="checkbox"/> b. MD Specialist/Specialty Unit not available at original facility. (Explain in Clinical)
	<input checked="" type="checkbox"/> c. Back transfer to lower level of care facility. (select all that apply)
	<input type="checkbox"/> 1. Higher level of care is no longer warranted.
	<input checked="" type="checkbox"/> 2. Level of care continues to meet inpatient confinement.
	<input type="checkbox"/> 3. Transfer back does not compromise patient care.
	<input type="checkbox"/> 4. Transfer back is not to alleviate bed overcrowding at sending facility.
	<input type="checkbox"/> d. Patient/family/physician convenience. (Explain in Clinical)
	<input type="checkbox"/> e. No beds available at original facility. (Explain in Clinical)

Figure 36

Supporting Information:

This section captures information supporting the medical necessity of the services requested as related to severity of illness and intensity of services.

- 28. Enter a synopsis of the patient’s presenting clinical situation in the first box; and a description of the patient’s treatment in the second box.

Supporting Information
Please provide a brief synopsis of the patient’s presenting clinical situation and, if inpatient, describe the initial 24 -48 hours of treatment in the following boxes.
* Clinical Data to Support Request :
Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission
Enter clinical data
* Admitting Treatment Plan :
Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments.
Describe treatment plan

Figure 37

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to ‘No’.

Does this member have retro eligibility for the submitted dates of service ? Yes No

Figure 38

- 29. For members with Medicaid retro eligibility for the dates of service, click ‘Yes’.

Additional Information Questions:

In this section, additional questions related to the admission type, current location and diagnosis may display. For example, the next figure shows the additional information questions that display for an inpatient admission request for a member with Diabetes and hospital current location of 'General Acute Care Medical'.

30. Click 'Yes', 'No' or 'Unknown' for each question. These questions are required and must be completed in order to submit the request.

Additional Information

Please enter additional information. **All questions are required.**

Inpatient Diabetic - Adult

Clinical History and Findings Questions:

1 Did patient have a blood sugar below 50 or above 500 Yes No Unknown

Treatment Description Questions:

1 Did patient receive Insulin IV? Yes No Unknown

2 Did patient receive Insulin SQ with three or more adjustments per day? Yes No Unknown

3 Did patient receive multiple doses of glucose 50%? Yes No Unknown

Figure 39

31. After all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
32. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
33. Click **I Agree** in response to the *Attestation Statement*.
34. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
35. When the request is successfully submitted, the system displays the pending PA tracking number.
36. To enter a new PA request under the same Portal ID, click **Enter a New PA Request**. The PA/Review type list displays.

2.3.1.2 Outpatient Hospital Admission

The process for entering a request for outpatient hospital services is basically the same as entering a request for inpatient admission, except that ‘Place of Service’ is outpatient and **a procedure code or codes are required**. Additional information questions may be pulled into the request template depending on the procedure code or codes added to the request.

Web Submission Instructions:

1. Initiate the request by following the same process used for inpatient admissions as described in **Section 2.3.1.1** steps 1-10.
2. In the **Request Information** section, enter the admission date.
3. Select the ‘Admission Type’: Elective, Urgent, or Emergency.
4. Select *Outpatient* from the drop list for ‘Place of Service’.

The screenshot shows a form titled "Request Information" with the following fields:

- * Admit Date : 04/27/2010
- Discharge Date : [Empty] Still in Facility
- * Admission Type : Elective (dropdown menu)
- * Place of Service : Outpatient Hospital (dropdown menu)

Figure 40

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, primary diagnosis indicator, admission diagnosis indicator, and diagnosis type for each diagnosis code entered.

5. Enter a diagnosis code in the ‘Diag Code’ box; or search and the system will insert the diagnosis code. If the code includes a decimal point, enter the code with the decimal point.
6. Enter the date that this diagnosis was established in the ‘Date’ box. If not known, enter the admission date.
7. Denote the diagnosis entered as ‘Primary’, and indicate if this diagnosis is the admission diagnosis by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to ‘Primary’.
8. Click **Add** to add the diagnosis code to the request.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
789.00	ABDMNAL PAIN UNSPCF SITE	01/01/2014	Yes	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	01/01/2014	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 41

- Follow the same process to add other diagnoses. **Remember to click Add after each line of diagnosis information is entered.**

Procedures Table:

The Procedures Table captures the following information: CPT code, CPT description (system populated), procedure dates of service (From Date/To Date), units requested and modifier. Most procedures do not require a modifier.

- Enter the procedure code for the service requested in the ‘CPT Code’ box; or search for the code and the system will insert in the ‘CPT Code’ box. At least one procedure code is required. If a procedure code is not entered, the following message displays when **Review Request** is clicked: “Outpatient Hospital requests must include a least one procedure code. Please enter a procedure code.”
- Enter the date of service for the procedure in the ‘From Date’ box; and repeat that date in the ‘To Date’ box.
- Enter the units requested for the procedure under ‘Units’. If the procedure is to be rendered more than once during the 90 day authorization period, only enter one line for the procedure and request additional units.
- Click **Add** to add the procedure code to the request.

Procedures									
CPT Code	CPT Description	From Date	To Date	Units	Mod 1	Mod 2	Mod 3	Mod 4	
45378	DIAGNOSTIC COLONOSCOPY	04/27/2010	04/27/2010	1					EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 42

15. Follow the same process to add other procedure codes, if applicable. Remember to **click Add** after each procedure line is entered.

Procedure Validation Edits: When procedures are added, the procedure information is validated against the following system edits:

- The same procedure code is entered more than once. This edit message displays: “Procedure code <<code>> is already added to this PA. If you are providing the procedure more than once during the 90 day authorization period, please edit the existing procedure line and request additional units”.
- The procedure ‘From Date’ is more than ninety (90) days in the future. This edit message displays: “You have indicated a procedure <<CPT code>> with a date that is more than 90 days in the future. Please check your dates and make sure the date is correct before proceeding.” The date must be corrected in order to submit the request.
- The procedure ‘From Date’ is before the admission date. This edit message displays: “The procedure from date is before the admission date. The procedure from date should be the same as or after the admission date. Please correct either the admission date or procedure from date”. The date must be corrected in order to submit the request.

Patient Transfer:

This section captures the reasons for patient transfer to or from a facility.

The screenshot shows a form titled "Patient Transfer Information". It contains two questions, each with two radio button options: "Yes" and "No". The first question is "Is patient being transferred **TO** your facility?" and the second is "Is patient being transferred **FROM** your facility?". In both cases, the "No" option is selected, indicated by a filled green circle.

Figure 43

16. Respond ‘Yes’ or ‘No’ to the transfer questions. If yes is selected for either transfer question, additional transfer questions display and must be answered, as previously described under inpatient hospital admission.

Supporting Information:

This section captures information supporting the medical necessity of the services requested as related to severity of illness and intensity of services.

- 17. Enter a synopsis of the patient’s presenting clinical situation in the first box; and a description of the patient’s treatment in the second box.

Supporting Information

Please provide a brief synopsis of the patient’s presenting clinical situation and, if inpatient, describe the initial 24 –48 hours of treatment in the following boxes.

^ Clinical Data to Support Request :

Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission

Enter clinical data

^ Admitting Treatment Plan :

Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments.

Describe treatment plan

Figure 44

Retro-Eligibility:

- 18. The system defaults the question regarding member retro eligibility to ‘No’. For members with retro eligibility for the dates of service, click ‘Yes’.

Does this member have retro eligibility for the submitted dates of service ? Yes No

Figure 45

Additional Information Questions:

Additional questions are triggered and display at the bottom of the request form when certain procedure codes are added to the request. These questions are required and must be answered in order to submit the request. For example, the next figure shows the questions for a colonoscopy procedure.

ColonScopyFOC

1 Is this request for an initial screening Colonoscopy for a patient age 50 or more? Yes No

2 Is this request for a 2nd Colonoscopy for screening as a 10 year follow-up of a negative initial Colonoscopy for a patient age 50 or older? Yes No

3 Is this request for a 4 or more year follow-up of a patient with a history of Adenomatous Polyps or cancer of the colon/rectum? Yes No

4 Is this request for a patient who is 40 years old or more with a family history of colon/rectal cancer or Adenomatous Polyps in a 1st degree relative (parent, sibling, child)? Yes No

5 If this request is for situations other than those listed above, please explain.

Figure 46

19. Click 'Yes' or 'No' to each question. Question #5 in this series of questions does not need to be completed unless all other questions are No.
20. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
21. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to see what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
22. Click **I Agree** in response to the *Attestation Statement*.
23. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
24. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.

2.3.1.3 In-state Transplant Requests

The process for entering an *In-State Transplant* PA request is the same as entering an inpatient PA with a procedure code. Initiate the request by selecting **In-State Transplants** from the request menu and then enter the request data as described for an inpatient admission request. The request should include a transplant procedure code. There are no additional information questions for transplant requests.

2.3.2 Out of State Services (OOS)	
Program	Authorization Period
Precertification-Out of State	90 days unless the PA has a transplant code with a one year authorization
Description	
Precertification requests for out of state services (OOS) may be submitted via the web portal utilizing the <i>Out-of-State Services</i> request template. A Georgia Medicaid practitioner must be associated with the OOS request. If the PA is requested by a medical practitioner, a facility Reference ID is not required. If a facility requests the OOS PA, the Reference ID for the patient’s medical practitioner is required.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Out-of- State Services** from the list of review types.
4. On the *New Request for Prior Authorization* page, the provider ID associated with the portal user (requesting provider) displays in the appropriate Provider ID box. When the physician is the requestor, the only other ID that needs to be entered is the member’s Medicaid ID number. A GA facility provider reference ID is optional.

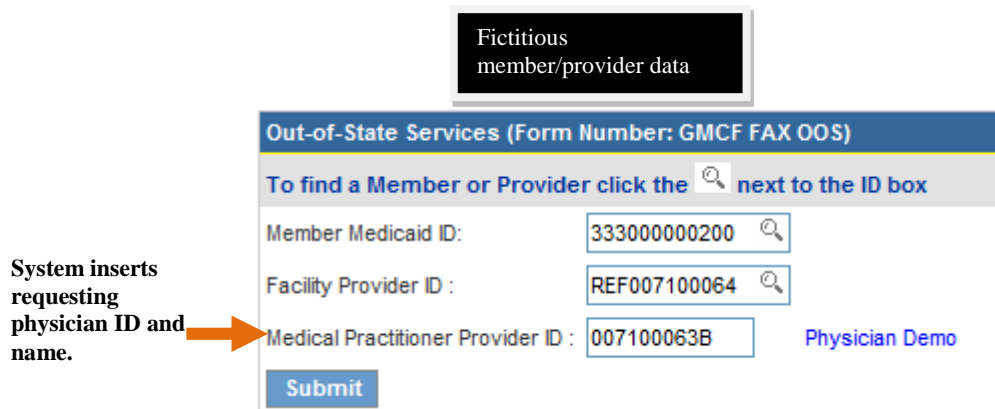




Figure 47

5. When a facility is the requestor, the member’s Medicaid ID **and** the Reference ID for the GA Medicaid physician must be entered.

System inserts requesting facility ID and name. →

Out-of-State Services (Form Number: GMCF FAX OOS)

To find a Member or Provider click the  next to the ID box

Member Medicaid ID: 

Facility Provider ID : **GMCF Hospital**


Medical Practitioner Provider ID : 

Figure 48

6. Click **Submit** to open the request form.
7. At the top of the request template, the member and provider information is system populated based on the Member ID and Provider ID(s) entered

Rendering Physician Information:

This section captures out of state physician information.

Rendering Physician Information

Out-of-State Provider Name :	<input type="text"/>	Taxonomy (Specialty) :	<input type="text" value=""/>
Address Line 1 :	<input type="text"/>	Address Line 2 :	<input type="text"/>
City :	<input type="text"/>	State :	<input type="text" value=""/>
Phone :	<input type="text" value="- -"/> Ext. <input type="text"/>	Zip :	<input type="text"/>
		Fax :	<input type="text" value="- -"/>

Figure 49

8. Enter the name of the out of state physician in the ‘Out-of-State Provider Name’ box.
9. Select the provider’s specialty from the ‘Taxonomy’ drop list.
10. Enter the physician’s address in the ‘Address Line 1’ box; and if needed, additional address information in the ‘Address Line 2’ box.
11. Enter the city in the ‘City’ box; and select the applicable state from the ‘State’ drop list.
12. Enter the five digit Zip Code in the ‘Zip’ box.
13. Enter the physician’s phone number in the ‘Phone’ box; and enter a phone extension, if applicable, in the ‘Ext’ box. Then, enter the physician’s fax number in the ‘Fax’ box.

Rendering Physician Information		Fictitious provider data	
Out-of-State Provider Name :	<input type="text" value="John Green"/>	Taxonomy (Specialty) :	<input type="text" value="Pediatric Pulmonology"/>
Address Line 1 :	<input type="text" value="12 Address Lane"/>	Address Line 2 :	<input type="text"/>
City :	<input type="text" value="Columbus"/>	State :	<input type="text" value="OH"/> Zip : <input type="text" value="45200"/>
Phone :	<input type="text" value="514-888-8000"/> Ext. <input type="text"/>	Fax :	<input type="text" value="514-888-8889"/>

Figure 50

Rendering Facility Information:

This section captures out of state facility information.

Rendering Facility Information			
Out-of-State Facility Name :	<input type="text"/>		
Address Line 1 :	<input type="text"/>	Address Line 2 :	<input type="text"/>
City :	<input type="text"/>	State :	<input type="text" value="OH"/> Zip : <input type="text"/>
Phone :	<input type="text" value="- -"/> Ext. <input type="text"/>	Fax :	<input type="text" value="- -"/>

Figure 51

14. Enter the name of the out of state facility in the ‘Out-of-State Facility Name’ box.
15. Enter the address for the facility in the ‘Address Line 1’ box, and if needed, additional address information in the ‘Address Line 2’ box.
16. Enter the facility’s city location in the ‘City’ box, and select the applicable state from the ‘State’ drop list.
17. Enter the five digit Zip Code in the ‘Zip’ box.
18. Enter the facility’s phone number in the ‘Phone’ box; and a phone extension, if applicable, in the ‘Ext’ box. Then, enter the facility’s fax number in the ‘Fax’ box.

Rendering Facility Information		Fictitious provider data	
Out-of-State Facility Name :	<input type="text" value="Columbus Kids Hospital"/>	<input type="text"/>	
Address Line 1 :	<input type="text" value="22 Address Lane"/>	Address Line 2 :	<input type="text"/>
City :	<input type="text" value="Columbus"/>	State :	<input type="text" value="OH"/> Zip : <input type="text" value="45200"/>
Phone :	<input type="text" value="514-888-8880"/> Ext. <input type="text"/>	Fax :	<input type="text" value="514-888-8889"/>

Figure 52

Contact Information:

The system pulls in the requesting provider's contact information.

19. Enter contact information that is required (name, phone email and fax) but is missing.



The screenshot shows a form titled "Contact Information" with the following fields:

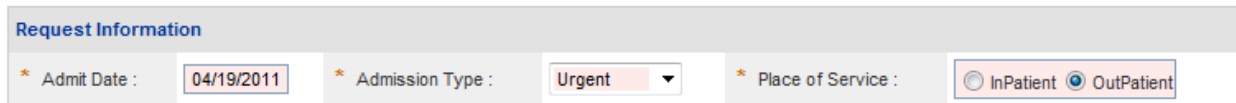
* Contact Name:	DBARRETT	* Contact Email:	DB@email.com
Contact Phone:	444-444-4444	Ext.:	
		* Contact Fax:	666-666-6666

Figure 53

Request Information:

This section captures the following required information: Admission Date, Admission Type, and Place of Service.

20. Enter the admission date in the 'Admit Date' box.
21. Select the 'Admission Type' (Elective, Emergency or Urgent) from the drop list.
22. Click the inpatient or outpatient button to select the 'Place of Service'.



The screenshot shows a form titled "Request Information" with the following fields:

* Admit Date :	04/19/2011	* Admission Type :	Urgent	* Place of Service :	<input type="radio"/> InPatient <input checked="" type="radio"/> OutPatient
----------------	------------	--------------------	--------	----------------------	---

Figure 54

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, primary diagnosis indicator, admission diagnosis indicator, and diagnosis type (ICD9 or ICD10) for each diagnosis code entered.

23. Enter the diagnosis code in the 'Diag Code' box; or search for the diagnosis and the system will insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
24. Enter the date that the diagnosis was established in the 'Date' box. If not known, enter the admission date.

25. Denote the diagnosis entered as ‘Primary’, and indicate if this diagnosis is the admission diagnosis by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to ‘Primary’.

26. Click **Add** to add the diagnosis code to the request.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
789.00	ABDMNAL PAIN UNSPCF SITE	01/01/2014	Yes	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	01/01/2014	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 55

27. Follow the same process to add other diagnosis codes, as applicable. Remember to **click Add** after each line of diagnosis information is entered.

Procedures Table:

The Procedures Table captures CPT Code(s), date of service From Date and To Date, and requested Units. Modifiers are generally not applicable to the procedures requested under this PA type.

28. Enter the procedure code for the service requested in the ‘CPT Code’ box; or search for and have system insert the procedure code.

29. Enter the date of service for the procedure in the ‘From Date’ box; and repeat that date in the ‘To Date’ box.

30. Enter the units requested for the procedure under ‘Units’.

31. Click **Add** to add the procedure code to the request.

32. Follow the same process to add other procedure codes, if applicable. Remember to **click Add** after each procedure line is entered.

Procedures									
CPT Code	CPT Description	From Date	To Date	Units	Mod 1	Mod 2	Mod 3	Mod 4	
32854	LUNG TRANSPLANT WITH BYPASS	05/12/2010	05/12/2010	1					EDIT DELETE
99255	INPATIENT CONSULTATION	05/12/2010	05/12/2010	1					EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 56

Supporting Information:

Out of State requests require the submission of additional supporting documentation. As a result, instead of entering the required information in these textboxes, a notation may be made that the information is attached.

Supporting Information

*** Clinical Data to Support Request :**
Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission

Attached to request

*** Admitting Treatment Plan :**
Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments.

Attached to request

Figure 57

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to ‘No’.

Does this member have retro eligibility for the submitted dates of service ? Yes No

Figure 58

33. For members with retro eligibility for the dates of service, click ‘Yes’.
34. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
35. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that ‘information is missing or incorrect’, scroll up the page to find what is missing or incorrect. ‘**Required**’ displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
36. Click **I Agree** in response to the *Attestation Statement*.
37. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
38. When the request is successfully submitted, the system displays the pending PA tracking number.

2.3.3 Hospital Outpatient Therapy Requests	
Program	Authorization Period
Hospital Outpatient Therapy	Up to 3 consecutive months
Description	
Requests for therapeutic services provided in an outpatient hospital setting are submitted via the web portal utilizing the <i>Hospital Outpatient Therapies</i> request template. Services may be requested for up to three (3) consecutive months on each request. If multiple services are requested for three months each, the same three consecutive months must be entered for each service. The <i>Hospital Outpatient Therapies</i> request form includes additional clinical and policy questions which are required regardless of the therapeutic services requested.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Hospital Outpatient Therapy** from the list of review types.
4. On the *New Request for Prior Authorization* page, click the **Fee for Service** button to indicate that this request is for a member in Fee for Service Medicaid.

Figure 59

5. The provider ID associated with the hospital portal user (requesting provider) displays in the 'Facility Provider ID' box. Enter the member's Medicaid ID.

Hospital Outpatient Therapy

To find a Member or Provider click the next to the ID box

Fee For Service or CMO PA ? Fee for Service
 Amerigroup Community Care
 Peach State Health Plan
 Wellcare Health Plans Inc.

Member Medicaid ID: 333000000300

Facility Provider ID : 007100064A

Submit

Fictitious member/provider data

Figure 60

6. Click **Submit** to open the request form.
7. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the hospital’s contact information.

8. Enter contact information that is required (name, phone, email and fax) but is missing. .

Contact Information

* Contact Name: DBARRETT * Contact Email: DB@email.com

Contact Phone: 444-444-4444 Ext. Contact Fax: 666-666-6666

Figure 61

Request Information:

This section captures the following required information: Place of Service, Therapy Start Date, and Admission Type.

9. The system defaults the ‘Place of Service’ to outpatient hospital.
10. Enter the date that the therapeutic services are **to begin related to this request** in the ‘Therapy Start Date’ box. Enter the date manually or use the calendar popup.

11. Select the ‘Admission Type’ (Elective, Emergency or Urgent) from the drop list.

The screenshot shows a form titled "Request Information" with three fields: "Place of Service" set to "Outpatient Hospital", "Therapy Start Date" set to "05/12/2010", and "Admission Type" set to "Elective".

Figure 62

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (auto-populated), diagnosis date, primary diagnosis indicator, admission diagnosis indicator, and diagnosis type (ICD9 or ICD10) for each diagnosis code entered.

12. Enter a diagnosis code in the ‘Diag Code’ box; or search for and have system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
13. Enter the date that the diagnosis was established in the ‘Date’ box. If not known, enter the therapy start date.
14. Denote the diagnosis entered as ‘Primary’, and indicate if this diagnosis is the admission diagnosis by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to ‘Primary’.
15. Click **Add** to add the diagnosis code to the request.

Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
343.9	CEREBRAL PALSY NOS	09/15/2014	Yes	No	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 63

16. Follow the same process to add other diagnosis codes, as applicable. Remember to **click Add** after each line of diagnosis information is entered.

Procedures Table:

The Procedures Table captures CPT Code(s), dates of service, requested units, and number of visits per week. Modifiers are not applicable to the procedures requested under this PA type.

17. Enter the procedure code for the service requested in the ‘CPT Code’ box; or search for and have system insert the procedure code.
18. In the ‘From Date’ box, enter the procedure start date of service, and, in the ‘To Date’ box, enter the procedure end date of service. The start and end dates for each procedure must be within the same discrete month.
19. Enter the number of visits requested for the procedure date span under ‘Units’.
20. Select from the ‘Number of Visits per Week’ drop list: the number of visits to be provided per week during the procedure from and to date span.
21. Click **Add** to add the procedure code to the request.

CPT Code	CPT Description	From Date	To Date	Units	Number of Visits Per Week	Mod 1	Mod 2	Mod 3	Mod 4	
97530	THERAPEUTIC ACTIVITIES	11/02/2010	11/30/2010	8	2x Per Week					EDIT
97530	THERAPEUTIC ACTIVITIES	12/01/2010	12/31/2010	8	2x Per Week					EDIT DELETE
97530	THERAPEUTIC ACTIVITIES	01/03/2011	01/31/2011	4	1x Per Week					EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="2x Per Week"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 64

22. Follow the same process to add other procedure codes, if applicable. **Remember to click Add after each procedure line is entered.**

Procedure Validation Edits: Procedure codes are validated against the following edits when procedures are added.

- Procedure added is an evaluation code (such as 97001), and more than 1 unit is requested or more than ‘1 Time Only’ is selected as the number of visits per week. This edit message displays: “Per DCH policy, only 1 unit per month may be authorized for evaluation codes. System has changed ‘Units’ to 1 for Procedure 97001”.

- Procedure ‘From Date’ and procedure ‘To Date’ are not within the same month. This edit message displays: “Hospital Outpatient therapies single line procedure code requests should end on the same month that they are requested. Please check your submission for <<CPT code>>.” The dates must be corrected in order to submit the request.
- Procedure ‘From Date’ is more than ninety (90) days in the future. This edit message displays: “You have indicated a procedure <<CPT code>> with a date that is more than 90 days in the future. Please check your dates and make sure the date is correct before proceeding.” The date must be corrected in order to submit the request.
- More than three consecutive months of services are requested. This edit message displays when **Review Request** is clicked: “Requests for Hospital Outpatient Therapies can only be requested for up to three consecutive calendar months. Please check the ‘From’ and ‘To’ Dates.” The dates must be corrected in order to submit the request

Supporting Information:

This section captures information supporting the medical necessity of the therapeutic services requested as related to patient’s acute condition.

23. Enter a synopsis of the patient’s presenting clinical situation in the first box; and a description of the patient’s treatment in the second box.

The screenshot shows a form titled "Supporting Information" with two main sections:

- * Clinical Data to Support Request :**
Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission.
Describe the patient's severity of illness/acute condition requiring therapeutic services.
- * Admitting Treatment Plan :**
Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments.
Describe the therapeutic services to be provided.

Figure 65

Clinical and Policy Questions:

The last section of the Hospital Outpatient Therapy request form includes clinical and policy related questions. All questions are required except for the ‘Range of Motion’ and ‘Strength

Evaluation' sections. However, these sections should be completed if the information provided supports the medical necessity of the services requested.

24. Respond *Yes* or *No* to each question. If 'Yes' is the response, additional data must be provided in the textboxes.

The following screen shot provides an example of the additional questions and responses.

Additional information is required for Code 97001,97530,97530,97530,97530,97530.

The following questions will be used for obtaining additional information related to Hospital Outpatient Therapies. For each PA, the page is only needed once. All questions require a response, with the exceptions being 'conditional' responses or sections designated as required for a PT or OT code.

Please note per section 903.5, Hospital Services Manual: **"Rehabilitation as defined by federal regulation is not covered in the Hospital program. However, short term rehabilitation services, i.e., physical therapy, occupational therapy and speech therapy are covered immediately following and in treatment of acute illness, injury or impairment. . ."** when certain conditions are met.

Are the services requested intended as short term therapy for an acute medical condition? Yes No

If Yes, provide the acute diagnosis :

and date of onset(mm/dd/yyyy) :

Is this a request for continued therapy services ? Yes No

If Yes, indicate the progress towards treatment goals during the last month.

Does the Member suffer from any chronic illness ? Yes No Unknown

If Yes, provide the diagnosis for the chronic illness.

Is the Member receiving other rehabilitative therapies under another Medicaid program (such as, Children's Intervention Services or Waiver program) ? Yes No Unknown

If Yes, indicate which programs.

Range of Motion Evaluation :
 If the therapy is related to range of motion, complete this section. Indicate the range of motion (ROM) in degrees for the affected part(s) of the body based on the most current assessment.

Affected Body Part	Side Affected	ROM
<input type="checkbox"/> Feet/Ankle	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input checked="" type="checkbox"/> Knee	<input type="radio"/> N/A <input checked="" type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	25
<input checked="" type="checkbox"/> Hip	<input type="radio"/> N/A <input checked="" type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	25
<input type="checkbox"/> Spine	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Shoulder	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Elbow	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Wrist	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Hand	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Fingers	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input checked="" type="checkbox"/> Neck	<input type="radio"/> N/A <input type="radio"/> Both <input checked="" type="radio"/> Left Side <input type="radio"/> Right Side	10
<input type="checkbox"/> Other <input type="text"/>	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>

Strength Evaluation :
 If the therapy is related to strength, complete this section. Indicate the current strength on a five (5) point scale for the affected part(s) of the body based on the most current assessment.

Affected Body Part	Side affected	Strength Score
<input type="checkbox"/> Feet/Ankle	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input checked="" type="checkbox"/> Knee	<input type="radio"/> N/A <input checked="" type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	2
<input checked="" type="checkbox"/> Hip	<input type="radio"/> N/A <input checked="" type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	2
<input type="checkbox"/> Spine	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Shoulder	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Elbow	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Wrist	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Hand	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Fingers	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Neck	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>
<input type="checkbox"/> Other <input type="text"/>	<input checked="" type="radio"/> N/A <input type="radio"/> Both <input type="radio"/> Left Side <input type="radio"/> Right Side	<input type="text"/>

Has a medical practitioner (physician, nurse practitioner or physician assistant) certified that these services are necessary for the treatment of the acute illness, injury or impairment; and/or that these services are necessary to the establishment of a safe and effective maintenance program? Yes No

If yes, date of certification:

Medical Practitioner Name :

Medical Practitioner contact number : aaa-xxx-xxxx

Is the treatment plan signed by a Medical Practitioner ? Yes No

If Yes, date signed by Medical Practitioner :

Does the treatment plan include a statement about the Member's rehabilitation potential ? Yes No

If Yes, provide this statement.

Can these therapy services be effectively provided by a family member/non-professional? Yes No Unknown

Figure 66

25. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.

26. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what

is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.

27. Click **I Agree** in response to the *Attestation Statement*.
28. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
29. When the request is successfully submitted, the pending PA tracking number shows at the top of the page.

2.3.4 Radiology Prior Authorization Requests	
Program	Authorization Period
Radiology Facility Setting	90 Days
Radiology Physician Office	90 Days
Description	
Requests for authorization of radiology services provided in an outpatient hospital or physician office are submitted via the web portal utilizing the <i>Radiology-Facility Setting</i> and <i>Radiology-Physician Office</i> request templates. The request templates for both radiology PA types are the same and may include additional clinical questions which are specific to the radiology code or code group requested. Only the radiology codes requiring prior authorization may be entered on a radiology PA request. Additionally, the system will not permit the entry of the radiology procedure codes on any other request type.	

2.3.4.1 Radiology Facility Setting

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Radiology-Facility Setting** from the list of review types to open the authorization request page.
4. Enter the member’s Medicaid ID.
5. **When the hospital is the requestor**, the hospital’s Provider ID is auto-populated.
6. If a medical practitioner is involved in the service, enter the Reference ID for the medical practitioner; otherwise, this box may be left blank.

System inserts requesting facility provider ID and name.

Radiology-Facility Setting	
To find a Member or Provider click the <input type="text"/> next	
Member Medicaid ID:	<input type="text" value="333000000400"/>
Facility Provider ID :	<input type="text" value="007100064A"/> GMCF Hospital
Medical Practitioner Reference ID :	<input type="text" value="REF007100063"/>
<input type="button" value="Submit"/>	

Fictitious member/provider data

Figure 67

7. **When the medical practitioner is the requestor**, the medical practitioner’s Provider ID is auto-populated.
8. Enter the hospital’s Reference ID. This is required.

System inserts requesting physician provider ID and name. →




Radiology-Facility Setting	
To find a Member or Provider click the  next to the ID box	
Member Medicaid ID:	<input type="text" value="333000000400"/> 
Facility Reference ID :	<input type="text" value="REF007100064"/> 
Medical Practitioner Provider ID :	<input type="text" value="007100063B"/> Physician Demo
<input type="button" value="Submit"/>	

Figure 68

9. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID(s) entered.

Contact Information:

The system pulls in the requesting provider contact information.

10. Enter contact information that is required (name, phone, email and fax) but is missing.

Contact Information			
* Contact Name:	<input type="text" value="DBARRETT"/>	* Contact Email:	<input type="text" value="DB@email.com"/>
Contact Phone:	<input type="text" value="444-444-4444"/> Ext. <input type="text"/>	* Contact Fax:	<input type="text" value="666-666-6666"/>

Figure 69

Request Information:

This section captures the Date of Service and Admission Type.

11. Enter the date that the radiology service was rendered or is to be provided in the ‘Date of Service’ box.

Note: When a date of service is entered that is more than 90 days greater than the request date, the PA is withdrawn by the system with the following decision comment: “Please resubmit request within 90 days of planned procedure date/admission date.” The decision comment may be viewed via the *Provider Workspace*.

12. Select the ‘Admission Type’ (Elective, Emergency or Urgent) from the drop list.

The screenshot shows a form titled "Request Information". It contains two fields: "Date of Service" with the value "12/15/2011" and "Admission Type" with a dropdown menu set to "Elective".

Figure 70

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator.

- 13. Enter the patient’s diagnosis code in the ‘Diag Code’ box; or search for and have system insert the diagnosis code. If the code includes a decimal point, enter the code with the decimal point.
- 14. Enter the date that this diagnosis was established in the ‘Date’ box. If not known, enter the date of service.
- 15. Denote the diagnosis entered as ‘Primary’ by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to ‘Primary’.
- 16. Click **Add** to add the diagnosis code to the request.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
780.39	CONVULSIONS NEC	11/10/2011	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>		ADD

Figure 71

17. Follow the same process to add other diagnosis codes, as applicable. Remember to **click Add** after each line of diagnosis information is entered.

Procedures Table:

The Procedures Table captures CPT Code(s), Code Description (system populated) and requested Units. Modifiers are not applicable to the procedures requested under this PA type.

18. Enter the CPT code for the requested radiology procedure in the ‘CPT Code’ box; or search for and have system insert the procedure code.
19. Enter the units requested for the procedure under ‘Units’.
20. Click **Add** to add the procedure code to the request.

Procedures							
CPT Code	CPT Description	Units	Mod 1	Mod 2	Mod 3	Mod 4	
70551	MRI BRAIN WWO DYE	1					EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 72

21. Follow the same process to add other procedure codes, if applicable. Remember to **click Add after each procedure line is entered.**

Supporting Information:

This section captures information supporting the medical necessity of the radiology services requested.

22. Enter a synopsis of the patient’s clinical situation requiring radiology services in the first box; and a description of the services in the second box.

Supporting Information
<p>Clinical Data to Support Request : Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission Describe the patient's condition requiring the radiology service</p>
<p>Admitting Treatment Plan : Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments. Describe the procedure to be provided.</p>

Figure 73

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to ‘No’.



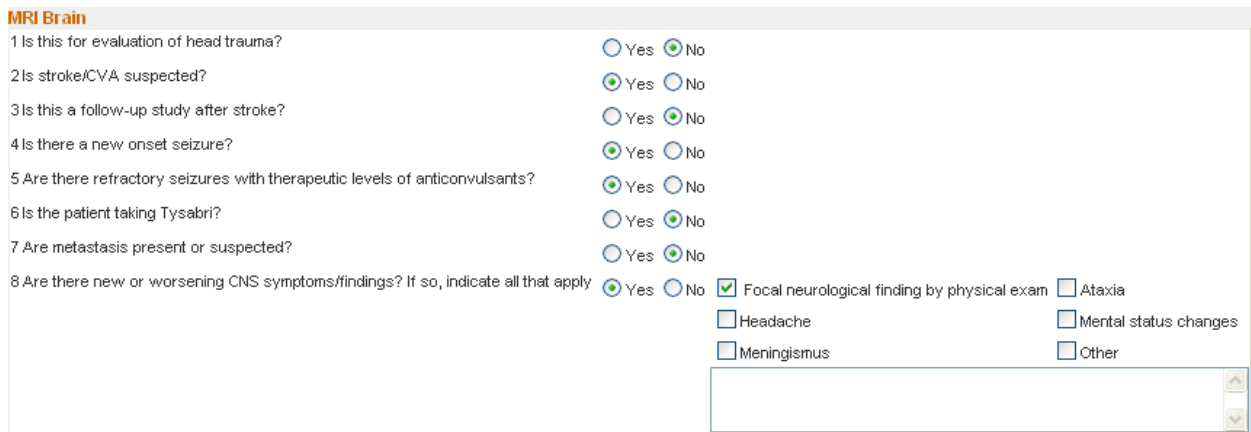
Figure 74

23. For members with retro eligibility for the dates of service, click ‘Yes’.

Additional Information Questions:

Additional Information questions are triggered by all radiology procedure codes. For example, the next figure shows the questions for MRI Brain FOC: 70551, 70552 and 70553. The questions are required and must be completed in order to submit the request.

24. Respond to each question as it applies to the patient’s condition by selecting Yes or No. If Yes is selected for item #8, at least one symptom checkbox must be selected. If the ‘Other’ checkbox is selected, an explanation must be provided in the textbox.



MRI Brain

1 Is this for evaluation of head trauma? Yes No

2 Is stroke/CVA suspected? Yes No

3 Is this a follow-up study after stroke? Yes No

4 Is there a new onset seizure? Yes No

5 Are there refractory seizures with therapeutic levels of anticonvulsants? Yes No

6 Is the patient taking Tysabri? Yes No

7 Are metastasis present or suspected? Yes No

8 Are there new or worsening CNS symptoms/findings? If so, indicate all that apply Yes No

Focal neurological finding by physical exam Ataxia
 Headache Mental status changes
 Meningismus Other

[Text input box for explanation]

Figure 75

25. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.

26. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that ‘information is missing or incorrect’, scroll up the page to find what is missing or incorrect. ‘**Required**’ displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.

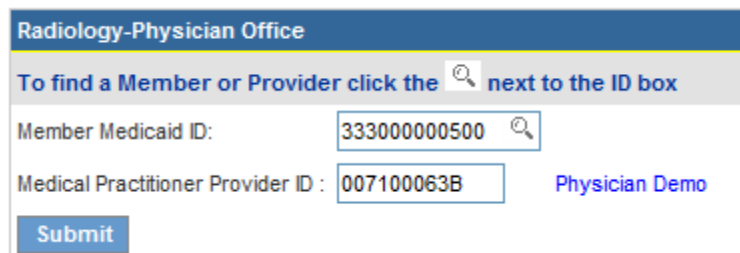
27. Click **I Agree** in response to the *Attestation Statement*.
28. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
29. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.

2.3.4.2 Radiology Physician Office

The web requests forms for Radiology Facility Setting and Radiology Physician Office are identical.

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Radiology-Physician Office** from the list of request types.
4. On the *New Request for Prior Authorization* page, the provider ID of the requesting medical practitioner is populated by the system.
5. Enter the member's Medicaid ID.



The screenshot shows a web form titled "Radiology-Physician Office". Below the title is a grey instruction bar: "To find a Member or Provider click the [magnifying glass icon] next to the ID box". There are two input fields: "Member Medicaid ID:" with the value "333000000500" and a magnifying glass icon to its right; and "Medical Practitioner Provider ID:" with the value "007100063B" and a "Physician Demo" link to its right. At the bottom left is a blue "Submit" button.

Figure 76

6. Click **Submit** to open the request form.
7. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.
8. Follow the instructions for entering request information as previously described for Radiology Facility Setting.

2.3.5 Medications Prior Authorization Requests	
Program	Authorization Period
Medications Facility Setting	Synagis – RSV Season; Other drugs: Variable authorization periods but usually 6 – 12 months.
Medications Physician Office	Synagis – RSV Season; Other drugs: Variable authorization periods but usually 6 – 12 months.
Description	
Requests for prior authorization of certain injectable drugs administered in an outpatient hospital or physician office are submitted via the web portal utilizing the <i>Medications PA Facility Setting</i> and <i>Medications PA Physician Office</i> request templates. Only a provider with a category of service of Outpatient Hospital (070) may request a Medications Facility Setting prior authorization; and only a medical practitioner may request a Medications Physician Office PA. The drug codes requiring prior authorization can only be entered on a Meds PA request. Meds PA requests may include additional clinical questions specific to the drug code requested; although not all drug codes trigger additional questions.	

2.3.5.1 Medications PA Facility Setting

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Medications PA Facility Setting** from the list of review types to open the *New Request for Prior Authorization* page.
4. The provider ID for the hospital is system populated in the ‘Facility Provider ID’ box.
5. Enter the member’s Medicaid ID. If a medical practitioner is involved in the service, the Reference ID for the medical practitioner may be entered but is not required.

Figure 77

6. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID(s) entered.

Contact Information:

The system pulls in the requesting provider contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.



The screenshot shows a form titled "Contact Information" with four input fields. The "Contact Name" field contains "DBARRETT", "Contact Email" contains "DB@email.com", "Contact Phone" contains "444-444-4444" and "Ext." is empty, and "Contact Fax" contains "666-666-6666".

Figure 78

Request Information:

This section captures the following required information: Admission Date, Admission Type, and Place of Service.

8. Enter the date of admission to the outpatient facility in the 'Admit Date' box.
9. Select the 'Admission Type' (Elective, Emergency or Urgent) from the drop list.
10. The system defaults the 'Place of Service' to outpatient hospital.



The screenshot shows a form titled "Request Information" with three input fields. "Admit Date" contains "01/17/2012", "Admission Type" is a dropdown menu set to "Elective", and "Place of Service" is a radio button set to "Outpatient Hospital".

Figure 79

Patient Information:

This required section captures the member's height in inches and the member's weight in pounds.

11. Enter the member's height in the box provided. Only a number value should be entered and it must be greater than zero.
12. Enter the member's weight in the box provided. Only a number value should be entered and it must be greater than zero.

Patient Information	
Patient Height (inches) :	55 in. Patient Weight (pounds) : 125 lb.

Figure 80

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator.

13. Enter the patient’s diagnosis code in the ‘Diag Code’ box; or search for and have system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
14. Enter the date that this diagnosis was established in the ‘Date’ box. If not known, enter the admit date.
15. Denote the diagnosis entered as ‘Primary’ by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to ‘Primary’.
16. Click **Add** to add the diagnosis code to the request.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
204.00	AC LYM LEUK WO ACHV RMSN	02/21/2010	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>		ADD

Figure 81

17. Follow the same process to add other diagnosis codes, as applicable. Remember to **click Add after each line of diagnosis information is entered.**

Procedures Table:

The Procedures Table captures the CPT drug code, NDC number, code description, drug start date, drug end date, and requested units.

18. Enter the CPT code for the requested drug by selecting the drug from the ‘CPT-NDC Code’ drop list.
19. Enter the start date of the medication in the ‘From Date’ box, and the end date of the medication in the ‘To Date’ box.
20. Enter the total units of medication requested for the entire date span in the ‘Units’ box.

21. Click **Add** to add the procedure code to the request.

Procedures					
CPT - HDC Code	CPT Description	From Date	To Date	Units	
J9033 - 63459039120 - Bendamustine HCl	BENDAMUSTINE INJECTION	05/17/2010	11/16/2010	12	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="ADD"/> <input type="button" value="CANCEL"/>

Figure 82

Supporting Information:

This section captures clinical information supporting the medication request.

22. Enter a synopsis of the patient’s clinical situation requiring drug therapy in the first box; and a description of the plan of treatment in the second box.

Supporting Information

*** Clinical Data to Support Request :**
 Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission

Enter clinical justification

*** Admitting Treatment Plan :**
 Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments.

Describe the treatment plan

Figure 83

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to ‘No’.

Does this member have retro eligibility for the submitted dates of service ? Yes No

Figure 84

23. For members with retro eligibility for the dates of service, click ‘Yes’.

Additional Information Questions:

Certain drug codes trigger additional questions related to DCH pharmacy authorization criteria. The questions display at the bottom of the request form. All questions are required and must be answered in order to submit the request. The next figure shows the questions for Treanda (J9033) with Yes/No responses.

The screenshot shows a form titled "Treanda" with the following questions and options:

- Additional information is required for Code J9033.**
Has the patient failed purine analog based therapy (fludarabine, pentostatin)? Yes No
If no, please comment:
- Has the patient previously or is currently being treated with Rituxin? Yes No
If no, please comment:
- Has the member's NHL progressed during or within six months of treatment with Rituxin (rituximab) or a regimen containing Rituxin, and Treanda is being used as monotherapy? Yes No
If no, please comment:
- Has the member's NHL responded well to Rituxin (rituximab) in the past, and Treanda is being used in combination with Rituxin? Yes No
If no, please comment:
Explain No response.

Figure 85

24. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
25. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
26. Click **I Agree** in response to the *Attestation Statement*.
27. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.

28. When the request is successfully submitted, the system displays the pending PA tracking number.

2.3.5.2 Medications PA Physician Office

The web request form for Meds PA Physician Office is almost identical to the Meds PA Facility form except for the **Request Information** section. The Medications Physician Office form captures the date of service instead of an admission date, and the place of service is defaulted to office instead of outpatient hospital.

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Medications PA Physician Office** from the list of request types to open the *New Request for Prior Authorization* page.
4. The medical practitioner's provider ID is system populated in the 'Medical Practitioner Provider ID' box.
5. Enter the member's Medicaid ID.

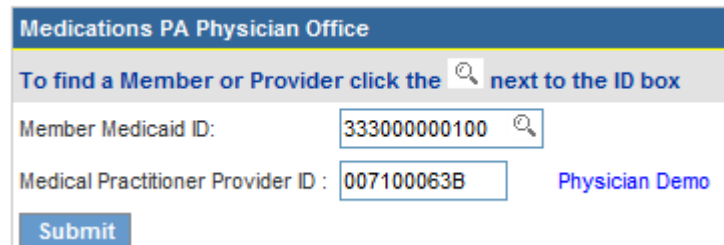


Figure 86

6. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the requesting provider contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.

Contact Information			
* Contact Name:	<input type="text" value="DBARRETT"/>	* Contact Email:	<input type="text" value="DB@email.com"/>
Contact Phone:	<input type="text" value="444-444-4444"/> Ext. <input type="text"/>	* Contact Fax:	<input type="text" value="666-666-6666"/>

Figure 87

Request Information:

This section captures the following required information: Date of Service, Admission Type, and Place of Service.

8. Enter the date that the medication is to start in the 'Date of Service' box.
9. Select the 'Admission Type' (Elective, Emergency or Urgent) from the drop list.
10. The system defaults the 'Place of Service' to office.

Request Information			
Date of Service	<input type="text" value="01/25/2012"/>	* Admission Type :	<input type="text" value="Elective"/> ▼
		* Place of Service :	<input checked="" type="radio"/> Office

Figure 88

11. Follow the instructions as previously described for Meds PA Facility Setting to complete the rest of the web form.

2.3.6 Practitioner’s Office Surgical Procedures	
Program	Authorization Period
Office Surgical Procedures	90 Days
Description	
Requests for authorization of procedures requiring prior approval and rendered in a physician’s office may be submitted via the web portal utilizing the <i>Practitioner’s Office Surgical Procedures</i> request template. The Office Surgical Procedures template may include additional clinical questions, which are added to the request template when certain procedures are requested. Response to the questions is required for PA submission.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Practitioner’s Office Surgical Procedures** from the list of request types to open the *New Request for Prior Authorization* page.
4. The medical practitioner’s provider ID is system populated in the ‘Medical Practitioner Provider ID’ box.
5. Enter the member’s Medicaid ID.

Figure 89

6. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the requesting provider contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.



The screenshot shows a form titled "Contact Information" with four fields: "Contact Name" (DBARRETT), "Contact Email" (DB@email.com), "Contact Phone" (444-444-4444) with an "Ext." field, and "Contact Fax" (666-666-6666). Each field has a red border and a red asterisk indicating it is required.

Figure 90

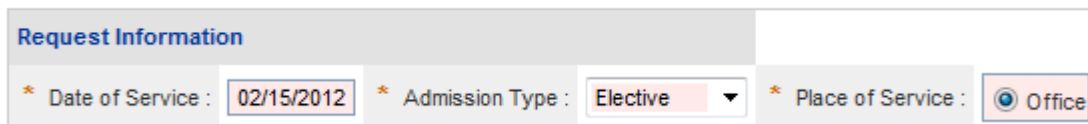
Request Information:

This section captures the following required information: Date of Service, Admission Type, and Place of Service.

8. Enter the procedure date of service in the 'Date of Service' box.

Note: When a date of service is entered that is more than 90 days greater than the request date, the PA is system withdrawn/denied with the following denial decision comment: "Please resubmit request within 90 days of planned procedure date/admission date." The decision comment can be viewed via the *Provider Workspace*.

9. Select the 'Admission Type' (Elective, Emergency or Urgent) from the drop list.
10. The system defaults the 'Place of Service' to office.



The screenshot shows a form titled "Request Information" with three fields: "Date of Service" (02/15/2012), "Admission Type" (Elective) with a dropdown arrow, and "Place of Service" (Office) with a radio button. Each field has a red border and a red asterisk indicating it is required.

Figure 91

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator. Admission indicator is not required.

11. Enter the patient's diagnosis code in the 'Diag Code' box; or search for and have system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
12. Enter the date that this diagnosis was established in the 'Date' box. If not known, enter the date of service.
13. Denote the diagnosis entered as 'Primary' by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to 'Primary'.

14. Click **Add** to add the diagnosis code to the request.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
727.1	BUNION	04/25/2010	Yes	No	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	04/25/2010	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 92

15. Follow the same process to add other diagnosis codes, as applicable. Remember to **click Add after each line of diagnosis information is entered.**

Procedures Table:

The Procedures Table captures the CPT code, CPT description (system populated), and requested units. Modifiers are generally not applicable to the procedures requested under this PA type.

16. Enter the CPT code for the requested procedure in the ‘CPT Code’ box; or search for and have system insert the procedure code.

17. Enter the total units requested for the procedure in the ‘Units’ box.

18. Click **Add** to add the procedure code to the request.

Procedures							
CPT Code	CPT Description	Units	Mod 1	Mod 2	Mod 3	Mod 4	
28290	CORRECTION OF BUNION	1					EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 93

19. Follow the same process to add other procedure codes. Remember to **click Add after each procedure line is entered.**

Supporting Information:

This section captures clinical information supporting the request.

20. A synopsis of the patient’s clinical situation is entered in the first box; and a description of the plan of treatment is entered in the second box.

Supporting Information

*** Clinical Data to Support Request :**
Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission
Enter clinical justification

*** Admitting Treatment Plan :**
Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments.
Describe the treatment plan

Figure 94

Retro-Eligibility:

21. The system defaults the question regarding member retro eligibility to ‘No’.

Does this member have retro eligibility for the submitted dates of service ? Yes No

Figure 95

22. Click ‘Yes’ if the member has retro Medicaid eligibility for the request dates of service.

Additional Information Questions:

Certain procedure codes trigger additional information questions that display at the bottom of the template. The questions are required and must be answered in order to submit the request.

The following screen shot shows the questions for procedure 28290 – Correction of Bunion.

Additional Information

Please enter additional information. **All questions are required.**

Outpatient Bunionectomy

1 Does pain at MTP joint interfere with ADLs, or make wearing closed shoes unbearable? Yes No

2 Is skin irritation or callus and a hallux valgus deformity present? Yes No

3 Is Hallux Valgus Angle between 15 & 35 degrees? Yes No

4 Has patient failed 12 or more weeks of conservative treatment with well fit, low heeled shoes, NSAIDS, bunion pads or orthotics? Yes No

Figure 96

23. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
24. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
25. Click **I Agree** in response to the *Attestation Statement*.
26. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
27. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.

2.3.7 Additional Physician Office Visits	
Program	Authorization Period
Physician Office Visits	Procedure from date to 12/31 of the Effective Date year
Description	
Requests for authorization of physician office visits, in excess of the twelve (12) allowed per year without prior authorization, may be submitted via the web portal utilizing the <i>Additional Physician Office Visit</i> request template.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Additional Physician Office Visit** from the list of request types to open the *New Request for Prior Authorization* page.
4. The medical practitioner’s provider ID is system populated in the ‘Medical Practitioner Provider ID’ box.
5. Enter the member’s Medicaid ID.

Figure 97

6. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the requesting provider contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.

Contact Information			
* Contact Name:	DBARRETT		* Contact Email: DB@email.com
Contact Phone:	444-444-4444	Ext. <input type="text"/>	* Contact Fax: 666-666-6666

Figure 98

Request Information:

This section captures Place of Service.

- Click *Office* or *Other* to enter the ‘Place of Service’.

Request Information	
* Place of Service :	<input checked="" type="radio"/> 11 - Office <input type="radio"/> 99 - Other

Figure 99

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator.

- Enter the patient’s diagnosis code in the ‘Diag Code’ box; or search for and have system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
- Enter the date that this diagnosis was established in the ‘Date’ box.
- Denote the diagnosis code entered as ‘Primary’ by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to ‘Primary’.
- Click **Add** to add the diagnosis code to the request.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
789.00	ABDMNAL PAIN UNSPCF SITE	08/01/2011	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	08/01/2011	<input type="checkbox"/>		ADD

Figure 100

- Follow the same process to add other diagnosis codes, as applicable. Remember to click **Add** after each line of diagnosis information is entered.

Procedures Table:

The Procedures Table captures the CPT code, CPT description (system populated), procedure start and end dates, and requested visits. Modifiers are not applicable to the procedures requested under this PA type.

Procedures									
CPT Code	CPT Description	From Date	To Date	Requested Visits	Mod 1	Mod 2	Mod 3	Mod 4	
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
									<input type="button" value="ADD"/> <input type="button" value="CANCEL"/>

Figure 101

14. Enter the office visit procedure code in the ‘CPT Code’ box.

Note: The office visit procedure codes are bundled in three code groups or family of codes (FOC): New Patient, Established Patient, and Consults. It is only necessary to **enter one code from a FOC** since the entire family is sent to the claims system. **If two or more codes from the same family are added to a PA request, the family of codes are NOT sent - only the actual code entered is sent to Claims.**

15. In the ‘From Date’ box, enter the date of the first visit related to the procedure requested. In the ‘To Date’ box, enter the date of the last visit related to the procedure.

16. In the ‘Requested Visits’ box, enter the number of additional visits requested for the request period and procedure.

17. Click **Add** to add the procedure code to the request.

Procedures									
CPT Code	CPT Description	From Date	To Date	Requested Visits	Mod 1	Mod 2	Mod 3	Mod 4	
99213	OFFICE/OUTPATIENT VISIT EST	10/24/2011	12/31/2011	4					<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
									<input type="button" value="ADD"/> <input type="button" value="CANCEL"/>

Figure 102

Note: When a procedure ‘From Date’ is added that is more than ninety (90) days in the future, the following edit message is triggered: “You have indicated a procedure <<CPT code>> with a date that is more than 90 days in the future. Please check your dates and make sure the date is correct before proceeding.” The date must be corrected in order to submit the request.

Physician Examination Dates:

- 18. Enter the date that the patient was first seen for the diagnosis entered on the request in the 'Date First Seen for Diagnosis' box.
- 19. Enter the date of the patient's most recent office visit in the 'Date of Most Recent Visit' box.

Physician's Examination Report and Recommendation :

Date Patient First Seen for Diagnosis : 06/01/2011 Date of Most Recent Visit : 09/05/2011

Figure 103

Justification for Services and Additional Visits:

This section captures information that justifies the need for additional office visits and includes four textboxes: Present Medical Status; Treatment/Services Rendered; Plan of Care and Justification and Circumstances for Requested Additional Services.

- 20. Enter information in each textbox. This is required in order to submit the request.

Patient's Present Medical Status :
Include pertinent clinical information to support the need for additional physician office visits.
Describe the patient's current medical condition for which the office visits are necessary.

Treatment or Services Rendered :
Describe the specific services to be provided to the patient during the requested additional office visits.
Describe the services to be provided.

Plan of Care :
Summarize the patient's plan of treatment.
Summarize the plan of care.

Justification and Circumstances for Requested Additional Services :
Provide the clinical rationale for these additional office visits.
Enter clinical rationale.

Figure 104

21. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
22. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
23. Click **I Agree** in response to the *Attestation Statement*.
24. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
25. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.

2.3.8 Additional Psychological or Psychiatric Services	
Program	Authorization Period
Psychiatric Services	6 months to end of month, or until 12/31 of Effective Date year
Psychological Services	6 months to end of month, or until 12/31 of Effective Date year
Description	
Requests for authorization of psychological or psychiatric visits, in excess of the twenty-four (24) visits allowed per year without PA, may be submitted via web portal utilizing the <i>Additional Psychiatric Services</i> or <i>Additional Psychological Services</i> request templates. Only Providers with a 570 category of service may request additional psychological services; and only providers with a 430 category of service may request additional psychiatric services. The same request template is used for both PA types. The system derives the PA type based on the requesting provider category of service (COS).	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. If the provider ID is associated with a 430 COS, the link for **Additional Psychiatric Services** displays. If the provider ID is associated with a 570 COS, the link for **Additional Psychological Services** displays. Click the applicable request type to open the *New Request for Prior Authorization* page.
4. The medical practitioner’s provider ID is system populated in the ‘Medical Practitioner Provider ID’ box.
5. Enter the member’s Medicaid ID.

Figure 105

6. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the requesting provider contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.

The screenshot shows a form titled "Contact Information" with the following fields: "Contact Name" with the value "DBARRETT", "Contact Email" with the value "DB@email.com", "Contact Phone" with the value "444-444-4444" and an empty "Ext." field, and "Contact Fax" with the value "666-666-6666".

Figure 106

Request Information:

This section captures the Place of Service, and verification that the services requested are for additional visits beyond the visits allowed per year without PA.

8. Click *Office* or *Other* to enter the 'Place of Service'.
9. Indicate whether or not the request is for additional visits beyond the 24 visits permitted without PA by selecting *Yes* or *No*. **This question was added as a reminder that 24 visits are allowed per calendar year without PA.**

The screenshot shows a form titled "Request Information" with two main sections. The first section is "Place of Service" with radio buttons for "11 - Office" (selected) and "99 - Other". The second section is a question: "Is this a request for additional visits beyond the 24 visits permitted per calendar year without a PA? (If YES, continue with submission; If NO, PA is not required.)" with radio buttons for "Yes" (selected) and "No".

Figure 107

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator.

10. Enter the patient's diagnosis code in the 'Diag Code' box; or search for and have system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
11. Enter the date that this diagnosis was established in the 'Date' box.
12. Denote the diagnosis entered as 'Primary' by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to 'Primary'.
13. Click **Add** to add the diagnosis code to the request.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
300.02	GENERALIZED ANXIETY DIS	01/01/2012	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text" value="01/01/2012"/>			ADD

Figure 108

- Follow the same process to add other diagnosis codes, as applicable. Remember to **click Add** after each line of diagnosis information is entered.

Procedures Table:

The Procedures Table captures the CPT code, CPT description (system populated), service start/end dates, number of visits requested, number of visits per week, and duration of each visit. Modifiers are not applicable to the procedures requested under this PA type.

- Enter the procedure code for the psychological/psychiatric service requested in the ‘CPT Code’ box.
- In the ‘From Date’ box, enter the start date for the requested service; and in the ‘To Date’ box, enter the last date of service for the procedure requested.
- Enter the total number of additional visits requested for the procedure code in the ‘Number of Visits Requested’ box. If the service is only to be provided once during the date span, enter ‘1’.
- Select the frequency of visits per week from the ‘Number of Visits per Week’ drop list. If the service is only to be provided one time, select *1 Time Only*.
- Click **Add** to add the procedure code to the request.

Procedures											
CPT Code	CPT Description	From Date	To Date	Number of Visits Requested	Number of Visits Per Week	Duration of Visit	Mod 1	Mod 2	Mod 3	Mod 4	
90804	PSYTX OFFICE 20-30 MIN	04/18/2012	06/19/2012	8	1x Per Week	20m					EDIT
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="1x Per Week"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 109

- Follow the same process to add another procedure code, if applicable. Remember to **click Add** after each procedure line is entered.

Procedure Validation Edits: Procedure dates are validated against the following edits when procedures are added. Date corrections are necessary in order to submit the PA.

- The procedure 'From Date' is more than ninety (90) days in the future. This edit message displays: "You have indicated a procedure <<CPT code>> with a date that is more than 90 days in the future. Please check your dates and make sure the date is correct before proceeding."
- The procedure 'To Date' is beyond 12/31 of the current calendar year. This edit message displays: "You cannot request additional visits on this PA beyond 12/31 <<current year>>. Please correct the 'To Date.'"

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to 'No'.



Figure 110

21. If the member has retro Medicaid eligibility for the dates of service, click 'Yes'.

Note: When the retro eligibility indicator is No and a procedure 'From Date' is added that is before the PA request date, the following message displays when **Review Request** is clicked: "The procedure from date must be equal to or after today's date unless the member has retro eligibility for the date of service (DOS). Please fix the procedure from date or check 'Yes' for retro eligibility if the member has retro eligibility for the DOS." The request cannot be submitted until the data is corrected.

Justification for Additional Services:

The next sections capture information regarding the patient's psychiatric history, treatment progress to date, treatment goals, GAF score, current signs/symptoms, medications, and justification for services. These sections must be completed in order to submit the request.

22. In the 'Progress to Date' textbox, summarize the patient's psychological history and treatment progress to date including level of compliance with treatment.
23. In the 'Anticipated Goals' textbox, indicate the expected outcome for additional services.
24. Enter the patient's current Global Assessment of Functioning score in the 'GAF' box provided.
25. Select the emotional/behavioral symptoms that apply to the patient by clicking the corresponding checkbox. Select all that apply. If 'Other' is selected as a symptom, an explanation is required in the textbox provided.
26. List the member's current medications and frequency in the 'Medications' box.

27. Describe the additional services requested and explain why the services are needed in the 'Justification and Circumstances' textbox.

The screenshot shows a web-based request form with the following sections:

- Progress to Date Including Compliance with Recommended Treatment**: A text area with the prompt "Provide brief psychological history and patient's compliance with treatment regimen."
- Current Clinical and Anticipated Goals for Additional Hours**: A text area with the prompt "Describe the expected outcome resulting from additional hours of treatment."
- Current Clinical Information to Support Request (Complete Checklist and Explanation)**:
 - A dropdown menu for "Current Global Assessment of Functioning (GAF Scale 0-100):" with the value "30" selected.
 - A section titled "Which of the following conditions does the Patient display? (Check all that apply)" with a grid of checkboxes:

<input type="checkbox"/> Currently Suicidal	<input checked="" type="checkbox"/> Suicidal by History	<input type="checkbox"/> Homicidal	<input type="checkbox"/> History of Significant Psychological Trauma
<input type="checkbox"/> Specialized School Placement	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Sexually Aggressive	<input type="checkbox"/> Foster Home
<input type="checkbox"/> Psychotic	<input type="checkbox"/> Physically Aggressive	<input type="checkbox"/> Multiple Foster Homes	<input type="checkbox"/> Serious Runaway Behavior
<input type="checkbox"/> Legal Issues	<input checked="" type="checkbox"/> Severe Somatization	<input checked="" type="checkbox"/> Physically Self-Destructive	<input type="checkbox"/> Other (Please specify in comment below)
 - A text area for additional comments.
- Medications**: A text area with the prompt "List the member's medications and frequency"
- Justification and Circumstances for Requested Additional Services (Include meds)**: A text area with the prompt "Provide the justification for the requested additional services - why the services are medically necessary."

Figure 111

28. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.

29. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.

30. Click **I Agree** in response to the *Attestation Statement*.

31. Review the request. To change information entered, click [Edit Request](#). Otherwise, click [Submit Request](#).
32. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.

2.3.9 Dental Services	
Program	Authorization Period
EPSDT Health Check Dental	One year to month end
Adult Dental	One year to month end
Description	
Requests for authorization of dental services for children and adults may be submitted via the web portal utilizing the <i>Early Periodic Screening Diagnosis and Treatment Dental (EPSDT)</i> and <i>Adult Dental</i> request templates. The same template is used to request adult and health check dental services. Providers with a 450 category of service (COS) may request a Health Check Dental PA; and providers with a 460 COS may request an Adult Dental PA. Additional information questions are pulled into the request template when certain dental procedures are requested. The questions must be answered in order to submit the request.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. If the provider ID is associated with a 450 COS, the link for **Health Check Dental** displays. If the provider ID is associated with a 460 COS, the link for **Adult Dental** displays. Both request types may display if the provider ID is associated with both adult and pediatric dental categories of service. Click the applicable request type to open the *New Request for Prior Authorization* page.
4. The dental provider’s ID is system populated in the ‘Dental Provider ID’ box.
5. Enter the member’s Medicaid ID.

Figure 112

6. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the requesting provider contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.



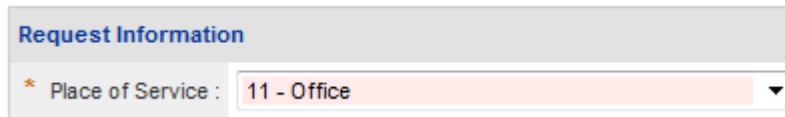
The screenshot shows a form titled "Contact Information" with four input fields. The "Contact Name" field contains "DBARRETT", "Contact Email" contains "DB@email.com", "Contact Phone" contains "444-444-4444" and "Ext." is empty, and "Contact Fax" contains "666-666-6666".

Figure 113

Request Information:

This section captures the Place of Service.

8. Enter the 'Place of Service' by selecting the applicable place of service from the drop list.



The screenshot shows a form titled "Request Information" with a dropdown menu for "Place of Service" set to "11 - Office".

Figure 114

Procedures Table:

The Procedures Table captures the dental procedure code, dental procedure description (system populated), service start and end date, requested quantity of units, total cost, and the following data as applicable to the service requested: tooth code, tooth surface, tooth quad, oral cavity code and code list qualifier.

9. Enter the dental code in the 'CPT Code' box.
10. In the 'From Date' box, enter the start date for the requested dental service; and in the 'To Date' box, enter the end date for the dental service requested.
11. Under 'Quantity', enter the total number of units requested for the dental service.
12. Under 'Amount', enter the total cost of the service in dollars and cents. Do not enter a dollar sign.
13. If a 'Tooth Code' is required for the service requested, select the applicable tooth code from the drop list.

14. If a ‘Tooth Surface’ is required for the service requested, select the applicable surface from the drop list.
15. If a ‘Tooth Quad’ is required for the service requested, select the applicable quadrant from the drop list.
16. If an ‘Oral Cavity Code’ or ‘Code List Qualifier’ is required for the service requested, enter the information in the boxes provided.

Procedures											
CPT Code	CPT Description	From Date	To Date	Quantity	Amount	Tooth	Surface	Tooth Quad	Oral Cavity Code	Code List Qualifier	
D9920		05/17/2010	05/26/2010	1	100.00						<input type="button" value="ADD"/> <input type="button" value="CANCEL"/>

Figure 115

17. Click **Add** to add the procedure code to the request. Follow the same process just described to add other codes to the request. Remember to **click Add after each procedure line is entered.**

Procedure Validation Edits: When procedure information is added, the information is validated against the following edits.

- The procedure ‘From Date’ is more than ninety (90) days in the future. The following edit message displays: “You have indicated a procedure <<CPT code>> with a date that is more than 90 days in the future. Please check your dates and make sure the date is correct before proceeding.” The date must be corrected in order to submit the request.
- An attempt is made to add the same procedure more than once. The following edit message displays: "Duplicate procedures are not permitted unless the procedures requested are for different tooth codes, tooth surface, tooth quadrants, etc." To remove the edit message, add a tooth code, etc; or cancel the duplicate procedure line.

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to ‘No’.

Does this member have retro eligibility for the submitted dates of service ? Yes No

Figure 116

18. If the member has Medicaid retro eligibility for the dates of service, click ‘Yes’.

Missing Teeth:

This section documents the member’s missing ‘Permanent Teeth’ and/or ‘Primary Teeth’.

Identify all missing teeth :

Permanent Teeth

01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Primary Teeth

A B C D E F G H I J

T S R Q P O N M L K

Figure 117

19. Select the applicable tooth identifiers under both categories.

Justification for Services:

This textbox captures the reasons why the dental services are medically necessary.

20. In the text box provided, summarize the radiological findings and explain why the services are needed.

Remarks / Summary of Radiology Findings :

Include dentist's interpretation of X-rays and justification for the services requested. (At least 15 characters must be entered in the following textbox.)

Interpretation of Xrays and justification for services requested.

Figure 118

Additional Information Questions:

Additional questions may display at the bottom of the request form depending on the dental PA type and the dental service requested. For example, the next figure shows the additional questions that are triggered when dental code D9920 is added to a Health Check Dental request.

Additional Information

Please enter additional information. All questions are required.

Child Dental D9920 Behavior Management

Please select from the following clinical situations, which describes the information entered in the Remarks box.

1 Is patient under age 21 with a diagnosis of Mental Illness or Mental Retardation or Developmental Delay that prevents or severely inhibits patient's ability to cooperate with dental treatment? Yes No

2 Is patient under age 21 with a physical disability that prevents or severely inhibits patient's ability to cooperate with dental treatment? Yes No

3 Is patient under age 3 years and 1 day and unable to cooperate with dental treatment? Yes No

Figure 119

21. Click Yes or No to each question. All are required.
22. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
23. If the attestation statement does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. '**Required**' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
24. Click **I Agree** in response to the *Attestation Statement*.
25. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
26. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.

2.3.10 Oral Maxillofacial Surgery Requests	
Program	Authorization Period
Oral Maxillofacial Surgery	90 Days
Description	
Requests for authorization of Oral Maxillofacial surgery services may be submitted via the web portal utilizing the <i>Oral Max (Form Number: DMA-81)</i> request template. Providers with any one of the following categories of service may request this PA type: 430, 450, 460 and 490.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Oral Max** from the list of request types to open the *New Request for Prior Authorization* page.
4. The medical practitioner’s provider ID is system populated in the ‘Medical Practitioner Provider ID’ box.
5. Enter the member’s Medicaid ID.

Figure 120

6. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the requesting provider contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.

Contact Information					
* Contact Name:	DBARRETT		* Contact Email:	DB@email.com	
Contact Phone:	444-444-4444	Ext.		* Contact Fax:	666-666-6666

Figure 121

Request Information:

This section captures the following required information: Admission Date, and Place of Service. The Discharge Date is not required.

8. Enter the date of service in the ‘Admission Date’ box. Enter the date manually or use the calendar popup.
9. Select the place where the service is to be provided from the ‘Place of Service’ drop list.

Request Information					
* Admission Date :	03/31/2012	Discharge Date :	03/31/2012	* Place of Service :	11 - Office

Figure 122

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator.

10. Enter the patient’s diagnosis code in the ‘Diag Code’ box; or search for and have the system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
11. Enter the date that this diagnosis was established in the ‘Date’ box. If not known, enter the admission date.
12. Denote the diagnosis entered as ‘Primary’ by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to ‘Primary’.
13. Click **Add** to add the diagnosis code to the request.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
524.04	MANDIBULAR HYPOPLASIA	04/01/2010	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	04/01/2010	<input type="checkbox"/>		ADD

Figure 123

14. Follow the same process to add other diagnosis codes, as applicable. Remember to **click Add** after each line of diagnosis information is entered.

Procedures Table:

The Procedures Table captures the CPT code, CPT description (system populated), service from date and service to date, and requested units. Modifiers are generally not applicable to the procedures requested under this PA type.

15. Enter the CPT code for the requested oral max procedure in the ‘CPT Code’ box.
16. Enter the date of service in the ‘From Date’ box; and enter the same date in the ‘To Date’ box. An authorization span of 90 days is auto-calculated.
17. Enter the total units requested for the procedure in the ‘Units’ box.
18. Click **Add** to add the procedure code to the request.

Procedures									
CPT Code	CPT Description	From Date	To Date	Units	Mod 1	Mod 2	Mod 3	Mod 4	
21040	EXCISE MANDIBLE LESION	05/18/2010	05/18/2010	1					EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 124

19. Follow the same process to add another procedure code as applicable. Remember to **click Add** after each procedure line is entered.

Date of Most Recent Visit:

20. Enter the date of the patient’s most recent visit for services in the box provided. Enter manually or use the calendar popup.

Date of Most Recent Visit :

Figure 125

Supporting Information:

This section includes four textboxes to capture information to support the request for oral max surgery services. Information related to the following categories needs to be provided: current medical status, treatment/services rendered, plan of care, and justification for services requested.

21. Enter information in each textbox. All are required.

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to ‘No’.



Figure 126

22. If the member has Medicaid retro eligibility for the dates of service, click ‘Yes’.
23. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
24. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that ‘information is missing or incorrect’, scroll up the page to find what is missing or incorrect. ‘**Required**’ displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
25. Click **I Agree** in response to the *Attestation Statement*.
26. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
27. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.

2.3.11 Emergency and Non-Emergency Transport Services			
Program		Authorization Period	
Emergency Air Ambulance Service		One Day	
Emergency Ground Ambulance Service		One Day	
Non-Emergency Travel Services		Equal to service date span	
Description			
Requests for authorization of emergency air, emergency ground and exceptional (non-emergency) transport services may be submitted via the web portal utilizing the <i>Emergency Air Ambulance</i> , <i>Emergency Ground Ambulance</i> and <i>Exceptional Transport</i> (Non-Emergency Ground) request templates, respectively. The web request forms for these PA types are basically the same with the following exceptions:			
Program Type	Mode of Transport Defaults to:	Emergency Transport Indicator – Defaults to:	Place of Service Defaults to:
Emergency Ground	Licensed Ambulance	Yes	Ambulance - Land
Emergency Air	Air Transportation	Yes	Ambulance – Air or Water
Exceptional Transport	Medically Related Transportation	No	No Default

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. If the requesting provider COS is 370, the **Emergency Ground Ambulance** request type displays. If the requesting provider COS is 371, the **Emergency Air Ambulance** displays; and if the requesting provider COS is 380, the **Non–Emergency Ambulance** request type displays. Select the request type to open the *New Request for Prior Authorization* page.
4. The transport provider ID is system populated in the ‘Transport Provider ID’ box.
5. Enter the member’s Medicaid ID.

Figure 127

6. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the requesting provider contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.

The screenshot shows a form titled "Contact Information" with the following fields:

* Contact Name:	DBARRETT	* Contact Email:	DB@email.com
Contact Phone:	444-444-4444	Ext.:	
		* Contact Fax:	666-666-6666

Figure 128

Request Information:

This section captures the Place of Service.

8. The system defaults the 'Place of Service' to *Ambulance Land* for emergency ground transport, and defaults to *Ambulance-Air or Water* for emergency air transport. The place of service for exceptional transport must be selected from the 'Place of Service' drop list.

The screenshot shows a form titled "Request Information" with a dropdown menu for "Place of Service" set to "41 - Ambulance - Land".

Figure 129

Origin and Destination:

This section captures the location name and address where the transport originated and ended.

9. Under 'Origin Data', enter the transport start location 'Name' (such as 'Residence' or a facility name), and enter the address (street address, city, state and zip code). All data is required.
10. Under 'Destination Data', enter the transport end location name and address (street address, city, state and zip code). All data is required.

The screenshot shows a form with two columns: "Origin Address" and "Destination Address".

Origin Address			Destination Address		
* Name :	Residence	* Address :	1127 Test St	* Name :	Good Hospital
* City :	Atlanta	* State :	GA	* City :	Atlanta
		* Zip :	30030	* State :	GA
				* Zip :	30030

Figure 130

Transport Type and Miles:

11. The ‘Mode of Transportation’ and ‘Emergency Transportation’ indicators are auto-populated based on the request type selected.
12. Enter the total distance in miles of the transport in the ‘Total Miles’ box.

A screenshot of a web form. It contains three main sections: 'Mode of Transportation' with a dropdown menu set to 'Licensed Ambulance', 'Emergency Transportation' with radio buttons for 'Yes' (selected) and 'No', and 'Total Miles' with a text input field containing the number '200'.

Figure 131

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator.

13. Enter the patient’s diagnosis code in the ‘Diag Code’ box; or search for and have the system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
14. Enter the date that the diagnosis was established related to this transport in the ‘Date’ box. If not known, enter the date of transport.
15. Denote the diagnosis entered as ‘Primary’ by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to ‘Primary’.
16. Click **Add** to add the diagnosis code to the request.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
427.5	CARDIAC ARREST	05/18/2010	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>		ADD

Figure 132

17. Follow the same process to add other diagnosis codes, if applicable. Remember to **click Add after each line of diagnosis information is entered.**

Procedures Table:

The Procedures Table captures the CPT code, CPT description (system populated), the transport from date and transport to date, requested units, requested amount, and modifiers (exceptional transport only).

18. Enter the service/procedure code for the requested transport service in the ‘CPT Code’ box.
Note: Only procedure codes A0428, A0426 and A0425 may be added to an Emergency Ground transport PA.
19. Enter the transport start date in the ‘From Date’ box; and enter the transport end date in the ‘To Date’ box. For emergency air and ground transport, the ‘From’ and ‘To’ dates are the same date. Enter the dates manually or use the calendar popup.
20. If the request is for ground or air transport, enter one (1) as the requested unit amount in the ‘Units’ box. If the request is for exceptional transport, enter the number of units for the service code requested.
21. Enter the total amount requested for the service in the ‘Requested Amount’ box. Do not enter a dollar sign.
22. If the service requested is for exceptional transport and a modifier is required, enter the modifier in the ‘Mod 1’ box. For emergency air and ground requests, it is not required to enter modifiers on the PA request; although modifiers are required for billing.
23. Click **Add** to add the service/procedure code to the request. When the request is for ground transport and the code requested is not one of A0428, A0426 or A0425, this edit message displays: “<<transport code>> does not require prior authorization for ground transport, please remove from this request.”

Procedures										
CPT Code	CPT Description	From Date	To Date	Units	Requested Amount	Mod 1	Mod 2	Mod 3	Mod 4	
A0426	ALS 1	05/18/2010	05/18/2010	1	850.00					EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 133

24. Follow the same process to add another procedure code if applicable. Remember to **click Add after each procedure line is entered.**

Ambulance Certification:

This section captures the ‘Ambulance Transport Code’ and the ‘Ambulance Transport Reason Code’.

25. Enter the type of ambulance trip by selecting the applicable code from the ‘Ambulance Transport Code’ drop list.
26. Enter the transport reason code by selecting the reason for transport from the drop list.

The screenshot shows a form titled "Ambulance Certification". It contains two dropdown menus. The first is labeled "Ambulance Transport Code" and has "Initial Trip" selected. The second is labeled "Ambulance Transport Reason Code" and has "Patient was transported for a higher level of care or availability of specialized equipment or specialist" selected. A mouse cursor is visible over the second dropdown menu.

Figure 134

Medical Services Rendered:

This section captures the specific services provided during transport.

- 27. Enter the types of services provided during transport by clicking the applicable checkboxes. Select all that apply. If 'Other' is selected, describe the service in the textbox provided.

The screenshot shows a form titled "Please Select Medical Services Rendered (Check all that apply.)". It contains several checkboxes: "IV/PICC Line", "Medications IV/IM", "Cardiac Monitor", "Oxygen", "Ventilator", "Trach Tube", "Peg Tube", "Foley Catheter", and "Other (Please specify in the box below. For example, wound care)". The "Oxygen", "Ventilator", and "Trach Tube" checkboxes are checked. Below the checkboxes is a text box containing the text "STRETCHER AND DRAWSHEET ENROUTE."

Figure 135

Supporting Information:

- 28. This section captures information that supports the request for transport services. Enter information in each textbox.

The screenshot shows a form titled "Description of Services Requested". It contains two text boxes. The first text box is labeled "Describe the services that were provided during transportation." and contains the text "Describe services provided during the transport". The second text box is labeled "Justification and Circumstances for Requested Services" and contains the text "Provider rationale for service provided including staffing".

Figure 136

29. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
30. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. '**Required**' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
31. Click **I Agree** in response to the *Attestation Statement*.
32. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
33. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.

2.3.12 Durable Medical Equipment Requests	
Program	Authorization Period
Durable Medical Equipment	Four months to one year depending on procedure code/modifier
Description	
Requests for authorization of Durable Medical Equipment (DME) are submitted via the web portal utilizing the <i>Durable Medical Equipment</i> request template. The DME request form may include additional information questions which are added to the request form when certain equipment/services are requested. Some DME requests may also require the submission of supporting documentation which must be attached to the PA request via the Portal/Provider Workspace.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Durable Medical Equipment** to open the *New Request for Prior Authorization* page.
4. The DME provider ID is system populated in the ‘Service Provider ID’ box.

New Request for Prior Authorization

Figure 137

5. Enter the member’s Medicaid ID.

Figure 138

6. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the requesting provider contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.



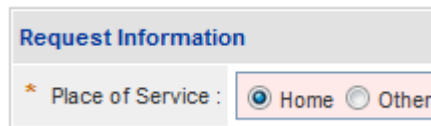
The screenshot shows a form titled "Contact Information" with four input fields. The "Contact Name" field contains "DBARRETT", "Contact Email" contains "DB@email.com", "Contact Phone" contains "444-444-4444" and "Ext." is empty, and "Contact Fax" contains "666-666-6666".

Figure 139

Request Information:

This section captures the Place of Service.

8. Enter the 'Place of Service' by clicking *Home* or *Other*.



The screenshot shows a form titled "Request Information" with a "Place of Service" field. The "Home" radio button is selected, and the "Other" radio button is unselected.

Figure 140

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator.

9. Enter the patient's diagnosis code in the 'Diag Code' box; or search for and have system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
10. Enter the date that this diagnosis was established in the 'Date' box. If not known, enter the request date.
11. Denote the diagnosis entered as 'Primary' by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to 'Primary'.

12. Click **Add** to add the diagnosis code to the request.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
786.03	APNEA	03/16/2010	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text" value="03/16/2010"/>			ADD

Figure 141

13. Follow the same process to add other diagnosis codes, as applicable. Remember to **click Add after each line of diagnosis information is entered.**

Procedures Table:

The Procedures Table captures the following required information: equipment/repair procedure code, procedure description (system populated), procedure dates of service, months/units requested, price requested per unit, and procedure modifier.

14. Enter the code for the equipment/repair procedure in the ‘CPT Code’ box.

15. Enter the date that the equipment or service started, or is to start, in the ‘From Date’ box. For rental equipment, enter the rental end date in the ‘To Date’ box. A ‘To Date’ is not required for purchase.

Note: When the ‘From Date’ is more than ninety (90) days in the future, the following edit message displays when the procedure is added: “You have indicated a procedure <<procedure code>> with a date that is more than 90 days in the future. Please check your dates and make sure the date is correct before proceeding.” The date must be corrected in order to submit the request.

16. Enter the months requested (for rental), or the units requested (for purchase/repair) in the ‘Months or Units of Service Requested’ box.

Note: The allowable requested units for any DME procedure with a RR modifier cannot exceed 12 units.

17. Enter the price per unit for the equipment in the ‘Requested Price/Unit’ box.

18. Enter the procedure modifier in the ‘Mod 1’ box. A modifier is required for most (but not all) DME procedure codes.

19. If applicable to the equipment requested, enter the following information: ‘Equipment Make’, ‘Equipment Model’, ‘Manufacturer ID’ and ‘Serial No’ (if available). If not applicable, leave the boxes blank.

20. Click **Add** at the end of the procedure table to add the procedure code information to the request.

Procedures												
CPT Code	CPT Description	From Date	To Date	Months or Units of Service Requested	Requested Price/Unit	Mod 1	Mod 2	Equipment Make	Equipment Model	Manufacturer ID	Serial No	
E0431	PORTABLE GASEOUS 02	05/10/2010	03/09/2011	10	300.00	RR						<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="ADD"/> <input type="button" value="CANCEL"/>

Figure 142

21. Follow the same process to add other procedure codes, as applicable. Remember to click **Add** after each procedure line is entered.

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to ‘No’.

Does this member have retro eligibility for the submitted dates of service ? Yes No

Figure 143

22. Click ‘Yes’ if the member has retro eligibility for the requested dates of service.

Repairs and Replacements:

This section captures information for equipment repairs and replacements over \$200.00. Complete this section if the request includes repair/replacement codes

For Repairs / Replacements over \$200.00					
Manufacturer ID	Serial No	Warranty Registration Number	Date of Original Purchase	Manufacturer Warranty Duration (In Months)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="ADD"/>

Figure 144

23. In the boxes provided, enter the following information: manufacturer ID, serial number, warranty registration number, date that the original equipment was purchased, and the duration of the warranty in months.

24. Then, click **Add** to add the information to the request.

Therapist or Other Service Provider Name and Certification

This section captures the therapist or other service provider who evaluated the member or is involved in the member’s treatment and their license or certification number. It also captures the member’s height and weight.

25. Enter the therapist/service provider name and the license or certification number in the boxes provided. **This information is not required on the form but should be entered if required by policy for the equipment requested** (refer to the Durable Medical Equipment provider manual).

26. Enter the member’s height in inches and weight in pounds in the boxes provided. Enter a number value that is greater than zero. This information is required.

Therapist Information		Patient Information	
Therapist / Other Service Provider Name :	<input type="text"/>	Georgia License / Certification Number :	<input type="text"/>
		Patient Height (inches) :	<input type="text" value="22"/> in.
		Patient Weight (pounds) :	<input type="text" value="22"/> lb.

Figure 145

Justification for Services Requested:

This textbox captures the reasons why the durable medical equipment, repair or product is medically necessary.

27. Enter the justification in the textbox provided.

Justification and Circumstances for Requested Services :
Describe why the patient needs O/P, medical justification for services requested.
<input type="text" value="Provide medical justification for the requested services."/>

Figure 146

Physician Prescription and Encounter Information:

This required section provides confirmation of a signed physician prescription or Certificate of Medical Necessity (CMN) on file, and confirmation of a face to face encounter with the physician.

28. Select *Yes* or *No* to indicate whether or not a signed prescription or certificate of medical necessity is on file.

29. Select *Yes* or *No* to indicate whether or not the patient was seen by the physician.

30. If yes to physician encounter, enter the date of the face to face encounter.

31. Then, enter the ordering physician's last name and first name in the boxes provided.

Was a signed physician's prescription or Certificate of Medical Necessity on file within 90 days of request ?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Did the practitioner signing the CMN/prescription have a face to face encounter with the member regarding the items in this request?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Date of face to face encounter :	05/10/2010
Ordering Practitioner Last Name :	Doe
Ordering Practitioner First Name :	John

Figure 147

Additional Information Questions:

Additional information questions are added to the PA form depending on the procedure codes requested. The next figure shows the questions that are triggered when oxygen codes E0431RR or E1390RR are entered on the request.

32. Provide the information requested by selecting Yes or No and by entering information in the text boxes.

Additional information is required for the following Procedure code / Modifier combinations : E0431RR

Is Member on continuous Oxygen Therapy ? Yes No

Prescription Information :

Date oxygen prescribed : 05/17/2010 Initial Renewal Date last seen by physician : 05/17/2010 Method of delivery : Mask

Liters per minute: 1 Hours per day : 5 Estimated length of time oxygen is needed: 4 month(s)

If portable oxygen prescribed, please select at least one of the following :

Doctor's office visits Use at night Shopping/Church Other (please describe)

If Other is selected, please describe :

Is there a signed statement on file verifying that there is no smoking in the Member's home? Yes No

Laboratory Results :

ABG performed? Yes No Date of test : PO2 Result :

Oxygen saturation performed? Yes No Date of test : 05/17/2010 Oxygen Saturation Test Result : 89 %

Was the test performed on room air? Yes No

If test was not performed on room air, provide explanation :

Explain why test not performed on room air.

If ABG result exceeds 60mmHg, provide medical justification for the need for oxygen :

Figure 148

33. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
34. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
35. Click **I Agree** in response to the *Attestation Statement*.
36. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
37. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.
38. At this point, required documentation may be attached using *Create an Attachment*.

Attach Documentation:

For some DME codes, document type checkboxes are available in the attachment panel section. The checkboxes correspond to the additional supporting documentation that is required for the services requested. The next figure shows the checkboxes that display for oxygen codes E0431 and E1390.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)

Codes	Documents
E0431	<input type="checkbox"/> Certificate of Medical Necessity (CMI) <input type="checkbox"/> Copy of Testing Results

Figure 149

39. To attach a file, first check the boxes for the documentation that is included in the file to be attached. **Note:** It is recommended to attach one PDF file that includes all the required information.
40. Click **Browse** to find the file. Select the file and it displays in the attachment panel.
41. Click **Attach File**. Once the file is attached, the file is associated with the document types in the **Attached Files** table.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

File uploaded successfully.

Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)

Codes	Documents
E0431	<input type="checkbox"/> Certificate of Medical Necessity (CMN) <input type="checkbox"/> Copy of Testing Results

Attached Files



File	Type	Code	Document Name	User	Date	
 CMN and Testing Results.pdf	4	E0431	Copy of Testing Results		5/18/2010 2:38:52 PM	✘
 CMN and Testing Results.pdf	4	E0431	Certificate of Medical Necessity (CMN)		5/18/2010 2:38:52 PM	✘

Figure 150

2.3.13 Orthotics/Prosthetics and Hearing Requests	
Program	Authorization Period
Orthotics and Prosthetics	4 months to one year depending on procedure code and modifier
Hearing Services	4 months to one year depending on procedure code and modifier
Description	
Requests for authorization of Orthotics/Prosthetics or Hearing Services are submitted via the Web Portal utilizing the <i>Orthotics and Prosthetics</i> request template and <i>Orthotics and Prosthetics/Hearing</i> request template, respectively. Additional information questions may be added to the online form when certain orthotics/prosthetic procedures are requested. Response to the additional questions is required in order to submit the PA.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Orthotics and Prosthetics** or, for hearing services, **Orthotics and Prosthetics (Hearing)** to open the *New Request for Prior Authorization* page.
4. The provider ID is system populated in the ‘Service Provider ID’ box.
5. Enter the member’s Medicaid ID.

Figure 151

6. Click **Submit** to open the request form.
7. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the requesting provider contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.



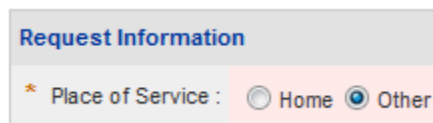
A screenshot of a web form titled "Contact Information". The form contains four input fields: "Contact Name" with the value "DBARRETT", "Contact Email" with the value "DB@email.com", "Contact Phone" with the value "444-444-4444" and an empty "Ext." field, and "Contact Fax" with the value "666-666-6666". Each field is preceded by an asterisk, indicating it is a required field.

Figure 152

Request Information:

This section captures the Place of Service.

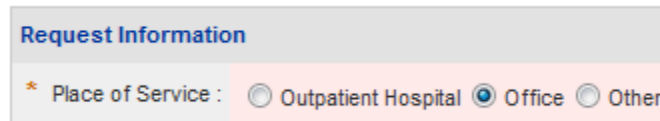
8. For Orthotics/Prosthetics requests, enter the 'Place of Service' by clicking *Home* or *Other*.



A screenshot of a web form titled "Request Information". It features a single radio button selection for "Place of Service", with "Home" and "Other" as options. The "Other" option is selected.

Figure 153

9. For Hearing requests, enter the 'Place of Service' by clicking *Outpatient Hospital*, *Office* or *Other*.



A screenshot of a web form titled "Request Information". It features a radio button selection for "Place of Service", with "Outpatient Hospital", "Office", and "Other" as options. The "Office" option is selected.

Figure 154

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator.

9. Enter the patient's diagnosis code in the 'Diag Code' box; or search for and have system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
10. Enter the date that this diagnosis was established in the 'Date' box. If not known, enter the request date.

11. Denote the diagnosis entered as ‘Primary’ by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to ‘Primary’.
12. Click **Add** to add the diagnosis code to the request.

* Diagnosis				
Diag Code	Diagnosis Description	Date	Primary	Type
728.71	PLANTAR FIBROMATOSIS	02/14/2010	Yes	ICD-9
		02/14/2010		

Figure 155

13. Follow the same process to add other diagnosis codes, as applicable. Remember to **click Add** after each line of diagnosis information is entered.

Procedures Table:

The Procedures Table captures the following required information: procedure code, procedure description (system populated), procedure dates of service, months/units requested, price requested per unit, and procedure modifier.

14. Enter the procedure code for the orthotics/prosthetics/hearing service in the ‘CPT Code’ box.
15. Enter the date that the service started or is to start in the ‘From Date’ box.
16. The procedure ‘To Date’ box may be left blank since it is not required for orthotics/prosthetics or hearing services.
17. Enter the total units of service requested in the ‘Months or Units of Service Requested’ box.
18. Enter the price per unit for the item requested in the ‘Requested Price/Unit’ box.
19. The modifier box should be left blank. Modifiers may be required on claims but not on the PA request.
20. Click **Add** at the end of the procedure line to add the procedure code information to the request.

Note: When the ‘From Date’ added is more than ninety (90) days in the future, the following edit message displays: “You have indicated a procedure <<procedure code>> with a date that is more than 90 days in the future. Please check your dates and make sure the date is correct before proceeding.” The date must be corrected in order to submit the request.

21. Follow the same process to add other procedure codes, as applicable. Remember to **click Add** after each procedure line is entered.

Procedures													
CPT Code	CPT Description	From Date	To Date	Months or Units of Service Requested	Requested Price/Unit	Mod 1	Mod 2	Equipment Make	Equipment Model	Manufacturer ID	Serial No		
L1901	PREFAB ANKLE ORTHOSIS	05/19/2010		2	25.00								EDIT DELETE
L3020	FOOT LONGITUD/METATARSAL SUP	05/19/2010		2	10.00								EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 156

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to ‘No’.

Does this member have retro eligibility for the submitted dates of service ? Yes No

Figure 157

22. Click ‘Yes’ if the member has retro eligibility for the requested dates of service.

Repairs and Replacements:

This section captures information for repairs and replacements of devices over \$200.00. Complete this section if the request includes repair/replacement codes.

For Repairs / Replacements over \$200.00					
Manufacturer ID	Serial No	Warranty Registration Number	Date of Original Purchase	Manufacturer Warranty Duration (In Months)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

Figure 158

23. In the boxes provided, enter the following information: manufacturer ID, serial number, warranty registration number, date that the original equipment was purchased, and the duration of the warranty in months.

24. Then, click **Add** to add the information to the request.

Therapist or Other Service Provider Name and Certification

This required section captures the therapist or other service provider who evaluated the member or is involved in the member’s treatment, and their license **or** certification number.

25. Orthotics/Prosthetics requests:

- Enter the name of the therapist/service provider in the ‘Therapist/Other Service Provider Name’ box.
- Enter the license or certification number in the ‘Georgia License/Certification’ number box.
- Select the ‘Certification Type’ from the drop list.
- Enter the member’s height in inches and weight in pounds in the boxes provided. **This is required.** Enter a number value that is greater than zero.

Therapist Information			Patient Information	
* Therapist / Other Service Provider Name :	* Georgia License / Certification Number :	* Certification Type :	Patient Height (inches) :	Patient Weight (pounds) :
JANE THERAPIST	CO1111111111	CO ▾	60 in.	110 lb.

Figure 159 Orthotics/Prosthetics

26. Hearing requests:

- Enter the name of the audiologist in the ‘Audiologist Name’ box.
- Enter the audiologist’s license/certification number. The number must start with AUD followed by six (6) digits.
- The member’s **height and weight is not required.**

Therapist Information		Patient Information	
* Audiologist Name :	* Georgia License / Certification Number :	Patient Height (inches) :	Patient Weight (pounds) :
Jane Audio	AUD123456	in.	lb.

Figure 160 Hearing

Justification for Purchase, Repair or Replacement of Devices:

This textbox captures the reasons why the purchase or repair/replacement of the devices is medically necessary.

27. Enter the justification in the textbox provided.

Justification and Circumstances for Requested Services :

Describe why the patient needs O/P, medical justification for services requested.

Member is a chronic Diabetic with neurological damage to ankles and feet- needs custom molded inserts and ankle orthosis in order to ambulate.

Figure 161

Physician Prescription:

This required question documents that a signed physician prescription or Certificate of Medical Necessity was on file within 90 days of the date that the request was submitted.

28. Select *Yes* or *No* to indicate whether or not a signed prescription or certificate of medical necessity is on file.

Was a signed physician's prescription or Certificate of Medical Speciality on file within 90 days of request ?

Yes No

Figure 162

Additional Information Questions:

Additional information questions are pulled into an Orthotics/Prosthetics request when certain procedure codes for diabetic shoes, foot/wrist/knee orthotics are added to the request. The next figure shows the questions for a L1901, which is one of the foot and ankle orthotics codes.

Additional Information

Please enter additional information. **All questions are required.**

Foot and Ankle Orthotics

Is this an orthotic for (select one): Ankle Foot Knee Wrist

Does member have a history of:

1 Stroke or CVA affecting lower leg below the knee at ankle or foot? Yes No Unknown

2 Cerebral Palsy affecting lower leg below the knee at ankle or foot? Yes No Unknown

3 Neurologic Damage to leg below the knee at ankle or foot? Yes No Unknown

4 Contracture to lower leg below the knee at ankle or foot? Yes No Unknown

Figure 163

29. Indicate the type of orthotic by clicking the *Ankle*, or *Foot*, or *Knee* or *Wrist* button.

30. Select '*Yes*' or '*No*' or '*Unknown*' for each question.

Additional Information

Please enter additional information. **All questions are required.**

Foot and Ankle Orthotics

Is this an orthotic for (select one): Ankle Foot Knee Wrist

Does member have a history of:

1 Stroke or CVA affecting lower leg below the knee at ankle or foot? Yes No Unknown

2 Cerebral Palsy affecting lower leg below the knee at ankle or foot? Yes No Unknown

3 Neurologic Damage to leg below the knee at ankle or foot? Yes No Unknown

4 Contracture to lower leg below the knee at ankle or foot? Yes No Unknown

Figure 164

31. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
32. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
33. Click **I Agree** in response to the *Attestation Statement*.
34. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
35. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.

2.3.14 Vision Services Requests	
Program	Authorization Period
Vision Care Services	90 Days
Description	
Requests for authorization of glasses and contacts for members under 21 years may be submitted via the web portal utilizing the <i>Vision Services</i> request template.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Vision Services** to open the *New Request for Prior Authorization* page.
4. The provider ID is system populated in the ‘Service Provider ID’ box.
5. Enter the member’s Medicaid ID.

The screenshot shows a web form titled "Vision Services (Form Number: DMA-81)". Below the title is a search instruction: "To find a member or provider ID click the [magnifying glass icon] next to the ID box". There are two input fields: "Member Medicaid ID" with the value "333000000500" and "Service Provider ID" which is currently blank. A blue "Submit" button is located at the bottom left of the form.

Figure 165

6. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the requesting provider contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.

The screenshot shows a form titled "Contact Information". It contains four input fields, each with a red asterisk indicating it is required: "Contact Name" with the value "DBARRETT", "Contact Email" with the value "DB@email.com", "Contact Phone" with the value "444-444-4444" and an empty "Ext." field, and "Contact Fax" with the value "666-666-6666".

Figure 166

Request Information:

This section captures the Place of Service.

8. Enter the 'Place of Service' applicable to the request by clicking the *Office* or *Other* button.

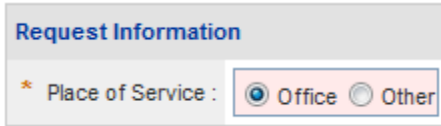


Figure 167

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator.

9. Enter the patient's diagnosis code in the 'Diag Code' box; or search for and have system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
10. Enter the date that this diagnosis was established, or the date that the patient was first seen for vision condition in the 'Date' box.
11. Denote the diagnosis entered as 'Primary' by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to 'Primary'.
12. Click **Add** to add the diagnosis code to the request.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
367.0	HYPERMETROPIA	05/20/2010	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text" value="05/20/2010"/>	<input type="checkbox"/>		ADD

Figure 168

13. Follow the same process to add other diagnosis codes, as applicable. Remember to **click Add after each line of diagnosis information is entered.**

Procedures Table:

The Procedures Table captures the following required information: procedure code, procedure description (system populated), procedure dates of service, units requested, and price requested per unit. Modifiers are not applicable to this request type.

14. Enter the procedure code for the vision service in the 'CPT Code' box.

15. Enter the date that the service started, or is to start, in the 'From Date' box; and enter the same date in the 'To Date' box. The actual authorization span for the PA is system calculated based on the 'From Date'.
16. Enter the total units requested for the service in the 'Units' box. Enter whole numbers only.
17. Enter the unit price for the service requested in the 'Requested Price/Unit' box.
18. Click **Add** at the end of the procedure line to add the procedure code information to the request.

Procedures										
CPT Code	CPT Description	From Date	To Date	Units	Requested Price/Unit	Mod 1	Mod 2	Mod 3	Mod 4	
92340	FITTING OF SPECTACLES	05/20/2010	05/20/2010	1	28.21					EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 169

Note: When a 'From Date' is added that is more than ninety (90) days in the future, the following edit message displays: "You have indicated a procedure <<procedure code>> with a date that is more than 90 days in the future. Please check your dates and make sure the date is correct before proceeding." The date must be corrected in order to submit the request.

19. Follow the same process to add other procedure codes, as applicable. Remember to **click Add** after each procedure line is entered.

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to 'No'.

Does this member have retro eligibility for the submitted dates of service ? Yes No

Figure 170

20. Click 'Yes' if the member has retro eligibility for the requested dates of service.

Physician Examination Visits:

This required section captures the dates that the patient was first seen for treatment and the most recent visit.

21. Enter the date of the patient’s first visit in the ‘Date Patient First Seen for Diagnosis’ box; and enter the date of the patient’s most recent visit in the ‘Date of Most Recent Visit’ box.



Figure 171

Justification for Services:

This required section captures the following information: Patient’s Present Medical Status, Treatment or Services Rendered, Plan of Care, and Justification for Vision Services. The information entered should support the request for vision care services.

22. Enter the information in each textbox.

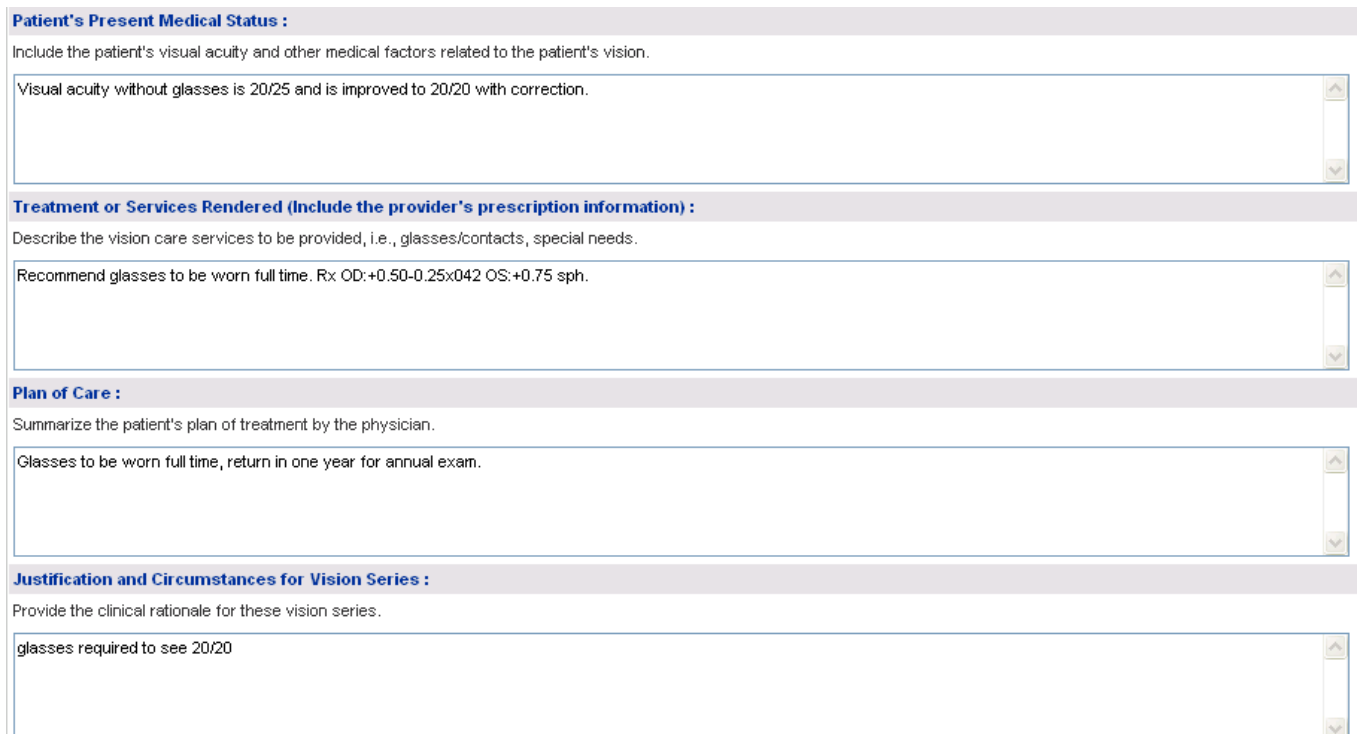


Figure 172

Prescription:

This required question is used to document that there is a signed prescription on file.

23. Click *Yes* or *No* to indicate whether or not there is a signed prescription on file.



Figure 173

24. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
25. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
26. Click **I Agree** in response to the *Attestation Statement*.
27. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
28. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.

2.3.15 Children’s Intervention Services	
Program	Authorization Period
Children’s Intervention Services	Up to 180 days
Description	
Requests for therapeutic services provided under the Children’s Intervention Services (CIS) program are submitted via the web portal utilizing the <i>Children’s Intervention Services</i> request template. Up to six (6) consecutive months of service may be entered on one request. Each procedure line must be for a discrete month. Procedure dates entered are validated to prevent submission of ‘retro’ requests.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Children Intervention Services** from the list of review types.
4. The requesting CIS provider ID is system populated in the ‘Therapist Provider ID’ box
5. Enter the member’s Medicaid ID.

Figure 174

6. Click **Submit** to open the request form. At the top of the request form, the member and provider information is system populated based on the Member ID and Provider ID entered.

Contact Information:

The system pulls in the CIS provider’s contact information.

7. Enter contact information that is required (name, phone, email and fax) but is missing.

Figure 175

Request Information:

This section captures the Place of Service.

8. Enter the 'Place of Service' by selecting the service location from the drop list. The applicable choices are: Office, Home, Outpatient Hospital or Other.

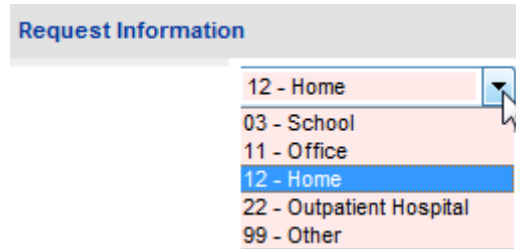


Figure 176

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator for each diagnosis code entered.

9. Enter a diagnosis code in the 'Diag Code' box; or search for and have system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
10. Enter the date that the patient's diagnosis was established in the 'Date' box. If not known, enter the date that the child was admitted to the CIS program.
11. Denote the diagnosis entered as 'Primary' by clicking the applicable checkbox. **Note:** If only one diagnosis code is added, the system will default that code to 'Primary'.
12. Click **Add** to add the diagnosis code to the request.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
728.9	MUSCLE/LIGAMENT DIS NOS	01/01/2011	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text" value="01/01/2011"/>	<input type="checkbox"/>		ADD

Figure 177

13. Follow the same process to add other diagnosis codes, as applicable. Remember to **click Add** after each line of diagnosis information is entered.

Procedures Table:

The Procedures Table captures the procedure code, code description (system populated), date of service from and to dates, units requested, requested number of months per service, and modifiers (optional).

14. Enter the procedure code for a therapeutic service in the ‘CPT Code’ box.
15. In the ‘From Date’ box, enter the start date of service, and, in the ‘To Date’ box, enter the end date of service. **The start and end dates for each procedure line must be within the same month.**
16. Enter the units requested for the service under ‘Units’. Enter whole numbers only.
17. Modifiers are optional but may be entered to denote the specific therapeutic specialty for service codes that apply to more than one therapeutic specialty. Modifiers should be entered in the correct order under ‘Mod 1’ and ‘Mod 2’, as applicable.
18. Click **Add** to add the procedure code to the request.
19. Follow the same process to add other procedure codes, if applicable. Remember to **click Add after each procedure line is entered.**

Procedures									
CPT Code	CPT Description	From Date	To Date	Units	Mod 1	Mod 2	Mod 3	Mod 4	
97530	THERAPEUTIC ACTIVITIES	06/01/2011	06/30/2011	10	HA	GO			EDIT DELETE
97530	THERAPEUTIC ACTIVITIES	07/01/2011	07/31/2011	10	HA	GO			EDIT DELETE
97530	THERAPEUTIC ACTIVITIES	08/01/2011	08/31/2011	8	HA	GO			EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 178

CIS Procedure Validation Edits: Procedure information is validated against the following edits.

- The procedure ‘From Date’ is before the PA request date. This edit message displays when the procedure is added: “A Children’s Intervention Services request cannot be entered that starts before the request date.” **The date must be corrected in order to submit the request.**
- The procedure ‘From Date’ and procedure ‘To Date’ are not within the same month. This edit message displays when the procedure is added: “Each procedure code line for Children’s Intervention Services PAs should end in the same month that they are requested. Please check your submission for code <<code>>.” **The dates must be corrected in order to submit the request.**

- More than six consecutive months of service are requested. The following edit message displays when **Review Request** is clicked: “Requests for Children’s Intervention Services can only be requested for up to 6 consecutive calendar months. Please check the ‘From and To Dates’.” **The procedure lines for the extra month(s) must be removed in order to submit the request.**

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to ‘No’.



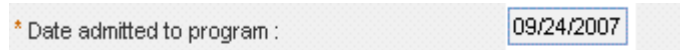
Does this member have retro eligibility for the submitted dates of service ? Yes No

20. Click ‘Yes’ if the member has retro eligibility for the requested dates of service.

Date Admitted, Services Requested and Justification:

This section captures the date that the child was first admitted to the CIS program; the therapeutic service type requested; and the justification for services.

21. Enter the date that the child was admitted to the CIS program in the ‘Date admitted to program’ box. Enter manually or use the calendar popup.



* Date admitted to program : 09/24/2007

Figure 179

22. Under ‘Description of Services Requested’, click the therapy type button that applies to the request being entered. Select *Physical Therapy* or *Occupational Therapy* or *Speech/Language Therapy*. Only one type may be selected.



Description of Services Requested : Physical Therapy Occupational Therapy Speech/Language Therapy

Figure 180

23. In the ‘Justification and Circumstances for Required Services’ textbox, explain why the requested services are medically necessary.
24. Enter the first and last name of the patient’s physician in the ‘Primary Care Physician Name’ box.

Justification and Circumstances for Required Services :

Medical necessity and expected outcomes.

The additional services are being requested for occupational therapy sessions. During these sessions, sensory integrative activities are utilized to enhance the child's sensory processing skills in order to increase attention to task. These activities facilitate improvement of the child's fine motor skills, visual-motor skills, hand strength and hand dexterity. Improvement in these skills will promote independence for the child and allow the child to perform at his potential. The occupational therapy sessions are needed twice a week in order for this child to develop into a functional, independent member of society.

Primary Care Physician Name:

Doctor Doctor

Figure 181

Outcomes:

This required section captures evaluation information, treatment goals and expectations, and treatment progress.

25. Enter information in each textbox. All are required.

Outcomes

A. What would you like to see change as a result of early intervention ?
(Goals and Expectations)

Improvement in fine motor skills, eye-hand skills, upper body and hand strength and improvement in cognitive status. It is expected that this child will continue to improve in skill development and decrease the gap between where they are performing and where their peers are performing.

B. What is happening now (Evaluation / Assessment information) ?
(Describe what is taking place at this time relative to the Goals and Expectations)

At this time: child is receiving occupational therapy twice a week. They are assessed on an ongoing basis, but have formal evaluation once a year to determine their progress and evaluate if therapy continues to be medically necessary.

C. Progress Statement: How will we know we are making progress with this child ?
(What will be different relative to the Goals and Expectations ?)

Progress is addressed through daily notes, ongoing clinical observation as well as the yearly assessment. The child's progress in meeting treatment and developmental goals are assessed.

Figure 182

CIS Request Submission Requirements:

This final section of the request form documents the type of additional information, and dates of such information, that are required for the Children's Intervention Services program.

26. Respond to each question by clicking the *Yes* or *No* button. In general, if *Yes* is selected, a date must be entered in the corresponding date box; and if *No* selected, an explanation must be provided in the corresponding textbox.

27. If applicable to the request, enter the name of the patient's service coordinator and title in the boxes provided.

The screenshot shows a web form with two columns of questions. The left column contains questions about previous PA requests, current IEP/FSP status, and attached documents. The right column contains conditional questions based on previous answers, including dates for IEP, Attestation, and testing, and a field for the service coordinator's name and title. Radio buttons are used for 'Yes' and 'No' responses, with 'No' selected for most questions.

Figure 183

28. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
29. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
30. Click **I Agree** in response to the *Attestation Statement*.
31. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
32. When the request is successfully submitted, the pending PA tracking number displays at the top of the page. At this point, required documents may be attached utilizing *Create an Attachment*.

The screenshot shows the 'Create an Attachment' section of the system. It includes a text input field for the document name, a 'Browse...' button, and an 'Attach File' button. Below this is a table with columns for 'Codes' and 'Documents'. The documents listed are 'Attestation Form', 'IFSP', 'Letter of Medical Necessity', 'Current Progress Notes', and 'Standardized testing', all of which are marked as required (indicated by red text).

Codes	Documents
ATTESTATION	<input type="checkbox"/> Attestation Form
IFSP	<input type="checkbox"/> IFSP
LMN	<input type="checkbox"/> Letter of Medical Necessity
PROGRESS NOTE	<input type="checkbox"/> Current Progress Notes
STANDARD TEST	<input type="checkbox"/> Standardized testing

Figure 184

33. To attach a file, first check the applicable document type checkboxes that relate to the file to be attached.

Note: The preferred method is to attach one PDF file that includes all the required documents in which case all the boxes would be checked.

34. Click **Browse** to find the file. Select and open the file. The file name displays in the attachment panel.

35. Click **Attach File**. The file is added to the **Attached Files** table.

2.3.16 Georgia Pediatric Program (GAPP)	
Program	Authorization Period
Georgia Pediatric Program DMA6A	One year
Georgia Pediatric Program DMA80	Up to six months
Description	
Requests for level of care and service authorizations under the Georgia Pediatric Program are submitted via the web portal utilizing the GAPP DMA-6A and GAPP DMA-80 request templates, respectively. Submission of requests for GAPP services is restricted to providers with a 971 GAPP In-Home Private Duty Nursing COS; or a 972 Medically Fragile Daycare COS. There must be a current, approved GAPP DMA-6A in the system for same member before a DMA-80 may be entered.	

2.3.16.1 GAPP DMA-6A

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Georgia Pediatric Program/Exceptional Children’s Services (Form DMA-6A)** to open the *New Request for Prior Authorization* page.
4. The requesting GAPP provider ID is system populated in the ‘Service Provider ID’ box
5. Enter the member’s Medicaid ID.
6. If the member’s physician is a Medicaid Provider, enter the physician’s Reference ID in the ‘Physician Reference ID’ box. The reference ID always starts with REF. **If the physician is not a Medicaid provider, leave this box blank.**

Figure 185

7. Click **Submit** to open the request form.

Note: Only a few sections of the request form are required. The following instructions indicate which are required and which are optional.

8. At the top of the request form, the member and GAPP provider are system populated based on the Member ID and Provider ID entered.
9. If the physician Reference number was entered, the physician information is also system populated. If the physician Reference number was not entered, enter the name of the physician in the **Physician Information** section. **Only the name is required.**

Contact Information: Required

The system pulls in the GAPP provider's contact information.

10. Enter contact information that is required (name, phone, email and fax) but is missing.

The screenshot shows a form titled "Contact Information" with a light gray header. Below the header, there are four input fields arranged in a 2x2 grid. The top-left field is labeled "* Contact Name:" and contains the text "DBARRETT". The top-right field is labeled "* Contact Email:" and contains "DB@email.com". The bottom-left field is labeled "Contact Phone:" and contains "444-444-4444", followed by an "Ext." label and an empty input box. The bottom-right field is labeled "* Contact Fax:" and contains "666-666-6666".

Figure 186

Request Information: Optional

This section captures information required for level of care authorization for members under 21 years of age including caretaker/parent information and authorization.

11. Indicate whether or not the member's caretaker believes that the child would require institutionalization if services were not provided by clicking the *Yes* or *No* button.
12. Indicate whether or not the child attends school by clicking the *Yes* or *No* button.
13. Enter the date that application to Medicaid was completed in the 'Date of Medicaid application' box. Enter the date manually or use the calendar popup.
14. Enter the first and last name of the child's primary caregiver in the 'Name of Caregiver #1' box, and secondary caregiver in the 'Name of Caregiver #2' box.
15. Indicate whether or not the child's parent/legal guardian has signed an authorization to release protected health information by clicking the *Yes* or *No* button; and enter the date that the release was signed in the 'Date of Parent of Legal Representative Signature

Request Information	
In the caretaker's opinion, would the child require institutionalization if the child did not receive services?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Does child attend school?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Date of MediCAID application :	02/28/2010
Name of Caregiver #1 : <input type="text" value="Jennie Test"/>	Name of Caregiver #2 : <input type="text" value="Fran Friend"/>
Parent or Legal Representative has signed the following statement: I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Department of Community Health and the Department of Human Resources, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.	<input checked="" type="radio"/> Yes <input type="radio"/> No
Date of Parent or Legal Representative Signature :	05/10/2010

Figure 187

Diagnosis Table: Required

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator for each diagnosis code entered. The Admission indicator is not required.

16. Enter the diagnosis code for the Member’s primary diagnosis as related to GAPP services in the ‘Diag Code’ box; or search for and have system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the decimal point when entering the code.
17. Enter the date that this diagnosis was established in the ‘Date’ box, or if not known, the date that the physician signed the DMA-6A.
18. Click the ‘Primary’ button to indicate that the diagnosis is the primary diagnosis. **Note:** If only one diagnosis is entered, the system will select that diagnosis as primary.
19. Click the **Add** at the end of the diagnosis line to add the diagnosis code to the request.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
783.41	FAILURE TO THRIVE-CHILD	12/29/2010	Yes	No	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	12/29/2010	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 188

20. If necessary, repeat the same steps to enter other diagnosis codes. Remember to **click Add after each diagnosis is entered**

Diagnosis on Admission to Hospital: Optional

Complete this section if the child is still in the hospital or was discharged within the last 30 days

Diagnosis on Admission to Hospital			
Diag Code	Diagnosis Description	Primary	
<input type="text"/>		<input type="checkbox"/>	<input type="button" value="ADD"/>

Figure 189

21. Enter the primary diagnosis code for the child’s diagnosis on admission; select ‘Primary’ and then click **Add**.

Medications and Diagnostic/Treatment Procedures: Optional

The *Medications* table captures the member’s primary medication including: type, dosage, route and frequency. The *Diagnostic and Treatment Procedures* table captures diagnostic/treatment procedures ordered as part of the member’s plan of care.

22. To enter medication information, first select the medication type by selecting a type from the ‘Name’ drop list.
23. Enter the dosage for the medication in the ‘Dosage’ box.
24. Enter the method of medication administration by selecting the method of administration from the ‘Route’ drop list (Oral or Parental or Rectal or Topical).
25. Enter the frequency of medication administration by selecting a frequency from the ‘Frequency’ drop list (Regular or PRN: As necessary or Regular & PRN).
26. Click **Add** at the end of the medication line to add the medication information to the DMA-6A.
27. Follow the same process to add other medication information.

Medications				
Name	Dosage	Route	Frequency	
Antibiotics	.5 ml	Oral	Regular	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
Steroids	10mg	Oral	Regular	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
Anticonvulsive	5mg	Rectal	Regular	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="ADD"/>

Figure 190

28. To add diagnostic or treatment procedures, first select the procedure type by selecting a type from the 'Type' drop list. Select 'Other', if the diagnostic/treatment procedure is not listed.
29. Next, enter the frequency of the diagnostic/treatment procedure in the 'Frequency' box.
30. Click **Add** to add the diagnostic/treatment procedure to the DMA-6A.

Diagnostic and Treatment Procedures	
Type	Frequency
Skin Care (Special)	Daily
<input type="text"/>	<input type="text"/>

EDIT DELETE ADD

Figure 191

31. Repeat the process to add other diagnostic/treatment procedures.

Treatment Plan: Optional

This section captures information related to the Member's plan of treatment including the level of care and the amount and type of services to be provided.

32. Enter the information in the textbox provided.

Treatment Plan :

Provide the complete treatment plan including medications, level of care requested, other services to be provided to the patient.

Describe the plan of treatment.

Figure 192

Level of Care and Care Recommendations: Optional

This section captures the physician's recommendation for level of care, type of placement, and estimated length of time that care is needed.

33. If the patient is currently in the hospital or a hospitalization is planned, enter the admission date in the 'Anticipated Dates of Hospitalization 'From Date' box; and enter the anticipated discharge date in the 'To Date' box.

34. Enter the level of care recommended by the child’s physician by selecting a level from the ‘Level of Care Recommended’ drop list.
35. Enter the type of placement recommended by selecting the *Continued Placement* or *Initial Placement* button.
36. Indicate the transferred from location by selecting one of the following: *Another NF (Nursing Facility)*, *Hospital*, *Lives at home* or *Private Pay*.
37. Indicate the length of time that care is needed by selecting the *Permanent* or *Temporary* button.
38. **If temporary selected**, enter the estimated months of temporary care in the box provided.

Anticipated Dates of Hospitalization From Date :	<input type="text"/>	To Date :	<input type="text"/>
Level of Care Recommended :	<input type="text" value="Hospital"/>	Type of Recommendation :	<input type="radio"/> Continued Placement <input checked="" type="radio"/> Initial Placement
Patient Transferred From :	<input type="radio"/> Another NF <input type="radio"/> Hospital <input checked="" type="radio"/> Lives at home <input type="radio"/> Private Pay		
Length of Time Care Needed :	<input type="radio"/> Permanent <input checked="" type="radio"/> Temporary	Estimated Months (if temporary) :	<input type="text" value="6"/>

Figure 193

Physician Certification: Optional

This section captures physician certification in regards to communicable diseases, level of care, and management of the Member’s condition via community care and/or home health services.

38. Indicate whether or not the member is free of communicable disease by selecting *Yes* or *No*.
39. Indicate whether or not the member’s condition can be managed by Community Care by selecting *Yes* or *No*.
40. Indicate whether or not the member’s condition can be managed by Home Health services by selecting *Yes* or *No*.
41. Indicate whether or not the physician has certified the level of care by selecting *Yes* or *No*.
42. The physician’s name and phone number display in the name and phone number boxes if the Physician’s reference number was entered to initiate the request.
43. If the Physician’s reference number was not entered, enter the physician’s name and phone number in the boxes provided.
44. Enter the date that the DMA-6A was signed by the member’s physician in the ‘Date Signed by Physician’ box.

<input checked="" type="radio"/> Yes <input type="radio"/> No	Is the patient free of communicable diseases?
<input checked="" type="radio"/> Yes <input type="radio"/> No	Can this patient's condition be managed by :
<input checked="" type="radio"/> Yes <input type="radio"/> No	- Community Care ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	- Home Health Services ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	Has the physician certified that this patient requires the level of care provided by a Nursing Facility, IC/MR Facility, or Hospital ?

Physician Name :	<input type="text" value="Doctor Doctor"/>	Date Signed by Physician :	<input type="text" value="05/10/2010"/>	Physician Phone :	<input type="text" value="444-444-4444"/>
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Figure 194

Evaluation of Nursing Care Needed: Optional

The next section documents the results of the evaluation to determine the nursing care/other services that are needed.

45. Under each main category, click the checkbox for each item that applies to the child's care. If 'Other' is checked, provide an explanation in the textbox.

Evaluation of Nursing Care Needed : (check all that apply)					
Nutrition :	Bowel :	Cardiopulmonary Status :	Mobility :	Behavioral Status :	Integument System :
<input type="checkbox"/> Regular <input type="checkbox"/> Diabetic Shots <input type="checkbox"/> Formula - Special <input type="checkbox"/> Tube Feeding <input type="checkbox"/> N/G-Tube / G-Tube <input checked="" type="checkbox"/> Slow Feeder <input type="checkbox"/> FTT or Premature <input type="checkbox"/> Hyperal <input type="checkbox"/> IV Use <input type="checkbox"/> Medications/GT Meds	<input type="checkbox"/> Age Dependent Incontinence <input checked="" type="checkbox"/> Incontinent - Age > 3 Years <input type="checkbox"/> Colostomy <input type="checkbox"/> Continent <input type="checkbox"/> Other <div style="border: 1px solid gray; height: 100px; width: 100%;"></div>	<input type="checkbox"/> Monitoring <input checked="" type="checkbox"/> CPAP/BI-PAP <input type="checkbox"/> CP Monitor <input type="checkbox"/> Pulse Ox <input type="checkbox"/> Vital Signs > 2 / days <input type="checkbox"/> Therapy <input checked="" type="checkbox"/> Oxygen <input type="checkbox"/> Home Vent <input type="checkbox"/> Trach <input type="checkbox"/> Nebulizer Tx <input type="checkbox"/> Suctioning <input type="checkbox"/> Chest - Physical Tx <input type="checkbox"/> Room Air	<input type="checkbox"/> Prosthesis <input type="checkbox"/> Splints <input type="checkbox"/> Unable to Ambulate > 18 Months Old <input type="checkbox"/> Wheel Chair <input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Agitated <input type="checkbox"/> Cooperative <input type="checkbox"/> Alert <input checked="" type="checkbox"/> Developmental Delay <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Suicidal <input type="checkbox"/> Hostile <input type="checkbox"/> Behavioral Problems Please describe(if checked) <div style="border: 1px solid gray; height: 50px; width: 100%;"></div>	<input type="checkbox"/> Burn Care <input type="checkbox"/> Sterile Dressings <input type="checkbox"/> Decubiti <input type="checkbox"/> Bedridden <input checked="" type="checkbox"/> Eczema-Severe <input type="checkbox"/> Normal
Neurological Status :	Urogenital :	Surgery :	Therapy / Visits :	Other Therapy Visits :	
<input type="checkbox"/> Deaf <input type="checkbox"/> Blind <input type="checkbox"/> Seizures <input checked="" type="checkbox"/> Neurological Deficits <input type="checkbox"/> Paralysis <input type="checkbox"/> Normal	<input type="checkbox"/> Dialysis in home <input type="checkbox"/> Ostomy <input checked="" type="checkbox"/> Incontinent - Age > 3 years <input type="checkbox"/> Catheterization <input type="checkbox"/> Continent	<input type="checkbox"/> Level 1 (5 or > Surgeries) <input type="checkbox"/> Level II (< 5 Surgeries) <input checked="" type="checkbox"/> None	Day Care Services <input type="checkbox"/> High Tech (>= 4 Times / Week) <input type="checkbox"/> Low Tech - (<= 3 Times / Week or MD Visits > 4 Times / Month) <input checked="" type="checkbox"/> None	<input type="checkbox"/> >= 5 Days / Week <input checked="" type="checkbox"/> < 5 Days / Week	

Figure 195

Remarks: Optional

Additional information or explanations regarding the nursing care, medications, diagnostic and treatment procedures or services needed may be entered in the 'Remarks' text box.

Signature: Optional

46. Enter the first name and last name of the physician or nurse who signed the DMA-6A in the box provided.

47. Enter the date signed in the 'Date Signed' box.



The image shows a screenshot of a web form. It has two input fields. The first field is labeled 'Name of MD / RN Signing Form' and contains the text 'Jean RN'. The second field is labeled 'Date Signed' and contains the text '05/10/2010'. The fields are separated by a vertical line.

Figure 196

48. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.

49. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.

50. Click **I Agree** in response to the *Attestation Statement*.

51. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**. The pending DMA6A tracking number displays at the top of the page after the request is submitted.

2.3.16.2 GAPP DMA-80

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Georgia Pediatric Program/Exceptional Children's Services (Form DMA-80)** to open the *New Request for Prior Authorization* page.
4. The requesting GAPP provider ID is system populated in the 'Service Provider ID' box

5. Enter the member's Medicaid ID.

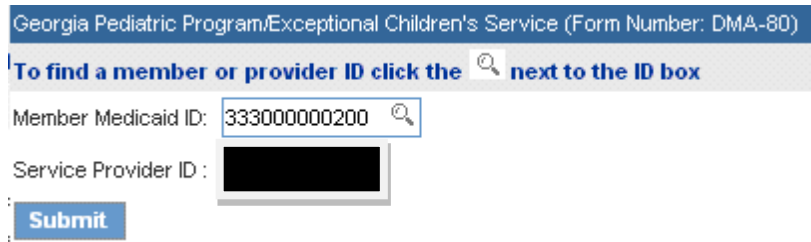


Figure 197

6. Click **Submit** to open the *DMA-6A Confirmation* page.
7. Enter the member's approved DMA-6A authorization number in the 'DMA-6 Prior Authorization Confirmation Number' box.

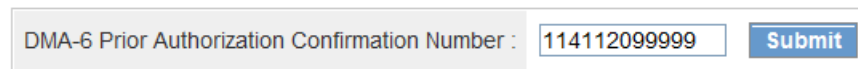


Figure 198

8. Click **Submit** to open the request form. If the DMA-6A number passes system confirmation, the DMA-80 request template opens. If the DMA-6A number does not pass confirmation, a message displays explaining why the DMA-6A is not valid.

Member/Provider Information:

At the top of the request form, the member information and GAPP provider information is system populated based on the Member ID and service Provider ID entered.

Contact Information:

The system pulls in the GAPP provider's contact information.

9. Enter contact information that is required (name, phone, email and fax) but is missing.



Figure 199

Request Information:

This section captures the location where GAPP services are to be provided, and displays the system assigned GAPP Patient ID.

10. Enter the location of service by selecting *Home* or *Other* (daycare).
11. The member’s unique patient ID displays in the ‘GAPP Member ID’ field. This ID is not the same as the Medicaid ID, but is a unique ID assigned by the system when the member is added to the PA system as a GAPP participant.



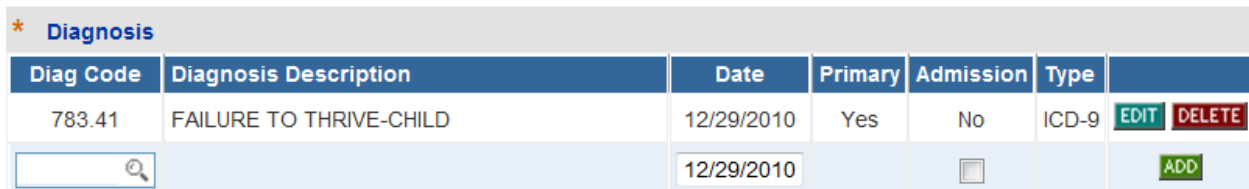
The screenshot shows a form titled "Request Information". It contains a field for "Place of Service" with two radio button options: "12 - Home" (which is selected) and "99 - Other". To the right of this field is a label "GAPP Member ID" followed by the value "149507".

Figure 200

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator for each diagnosis code entered.

12. Enter the diagnosis code for the Member’s primary diagnosis as related to GAPP services in the ‘Diag Code’ box; or search for and have system insert the diagnosis. If the diagnosis code includes a decimal point, enter the decimal point when entering the code.
13. Enter the date that this diagnosis was established in the ‘Date’ box, or if not known, the date that the physician signed the DMA-6A.
14. Click the ‘Primary’ button to indicate that the diagnosis is the primary diagnosis. **Note:** If only one diagnosis is entered, the system will select that diagnosis as primary.
15. Click the **Add** at the end of the diagnosis line to add the diagnosis code to the request.



* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
783.41	FAILURE TO THRIVE-CHILD	12/29/2010	Yes	No	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text" value="12/29/2010"/>	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 201

16. Follow the same process just described to add another diagnosis code.

Procedures Table:

The Procedures table captures the specific services requested including: service code, service description (system populated), requested start date, requested end date, units per day, week and month, and modifier. Each procedure line is entered for one month or part of a month.

17. Enter the code for the service requested in the ‘Service Code’ box.
18. Enter the date when the service is to start in the ‘From Date’ box; and enter the date when the service is to end in the ‘To Date’ box. The start and end dates should be within the same month.
19. Enter the units of service to be provided each week in the ‘Requested Units/Week’ box.
20. Enter the units of service to be provided each day in the ‘Requested Units/Day’ box.
21. Enter the number of units of service to be provided each month in the ‘Requested Units/Month’ box.
22. Enter a modifier in the ‘Mod 1’ box if applicable to the service requested.
23. Click the **Add** at the end of the procedure line to add the service information to the request. Follow the same process just described to add other services

Procedures											
Service Code	Service Description	From Date	To Date	Requested Units/Week	Requested Units/Day	Requested Units/Month	Mod 1	Mod 2	Mod 3	Mod 4	
S9124	NURSING CARE, IN THE HOME; B	05/01/2010	05/31/2010	40	8	200					<input type="button" value="EDIT"/>
S9124	NURSING CARE, IN THE HOME; B	06/01/2010	06/30/2010	40	8	200					<input type="button" value="EDIT"/>
S9124	NURSING CARE, IN THE HOME; B	07/01/2010	07/31/2010	40	8	200					<input type="button" value="EDIT"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="ADD"/> <input type="button" value="CANCEL"/>

Figure 202

Program Information:

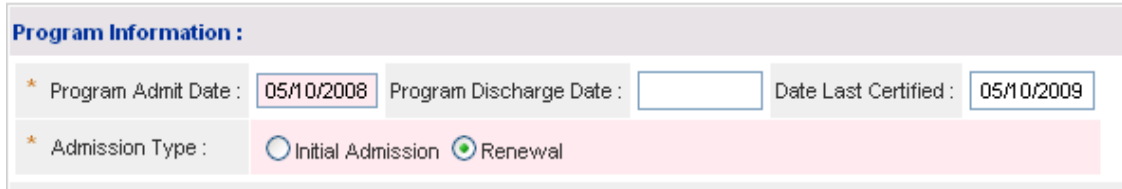
This section captures the date of admission to GAPP and the type of admission.

24. **Initial Admissions:** Enter the date that the child was admitted to GAPP in the ‘Program Admit Date’ box. Enter the date manually or use the calendar popup. Select the *Initial Admission* button for ‘Admission Type’.

Program Information :			
* Program Admit Date :	<input type="text" value="05/10/2010"/>	Program Discharge Date :	<input type="text"/>
		Date Last Certified :	<input type="text"/>
* Admission Type :	<input checked="" type="radio"/> Initial Admission <input type="radio"/> Renewal		

Figure 203

25. **Renewals:** Enter the date that the child was admitted to GAPP in the ‘Program Admit Date’ box. Select the *Renewal* button for ‘Admission Type’. Then enter the date that the member was last certified in the ‘Date Last Certified’ box. The last certified date is equal to the first day of the previous certification period.



The screenshot shows a form titled "Program Information :". It contains two rows of input fields. The first row has three fields: "Program Admit Date : 05/10/2008", "Program Discharge Date : [empty]", and "Date Last Certified : 05/10/2009". The second row has a label "Admission Type :" followed by two radio buttons: "Initial Admission" (unselected) and "Renewal" (selected).

Figure 204

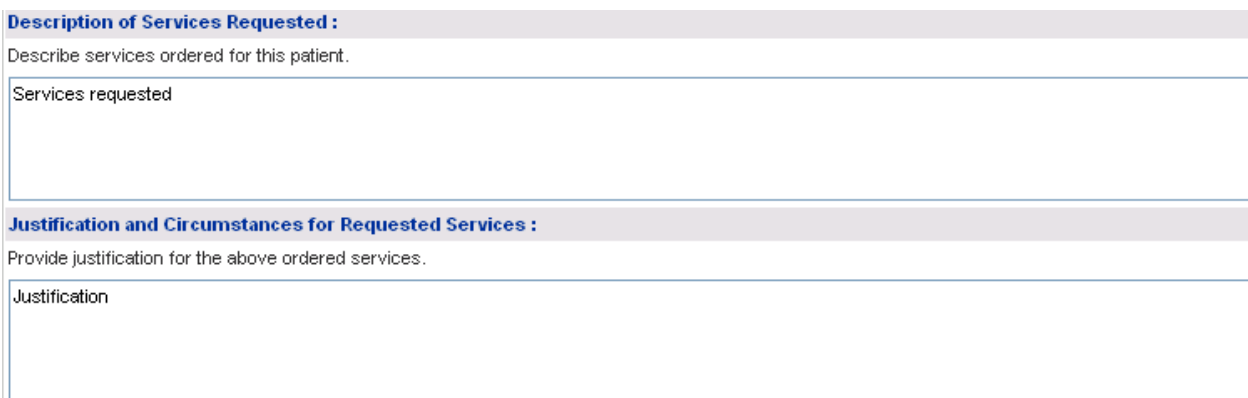
Initial or Renewal Comments:

26. An optional textbox is available to enter information related to the admission type.

Description and Justification for Services Requested:

This section captures a description of the services requested and the medical justification for the services.

27. Describe the services and frequency of services that have been ordered in the ‘description of Services’ box.
28. Describe why the ordered services are medically necessary in the ‘Justification and Circumstances’ box.



The screenshot shows two sections of a form. The first section is titled "Description of Services Requested :" and contains the instruction "Describe services ordered for this patient." followed by a large text area labeled "Services requested". The second section is titled "Justification and Circumstances for Requested Services :" and contains the instruction "Provide justification for the above ordered services." followed by a large text area labeled "Justification".

Figure 205

Required Documents and Assessment Date:

This section includes a series of questions related to the letters/documents that are required as part of admission to GAPP and/or the provision of GAPP services.

29. Indicate whether or not there is a signed letter of Medical Necessity by clicking *Yes* or *No*. If yes, enter the date signed in the 'Date Signed' box.
30. Indicate whether or not there is a signed Letter of Understanding by clicking *Yes* or *No*. If yes, enter the date signed in the 'Date Signed' box.
31. Indicate whether or not there is a signed letter of Notification on file by clicking *Yes* or *No*.
32. Indicate whether or not there is a completed Private Duty Summation Sheet by clicking *Yes* or *No*.
33. Indicate whether or not there is a signed Caregiver Competency Checklist for the primary caregiver by clicking *Yes* or *No*.
34. Indicate whether or not there is a signed Caregiver Competency Checklist for the secondary caregiver by clicking *Yes* or *No*.
35. Indicate whether or not there is a signed Freedom of Choice form in the member file by clicking *Yes* or *No*. If yes, enter the date signed in the 'Date Signed' box.
36. Indicate whether or not there is a signed parent/provider attestation regarding the IEP/IFSP for GAPP by clicking *Yes* or *No*. If yes, enter the date signed in the 'Date Signed' box.
37. Indicate whether or not the child is in foster care by clicking *Yes* or *No*.
38. Indicate if the Director of the count DFCS has signed all required paperwork by clicking *Yes* or *No*. If yes, enter the date signed in the 'Date Signed' box.
39. Enter the date that the child was evaluated for services in the 'Assessment Date' box.

* Is there a signed Letter of Medical Necessity at the agency ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed : 10/27/2014
* Is there a signed Letter of Understanding on file ?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Date Signed : <input type="text"/>
* Is the Letter of Notification signed on file ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	
* Is the Private Duty Summation Sheet completed ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	
* Is there a signed Caregiver Competency Checklist for the primary caregiver ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	
* Is there a signed Caregiver Competency Checklist for the secondary caregiver ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	
* Is there a signed Freedom of Choice form in the member file ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed : 10/06/2014
* Is there a signed Parent/Provider attestation regarding the IEP/IESP for the Georgia Pediatric Program ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed : 09/28/2014
* Is the child in foster care ?	<input type="radio"/> Yes <input checked="" type="radio"/> No	
* Has the Director of the county DFCS signed all required paperwork ?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Date Signed : <input type="text"/>
* Assessment Date : 10/01/2014		

Figure 206

Medications Table: Optional

The *Medications* table captures the member’s primary medication including: type, dosage, route and frequency.

40. To enter medication information, first select the medication type by selecting a type from the ‘Name’ drop list.
41. Enter the dosage for the medication in the ‘Dosage’ box.
42. Enter the method of medication administration by selecting the method of administration from the ‘Route’ drop list (Oral or Parental or Rectal or Topical).
43. Enter the frequency of medication administration by selecting a frequency from the ‘Frequency’ drop list (Regular or PRN: As necessary or Regular & PRN).
44. Click **Add** at the end of the medication line to add the medication information.
45. Follow the same process to add other medication information.

Medications				
Name	Dosage	Route	Frequency	
Antibiotics	.5 ml	Oral	Regular	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
Steroids	10mg	Oral	Regular	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
Anticonvulsive	5mg	Rectal	Regular	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="ADD"/>

Figure 207

Caregivers:

This section captures information regarding the competency and work schedules of the child’s caregivers.

- 46. Click *Yes* or *No* to indicate whether or not the primary caregiver is competent.
- 47. Click *Yes* or *No* to indicate whether or not the secondary caregiver is competent.
- 48. Click *Yes* or *No* to indicate whether or not the primary caregiver works
- 49. **If the primary caregiver is employed**, enter the total hours worked per week in the ‘Hours’ box; and enter the hours worked on weekends in the ‘Hours of work on weekends’ box. If the primary caregiver does not work on the weekend, enter zero (0).
- 50. Click *Yes* or *No* to indicate whether or not the secondary caregiver works.
- 51. **If the secondary caregiver is employed**, enter the total hours worked per week in the ‘Hours’ box; and enter the hours worked on weekends in the ‘Hours of work on weekends’ box. If the Secondary Caregiver does not work on the weekend, enter zero (0).

CareGivers			
Is the Primary Caregiver competent ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Is the Secondary Caregiver competent ?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Does Primary Caregiver work ?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Primary Caregiver's work schedule :	<input type="text"/> Hrs
Does Secondary Caregiver work ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Secondary Caregiver's work schedule :	<input type="text"/> Hrs
		Hours of work on weekends :	<input type="text"/> Hrs
		Hours of work on weekends :	<input type="text"/> Hrs

Figure 208

Skilled Nursing Needs:

This section records the type and amount of skilled nursing care that the child needs.

- 52. **Location:** Click ‘In-Home’ or ‘Day-Care’ to indicate where skilled care hours are provided.
- 53. **Skilled Care Hours:** In the ‘Current In-Home/Day-Care Hours’ box, enter the number of hours of skilled nursing care that the child is currently receiving per week.
- 54. In the ‘Requested In-Home/Day-Care Hours’ box, enter the number of hours per week of skilled nursing care that is requested.
- 55. **Nursing Assistant (NA) Hours:** Check the ‘Nursing Assistant’ box if the member is receiving nurse assistant services or if nurse assistant services are requested.
- 56. Indicate, if applicable, the current NA hours in the ‘Current Nurse Assistant Hours’ box; and the requested NA hours in the ‘Requested Nurse Assistant Hours’ box.
- 57. **Transfer:** Select ‘Yes’ if this request is for a transfer to a different service. If yes is selected, indicate if the transfer is to ‘In-Home’ or ‘Day-Care’ by clicking the applicable button. Also, indicate if the service transfer is within the same agency by clicking ‘Yes’.

The screenshot shows a form titled "Skilled Nursing Needs" with the following fields and values:

- Location:** Radio buttons for "In-Home" (selected) and "Day-Care".
- Current In-Home/Day-Care Hours:** Input field with value "8" and "Hrs" label.
- Requested In-Home/Day-Care Hours:** Input field with value "8" and "Hrs" label.
- Nursing Assistant:** A checkbox that is currently unchecked.
- Current Nurse Assistant Hours:** Input field with value "5" and "Hrs" label.
- Requested Nurse Assistant Hours:** Input field with value "5" and "Hrs" label.
- Transfer ?** Radio buttons for "Yes" and "No" (selected).
- If Yes, Transfer Type:** Radio buttons for "To In-Home (PDN)" and "To DayCare (MFDC)".
- Is it within the same agency?** Radio buttons for "Yes" and "No" (selected).

Figure 209

Respiratory Care:

This section records information regarding the child’s respiratory care. **Skip this section if none of the questions apply to the child.**

- 58. Indicate whether or not the child is receiving oxygen by clicking *Yes* or *No* to the question: ‘Is Recipient on O₂’.
- 59. **If receiving oxygen**, indicate the percentage of oxygen prescribed in the ‘%’ box, **and** the hours prescribed per day in the ‘Hours’ box.
- 60. Indicate whether or not the child requires pulse oximetry by clicking *Yes* or *No* to the question: ‘Pulse Oximetry’.
- 61. Indicate whether or not the child requires chest percussion treatment by clicking *Yes* or *No* to ‘CPT’.
- 62. Indicate whether or not the child receives tracheostomy care by clicking *Yes* or *No* to ‘Trach Care’.
- 63. If the child has a tracheostomy, indicate how often during the day the tracheostomy tube is suctioned in the ‘Suctioning/Frequency’ box.
- 64. Indicate whether or not the child is on ventilator treatment by clicking *Yes* or *No*.
- 65. Select the ‘During the Day’ checkbox if vent treatment is during the day, and enter the number of hours per day in the ‘Hours’ box.
- 66. If the child is on ventilator treatment during the night, select ‘During the Night’, and enter the number of hours per night in the ‘Hours’ box.
- 67. Indicate whether or not the child is receiving C-PAP or BI-PAP treatment by clicking *Yes* or *No*.
- 68. If Yes for C-PAP or BI-PAP, select ‘During the Day’ or ‘During the Night’ to indicate if treatment is during the day or night and enter the hours of treatment in the ‘Hours’ boxes provided. If treatment is provided during the day and night, select both boxes.

Respiratory Care							
Is Recipient on O ₂ ?	<input type="radio"/> Yes <input checked="" type="radio"/> No	If "Yes",	<input type="text"/> %	Hours per Day :	<input type="text"/> Hrs		
Pulse Oximetry :	<input type="radio"/> Yes <input checked="" type="radio"/> No	CPT :	<input type="radio"/> Yes <input type="radio"/> No	Trach Care :	<input checked="" type="radio"/> Yes <input type="radio"/> No	Suctioning / Frequency :	<input type="text" value="qid"/>
Ventilator :	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="checkbox"/> During the Day	<input type="text"/> Hrs	<input type="checkbox"/> During the Night	<input type="text"/> Hrs		
C-PAP or BI-PAP :	<input checked="" type="radio"/> Yes <input type="radio"/> No	<input checked="" type="checkbox"/> During the Day	<input type="text" value="5"/> Hrs	<input checked="" type="checkbox"/> During the Night	<input type="text" value="5"/> Hrs		

Figure 210

Nutritional Therapy:

This section captures information regarding the child’s nutritional therapy requirements.

- 69. In the ‘Nutrition’ box, enter the name of the nutritional supplement/formula or enter 'None', if child is not receiving nutritional therapy.
- 70. Indicate how the nutritional supplement/formula is administered by clicking one of the following: *Oral*, *G-Tube*, *J-Tube*, or *NA* (if member is not receiving nutritional therapy).
- 71. In the ‘Frequency’ box, enter the number of feedings per day.
- 72. In the ‘Precautions’ text box, enter any special precautions/circumstances regarding the nutritional therapy for the child. When there are no special precautions, enter ‘*None*’.

The screenshot shows a form titled "Nutritional Therapy". It contains the following fields and options:

- Nutrition(s):** A text box containing the word "supplements".
- Route:** Three radio button options: "Oral" (selected), "G-Tube", and "J-Tube".
- Frequency:** A text box containing "3x/day".
- Precautions:** A text area containing the text "No special precautions".

Figure 211

School Services:

This section documents the hours in school and the level of care that the child needs in school.

- 73. Click *Yes* or *No* to indicate whether or not the child is in school.
- 74. **If the child is in school** – enter the number of hours per day in school in the ‘Number of hours per day in school’ box; and enter the number of days per week in school in the ‘Number of days per week in school’ box.
- 75. Click *Yes* or *No* to indicate whether or not the child’s Individualized Family Service Plan (IFSP) is current. If it is not current or the child does not have an IFSP, select ‘*No*’.
- 76. Click *Yes* or *No* to indicate whether or not the child’s Individual Educational Plan (IEP) is current. If it is not current or the child does not have an IEP, select ‘*No*’.
- 77. Indicate the level of care in school by clicking *Skilled Nursing*, or *Unskilled Nursing (Aide)*, or *NA* (child is not in school).

78. Enter the number of hours per day that skilled or unskilled nursing is needed in school in the 'Hours' box.

School Services			
Is child in school ?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Number of hours per day in school :	<input type="text"/> Hrs
IFSP Current ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Number of days per week in school :	<input type="text"/> Hrs
Level of Care in School :	<input type="radio"/> Skilled Nursing <input type="radio"/> Unskilled Nursing (Aide) <input checked="" type="radio"/> N/A	IEP Current ?	<input type="radio"/> Yes <input checked="" type="radio"/> No
		Number of hours per day :	<input type="text"/> Hrs

Figure 212

Home Health Agency Nursing Assessment:

This section captures information regarding the child’s skilled nursing care needs; justification for the nursing care hours requested; and recommendations for treatment. When documents are attached to the request that provide the skilled nursing care needs and the justification for skilled care, it is permissible to enter “See documents attached” in the applicable boxes.

79. Provide a description of the child’s skilled nursing care needs in the ‘Skilled Nursing Care needs’ box.

80. Explain why the requested skilled care hours are medically necessary in the ‘Justification’ box.

81. Enter recommendations regarding the child’s service needs and plan of care in the ‘Recommendations’ box.

Home Health Agency Nursing Assessment
Skilled Nursing Care needs :
<input type="text"/>
Justification for requested skilled-nursing care hours :
<input type="text"/>
Recommendations :
<input type="text"/>

Figure 213

82. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
83. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that ‘information is missing or incorrect’, scroll up the page to find what is missing or incorrect. ‘**Required**’ displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
84. Click **I Agree** in response to the *Attestation Statement*.
85. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
86. Once the PA is submitted successfully, the pending PA tracking number displays at the top of the page. At this point, required documents may be attached to the PA utilizing **Create an Attachment**.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)

Type of Review	Documents
INITIAL	<input type="checkbox"/> Letter of Medical Necessity
	<input type="checkbox"/> Care Plan
	<input type="checkbox"/> Medical Plan of Treatment (MD-POT)
	<input type="checkbox"/> GAPP Assessment Form (Appendix K)
	<input type="checkbox"/> IFSP or IEP
	<input type="checkbox"/> Insurance Information
	<input type="checkbox"/> Signed LON

Figure 214

87. To attach a file, first check the applicable document type checkboxes that relate to the file to be attached.

Note: The preferred method is to attach one PDF file that includes all the required documents in which case all the boxes would be checked.

88. Click **Browse** to find the file. Select and open the file. The file name displays in the attachment panel.
89. Click **Attach File**. The file is attached to the PA and added to the **Attached Files** table.

2.3.17 TEFRA/Katie Beckett DMA6A	
Program	Authorization Period
TEFRA/Katie Beckett (DMA6A)	Usually one year but may be authorized for up to 3 years.
Description	
Katie Beckett waiver packets and DMA6As are enter via the web portal by the RSM Medicaid Unit. The submission process consists of two components: <ul style="list-style-type: none"> • Participant/packet entry • DMA6A request entry 	

2.3.17.1 Participant/Package Entry

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the portal *Secure Home* page, select **Prior Authorization** from the links at the top of the page.

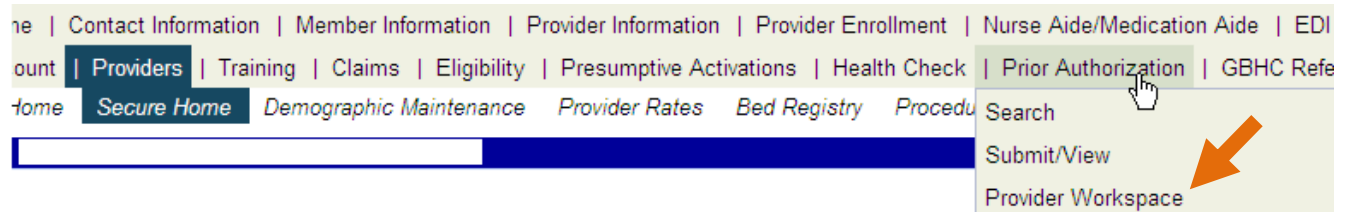


Figure 215

3. Then, select *Provider Workspace* from the drop list to open the workspace page.
4. Go to the **Katie Beckett Packet and DMA6A Submission** section, and click **Katie Beckett Participant Search**.

Note: Before entering any packet information, search for the participant first to avoid duplicate entries.

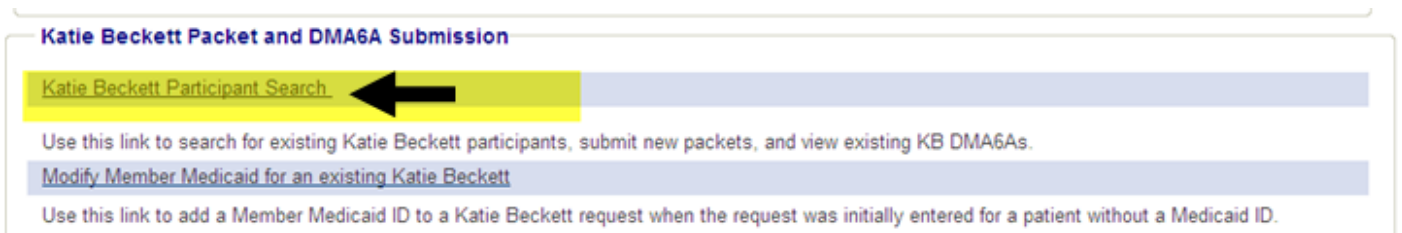
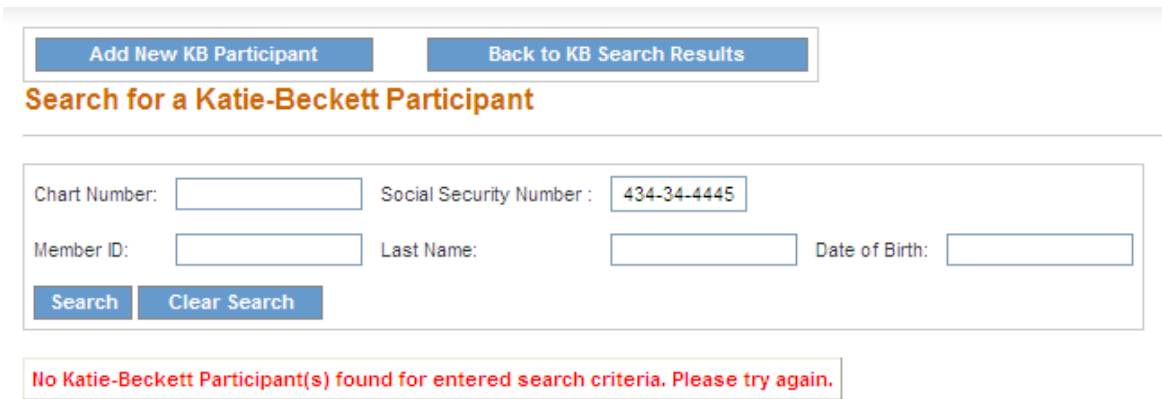


Figure 216

5. A search for participants/packets may be conducted using one or more of the following criteria:
 - **Chart Number:** This is the number **assigned by the system** when a participant is added. If a participant is already in the system, the chart number displays in the search results and also displays on the page displaying the participant information.
 - **Social Security Number (SSN):** The participant's SSN.
 - **Member ID:** The participant's Medicaid Member ID.
 - **Last Name:** Participant's last name
 - **Date of Birth:** Participant's date of birth.
6. **First, attempt a search by using the SSN only.** Enter the 9 digit SSN in the box provided. Then, click **Search**.



[Add New KB Participant](#) [Back to KB Search Results](#)

Search for a Katie-Beckett Participant

Chart Number: Social Security Number :
Member ID: Last Name: Date of Birth:
[Search](#) [Clear Search](#)

No Katie-Beckett Participant(s) found for entered search criteria. Please try again.

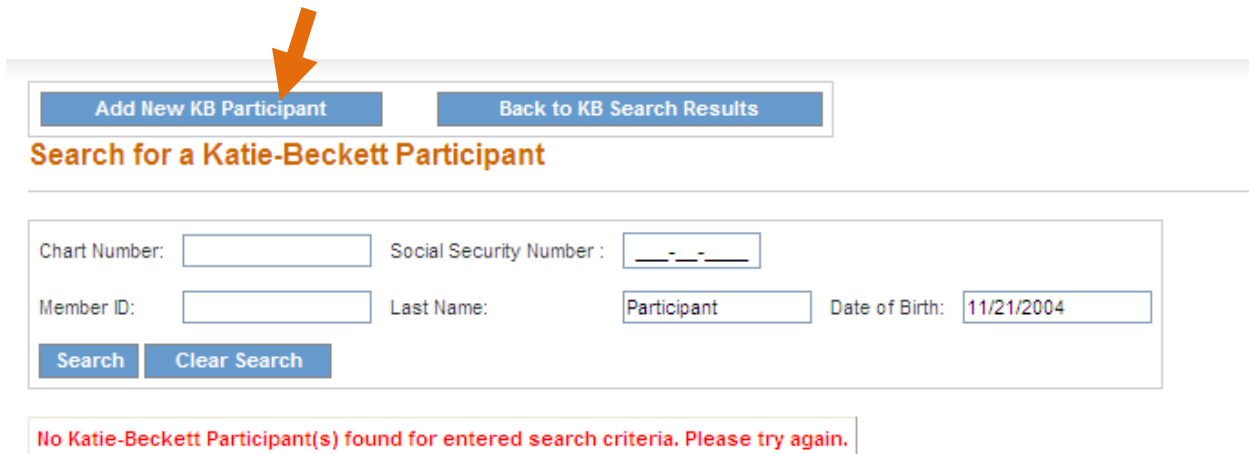
Figure 217

7. If no existing participant matching the SSN is found, a message in red displays indicating no participant found, as shown in the figure above. Click **Clear Search**.
8. Next, try searching for the participant by 'Last Name' and 'Date of Birth'. Enter the participant's last name; and enter the date of birth.
9. Click **Search**. If the message in red indicating no participant found remains, then proceed to enter a new participant/packet.

Note: If a SSN search does not return the participant but a search by name and DOB does, be sure that the SSN, Name, and DOB entered, were entered correctly. If all information was entered correctly but discrepancies still exist, do not enter a new participant but notify Alliant/GMCF using 'Contact Us' from the *Provider Workspace*.

Add a New Participant/Packet:

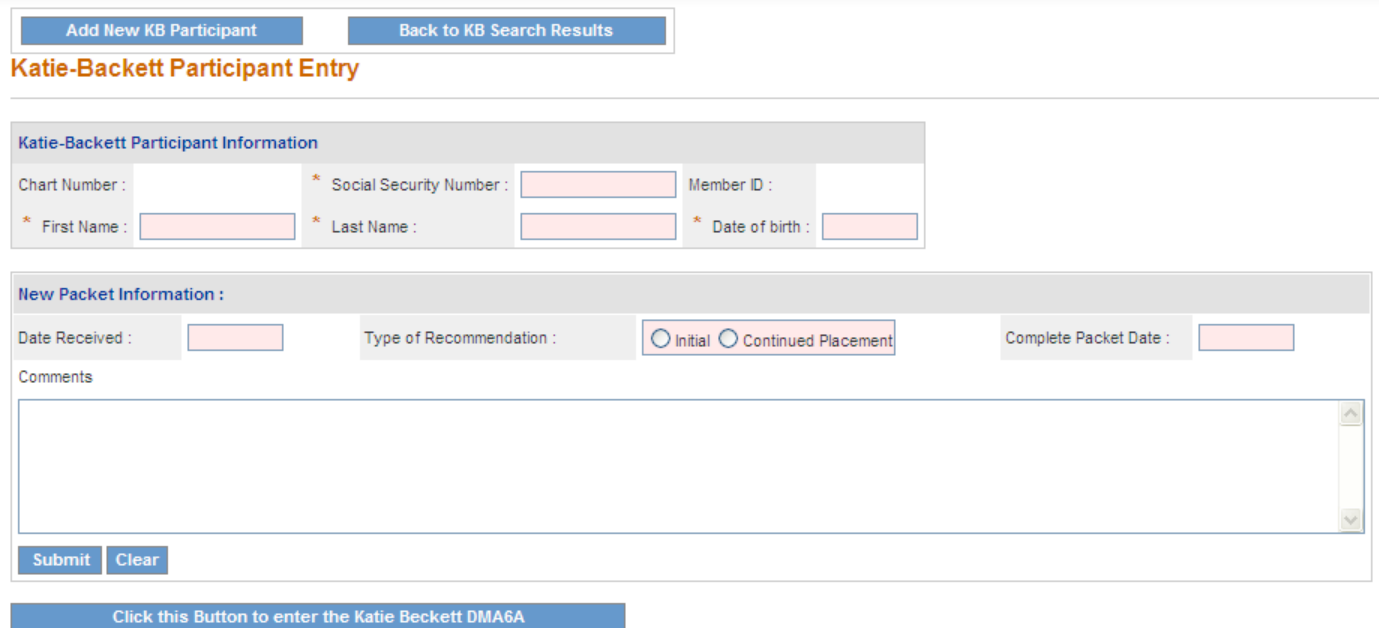
1. On the search page, click **Add New KB Participant**.



The screenshot shows a search interface with two buttons at the top: "Add New KB Participant" (highlighted with an orange arrow) and "Back to KB Search Results". Below the buttons is the heading "Search for a Katie-Beckett Participant". The search form contains the following fields: "Chart Number:" (empty), "Social Security Number:" (format: _-_-), "Member ID:" (empty), "Last Name:" (value: Participant), and "Date of Birth:" (value: 11/21/2004). There are "Search" and "Clear Search" buttons. A red error message at the bottom states: "No Katie-Beckett Participant(s) found for entered search criteria. Please try again."

Figure 218

2. The *Katie Beckett Participant Entry* page opens. This page is used to capture and track participant information and packet information.



The screenshot shows the "Katie-Beckett Participant Entry" page. At the top are buttons for "Add New KB Participant" and "Back to KB Search Results". The heading is "Katie-Beckett Participant Entry". The form is divided into two sections: "Katie-Beckett Participant Information" and "New Packet Information". The first section has fields for "Chart Number:", "* Social Security Number:", "Member ID:", "* First Name:", "* Last Name:", and "* Date of birth:". The second section has fields for "Date Received:", "Type of Recommendation:" (with radio buttons for "Initial" and "Continued Placement"), and "Complete Packet Date:". There is a "Comments" text area and "Submit" and "Clear" buttons at the bottom. A blue button at the very bottom says "Click this Button to enter the Katie Beckett DMA6A".

Figure 219

3. Enter the participant’s Social Security Number in the box provided.
4. Enter the participant’s first name in the ‘First Name’ box, and then the last name in the ‘Last Name’ box. **Suggestion:** Enter the first name and last name in all CAPS.

5. Enter the participant's birth date in the 'Date of birth' box.
6. In the *New Packet Information* section, enter the date that the packet information was received.
7. Select the 'Type of Recommendation' by clicking the *Initial* button, since this is a packet for a new participant.
8. The 'Complete Packet Date' is **read only**. The complete packet date is added by the Alliant/GMCF reviewer once all information has been received.
9. Additional information regarding the participant or packet may be entered in the 'Comments' box but this is optional.

Add New KB ParticipantBack to KB Search Results

Katie-Beckett Participant Entry

Katie-Beckett Participant Information

Chart Number :	* Social Security Number : 434344445	Member ID :	
* First Name : Katie	* Last Name : Participant	* Date of birth : 11/21/2004	

New Packet Information :

Date Received : 01/07/2013	Type of Recommendation : <input checked="" type="radio"/> Initial <input type="radio"/> Continued Placement	Complete Packet Date :	
----------------------------	---	------------------------	--

Comments

This box is optional but may be used to provide additional information regarding the participant and/or packet.

SubmitClear

Click this Button to enter the Katie Beckett DMA6A

Figure 220

10. Click **Submit** to save the participant/packet information.
11. Once the packet information is submitted successfully, the **Previous Comments** table opens below the 'Comments' box. This table displays all the packet information entered in the system for the participant. Once the DMA6A is submitted, the system inserts the DMA6A tracking/authorization number in this table under 'PA Number' to associate each packet with the corresponding DMA6A.

Comments

This box is optional but may be used to provide additional information regarding the participant and/or packet.

Submit Clear

Previous Comments

Date Received	Type Recommendation	Complete Pkt Date	Comments	PA Number	
1/7/2013 12:00:00 AM	Initial		This box is optional but may be used to provide additional information regarding the participant and/or packet.		EDIT

Click this Button to enter the Katie Beckett DMA6A

Figure 221

Add Packet for an Existing Participant

The process used to add a packet for a participant that already exists in the PA system is generally the same as adding a new participant packet. The main difference is that the participant information does not need to be added since the participant already exists in the system – only the packet information needs to be added.

1. First, it is necessary to search for the existing participant (follow the search instructions previously described). If the search is successful, the existing chart number and participant information will display in search results as shown in the next figure.

Search for a Katie-Beckett Participant

Chart Number: Social Security Number :

Member ID: Last Name: Date of Birth:

Search Clear Search

Fictitious member info

Chart Number	Member ID	Member Last Name	Member First Name	Social Security number	DOB
774048	333000000700	WILLIAMS	JAMES	818181818	2/3/2004 12:00:00 AM

Figure 222

2. Click the **Chart Number** that is underlined and in blue font.
3. The *KB Participant Entry* page opens. This page displays participant information (top of the page); and existing packets and DMA6A PAs previously submitted in the **Previous Comments** table. PA numbers listed in the **Previous Comments** are links to the PA. To check the decision and status of a previous PA, click the PA ID link.

Add New KB Participant
Back to KB Search Results

Katie-Beckett Participant Entry

Katie-Beckett Participant Information

Chart Number : 774048 * Social Security Number : 818181818 Member ID : 333000000700

* First Name : JAMES * Last Name : WILLIAMS * Date of birth : 02/03/2004

New Packet Information :

Date Received : Type of Recommendation : Initial Continued Placement Complete Packet Date :

Comments

Previous Comments

Date Received	Type Recommendation	Complete Pkt Date	Comments	PA Number	
3/28/2011 12:00:00 AM	Initial			111032800002	<input type="button" value="EDIT"/>

[Click this Button to enter the Katie Beckett DMA6A](#)

Figure 223

4. To add the continued placement packet information, enter the date that the packet was received in the ‘Date Received’ box.
5. Select *Continued Placement* as the ‘Type of Recommendation’, since the packet is for an existing participant who is continuing in the in the KB program.
6. Enter comments, if desired, and then click **Submit**. The packet information is added to the ‘Previous Comments’ table.

Previous Comments					
Date Received	Type Recommendation	Complete Pkt Date	Comments	PA Number	
3/28/2011 12:00:00 AM	Initial			111032800002	<input type="button" value="EDIT"/>
3/26/2012 12:00:00 AM	Continued Placement				<input type="button" value="EDIT"/>

Figure 224

2.3.17.2 Enter the DMA-6A

The DMA6A is entered **after** packet information has been added for a new participant; or after packet information has been added for an existing participant. **The packet information must be added before the DMA6A can be entered** to ensure that each packet is associated with a different DMA6A.

1. After submitting the packet information, select - **Click this Button to enter the Katie Beckett DMA6A** – below the ‘Previous Comments’ table.

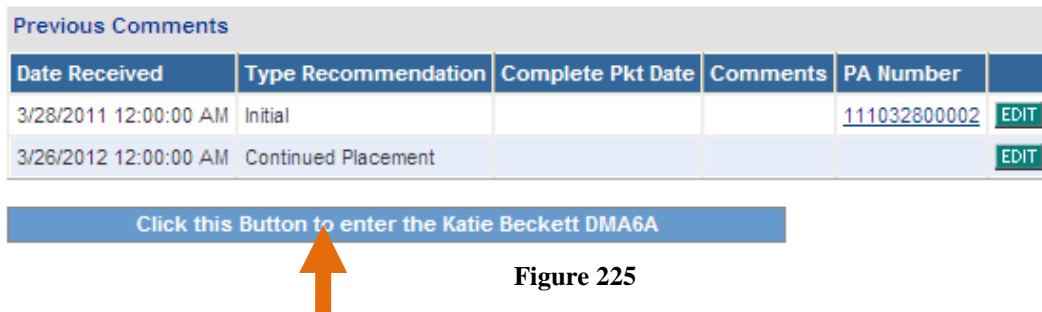


Figure 225

2. On the next screen, click **TEFRA/Katie Beckett (Form DMA-6A)**.

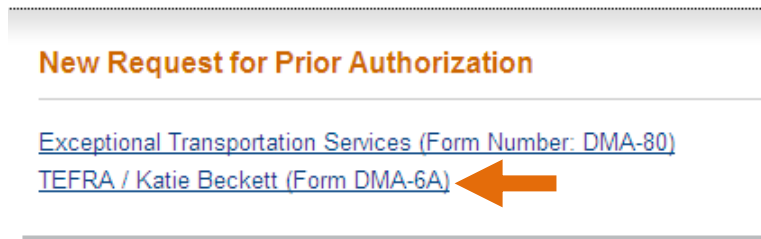


Figure 226

3. The *New Request for Prior Authorization* page opens, which displays the RSM Unit requesting provider ID (provider who logged into the portal).



Figure 227

Note: The provider ID may be changed to any DFCS office provider ID with a 380 COS when it is necessary to associate the DMA6A with a specific DFCS office.

- The authorization request page also displays the participant's SSN, **or** the participant's Medicaid ID if the participant is a Medicaid member. **No other member data needs to be entered on this page.**
- Click **Submit**.
- The next page lists the participant's available packets. 'Available packets' means that a DMA6A has not yet been entered for the packet. Select the applicable packet based on the date received and type of recommendation by clicking **Select** at the end of the packet line (shown in the figure below).

New Request for Prior Authorization

TEFRA / Katie Beckett (Form DMA-6A)

To find a member or provider ID click the next to the ID box

Member Medicaid ID:

Social Security Number :

Katie-Beckett Provider ID:

select the Katie-Beckett packet for which you want to create a PA. If you don't see the packet you want, you a packet.

Date Received	Type Recommendation	Comments	
3/26/2012 12:00:00 AM	Continued Placement		Select

Figure 228

- Once the packet is selected, the Katie Beckett DMA6A online form opens. At the top of the form the participant and provider information displays.

Note: Only the following information is required:

- Participant Address (if not system populated based on the Member's Medicaid ID).
- Contact Information (if not system populated)
- Diagnosis

8. The next section captures the member’s address. This information is important so that a decision notification can be sent to the member.

- **Participants with Member Medicaid IDs:** The system inserts the MMIS member address information for participants with Member Medicaid IDs. This information is **read only and cannot be edited**.
- **Participants who do not yet have a Member Medicaid ID:** The address information must be entered by the person entering the DMA6A. In the figure below, the member ID that displays is an example of the temporary member ID assigned by the PA system since this member is not in MMIS. These ‘temporary’ IDs end in GMC. When the member has one of these IDs, the participant address must be entered.

Member Information

Member ID : 03396GMC First Name : MI : Last Name : Suffix :

Date of Birth : Social Security Number : Gender :

Participant Address

Address Line 1 : **Required** Address Line 2 :

City : **Required** State : Zip : **Required**

Figure 229

9. Enter the participant’s street or PO Box address on ‘Address Line 1’. ‘Address Line 2’ may be used if more space is needed for the address (such as an apartment #); or there is a second line to the address.
10. Enter the ‘City’ in the box provided.
11. The ‘State’ defaults to Georgia.
12. Enter the five (5) digit zip code in the ‘Zip’ box.
13. The next required section captures contact information. **All data is required in this section.** Most of the information (except Contact Name) is auto-populated by the system based on the Provider ID associated with the request.

Contact Information

* Contact Name: Contact Email:

Contact Phone: Ext. * Contact Fax:

Figure 230

14. Review the contact information carefully. If information is missing or incorrect, edit as necessary. **It is especially important that the ‘Contact Email’ is correct since a notification email is sent to the email address entered in this section when a decision is rendered for the DMA6A.**
15. The last required section captures the participant’s diagnosis. At least one Diagnosis code is required. In the ‘Diag Code’ box, enter the diagnosis code for the participant’s primary diagnosis related to the Katie Beckett request. If the diagnosis code includes a decimal, enter with the decimal.
16. Enter the date that the diagnosis was determined in the ‘Date’ box. If not known, enter the date that the physician signed the DMA6A.
17. Click the ‘Primary’ checkbox to indicate that the diagnosis is the primary diagnosis.
18. Click **ADD** to add the diagnosis code to the request. When add is clicked, another blank diagnosis line is added; and **EDIT** and **DELETE** links appear. At this point, the code may be edited/deleted if entered incorrectly. However, **once the DMA6A is submitted, the diagnosis code cannot be removed or edited.**

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
343.9	CEREBRAL PALSY NOS	09/15/2014	Yes	No	ICD-9	EDIT DELETE
<input type="text"/>		<input type="text" value="09/15/2014"/>	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 231

19. Other diagnosis codes may be entered, following the same procedure just described.
20. After the contact information and diagnosis information is complete, go to the bottom of the form and click **Review Request**.
21. The next page displays an Attestation *Statement* (bottom of page).

To the best of my knowledge, the information I am submitting in this transaction is true, accurate, complete and is in compliance with applicable Department of Community Health policies and procedures. I am submitting this information to the Georgia Department of Community Health, Division of Medical Assistance, for the purpose of obtaining a prior authorization number.

I understand that any material falsification, omission or misrepresentation of any information in this transaction will result in denial of payment and may subject the provider to criminal, civil or other administration penalties.

To accept this information and proceed with your transaction, please click 'I agree'.

Figure 232

22. In order to proceed, **I Agree** must be clicked to confirm agreement with the statement.
23. When **I Agree** is clicked, the link to submit the request displays at the bottom of the page. Click **Submit Request**.
24. The next page displays the pending authorization tracking number (top of the page). If the DMA6A is approved, this number is the DMA6A authorization number.
25. At this point in the submission process, required documents may be attached to the request form. Go to **Create an Attachment** near the middle of the page.

The screenshot shows a web form titled "Create an Attachment". At the top, there is a text instruction: "If you want to attach a document to this Request, click on 'Browse...', select a document and then, click on 'Attach File'". Below this is a file input field with a "Browse..." button and an "Attach File" button. A note below the buttons says: "Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)". The main part of the form is a table with two columns: "Codes" and "Documents".

Codes	Documents
DEVELOPMENTAL	<input type="checkbox"/> Developmental/Psychological Evaluation
DMA6A	<input type="checkbox"/> DMA6A
IEP/IFSP	<input type="checkbox"/> IEP/IFSP
NURSING NOTES	<input type="checkbox"/> Nursing Notes
TEFRA	<input type="checkbox"/> TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
THERAPY NOTES	<input type="checkbox"/> Therapy Notes

Figure 233

Attach Documents

The attachment panel includes document type checkboxes related to the documents required for authorization. The purpose of the checkboxes is to associate the file attached to one or more required documents. One or more files may be attached. However, it is **recommended to attach one PDF file for all the required documents**.

1. For example, to attach one file for all documents, click in each checkbox.

This screenshot is identical to Figure 233, but with all the checkboxes in the "Documents" column selected. The "Therapy Notes" checkbox is highlighted with a dashed border.

Codes	Documents
DEVELOPMENTAL	<input checked="" type="checkbox"/> Developmental/Psychological Evaluation
DMA6A	<input checked="" type="checkbox"/> DMA6A
IEP/IFSP	<input checked="" type="checkbox"/> IEP/IFSP
NURSING NOTES	<input checked="" type="checkbox"/> Nursing Notes
TEFRA	<input checked="" type="checkbox"/> TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
THERAPY NOTES	<input checked="" type="checkbox"/> Therapy Notes

Figure 234

- Then, click **Browse** in the attachment panel to find the file saved to the file directory.
- Select and open the file. The file displays in the attachment panel next to browse, as shown in the next figure.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

X:\Attachment Test Docs\Member Records TEST 1.doc

Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)

Codes	Documents
DEVELOPMENTAL	<input checked="" type="checkbox"/> Developmental/Psychological Evaluation
DMA6A	<input checked="" type="checkbox"/> DMA6A
IEP/IFSP	<input checked="" type="checkbox"/> IEP/IFSP
NURSING NOTES	<input checked="" type="checkbox"/> Nursing Notes
TEFRA	<input checked="" type="checkbox"/> TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
THERAPY NOTES	<input checked="" type="checkbox"/> Therapy Notes

Figure 235

- Click **Attach File**. The file is attached and is associated with each document type in the **Attached Files** table as shown below.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

File uploaded successfully.

Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)

Codes	Documents
DEVELOPMENTAL	<input type="checkbox"/> Developmental/Psychological Evaluation
DMA6A	<input type="checkbox"/> DMA6A
IEP/IFSP	<input type="checkbox"/> IEP/IFSP
NURSING NOTES	<input type="checkbox"/> Nursing Notes
TEFRA	<input type="checkbox"/> TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
THERAPY NOTES	<input type="checkbox"/> Therapy Notes

Attached Files

File	Type	Code	Document Name	Size	User	Date	
Member Records TEST 1.doc	Web Upload	DEVELOPMENTAL	Developmental/Psychological Evaluation	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>
Member Records TEST 1.doc	Web Upload	DMA6A	DMA6A	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>
Member Records TEST 1.doc	Web Upload	IEP/IFSP	IEP/IFSP	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>
Member Records TEST 1.doc	Web Upload	NURSING NOTES	Nursing Notes	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>
Member Records TEST 1.doc	Web Upload	TEFRA	TEFRA/Katie Beckett Medical Necessity/Level of Care Statement	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>
Member Records TEST 1.doc	Web Upload	THERAPY NOTES	Therapy Notes	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>

Figure 236

2.3.17.3 Update Member ID

Katie Beckett participants may be added to the participant/packet tracking system before they have been assigned Member Medicaid IDs. When participants without Medicaid IDs are added, the PA system assigns a temporary ‘system’ ID, which ends in ‘GMC’. When the participant becomes a Medicaid member and is assigned a Medicaid Member ID, the Medicaid ID must be added to the participant’s chart and existing DMA6As **before** additional packets/DMA6As can be entered. When an attempt is made to enter the continued placement DMA6A before the Member ID is updated, the system triggers the following warning on the *New Request for Prior Authorization* page: ‘Multiple Member IDs associated with the SSN’. The user is directed to add the member’s Medicaid ID to the participant/packet as shown in the figure below.

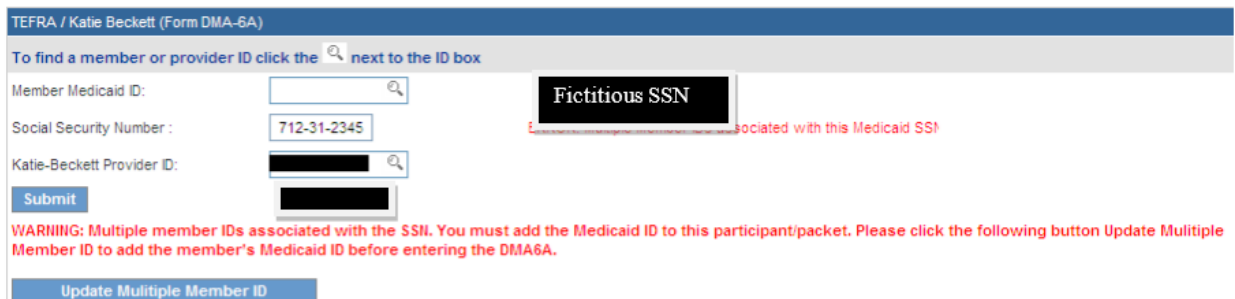


Figure 237

Note: At this time, the RSM Medicaid Unit may only update member IDs for DMA6As that are associated with their provider ID. Refer member updates for other DMA6As to Alliant/GMCF review staff.

1. To add the member’s Medicaid ID, click [Update Multiple Member ID](#).



Figure 238

2. When the update link is selected, the update page opens with the member’s SSN auto-populated.

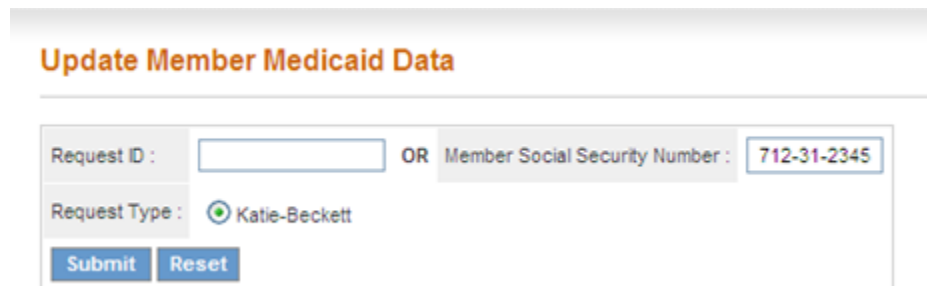


Figure 239

3. Do not enter any other information, just click **Submit**.
4. On the next page, the previous DMA6A request ID associated with the participant's temporary 'system' ID is shown.

Update Member Medicaid Data

Request ID	Member ID	Last Name	First Name	SSN	Status
[Blacked out]	00612GMC	NELSON	SHELLEY	712312345	Denied

Figure 240

5. Click the **Request ID** (blacked out in the screen shot above).
6. On the next page, under **Request Information**, enter the participant's Medicaid ID in the box next to the temporary ID.

ICD-9 Code	ICD-9 Description	ICD-9 Date	Primary
344	OTH PARALYTIC SYNDROMES	01/14/2013	Yes

Figure 241

7. Then, click **Update Member Medicaid ID**; and the request is updated with the member ID as shown in the next figure.

Request Information

Request ID : [REDACTED] Case Status : **Denied** Case Status Date : 01/14/2013

Member ID : 334000000700

Provider ID : [REDACTED]

Effective Date : 01/14/2013 Expiration Date : 01/13/2014

Denial Reason :

Type of Recommendation : Initial

Decision Type : Nurse Denied, Denial Reason: DOES NOT MEET PLCY GUIDELINES. Decision Date: 1/14/2013

Diagnosis

ICD-9 Code	ICD-9 Description	ICD-9 Date	Primary
344	OTH PARALYTIC SYNDROMES	01/14/2013	Yes

Attach File
Return To Search Results
Return to Provider Workspace
Contact Us

Return to the Auth Request Page

Figure 242

8. To return to the *New Request for Prior Authorization* page and enter the DMA6A, click **Return to the Authorization Request Page**.
9. On the next screen, click the link to the Katie Beckett request form.
10. The *New Request for Prior Authorization* page opens with the member's Medicaid ID and the requesting provider ID inserted by the system.

New Request for Prior Authorization

TEFRA / Katie Beckett (Form DMA-6A)

To find a member or provider ID click the next to the ID box

Member Medicaid ID:

Social Security Number :

Katie-Beckett Provider ID:

Submit

Figure 243

11. Click **Submit** to open the DMA6A form.

2.3.18 Independent Care Waiver Program (ICWP)	
Program	Authorization Period
Independent Care Waiver Program DMA6	Up to one year
Independent Care Waiver Program DMA80	Up to one year
Description	
Requests for level of care and service authorizations under the Independent Care Waiver Program are submitted via the web portal utilizing the ICWP DMA-6 and ICWP DMA-80 request templates, respectively. In order to enter the DMA80, the DMA6 must be approved and not expired.	

2.3.18.1 ICWP DMA6

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Independent Care Waiver Program/Traumatic Brain Injury (Form number DMA-6)** to open the *New Request for Prior Authorization* page.
4. The requesting ICWP provider ID is system populated in the ‘Service Provider ID’ box
5. Enter the member’s Medicaid ID.
6. If the member’s physician is a Medicaid Provider, enter the physician’s Reference ID in the ‘Physician Reference ID’ box. The reference ID always starts with REF. If the physician is not a Medicaid provider, leave this box blank.

Independent Care Waiver Program/Traumatic Brain Injury (ICWP/TBI) (Form Number: DMA-6)

To find a member or provider ID click the next to the ID box

Member Medicaid ID:

Service Provider ID :

Physician Reference ID :

Submit

Figure 244

7. Click **Submit** to open the request form.

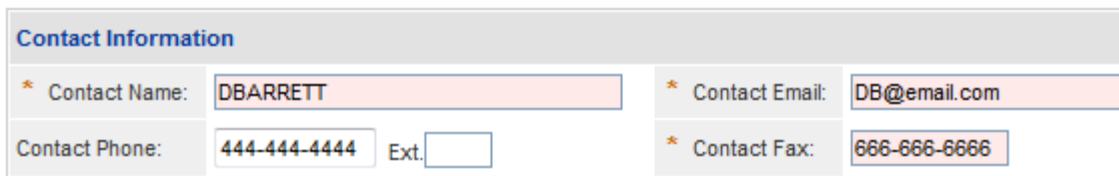
Member, Provider and Physician Information:

8. At the top of the request form, the member and ICWP provider are system populated based on the Member ID and Provider ID entered.
9. **If the physician Reference number was entered**, the physician information is also system populated.
10. **If the physician Reference number was not entered**, enter the name of the physician in the 'Physician Name' box.

Contact Information:

The system pulls in the ICWP provider's contact information.

11. Enter contact information that is required (name, phone, email and fax) but is missing.



The screenshot shows a form titled "Contact Information" with the following fields:

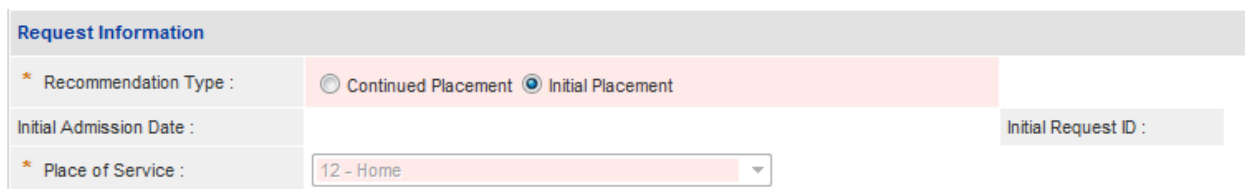
* Contact Name:	DBARRETT	* Contact Email:	DB@email.com
Contact Phone:	444-444-4444	Ext.:	
		* Contact Fax:	666-666-6666

Figure 245

Request Information:

This section captures the following required information: Recommendation Type and Place of Service.

12. Indicate if this DMA-6 is an initial request for placement in the ICWP, or a request for continued placement in the program by clicking the *Initial Placement* or *Continued Placement* button next to 'Recommendation Type'.
13. The system defaults the 'Place of Service' to *Home*.



The screenshot shows a form titled "Request Information" with the following fields:

* Recommendation Type :	<input type="radio"/> Continued Placement <input checked="" type="radio"/> Initial Placement	
Initial Admission Date :		Initial Request ID :
* Place of Service :	12 - Home	

Figure 246

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator for each diagnosis code entered. Admission indicator is not required.

14. Enter the diagnosis code for the Member’s primary diagnosis related to ICWP in the ‘Diag Code’ box. If the diagnosis code has a decimal point, include the decimal point when entering the code.
15. Enter the date that this diagnosis was established in the ‘Date’ box, or if not known, the date that the physician signed the DMA-6.
16. Click the ‘Primary’ button to indicate that the diagnosis is the primary diagnosis. **Note:** If only one diagnosis is entered, the system will select that diagnosis as primary.
17. Click the **Add** at the end of the diagnosis line to add the diagnosis code to the request.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
344.9	PARALYSIS NOS	01/01/2010	Yes	No	ICD-9	EDIT DELETE
<input type="text"/>		01/01/2010	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 247

18. If necessary, repeat the same steps to enter other diagnosis codes. Remember to **click Add after diagnosis is entered.**

Acute Care Hospital Dates and Diagnosis on Admission to Hospital:

These sections are not required but should be completed if applicable to the member.

Acute Care Hospital Dates : From Date : To Date :

Diagnosis on Admission to Hospital			
Diag Code	Diagnosis Description	Primary	
<input type="text"/>		<input type="checkbox"/>	ADD

Figure 248

Medications:

The *Medications* table captures the member’s primary medication including: type, dosage, route and frequency.

19. To enter medication information, first select the medication type by selecting a type from the ‘Name’ drop list.
20. Enter the dosage for the medication in the ‘Dosage’ box.
21. Enter the method of medication administration by selecting the method of administration from the ‘Route’ drop list (Oral or Parental or Rectal or Topical).
22. Enter the frequency of medication administration by selecting a frequency from the ‘Frequency’ drop list (Regular or PRN: As necessary or Regular & PRN).
23. Click **Add** at the end of the medication line to add the medication information to the DMA6.
24. Follow the same process to add other medication information.

Medications				
Name	Dosage	Route	Frequency	
Anticonvulsive	10mg	Rectal	PRN: As Necessary	EDIT DELETE
Anticonvulsive	312.5mg	Oral	Regular	EDIT DELETE
Narcotic	2.5mg	Oral	PRN: As Necessary	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

Figure 249

Diagnostic/Treatment Procedures:

The *Diagnostic and Treatment Procedures* table captures diagnostic/treatment procedures ordered as part of the member’s plan of care.

25. To add diagnostic or treatment procedures, first select the procedure type by selecting a type from the ‘Type’ drop list. Select ‘Other’, if the diagnostic/treatment procedure is not listed.
26. Next, enter the frequency of the diagnostic/treatment procedure in the ‘Frequency’ box.
27. Click **Add** to add the diagnostic/treatment procedure to the DMA-6.

Diagnostic and Treatment Procedures		
Type	Frequency	
Patient/Family Education	monthly	EDIT DELETE
Clean Dressing	bid	EDIT DELETE
<input type="text"/>	<input type="text"/>	ADD

Figure 250

28. Repeat the process to add other diagnostic/treatment procedures.

Treatment Plan:

This section captures information related to the Member’s plan of treatment including the level of care and the amount and type of services to be provided.

29. Enter the information in the textbox.

Treatment Plan :

Provide the complete treatment plan including medications, level of care requested, other services to be provided to the patient.

Describe the treatment plan.

Figure 251

Physician Certification:

This section captures physician certification in regards to communicable diseases, level of care, and management of the Member’s condition via community care and/or home health services

Note: The system defaults the responses to No.

- 30. Select ‘Yes’ to indicate that the Member is free of communicable diseases.
- 31. Select ‘Yes’ to indicate that the Member’s condition can be managed by Community Care.
- 32. Select ‘Yes’ to indicate that the Member’s condition can be managed by Home Health services.
- 33. Select ‘Yes’ to indicate that the physician has certified the level of care.
- 34. Enter the date that the DMA-6 was signed by the member’s physician in the ‘Date Signed by Physician’ box.

<input checked="" type="radio"/> Yes <input type="radio"/> No	Is the patient free of communicable diseases?
Can this patient's condition be managed by :	
<input checked="" type="radio"/> Yes <input type="radio"/> No	- Community Care ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	- Home Health Services ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	Has the physician certified that this patient requires the level of care provided by a nursing facility or an intermediate care facility for the mentally retarded ?

Date Signed by Physician :	<input type="text" value="04/26/2010"/>
----------------------------	---

Figure 252

Evaluation of Nursing Care Needed:

This section documents the results of the nursing care evaluation.

35. Under each main category, select the applicable item(s) by clicking the corresponding checkbox or button. This section is required.

36. If applicable, enter the number of hours 'out of bed' per day in the 'Hours out of the bed per day' box.

Evaluation of Nursing Care Needed : <i>(check all that apply)</i>					
Diet :	Bladder :	Bowel :	Decubiti :	Restorative Potential :	Overall Condition :
<input checked="" type="checkbox"/> Regular	<input type="radio"/> Continent	<input checked="" type="radio"/> Continent	<input type="checkbox"/> Yes	<input type="radio"/> Good	<input type="radio"/> Improving
<input type="checkbox"/> Diabetic	<input checked="" type="radio"/> Occasionally Incontinent	<input type="radio"/> Occasionally Incontinent	<input checked="" type="checkbox"/> No	<input checked="" type="radio"/> Fair	<input checked="" type="radio"/> Stable
<input type="checkbox"/> Formula	<input type="radio"/> Incontinent	<input type="radio"/> Incontinent	<input type="checkbox"/> Infected	<input type="radio"/> Poor	<input type="radio"/> Fluctuating
<input type="checkbox"/> Low Sodium	<input type="radio"/> Other	<input type="radio"/> Colostomy	<input type="checkbox"/> On Admission	<input type="radio"/> Questionable	<input type="radio"/> Deteriorating
<input type="checkbox"/> Tube Feeding			<input type="checkbox"/> Surgery Date	<input type="radio"/> None	<input type="radio"/> Critical
<input type="checkbox"/> Other					<input type="radio"/> Terminal
Mental & Behavioral Status : <i>(check all that apply)</i>			Nursing Care and Treatment : <i>(Check all that apply)</i>		
<input type="checkbox"/> Agitated	<input type="checkbox"/> Noisy	<input checked="" type="checkbox"/> Dependent	<input type="checkbox"/> Catheter Care	<input type="checkbox"/> Bedfast	
<input type="checkbox"/> Confused	<input type="checkbox"/> Nonresponsive	<input type="checkbox"/> Independent	<input type="checkbox"/> Intake	<input type="checkbox"/> Colostomy Care	
<input type="checkbox"/> Cooperative	<input type="checkbox"/> Vacillating	<input type="checkbox"/> Anxious	<input type="checkbox"/> Output	<input type="checkbox"/> Sterile Dressings	
<input type="checkbox"/> Depressed	<input type="checkbox"/> Violent	<input type="checkbox"/> Well Adjusted	<input type="checkbox"/> IV	<input type="checkbox"/> Suctioning	
<input type="checkbox"/> Forgetful	<input type="checkbox"/> Wanders	<input type="checkbox"/> Disoriented	<input checked="" type="checkbox"/> N/A		
<input type="checkbox"/> Alert	<input checked="" type="checkbox"/> Withdrawn	<input type="checkbox"/> Inappropriate Reaction			

Hours out of the Bed Per Day :	<input type="text" value="12"/> Hrs.
--------------------------------	--------------------------------------

Figure 253

Frequency per Week (Hours):

This section documents the frequency per week in hours of therapies that are provided and needed. This section is not required, but should be completed if applicable to the Member’s plan of care.

37. For each therapy that the member is receiving or needs, enter the number of hours **received** per week in the first column; and the number of hours of therapy that is **needed** in the second column.

Indicate Frequency Per Week (in Hours)		
	Received	Needed
Physical Therapy	<input type="text" value="4"/>	<input type="text" value="6"/>
Occupational Therapy	<input type="text" value="0"/>	<input type="text" value="4"/>
Remotive Therapy	<input type="text"/>	<input type="text"/>
Reality Orientation	<input type="text"/>	<input type="text"/>
Speech Therapy	<input type="text"/>	<input type="text"/>
Bowel and Bladder Retrain	<input type="text"/>	<input type="text"/>
Activities Program	<input type="text"/>	<input type="text"/>

Figure 254

Level of Impairment and Activities of Daily Living:

This section captures the member’s level of impairment in regards to sight, hearing, speech, limitation in motion, and paralysis. It also captures the member’s current abilities regarding activities of daily living in regards to eating, wheelchair, transferring, bathing, ambulating and dressing.

<input type="text"/>
Mild
Moderate
None
Severe

Figure 255 Rating Selections for Level of Impairment

<input type="text"/>
Dependent
Independent
Needs Assistance
Not Appropriate

Figure 256 Rating Selections for ADLs

38. Select the appropriate description for each item from the ‘Level of Impairment’ and ‘Activities of Daily Living’ drop lists.

Activities of Daily Living	
Eating	Independent
Wheelchair	Dependent
Transferring	Needs Assistance
Bathing	Dependent
Ambulating	Not Appropriate
Dressing	Independent

Level of Impairment	
Sight	Moderate
Hearing	Moderate
Speech	None
Limited Motion	Severe
Paralysis	Severe

Figure 257

Justification and Circumstances:

This required section captures information related to the member’s condition that justifies the level of care and services requested.

- 39. Enter the information in the textbox provided.
- 40. In the ‘Name of MD/RN Signing Form’ box, the name of the client’s case manager who signed the DMA-6 may be entered.
- 41. Enter the date that the form was signed in the ‘Date Signed’ box.

Justification and Circumstances for Admission or Continued Placement :

Provide a brief summary of the pertinent information that justifies medical necessity.

Summary of pertinent information that supports medical necessity.

Name of MD / RN Signing Form : John Smith Date Signed : 04/26/2010

Figure 258

42. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.

43. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that ‘information is missing or incorrect’, scroll up the page to find what is missing or incorrect. ‘Required’ displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
44. Click **I Agree** in response to the *Attestation Statement*.
45. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
46. When the request is successfully submitted, the pending PA tracking number displays at the top of the page.

2.3.18.2 ICWP DMA-80

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Independent Care Waiver Program (Form number DMA-80)** to open the *New Request for Prior Authorization* page.
4. The requesting ICWP provider ID is system populated in the ‘Service Provider ID’ box

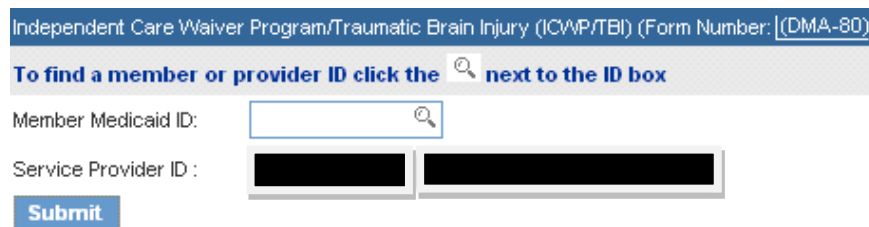


Figure 259

5. Enter the member’s Medicaid ID.
6. Click **Submit** to open the *DMA-6 Confirmation* page.
7. Enter the DMA-6 authorization number in the ‘DMA-6 Prior Authorization Confirmation Number’ box. The DMA-6 must be for same member, approved and not expired.

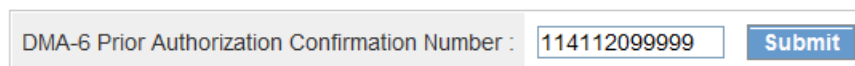


Figure 260

8. Click **Submit**. When the DMA-6 number **does not pass confirmation**, a message displays explaining why the DMA-6 is not valid.
9. When the DMA-6 number **passes confirmation**, the DMA-80 request template opens. At the top of the request form, the Member and requesting ICWP Provider information are system populated based on the Member and Provider ID entered on the *New Request for Prior Authorization* page.

Contact Information:

The system pulls in the ICWP provider’s contact information.

10. Enter contact information that is required (name, phone, email and fax) but is missing.



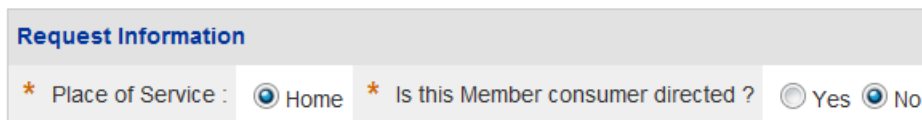
The screenshot shows a form titled "Contact Information" with four input fields. The "Contact Name" field contains "DBARRETT". The "Contact Email" field contains "DB@email.com". The "Contact Phone" field contains "444-444-4444" and an empty "Ext." field. The "Contact Fax" field contains "666-666-6666".

Figure 261

Request Information:

This section captures the following request information: location where services are provided and consumer directed status.

11. The system defaults the ‘Place of Service’ to *Home*.
12. The response to the Consumer Directed question defaults to No. If the member is a consumer directed participant click Yes.



The screenshot shows a form titled "Request Information" with two radio button options. The "Place of Service" field has "Home" selected. The "Is this Member consumer directed?" field has "No" selected.

Figure 262

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type (ICD9 or ICD10), and primary diagnosis indicator for each diagnosis code entered. The Admission indicator is not required.

13. Enter the diagnosis code for the Member’s primary diagnosis related to ICWP in the ‘Diag Code’ box; or search for and have the system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the decimal point when entering the code.
14. Enter the date that this diagnosis was established in the ‘Date’ box, or if not known, the date that the physician signed the DMA-6.
15. Click the ‘Primary’ button to indicate that the diagnosis is the primary diagnosis. **Note:** If only one diagnosis is entered, the system will select that diagnosis as primary.
16. Click **Add** at the end of the diagnosis line to add the diagnosis code to the request.

Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
344.9	PARALYSIS NOS	01/01/2010	Yes	No	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	01/01/2010	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 263

17. If necessary, repeat the same steps to enter other diagnosis codes. Remember to **click Add after diagnosis is entered.**

Procedures Table:

The Procedures Table captures the specific services requested including: service code, service description (system populated), requested start date, requested end date, total units requested, units requested for the month, requested amount, cost sharing amount, if applicable, and modifier(s), if applicable.

18. Enter the code for the service requested in the ‘Service Code’ box; or search for the code and the system will insert the code in the box.
19. Enter the service start date in the ‘From Date’ box; and enter the service end date in the ‘To Date’ box.
20. Enter the total number of units requested for the entire service period in the ‘Units’ box. Enter whole numbers only.
21. Enter ‘0’ for ‘Requested Units/Day’.
22. Enter the number of units to be provided each month in the ‘Requested Units/Month’ box.
23. Enter the total cost of the service requested for the service period in the ‘Requested Amount’ box.

24. Enter the 'Cost Sharing Amount' in the box provided if the member shares the cost of the service.
25. Next, add the appropriate modifier or modifiers, if applicable to the service requested.
26. Click **Add** at the end of the procedure line to add the service information to the request.

Procedures													
Service Code	Service Description	From Date	To Date	Units	Requested Units/Day	Requested Units/Month	Requested Amount	Cost Sharing Amount	Mod 1	Mod 2	Mod 3	Mod 4	
T1016	CASE MANAGEMENT	05/03/2010	05/02/2011	480	0	40	3,000.00	200.00	U1				EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 264

27. If necessary, repeat the same steps to enter another service code. Remember to **click Add after each code is entered.**

Program Information:

This section captures program information including: Admission Date, Type of Admission and Certification Date. Discharge Date is not required.

28. Enter the date that the member was **initially** admitted to the ICWP in the 'Program Admit Date' box.
29. Indicate if the DMA-80 is for an initial admission or for a continuation of services (renewal) by selecting the *Initial Admission* or *Renewal* button.
30. **If 'Renewal' is selected**, also enter the date of the last annual care plan in the 'Date Last Certified' box.

Program Information :

* Program Admit Date : Program Discharge Date : Initial Admission Renewal Date Last Certified :

Figure 265

Supporting Information:

This section captures a description of the services ordered for the member; and the medical justification for providing the services.

31. Describe the services and frequency of services that have been ordered in the 'Description of Services Requested' textbox.
32. Enter a description of the member's diagnosis/condition, and any other information related to the member's condition that justifies the services requested in the 'Justification and Circumstances' textbox; **OR** enter 'see record' or 'see attachment' if this information is to be attached to the PA.

Social History:

The section captures information regarding the Member's social history including:

- **Presenting Problems:** Member's presenting problems and the reason(s) for this evaluation.
 - **Family Information:** Member's family and living situation including information related to significant others and guardian.
 - **Birth and Early Development:** Member's birth and early developmental issues.
 - **Medical Information:** Clinical information related to the Member's present medical status.
 - **Training and Education:** Education or training this Member has or is receiving.
 - **Current Functioning:** Member's present level of functioning including capabilities and disabilities.
 - **Summary of Social History:** Summary of the Member's social history.
33. Enter the required information in each textbox. **In lieu of manually entering the information, it is permissible to enter 'see record' or 'see attachments' in the text boxes if the information is to be attached to the PA.**

Required Documents/Letters:

This section includes a series of questions related to required letters and documents. **Note: The system defaults the responses to No. You must change to Yes if yes is the intended response.**

34. Click 'Yes' to indicate that there is a signed *Letter of Medical Necessity* at the agency. If 'Yes', enter the date that the *Letter of Medical Necessity* was signed in the 'Date Signed' box.
35. Click 'Yes' to indicate that there is a signed *Letter of Understanding* on file. If 'Yes', enter the date that the *Letter of Understanding* was signed in the 'Date Signed' box.
36. Click 'Yes' to indicate that there is a signed *Client Rights and Responsibilities* on file. If 'Yes', enter the date that the *Client Rights and Responsibilities* was signed in the 'Date Signed' box.
37. Click 'Yes' to indicate that there is a signed *Freedom of Choice* form on file. If 'Yes', enter the date that the *Freedom of Choice* form was signed in the 'Date Signed' box.
38. If the member is receiving other waiver services, click 'Yes'.

Is there a signed Letter of Medical Necessity at the agency ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed :	<input type="text" value="04/30/2010"/>
Is there a signed Letter of Understanding on file ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed :	<input type="text" value="04/30/2010"/>
Is there a signed Client Rights and Responsibilities on file ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed :	<input type="text" value="04/30/2010"/>
Is there a signed Freedom of Choice form on file ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed :	<input type="text" value="04/30/2010"/>
Is the patient receiving any other waiver services ?	<input type="radio"/> Yes <input checked="" type="radio"/> No		

Figure 266

39. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
40. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
41. Click **I Agree** in response to the *Attestation Statement*.
42. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
43. When the request is successfully submitted, the pending PA tracking number displays at the top of the page. At this point, additional required documents may be attached utilizing *Create an Attachment*.
44. To attach a file, first check the applicable document type checkboxes that relate to the file to be attached. **Note: The preferred method is to attach one PDF file that includes all the required documents** in which case all the boxes would be checked.

45. Click **Browse** to find the file. Select and open the file. The file name displays in the attachment panel.

46. Click **Attach File**. The file is attached to the PA and added to the **Attached Files** table.

2.3.19 Service Options Using Resources in Community Environments (SOURCE)	
Program	Authorization Period
SOURCE Level of Care and Placement	Initial and Reassessments: 3 months to one year
SOURCE Services	Up to one year
Description	
<p><i>Level of Care and Placement</i> (LOC) requests for initial admission and reassessment are submitted by providers via web portal. The provider is required to attach additional supporting documentation to the LOC request. This additional documentation may be attached when the request is submitted, or attached to an existing LOC PA request that is pending or initially tech denied for missing information</p> <p><i>Services</i> PA are submitted by SOURCE case managers via the web portal, and are considered ‘pass-through’ PAs. These PAs are not reviewed by Alliant/GMCF but are auto approved and then transmitted to MMIS.</p>	

2.3.19.1 SOURCE LOC

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select the **SOURCE Level of Care and Placement** link.
4. On the *New Request for Prior Authorization* page, the requesting SOURCE provider ID is system populated in the ‘SOURCE Provider ID box’. Enter the member’s Medicaid ID in the ‘Member Medicaid ID’ box.

New Request for Prior Authorization

Figure 267

5. Click **Submit** to open the *Level of Care and Placement* request form.

- The system populates the requesting provider information and the member information at the top of the request form.

Physician Information:

This section captures information about the member’s primary physician and/or SOURCE Site Medical Director.

- Enter the physician’s first name and last name in the ‘Physician Name’ box (required).
- If the physician is the member’s primary physician, select the ‘Primary Physician’ checkbox. If the physician is the SOURCE Site Medical Director, select the ‘SOURCE Site Medical Director’ checkbox. Select both checkboxes if the physician is the primary physician and the Medical Director.
- Enter the physician’s phone number in the ‘Phone’ box (required).
- Enter the date that the physician signed the Level of Care and Placement in the ‘Date LOC Signed’ box (required).
- The physician address information and license number are not required.

Physician Information			
* Physician Name :	<input type="text" value="John Physician"/>	<input checked="" type="checkbox"/> Primary Physician <input type="checkbox"/> SOURCE Site Medical Director	Physician ID :
Address Line 1 :	<input type="text"/>	Address Line 2 :	<input type="text"/>
City :	<input type="text"/>	State : <input type="button" value="v"/>	Zip : <input type="text"/> County : <input type="button" value="v"/>
* Phone :	<input type="text" value="404-444-4444"/>	Ext. <input type="text"/>	Fax : <input type="text" value="- -"/>
* Date LOC signed by Physician:	<input type="text" value="06/07/2012"/>	Physician License Number :	<input type="text"/>

Figure 268

Contact Information:

The system pulls in the requesting provider’s contact information.

- Enter contact information that is missing. If any information is incorrect, change the information. It is important to verify the ‘Contact Email’ since the email address listed here is used for any email notifications.

Contact Information			
* Contact Name:	<input type="text" value="DBARRETT"/>	* Contact Email:	<input type="text" value="DB@email.com"/>
Contact Phone:	<input type="text" value="444-444-4444"/>	Ext. <input type="text"/>	* Contact Fax: <input type="text" value="666-666-6666"/>

Figure 269

Request Information:

This section captures information specific to the level of care and placement request including: recommendation type, DON-R score, initial admit date, *Money Follows the Person* indicator, and place of service. All information is required.

13. Select the ‘Recommendation Type’. Click the *Initial* button if this is the initial level of care request for the member. Click *Reassessment* if this request is for a level of care reassessment.
14. If an initial request, enter the DON-R screening score in the ‘DON-R Telephone Screening Score’ box. The DON-R score is not required for Reassessments.
15. If an initial request, enter the date admitted to the program or the planned admission date in the ‘Initial Admit Date’ box.
16. If a reassessment request, enter the date that the member was **initially** admitted to SOURCE in the ‘Initial Admit Date’ box.
17. Indicate whether or not the member is approved for *Money Follows the Person* by selecting *Yes* or *No*.
18. From the ‘Place of Service’ drop list, select the location where services are provided or to be provided. The choices are *Home* or *Other*.

Request Information			
* Recommendation Type :	<input checked="" type="radio"/> Initial <input type="radio"/> Reassessment	DON-R Telephone Screening Score :	<input type="text" value="25"/>
* Initial Admit Date :	<input type="text" value="01/01/2014"/>	* Approved for Money Follows the Person?	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Place of Service :	<input type="text" value="12 - Home"/>		

Figure 270

Diagnosis:

This table captures the diagnosis code (or codes) associated with the patient’s condition; diagnosis description (system populated); diagnosis date; diagnosis type (ICD9 or ICD10); and specifies the primary diagnosis. At least one diagnosis code is required.

19. Enter the diagnosis code in the ‘Diag Code’ box. If the diagnosis code includes a decimal point, enter the decimal point when entering the code. The system populates the diagnosis description when the diagnosis is added.

20. Enter the date that the diagnosis was determined in the 'Date' box. If not known, enter the initial admission date/planned admission date to the SOURCE Program.
21. Click the 'Primary' checkbox to indicate that the diagnosis is the member's primary diagnosis. The 'Admission' checkbox is optional. **Note:** If only one diagnosis is entered, the system will select that diagnosis as primary.
22. Click **Add** at the end of the diagnosis line. **You must click Add to add the diagnosis information to the request.**

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
344.1	PARAPLEGIA NOS	01/01/2012	Yes	No	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 271

23. Repeat the same process to add other diagnosis codes, if necessary. Remember to **click Add after each addition.**

Acute Care Hospital Dates and Diagnosis on Admission to Hospital:

This information is not required but may be entered if applicable to the request.

24. If the member was admitted to an acute hospital setting in the past six (6) months, enter the admission date in the 'From Date' box and enter the discharge date in the 'To Date' box.
25. Enter the member's primary admission diagnosis code in the 'Diag Code' box. The system will insert the diagnosis description when the diagnosis is added. Select the 'Primary' indicator.
26. Click **Add**.

Acute Care Hospital Dates : From Date : To Date :

Diagnosis on Admission to Hospital			
Diag Code	Diagnosis Description	Primary	
362.07	DIABETIC MACULAR EDEMA	Yes	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	ADD

Figure 272

Medications and Diagnostic/Treatment Procedures:

This section captures medications and treatment procedures applicable to the member’s plan of care. In lieu of manually entering information for medications and diagnostic/treatment procedures, the information may be attached to the *Level of Care and Placement*. To let the reviewer know that this information is attached, enter “See Attached” in the ‘Treatment Plan’ text box.

27. To add medication information, click the down arrow in the ‘Name’ drop list and select a medication category.
28. Enter the dosage of the medication in the ‘Dosage’ box.
29. Select the administration method from the ‘Route’ drop list, and the frequency of administration from the ‘Frequency’ drop list.
30. Click **Add**.
31. Follow the same process to add other medications to the request.

Medications				
Name	Dosage	Route	Frequency	
Antihypertensive	30mg	Oral	Regular	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
Sed/hypnotic	50mg	Oral	Regular	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="button" value="ADD"/>

Figure 273

32. To add a diagnostic/treatment procedure, select a diagnostic/treatment procedure from the ‘Type’ drop list
33. Enter the frequency for the treatment procedure in the ‘Frequency’ box.
34. Click **Add**.

Diagnostic and Treatment Procedures		
Type	Frequency	
Medication Regulation	Daily	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text" value=""/>	<input type="text" value=""/>	<input type="button" value="ADD"/>

Figure 274

35. Follow the same process to add other treatments/procedures.

Services:

This section captures the SOURCE services that are requested as part of the member’s plan of care. This information is required.

- 36. Click the down arrow from the ‘Services’ drop list and select a service type.
- 37. In the ‘Amount’ box, enter the unit of service requested.
- 38. In the ‘Frequency’ box, enter the service frequency for a specified period of time. If the service is only to be provided one time, enter *one time* as the frequency.
- 39. In the ‘Duration’ box, enter how long the service is to be provided. If the service is only to be provided once, enter *one time*.
- 40. Click **Add** to add the service information to the request.

Services
Describe the services and for each service indicate the amount, frequency and duration (example: RN Service, 1 session or 1 visit, 2X/week, (for) 6 weeks).

Services	Amount	Frequency	Duration	
T1030-Skilled Nursing Services RN	1 visit	2X week	6 weeks	ADD

Figure 275

- 41. Follow the same process to add other services. Remember to click **Add** after entering each line of service information.

Services
Describe the services and for each service indicate the amount, frequency and duration (example: RN Service, 1 session or 1 visit, 2X/week, (for) 6 weeks).

Services	Amount	Frequency	Duration	
T1031-Skilled Nursing Services LPN	1 visit	2X week	6 weeks	EDIT DELETE
S5170-Home Delivered Meals	2 meals	7 days/week	6 months	EDIT DELETE
				ADD

Figure 276

Treatment Plan:

This textbox captures a description of the member’s treatment plan.

- 42. Summarize the treatment plan to include information not otherwise specified on the request, including the name of specific medications, level of care requested, residential history, and other services to be provided. This information is required. However, in lieu of entering this information manually, you may attach this information to the PA. To let the reviewer know that the information is attached, enter “See Attached Treatment Procedures or Medications” in the text box.

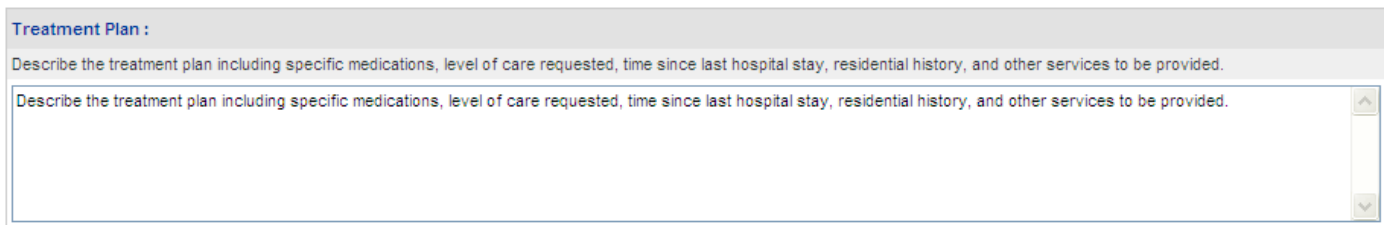


Figure 277

Certification Questions:

This section captures the physician’s certification for the level of care and placement. A *Yes* or *No* response is required for each question.

- 43. Indicate whether or not the member is free of communicable diseases.
- 44. Indicate whether or not the member’s condition is manageable by SOURCE.
- 45. Indicate whether or not the member’s condition is manageable by Home Health Services.
- 46. Indicate whether or not the physician has certified that the member requires intermediate level of care provided by a nursing facility.
- 47. Indicate whether or not the physician has certified that the attached plan of care addresses the client’s needs for Community Care.

<input checked="" type="radio"/> Yes <input type="radio"/> No	Is the patient free of communicable diseases?
	Can this patient's condition be managed by :
<input checked="" type="radio"/> Yes <input type="radio"/> No	- Source ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	- Home Health Services ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	Has the physician certified that this patient requires the intermediate level of care provided by a nursing facility?
<input checked="" type="radio"/> Yes <input type="radio"/> No	Has the physician certified that the attached plan of care addresses the client's needs for Community Care?

Figure 278

Evaluation of Nursing Care Needed:

This section captures the member’s nursing needs identified in the nursing care evaluation.

- 48. Required - For each nursing evaluation category, select the nursing need item(s) necessary for the member’s care. More than one item may be selected for nursing evaluation categories with checkboxes, such as ‘Diet’. However, only one item can be selected for other categories with radio buttons, such as ‘Restorative Potential’.
- 49. Optional - Enter the number of hours that the member is usually out of bed per day in the ‘Hours out of the bed Per Day’ box.

Evaluation of Nursing Care Needed : (check all that apply)					
Diet :	Bladder :	Bowel :	Decubiti :	Restorative Potential :	Overall Condition :
<input checked="" type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Formula <input type="checkbox"/> Low Sodium <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Other	<input type="radio"/> Continent <input type="radio"/> Occasionally Incontinent <input checked="" type="radio"/> Incontinent <input type="radio"/> Other	<input type="radio"/> Continent <input type="radio"/> Occasionally Incontinent <input type="radio"/> Incontinent <input checked="" type="radio"/> Colostomy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Infected <input type="checkbox"/> On Admission <input type="checkbox"/> Surgery Date	<input type="radio"/> Good <input checked="" type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Questionable <input type="radio"/> None	<input type="radio"/> Improving <input type="radio"/> Stable <input checked="" type="radio"/> Fluctuating <input type="radio"/> Deteriorating <input type="radio"/> Critical <input type="radio"/> Terminal
Mental & Behavioral Status : (check all that apply)			Nursing Care and Treatment : (Check all that apply)		
<input type="checkbox"/> Agitated <input checked="" type="checkbox"/> Confused <input type="checkbox"/> Cooperative <input type="checkbox"/> Depressed <input type="checkbox"/> Forgetful <input type="checkbox"/> Alert	<input type="checkbox"/> Noisy <input type="checkbox"/> Nonresponsive <input type="checkbox"/> Vacillating <input type="checkbox"/> Violent <input checked="" type="checkbox"/> Wanders <input type="checkbox"/> Withdrawn	<input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Anxious <input type="checkbox"/> Well Adjusted <input checked="" type="checkbox"/> Disoriented <input type="checkbox"/> Inappropriate Reaction	<input type="checkbox"/> Catheter Care <input type="checkbox"/> Intake <input type="checkbox"/> Output <input type="checkbox"/> IV <input checked="" type="checkbox"/> N/A	<input type="checkbox"/> Bedfast <input checked="" type="checkbox"/> Colostomy Care <input checked="" type="checkbox"/> Sterile Dressings <input type="checkbox"/> Suctioning	
Hours out of the Bed Per Day : <input type="text" value="10"/> Hrs.					

Figure 279

Frequency of Therapies, Activities of Daily Living and Level of Impairment:

These sections capture additional evaluation information including: assessment of the member’s activities of daily living, level of impairment, and need for specific therapies.

- 50. **Therapies:** If applicable to the member’s plan of treatment, enter the hours per week of therapy received and the hours needed in the boxes provided.
- 51. **Activities of Daily Living:** For each ADL category, select the level of assistance needed from the drop list.
- 52. **Level of Impairment:** For each category of impairment, select the level impairment from the drop list.

Indicate Frequency Per Week (in Hours)		
	Received	Needed
Physical Therapy	<input type="text"/>	<input type="text"/>
Occupational Therapy	<input type="text"/>	<input type="text"/>
Restorative Therapy	<input type="text"/>	<input type="text"/>
Reality Orientation	<input type="text" value="0"/>	<input type="text" value="15"/>
Speech Therapy	<input type="text"/>	<input type="text"/>
Bowel and Bladder Retrain	<input type="text" value="2"/>	<input type="text" value="4"/>
Activities Program	<input type="text"/>	<input type="text"/>

Activities of Daily Living	
Eating	<input type="text" value="Independent"/>
Wheelchair	<input type="text" value="Needs Assistance"/>
Transferring	<input type="text" value="Dependent"/>
Bathing	<input type="text" value="Needs Assistance"/>
Ambulating	<input type="text" value="Not Appropriate"/>
Dressing	<input type="text" value="Needs Assistance"/>

Level of Impairment	
Sight	<input type="text" value="Mild"/>
Hearing	<input type="text" value="Moderate"/>
Speech	<input type="text" value="Severe"/>
Limited Motion	<input type="text" value="Severe"/>
Paralysis	<input type="text" value="None"/>

Figure 280

Justification and Circumstances for Admission of Continued Placement:

This section captures justification for the services ordered, the name of the RN or LPN signing the request, and the date signed.

53. In the ‘Justification and Services’ textbox, explain why SOURCE services are necessary for the member’s care.
54. Enter the first name and last name of the RN who signed the *Level of Care and Placement* in the ‘Name of RN Signing Form’ box.
55. Enter the date that the form was signed in the ‘Date Signed’ box.

Justification and Circumstances for Admission or Continued Placement :

Provide justification for the services ordered.

Describe the treatment plan including specific medications, level of care requested, time since last hospital stay, residential history, and other services to be provided. Describe the treatment plan including specific medications, level of care requested, time since last hospital stay, residential history, and other services to be provided. Describe the treatment plan including specific medications, level of care requested, time since last hospital stay, residential history, and other services to be provided.

Name of RN Signing Form : Date Signed :

Figure 281

56. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
57. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that ‘information is missing or incorrect’, scroll up the page to find what is missing or incorrect. ‘**Required**’ displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.

- 58. Click '*I Agree*' in response to the *Attestation Statement* to confirm that all information is true and in accordance with Department of Community Health policy.
- 59. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
- 60. When the request is successfully submitted, the pending PA tracking number displays at the top of the page. At this point, additional supporting documents required for SOURCE requests may be attached via *Create an Attachment*.

The screenshot shows a web interface titled "Create an Attachment". It includes instructions on how to attach a document and a warning that the case will not be accepted for review until all required documents are attached. Below this is a text input field, a "Browse..." button, and an "Attach File" button. A table lists required documents for "SOURCE-INITIAL" with checkboxes. The documents are: Appendix F - Level of Care and Placement Instrument Form, Appendix I - Level of Care Justification for Intermediate Nursing Facility Care, Appendix S-MDS-HC Form, Appendix C-SOURCE Assessment Addendum, Medication Record, Case Notes, and DON-R Screening Tool. All checkboxes are currently unchecked.

Codes	Documents	
SOURCE-INITIAL	<input type="checkbox"/> Appendix F - Level of Care and Placement Instrument Form	<input type="checkbox"/> Medication Record
	<input type="checkbox"/> Appendix I - Level of Care Justification for Intermediate Nursing Facility Care	<input type="checkbox"/> Case Notes
	<input type="checkbox"/> Appendix S-MDS-HC Form	<input type="checkbox"/> DON-R Screening Tool
	<input type="checkbox"/> Appendix C-SOURCE Assessment Addendum	

Figure 282

Attach Documents

The attachment panel includes checkboxes for each required document. The documents listed are specific to the type of recommendation requested on the Level of Care. One file or multiple files may be attached. **It is recommended, however, to attach one PDF file for all the required documents.**

Attach one file for all document types:

- 1. Click each document type checkbox.

This screenshot is identical to Figure 282, but all checkboxes in the table are now checked, indicating that all required documents have been selected for attachment.

Codes	Documents	
SOURCE-INITIAL	<input checked="" type="checkbox"/> Appendix F - Level of Care and Placement Instrument Form	<input checked="" type="checkbox"/> Medication Record
	<input checked="" type="checkbox"/> Appendix I - Level of Care Justification for Intermediate Nursing Facility Care	<input checked="" type="checkbox"/> Case Notes
	<input checked="" type="checkbox"/> Appendix S-MDS-HC Form	<input checked="" type="checkbox"/> DON-R Screening Tool
	<input checked="" type="checkbox"/> Appendix C-SOURCE Assessment Addendum	

Figure 283

- 2. Click **Browse** in the attachment panel to open the file directory

- Find the file that is to be attached. Select the file by double clicking the file, or highlight the file and then click **Open**.
- Once the file is selected, the file name displays in the attachment panel.

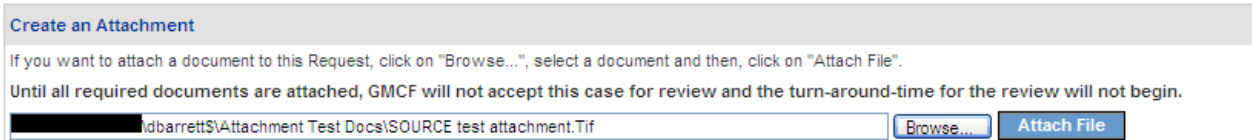


Figure 284

- Click the **Attach File** button. If the file is uploaded, the 'File uploaded successfully' message displays. The **file is associated with each document type selected**, which can be viewed in the **Attached Files** table. The document types no longer display in red indicating that each document has been attached.

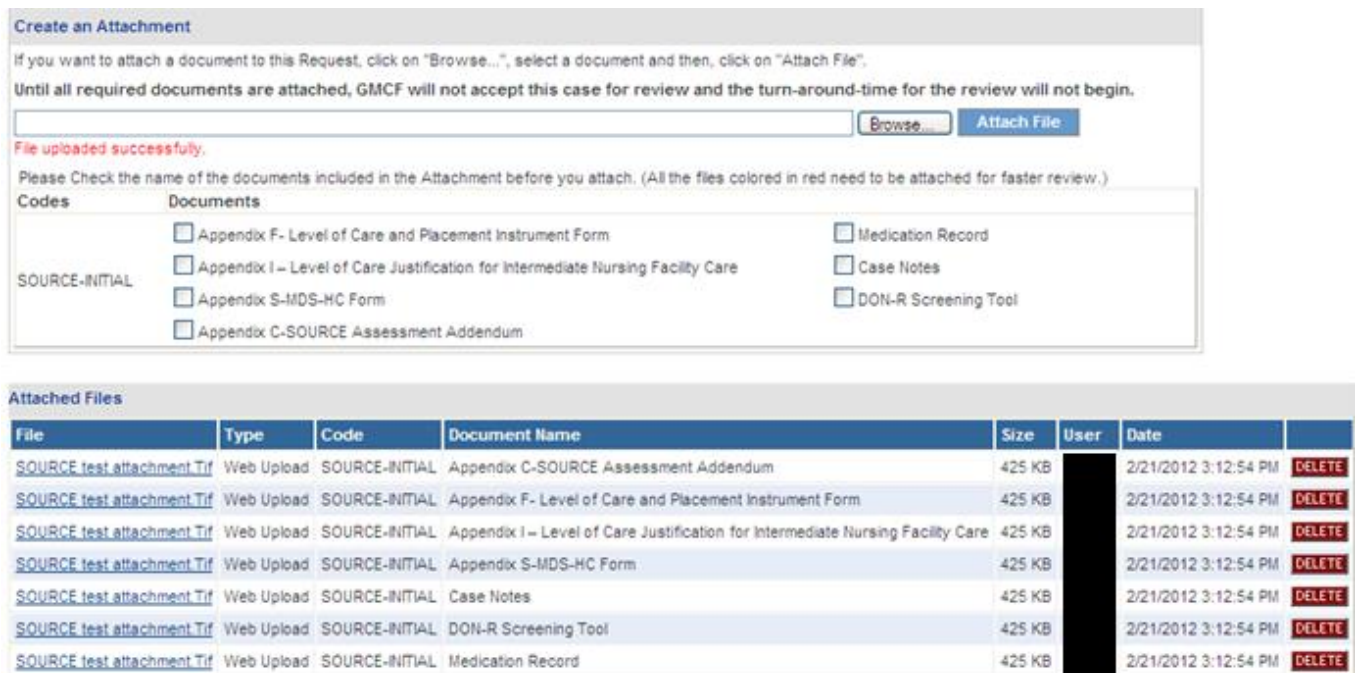


Figure 285

Attach more than one file for different document types:

- Select the document type checkbox or checkboxes that relate to the first file to be attached. Click **Browse**; find and select the file; and then click **Attach File**. The file attached is associated with the document type or types selected.
- Repeat this process until all checkboxes have been selected.

Level of Care Notifications

When a SOURCE Level of Care and Placement request is initially approved or initially tech denied, a **no-reply** email notification is sent to the provider. The notification indicates that the case was approved or denied and refers the provider to the **PA Notifications** on the *Provider Workspace* for details. If the case was denied for missing information, the notification also specifies what documents are missing. There are two ways to view notification details via the *Provider Workspace*:

- ‘Last Ten PA Notifications’: This section of the workspace shows the last ten notifications associated with the provider ID.
- Search for the PA and open the *Review Request* page: This is useful to view ‘older’ notifications.

Last Ten PA Notifications:

1. Log into the web portal and select **Prior Authorization** and then **Provider Workspace**.
2. At the top of the workspace, a ‘PA Notifications’ drop list shows the last ten PAs with notifications related to the provider’s ID.

Provider Workspace

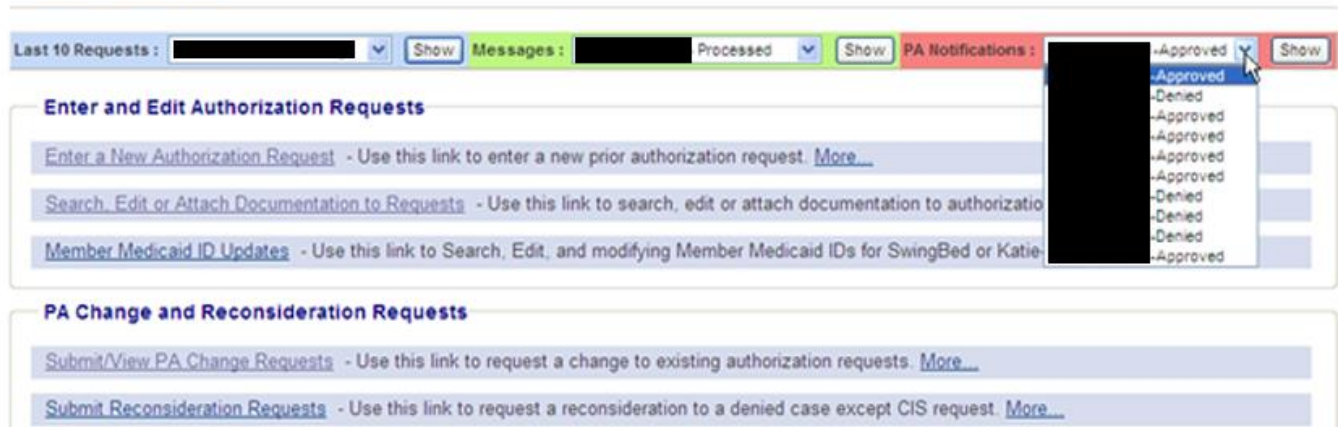


Figure 286

3. To access the notification details for a PA in the drop list, first click on and highlight the desired PA.
4. Then, click **Show** to open the *PA Review Request* page. The *PA Review Request* page shows all the SOURCE notifications related to a single PA. The notification details display at the top of the page as shown in the following figure.

Prior Authorization - Review Request

This PA cannot be edited. Either the PA is currently under process or the decision is taken or this PA type cannot be edited once it is submitted.

Notification(s) for this PA

Date	Status	Notification
12/27/2011		The Source PA # [REDACTED] submitted by you, has been Denied. The PA is missing some document(s) : Appendix F- Level of Care and Placement Instrument Form , Appendix I – Level of Care Justification for Intermediate Nursing Facility Care , Appendix S-MDS-HC Form , Appendix C-SOURCE Assessment Addendum , Medication Record , Case Notes ,

Request Information

Request ID : [REDACTED] Case Status : **Denied** Case Status Date : 12/27/2011
 Member ID : 333000000500
 Provider ID : [REDACTED]
 Admission Date : 12/27/2011 Discharge Date :
 Effective Date : 12/27/2011 Expiration Date : 03/26/2012
 Denial Reason :

Diagnosis

ICD-9 Code	ICD-9 Description	ICD-9 Date	Primary
344	OTH PARALYTIC SYNDROMES	12/27/2011	Yes

[Attach File](#) [Return To Search Results](#) [Return to Provider Workspace](#) [Contact Us](#)

Figure 287

5. If the PA was tech denied initially and then approved later, this page shows both the denial and approval notifications by date.

2.3.19.2 SOURCE Services PA

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.

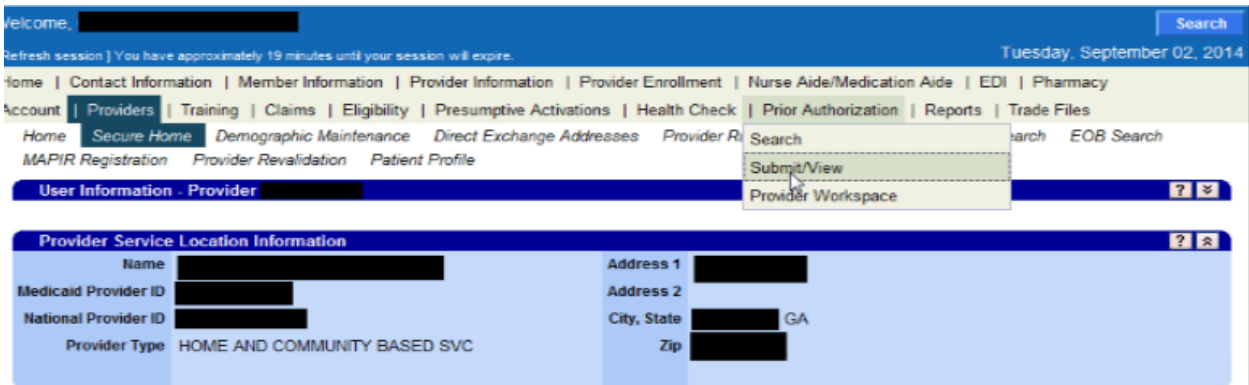


Figure 288

3. **OR** – Select **Provider Workspace**; and on the workspace page, click **Enter a New Authorization Request**.
4. On the next window, click the **Source Services** option.

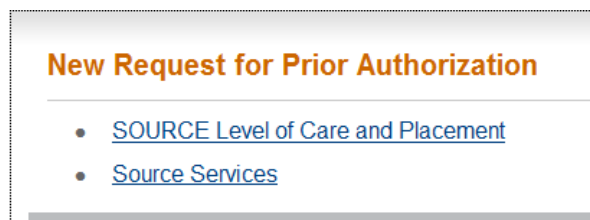




Figure 289

5. On the next screen, the case manager's provider ID is prepopulated based on portal login credentials.
6. Enter the member's Medicaid ID and click **Submit**.

New Request for Prior Authorization

Source

To find a Member or Provider click the  next to the ID box

Member Medicaid ID: 

Source Provider ID:

Figure 290

7. On the next page, enter the authorization number for the SOURCE Level Care and Placement associated with the SOURCE Services request in the 'SOURCE LOC PA Confirmation Number' box.

New Request for Prior Authorization

Source LOC Prior Authorization Confirmation Number :

Figure 291

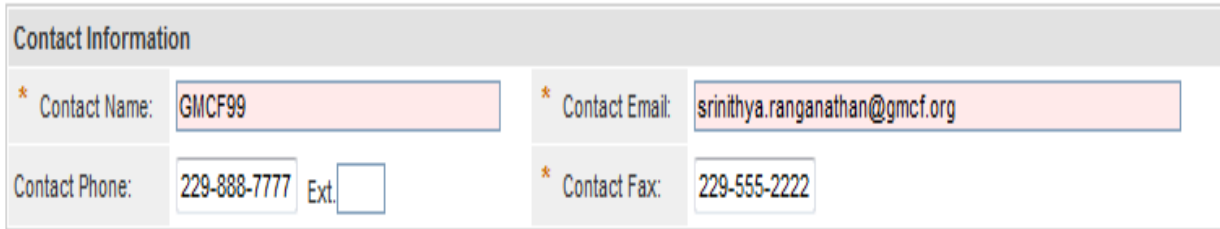
8. Click **Submit**. The system validates that the LOC is approved, has not expired, and is for the same member associated with the Services request.

Provider/Member Information:

9. If the LOC PA ID passes validation, the SOURCE PA template opens with the case manager and member information prepopulated on the form.

Contact Information:

10. The requesting provider contact information is populated by the system. Check the information for accuracy. If any information is missing or incorrect, enter or correct the information. All fields are required.

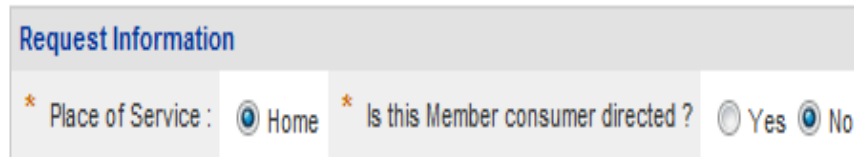


The screenshot shows a 'Contact Information' form with the following fields: Contact Name (GMCF99), Contact Email (srinithya.ranganathan@gmcf.org), Contact Phone (229-888-7777), Contact Fax (229-555-2222), and an empty Ext. field.

Figure 292

Request Information:

- 11. The 'Place of Service' defaults to *Home*.
- 12. Click 'Yes' if the member is consumer directed; otherwise leave as 'No'.



The screenshot shows a 'Request Information' form with the following fields: Place of Service (radio button selected for Home) and Is this Member consumer directed? (radio buttons for Yes and No, with No selected).

Figure 293

Diagnosis:

At least one diagnosis code is required.


- 13. Enter the diagnosis code for the member's primary diagnosis related to SOURCE services in the 'Diag Code' box. The system populates the diagnosis description when the diagnosis is added to the request.
- 14. Enter the date that the diagnosis was established; if not known, enter the date that the member started in SOURCE.
- 15. Click the 'Primary' diagnosis button. If only one diagnosis is added to the request, the system will designate that diagnosis as primary. If more than one diagnosis is added, the user must select one of the diagnoses as primary.
- 16. Click **Add** to add the diagnosis information to the request. When **Add** is selected, a blank diagnosis line becomes available for adding another diagnosis.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
344.00	QUADRIPLÉGIA, UNSPECIFD	01/01/2010	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>			ADD

Figure 294

Services:

This section captures the procedure information for the services requested. Case Managers enter one PA for up to a year date span for case management services, and for services rendered by other SOURCE providers.

16. In the ‘Service Code’ box, enter the procedure code for one of the services requested. The system inserts the description. **Suggestion:** If case management services are to be requested for a year, enter that service line first.
17. Enter the first date of service in the ‘From Date’ box and the end date of service in the ‘To Date’ box. The date span cannot exceed one year.
18. Enter the total units requested for the service and for the date span in the ‘Units’ box.
19. Enter the units of service requested per month in the ‘Requested Units/Month’ box.
20. Enter the total dollar amount requested in the ‘Amount’ box. Do not enter a dollar sign.
21. If applicable, enter the amount of cost sharing for the service in the ‘Cost Sharing Amount’ box.
22. Enter the provider ID for the provider who is rendering the service. The provider ID may be entered manually, or have the system auto-insert the provider ID by using search.
23. Click the search icon  in the ‘Rendering Provider ID’ box to open a search page. Enter the provider ID or provider name and click **Search**. Select the correct provider in the search results, and the system inserts the provider ID in the ‘Rendering Provider ID’ box on the service line.
24. If a modifier or modifiers are applicable to the service procedure code, enter the first modifier in the ‘Mod 1’ box. If there is a second modifier, enter in the ‘Mod 2’ box.
25. Click **Add**. The service procedure code is added to the PA and another blank service line becomes available to enter another procedure code and service information to the request.

Procedures												
Service Code	Service Description	From Date	To Date	Units	Req Units / Month	Amount	Cost Sharing Amount	Rendering Provider ID	Mod 1	Mod 2	Mod 3	
T2022	CASE MANAGEMENT, PER MONTH	08/04/2014	08/04/2015	12	1	1,800.00	0.00		SE			EDIT DELETE
T1021	HH AIDE OR CN AIDE PER VISIT	09/01/2014	08/04/2015	5,700	480	3,000.00	0.00		TF			EDIT DELETE
S5170	HOMEDELIVERED PREPARED MEAL	09/15/2014	03/15/2015	672	56	2,210.00	0.00					EDIT DELETE
												ADD CANCEL

Figure 295

Note: When procedure lines are entered, system validation prevents the addition of duplicate service lines. Case Managers are alerted when attempting to add a service line that is a ‘possible’ duplicate if the ‘new’ service line dates of service conflict with an approved SOURCE PA for same member, provider, procedure code/modifier - for a given time period

Program Information:

26. Enter the date that the member was initially admitted to SOURCE in the ‘Program Admit Date’ box.
27. Click ‘Initial Admission’ (initial admission to SOURCE) or ‘Renewal’ (Reassessment). If Renewal is selected, enter the date that the member was last assessed in the ‘Date Last Certified’ box. **Note:** ‘Program Discharge Date’ is not required.

Program Information :

* Program Admit Date : Program Discharge Date :

Initial Admission Renewal Date Last Certified :

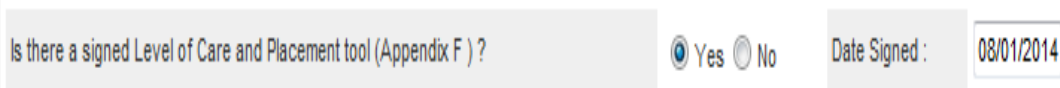
Figure 296

Supporting Information and Social History:

The next section of the request form consists of 9 textboxes which may be used to capture supporting information and member social history. **These textboxes are optional and may be left blank.**

Appendix F Confirmation:

28. In the last section, indicate if there is a signed Level of Care (Appendix F) by clicking ‘Yes’.
29. Lastly, enter the date that the Level of Care was signed.



Is there a signed Level of Care and Placement tool (Appendix F) ? Yes No Date Signed : 08/01/2014

Figure 297

30. Once all required data has been entered on the request form, click **Review Request**. An *Attestation Statement* displays.
31. Read the statement and confirm agreement by clicking **I Agree**. **This is required to submit the request.**
32. Next, review the request information entered to be sure it is correct. Information may be corrected by clicking **Edit Request**.
33. When all information entered is correct, click **Submit Request**. The next page displays the 'Request ID' at the top of the page, which is the authorization number when the request is in Approved status

Editing Source Services PAs

Existing SOURCE PAs may need to be edited (units and dates adjusted) by case managers when a rendering provider associated with a service line changes or when a member's status changes. The case manager may need to cutback an existing service line for a given Provider who is rendering a specific service, and then add a second line **to the same PA** for a new provider for the **same service but for different dates of service**. SOURCE PAs may also need to be modified if there is a PA Edit attached to the PA. When a PA is sent to MMIS, the data is validated against certain criteria and an edit 'error' may be triggered. It may be necessary to modify the request information in order to remove the edit and allow the PA to transmit to MMIS. Case managers are notified by email when a SOURCE PA entered by the case manager has an edit.

1. To edit a PA, the first step is to find the PA using the PA search option on the *Provider Workspace*. Open the *Provider Workspace* and click **Search, Edit or Attach Documentation to Requests**.
2. On the Search page, the requesting provider ID is populated by the system. Enter the 12 digit PA ID (Request ID) in the 'Request ID' box. **No other information needs to be entered**. Click **Search**.

Prior Authorization Request Search

Request ID :	<input type="text" value="114090299999"/>	PA Status:	<input type="text" value=""/>	Provider ID :	<input type="text" value=""/>
Request From Date :	<input type="text" value=""/>	Request To Date :	<input type="text" value=""/>		
Member Medicaid ID :	<input type="text" value=""/>	Member First Name :	<input type="text" value=""/>	Member Last Name :	<input type="text" value=""/>
Effective Date :	<input type="text" value=""/>	Expiration Date :	<input type="text" value=""/>	Include PA Notifications :	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ALL
<input type="button" value="Search"/> <input type="button" value="Reset"/>					

Figure 298

- Click the 'Request ID' that displays in the search results. The PA *Review Request* page opens which provides a summary of the PA information.

Prior Authorization - Source Review Request

Warning: You cannot submit a change request for this PA Type.

Request Information			
Request ID :	<input type="text" value=""/>	Case Status :	Approved
Member ID :	333000000400	Case Status Date :	09/03/2014
Social Security Number :	132549678		
Provider ID :	<input type="text" value=""/>	CMO PA Request ID :	<input type="text" value=""/>
Admission Date :	<input type="text" value=""/>	Discharge Date :	<input type="text" value=""/>
Effective Date :	09/01/2014	Expiration Date :	09/01/2015

Diagnosis				
Diag Code	Diagnosis Description	Date	Primary	Type
344.00	QUADRIPLEGIA, UNSPECIFD	09/03/2014	Yes	ICD-9

Procedures									
CPT Code	CPT Description	Effective Date	Expiration Date	Units	Approved Units	Approved Amount	Decision	Reason	Family of Code(s)
S5170	HOMEDELIVERED PREPARED MEAL	09/01/2014	09/01/2015	672	672	2210.00	Approved		No
T1021	HH AIDE OR CN AIDE PER VISIT	09/01/2014	09/01/2015	850	850	2800.00	Approved		No
T2022	CASE MANAGEMENT, PER MONTH	09/01/2014	09/01/2015	12	12	1800.00	Approved		No

Figure 299

- To edit the PA, click **Edit Request** at the bottom of the page.
- On the next page, go to the **Procedures** table and click **Edit** at the end of the procedure line that needs to be modified.

Service Code	Service Description	From Date	To Date	Units	Req Units / Month	Amount	Cost Sharing Amount	Rendering Provider ID	Mod 1	Mod 2	Mod 3	
S5170	HOMEDELIVERED PREPARED MEAL	09/01/2014	09/01/2015	672	56	2,210.00	0.00	[REDACTED]				EDIT
T1021	HH AIDE OR CN AIDE PER VISIT	09/01/2014	09/01/2015	850	200	2,800.00	0.00	[REDACTED]	TF			EDIT
T2022	CASE MANAGEMENT, PER MONTH	09/01/2014	09/01/2015	12	1	1,800.00	0.00	[REDACTED]	SE			EDIT

Figure 300

- The following data may be modified:
 - Procedure start and end dates
 - Units
 - Units per Month
 - Amount
 - Cost Sharing
- After modifying data, click **Save** at the end of the procedure line.
- When a procedure line for a ‘new’ provider needs to be added, enter the service information on the open (blank) procedure line. Click **Add** after all the required information is entered. In the figure below, the first highlighted service line is the original service line for T1021 which was ‘cut back’ and end dated to 12/1/14. A new service line for the new provider (second highlighted line) was added for the same procedure, different provider, and a start date of 12/2/14 – a day after the end of the other service line.

Service Code	Service Description	From Date	To Date	Units	Req Units / Month	Amount	Cost Sharing Amount	Rendering Provider ID	Mod 1	Mod 2	Mod 3	
T1021	HH AIDE OR CN AIDE PER VISIT	09/01/2014	12/01/2014	400	100	1,400.00	0.00	[REDACTED]	TF			EDIT
S5170	HOMEDELIVERED PREPARED MEAL	09/01/2014	09/01/2015	672	56	2,210.00	0.00	[REDACTED]				EDIT
T2022	CASE MANAGEMENT, PER MONTH	09/01/2014	09/01/2015	12	1	1,800.00	0.00	[REDACTED]	SE			EDIT
T1021	HH AIDE OR CN AIDE PER VISIT	12/02/2014	09/01/2015	180	60	1,000.00	0.00	[REDACTED]	TF			EDIT

Figure 301

- To submit the changes made to the PA, go to the bottom of the page and click **Review Request**.
- Then click **I Agree** to the *Attestation Statement* again, and then **Submit Request**. **The PA is modified but the authorization ID remains the same.**

2.3.20 Community Care Services Program (CCSP) Level of Care	
Program	Authorization Period
CCSP Level of Care and Placement	Initial and Reassessment up to one year
Description	
<p><i>Level of Care (LOC) and Placement</i> requests for initial admission and reassessment under the Community Care Services Program (CCSP) are submitted via the web portal. In addition to the LOC request form, CCSP providers are required to submit additional supporting documentation. This additional documentation may be attached when the request is submitted, or attached to an existing LOC request that is pending or initially tech denied for missing information.</p>	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. On the next screen, select **CCSP Level of Care and Placement**.
4. On the *New Request for Prior Authorization* page, the requesting CCSP provider ID is system populated in the ‘CCSP Provider ID’ box.
5. Enter one member identifier. Enter the AIMS Number **OR** the member’s Social Security Number **OR** the member’s Medicaid ID number. **Enter only one identifier.**

The screenshot shows a web form titled "CCSP Level of Care and Placement". At the top, there is a blue header bar with the title. Below the header, a grey instruction bar says "To find a Member or Provider click the [magnifying glass icon] next to the ID box". The form contains four input fields: "Member Medicaid ID:" with a magnifying glass icon, "AIMs Number :" with the value "AIMS11111", "Social Security Number :" with a dash-separated format, and "CCSP Provider ID :" with the value "00000009A" and a magnifying glass icon. A blue "Submit" button is located at the bottom left of the form.

Figure 302

6. Click **Submit** to open the *Level of Care and Placement* request form.

Provider/Member Information:

7. When the request form opens, the requesting provider information is auto-populated.

8. Member information is also populated according to these rules:

- If the applicant’s Medicaid ID was entered, the system populates the member information including the member’s address. The system also populates the AIMS number if the Medicaid ID number is included in the AIMS file.
- If the AIMS number was entered and the number matches a number in the AIMS file provided to Alliant/GMCF, the system populates the member information. If a valid SSN is entered and that number is associated with an AIMS number or a Medicaid ID, then the member information is also system populated.

9. If an AIMS number or SSN is entered but there is no match to an AIMS number or Medicaid member in the database, the member information must be entered manually, similar to what is shown in the next figure.

The screenshot shows a web form with two main sections: "Member Information" and "Participant Address".

Member Information:

Member ID :		First Name :	VICKY	MI :	M	Last Name :	TEST MEMBER	Suffix :	
Date of Birth :	05/20/1970	Social Security Number :	765-43-2111	Gender :	Female	AIMS Number :	AIMS23456		

Participant Address:

Address Line 1 :	22 SHADOW LANE	Address Line 2 :			
City :	CITY	State :	GA	Zip :	33333

Figure 303

Physician/Care Coordinator Contact Information:

These sections capture physician and care coordinator information.

10. Enter the physician’s first and last name.
11. Enter the physician’s phone number.
12. Generally, the Care Coordinator/Nurse information is populated by the system based on the requesting provider ID. Since all fields are required, however, enter any information that is missing. Additionally, these fields may be edited if the contact information is incorrect.

Physician Information			
* Physician Name :	DOCTOR DOCTOR		
* Phone :	404-999-1111	Ext.:	
		Fax :	- -

Care Coordinator/Assessment Nurse Contact Information					
* Contact Name:	JEAN THE COORDINATOR		* Contact Email:	JCOORD@GMAIL.COM	
Contact Phone:	404-999-2222	Ext.:		* Contact Fax:	404-999-3333

Figure 304

Request Information:

13. Select *Initial* (initial placement in CCSP) or *Reassessment* (continued placement in CCSP) as the ‘Recommendation Type’.
14. If *Initial* was selected as the type of recommendation, enter the DON-R screening score. The screening score is only required for initial placement requests.
15. Enter the date that the applicant was evaluated in the ‘Assessment Date’ box.
16. Select *Yes* or *No* for MFP approval.

Request Information			
* Recommendation Type :	<input checked="" type="radio"/> Initial <input type="radio"/> Reassessment	DON-R Telephone Screening Score :	36
* Assessment Date	08/01/2014	* Approved for Money Follows the Person?	<input type="radio"/> Yes <input checked="" type="radio"/> No

Figure 305

Diagnosis:

This section captures the participant’s primary diagnosis or diagnoses related to CCSP participation. At least one diagnosis is required.

17. Enter the diagnosis code for the participant’s primary diagnosis in the ‘Diagnosis Code’ box. System populates the description.
18. Enter the date that the diagnosis was established. If not known, enter the CCSP assessment date.
19. Click the ‘Primary’ checkbox.
20. Click [Add](#).

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
344.1		01/01/2014	<input checked="" type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 306

21. The diagnosis is added to the request and a blank diagnosis line opens and may be used to add another diagnosis. The options to **Edit** the diagnosis line and **Delete** the diagnosis line also become available.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
344.1	PARAPLEGIA NOS	08/01/2014	Yes	No	ICD-9	EDIT DELETE
				<input type="checkbox"/>		ADD

Figure 307

Additional Information:

The Additional Information sections capture information related to recent hospital admission, medication types, diagnostic/treatment procedures, and plan of treatment. However, these fields **are not required** and may be left blank.

Acute Care Hospital Dates ; From Date : To Date :

Diagnosis on Admission to Hospital

Diag Code	Diagnosis Description	Primary	
<input type="text"/>		<input type="checkbox"/>	ADD

Diagnostic and Treatment Procedures

Type	Frequency	
<input type="text"/>	<input type="text"/>	ADD

Medications

Name	Dosage	Route	Frequency	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

Services

Describe the services and for each service indicate the amount, frequency and duration (example: RN Service, 1 session or 1 visit, 2X/week, (for) 6 weeks).

Services	Amount	Frequency	Duration	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

Treatment Plan :

Provide the complete treatment plan including medications, level of care requested, other services to be provided to the patient.

Figure 308

22. Once all required information has been entered, click **Review Request**. Review the information entered to be sure it is accurate. Then, review the *Attestation Statement*.
23. Click **I Agree** in response to the *Attestation Statement*. This must be done before the request can be submitted.
24. Next, click **Submit Request**.
25. The next page shows the **pending Request ID** (top of page). Required documentation may be attached to the LOC at this point.

Attach Supporting Documentation When PA Submitted:

To attach documents, go to the **Create an Attachment** section (middle of page). This section includes a checkbox for each required document type. When a document type checkbox is checked, and then a file is attached, the attached file is associated with the document type. One file or multiple files may be attached. However, if possible, it is recommended to attach one PDF file that contains all the required documents. If multiple files are attached, each file must have a different name. The following file types may be attached: DOC, DOCX, JPG, PDF, TIF, and TXT; although **PDF files are preferred**. Each file cannot be more than 20 MB in size. For complete attachment criteria, please refer to the *Attach Files to a PA Request* user guide located on the Provider Workspace/Education and Training/User Manuals.

26. To attach a file related to a specific required document or documents, first click the document type checkbox or checkboxes.
27. Click **Browse** in the attachment panel, and find the file saved to your directory.
28. Open the file and then click **Attach File**. The file attached is associated with the required document(s) selected and displays in the **Attached Files** table. This information is available to the GMCF reviewer.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

File uploaded successfully.

Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)

Codes	Documents
CCSP-INITIAL	<input type="checkbox"/> Appendix E- Level of Care and Placement Instrument Form
	<input type="checkbox"/> Crosswalk from AIMS
	<input type="checkbox"/> Minimum Data Set (MDS) for Home Care (MDS-HC) from AIMS
	<input type="checkbox"/> Demographic information from AIMS
	<input type="checkbox"/> Medication Record
	<input type="checkbox"/> Case notes from AIMS
	<input type="checkbox"/> DON-R

Attached Files

File	Type	Code	Document Name	Size	User	Date	
CCSP Required Documentation.docx	Web Upload	CCSP-INITIAL	Appendix E- Level of Care and Placement Instrument Form	22 KB		8/20/2014 8:33:15 AM	DELETE
CCSP Required Documentation.docx	Web Upload	CCSP-INITIAL	Case notes from AIMS	22 KB		8/20/2014 8:33:15 AM	DELETE
CCSP Required Documentation.docx	Web Upload	CCSP-INITIAL	Crosswalk from AIMS	22 KB		8/20/2014 8:33:15 AM	DELETE
CCSP Required Documentation.docx	Web Upload	CCSP-INITIAL	DON-R	22 KB		8/20/2014 8:33:15 AM	DELETE
CCSP Required Documentation.docx	Web Upload	CCSP-INITIAL	Demographic information from AIMS	22 KB		8/20/2014 8:33:15 AM	DELETE
CCSP Required Documentation.docx	Web Upload	CCSP-INITIAL	Medication Record	22 KB		8/20/2014 8:33:15 AM	DELETE
CCSP Required Documentation.docx	Web Upload	CCSP-INITIAL	Minimum Data Set (MDS) for Home Care (MDS-HC) from AIMS	22 KB		8/20/2014 8:33:15 AM	DELETE

Figure 309

Attach Supporting Documentation To an Existing LOC:

Additional documentation may also be attached to LOCs previously submitted that are still in pending status or are initially tech denied.

1. Go to the *Provider Workspace* and select **Search, Edit or Attach Documentation to Requests**.
2. Search for the LOC by entering the 'Request ID' and clicking **Search**.
3. Select the request in the search results to open the *Review Request* page.
4. If the LOC is pending or is initially tech denied, click the **Attach File** link at the bottom of the page.
5. Go to **Create an Attachment** and follow the same process to attach a file as previously described.

2.3.20.1 System Decision Notifications

When a CCSP LOC is approved or denied, the requesting provider is notified via a ‘no reply’ email. When the decision is an initial tech denial for missing information, the email also specifies what information is missing. The email notification directs the provider to check the *Provider Workspace* for decision details.

View Decision Details:

1. To view decision details, open the *Provider Workspace* and click **Search, Edit or Attach Documentation to Requests**.
2. Search for the CCSP LOC by entering the ‘Request ID’ and clicking **Search**. Then click the PA that displays in the search results.

-OR-

3. Open the *Provider Workspace* and access the LOC via the **PA Notifications** drop list. This list shows the **last ten** PA notifications. Select a PA number on the list and click **Show**.

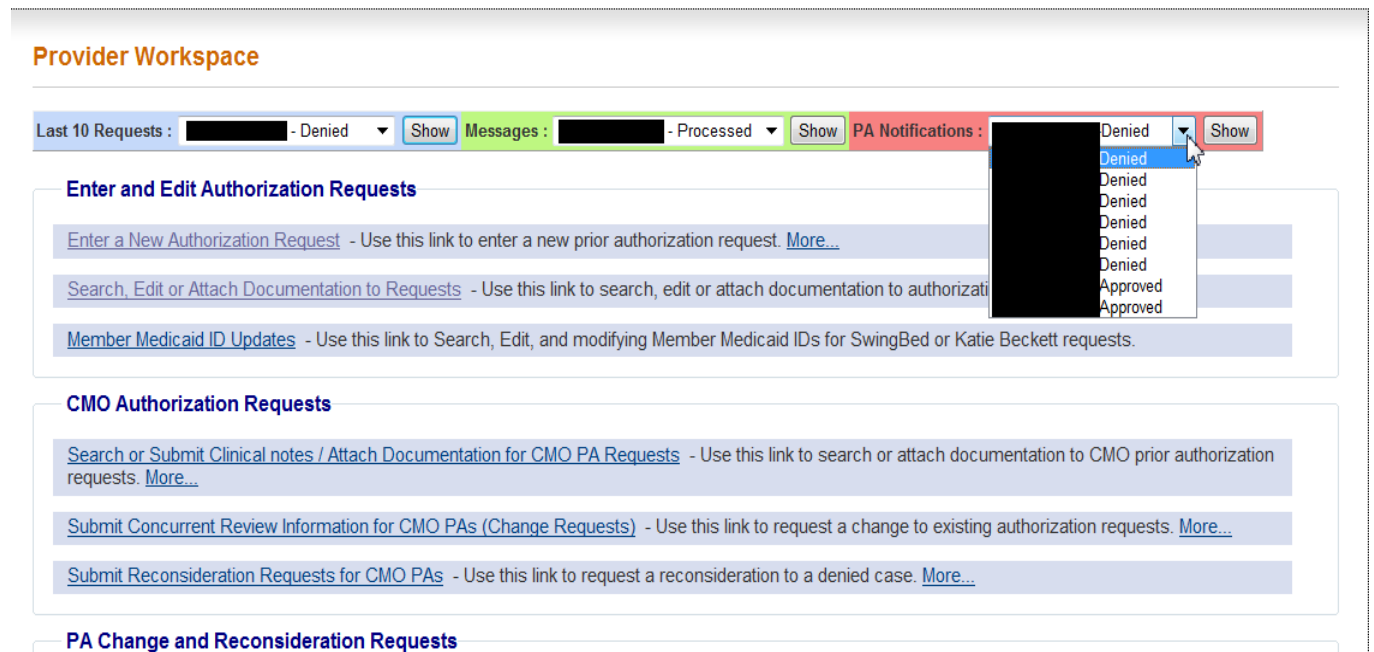


Figure 310

4. No matter which route is used to view decision details, the LOC opens on the *Review Request* page. The decision information displays in the following sections:

- **PA Notifications:** This section shows the same information sent in the ‘no-reply’ email notification.
- **Denial Notifications:** This section shows the specific decision date, the letter type that was sent, and the reviewer’s denial rationale noted on the letter.
- **Request Information:** This section shows the specific type of decision and decision date.

Prior Authorization - CCSP Level of Care and Placement Review Request

Notification(s) for this PA		
Date	Status	Notification
07/29/2014		The CCSP PA # [REDACTED] submitted by you, has been Denied. The PA is missing some document(s) : Case notes from AIMS.

Denial Notification(s)		
Denial Decision Date	Letter Type	Reason for Denial
7/29/2014 8:33:30 AM	Technical Denial Notification	We are unable to make a decision regarding level of care since the Case Notes from AIMS were never submitted; and the other documents submitted were incomplete. You may request a hearing if you disagree with this decision.

Request Information			
Request ID :	[REDACTED]	Case Status :	Denied Case Status Date : 07/29/2014
Member ID :	[REDACTED]		
Social Security Number :	[REDACTED]		
Provider ID :	[REDACTED]	CMO PA Request ID :	
Effective Date :	07/29/2014	Expiration Date :	10/27/2014
Denial Reason :			

Type of Recommendation :	Reassessment
Decision Type :	Final Tech Denial. Decision Date: 7/29/2014

Figure 311

2.3.21 NOW and COMP	
Program	Authorization Period
NOW and COMP Level of Care and Placement	Initial and Reassessment up to one year
Description	
<p><i>Level of Care (LOC) and Placement</i> requests for initial placement and reassessment under the Comprehensive Supports Waiver Program (COMP) and the New Options Waiver (NOW) are submitted via the web portal by the DBHDD regional offices. The NOW or COMP online form is completed and additional supporting documentation is attached to the form. This additional documentation may be attached when the request is submitted, or attached to an existing LOC request that is pending or initially tech denied for missing information.</p>	

Web Submission Instructions:

1. Go to the **Georgia Web Portal** at www.mmis.georgia.gov and log in using your assigned user name and password.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. On the next screen, select **NOW Level of Care and Placement** or select **COMP Level of Care and Placement**. Only the PA type associated with the requesting ‘provider’ category of service displays (NOW 680; COMP 681).
4. On the *New Request for Prior Authorization* page, the requesting ‘provider’ ID is system populated in the Provider ID box.
5. Enter the applicant’s Medicaid ID **OR** enter the applicant’s Social Security Number (SSN) if the applicant does not have a Medicaid ID. Do not enter both.

Figure 312

6. Click **Submit** to open the *Level of Care and Placement* request form.

Member Information and DBHDD Regional Office Information:

7. When the request form opens, the requesting regional office ‘provider’ information is pre-populated.
8. Member information is also populated according to these guidelines:
 - If a Medicaid ID was entered **or** if the SSN entered matches a Medicaid participant, the system populates the member information including the member’s address.
 - If a SSN is entered but there is no match to a Medicaid member in the database, the member information must be entered manually, including the applicant’s address information, similar to what is shown in the next figure.

The screenshot shows a form with two main sections. The first section, titled 'Member Information', contains fields for Member ID, First Name (Jean), MI, Last Name (TEST MEMBER), Suffix, Date of Birth (04/26/2002), Social Security Number (111-11-1111), and Gender (Female). The second section, titled 'Participant Address', contains fields for Address Line 1 (666 Participant Address Lane), Address Line 2 (APT 2233), City (Lane), State (GA), and Zip (33333).

Figure 313

DBHDD Regional Office Contact Information:

This section captures the regional office contact information.

9. In general, the contact information is populated by the system based on the requesting regional office ‘provider’ ID. Since all fields are required, however, enter any information that may be missing or correct information that is inaccurate, especially the email address.

The screenshot shows a form titled 'DBHDD Regional Office Contact Information'. It contains four fields: Contact Name (Ms Nice), Contact Email (srinithya.ranganathan@gmcf.org), Contact Phone (444-555-6666 Ext.), and Contact Fax (555-666-7777).

Figure 314

Request Information:

1. Select *Initial* (initial placement) or *Reassessment* (continued placement) as the ‘Recommendation Type’. This is required.

2. Enter the date that the applicant was evaluated for the program in the ‘Assessment Date’ box. If not know, enter today’s date. This is currently required.
3. If known, select *Yes* or *No* for MFP approval. Otherwise, leave blank – this is an optional field.

Request Information			
* Recommendation Type :	<input checked="" type="radio"/> Initial <input type="radio"/> Reassessment		
* Assessment Date	<input type="text" value="07/28/2015"/>	* Approved for Money Follow s the Person?	<input checked="" type="radio"/> Yes <input type="radio"/> No

Figure 315

Diagnosis:

This section captures the participant’s primary diagnosis or diagnoses related to NOW or COMP participation. At least one diagnosis is required.

4. Enter the diagnosis code for the participant’s primary diagnosis in the ‘Diagnosis Code’ box. System populates the description.
5. Enter the date that the diagnosis was established. If not known, enter today’s date.
6. Click the ‘Primary’ checkbox.
7. Click **Add**.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
<input type="text" value="758.0"/>		<input type="text" value="07/01/2002"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 316

8. The diagnosis is added to the request and a blank diagnosis line opens and may be used to add another diagnosis. The options to **EDIT** the diagnosis line and **DELETE** the diagnosis line also become available.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
<input type="text" value="758.0"/>	DOWN'S SYNDROME	<input type="text" value="07/01/2002"/>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	ICD-9	EDIT DELETE
<input type="text"/>		<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 317

Comments Box:

The Comments/Messages box is an optional textbox but can be used to provide additional information regarding the LOC request.

19. Once all required information has been entered, click **Review Request**. Review the information entered to be sure it is accurate. To correct information that was provided, click **Edit Request**. Correct or update the request information, then click **Review Request** again.
20. Next, review the *Attestation Statement*.
21. Click **I Agree** in response to the *Attestation Statement*. This must be done before the request can be submitted.
22. Then, click **Submit Request**.
23. Once the request is successfully submitted, the **pending Request ID** displays at the top of the page. Required documentation may be attached to the LOC at this point.

Attach Supporting Documentation:

To attach documents, go to **Create an Attachment** (middle of page). This section includes a checkbox for each required document type. The document type checkboxes are used to associate the file attached with the document type. One file or multiple files may be attached. However, if possible, it is recommended to attach one PDF file that contains all the required documents. If multiple files are attached, each file must have a different name. The following file types may be attached: DOC, DOCX, JPG, PDF, TIF, TXT and EXCEL; although **PDF files are preferred**. Each file cannot be more than 20 MB in size. For complete attachment criteria, please refer to the *Attach Files to a PA Request* user guide located on the Provider Workspace/Education and Training/User Manuals.

24. To attach a file related to a specific required document or documents, first click the document type checkbox or checkboxes.
25. Click **Browse** and find the file saved to your directory.
26. Open the file and then click **Attach File**. The file attached is associated with the required document(s) selected and displays in the **Attached Files** table. The attached files are available to the GMCF reviewer.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

Browse... **Attach File**

File uploaded successfully.

Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)

Codes	Documents
COMP-INITIAL	<input type="checkbox"/> DMA6/6A(Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded) <input type="checkbox"/> Nursing Assessment *Optional* <input type="checkbox"/> Psychological/Behavioral Assessment
	<input type="checkbox"/> Health Risk Screening Tool (HRST) *Optional* <input type="checkbox"/> Social Work Assessment *Optional* <input type="checkbox"/> Initial Behavioral Assessment *Optional*
	<input type="checkbox"/> Support Intensity Scale (SIS) *Optional*

Attached Files

File	Type	Code	Document Name	Size	User	Date	
COMP Attachments.docx	Attached By Nurse	COMP-INITIAL	Psychological/Behavioral Assessment	14 KB	DBARRETT	7/20/2015 9:48:42 AM	DELETE
COMP Attachments.docx	Attached By Nurse	COMP-INITIAL	DMA6/6A(Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded)	14 KB	DBARRETT	7/20/2015 9:48:42 AM	DELETE

Figure 318

Note: Additional documentation may also be attached to LOCs previously submitted that are still in pending status or are initially tech denied.

1. To attach documents to an existing LOC, open the *Provider Workspace*.
2. Select **Search, Edit or Attach Documentation to Requests**.
3. Search for the PA by entering the 'Request ID' and clicking **Search**.
4. Select the request in the search results to open the *Review Request* page.
5. If the LOC is pending or is initially tech denied, click the **Attach File** link at the bottom of the page.
6. Go to *Create an Attachment* and follow the same process to attach a file as previously described.

2.3.21.1 System Decision Notifications

When a NOW or COMP LOC is approved or denied, the requesting 'provider' is notified via a 'no reply' email. When the decision is an initial tech denial for missing information, the email also specifies what information is missing. The email notification directs the 'provider' to check the *Provider Workspace* for decision details.

View Decision Details:

1. To view decision details, open the *Provider Workspace* and click **Search, Edit or Attach Documentation to Requests**.
2. Search for the LOC by entering the 'Request ID' and clicking **Search**. Then, click the PA that displays in the search results.

-OR-

3. Open the *Provider Workspace* and access the LOC via the **PA Notifications** drop list. This list shows the **last ten** PA notifications. Select a PA number on the list and click **Show**.

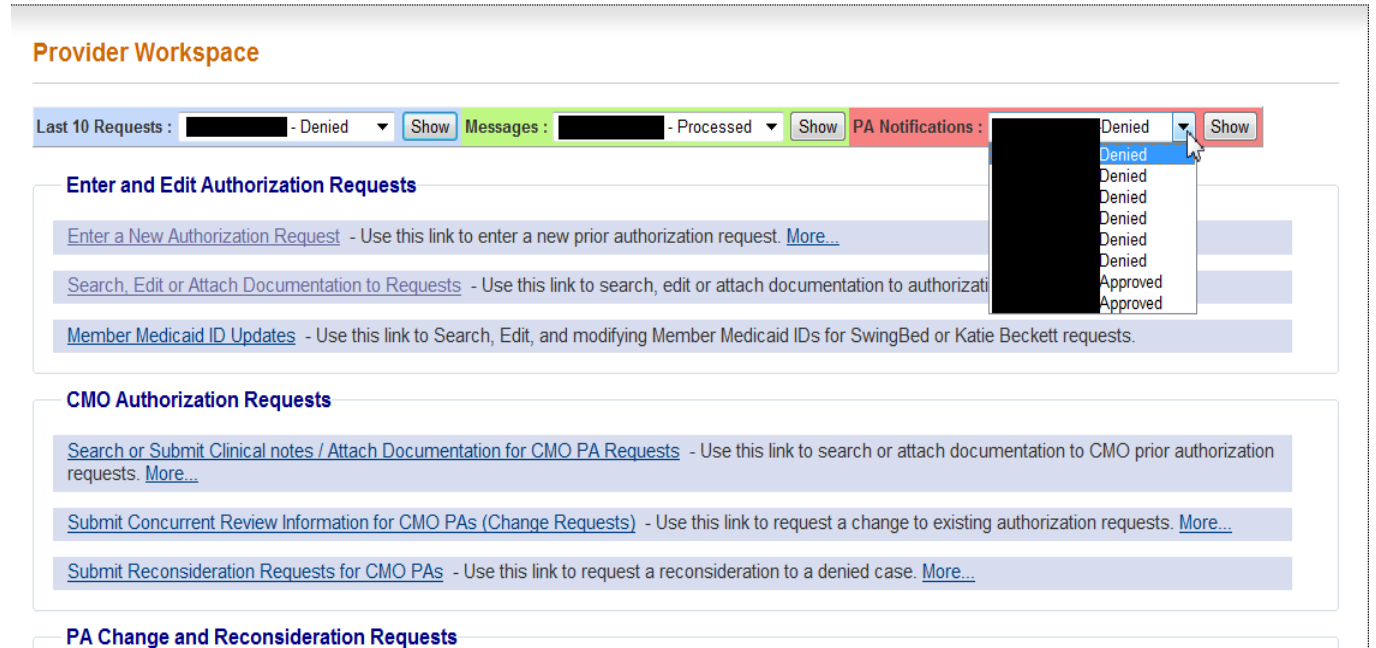


Figure 319

4. No matter which route is used to view decision details, the LOC opens on the *Review Request* page. The decision information displays in the following sections:
 - **PA Notifications:** This section shows the same information sent in the ‘no-reply’ email notification.
 - **Denial Notifications:** This section shows the specific decision date, the letter type that was sent, and the reviewer’s denial rationale noted on the letter.
 - **Letter Information:** If a decision notification (letter) has been sent to the Member, the letter is attached in this section. Click the file name to view.
 - **Request Information:** This section shows the specific type of decision and decision date.

Notification(s) for this PA

Date	Status	Notification
06/16/2015		The COMP PA # [REDACTED] submitted by you, has been Denied. The PA is missing some document(s) : DMA-7 (Level of Care Re-Evaluation Form for ICFID) , Psychological/Behavioral Assessment Update (Required Q3 years if 16 years or younger).

Denial Notification(s)

Denial Decision Date	Letter Type	Reason for Denial
6/16/2015 12:00:00 AM	Standard Approval/Denial Notification	

Letter Information

Letter Type	File	Reason	Letter Sent Date
Member	[REDACTED].LTRTOMBR.pdf	Manual Update by Nurse	10/03/2014

Request Information

Request ID :	[REDACTED]	Case Status :	Denied	Case Status Date :	06/16/2015
Member ID :	[REDACTED]				
Social Security Number :	[REDACTED]				
Provider ID :	[REDACTED]	CMO PA Request ID :			
Effective Date :	05/25/2015	Expiration Date :	05/25/2016		
Denial Reason :					

Type of Recommendation : Reassessment
 Decision Type : Final Tech Denial. Decision Date: 6/16/2015

Diagnosis

Diag Code	Diagnosis Description	Date	Primary	Type
334.9	SPINOCEREBELLAR DIS NOS	01/01/2000	Yes	ICD-9

Attached Files

File	Type	Document Name	User	Date
Chapter Header.docx	Web Upload	Health Risk Screening Tool (HRST) *Optional*	[REDACTED]	5/26/2015 11:54:57 AM

[Enter Change Request](#)
[Attach File](#)
[Return To Search Results](#)
[Return to Provider Workspace](#)
[Contact Us](#)

Figure 320

2.3.22 Swingbed Requests	
Program	Authorization Period
Swingbed Adult	14 days – Initial Placement
Swingbed – Child (DMA6A)	30 days – Continued Placement
Description	
Requests for Swingbed (SW) admission and continued stay may be submitted via the web portal using the <i>Swingbed Form DMA-6</i> for individuals 21 years and older; and <i>Swingbed Form DMA6A</i> for individuals under 21 years. Submission of Swingbed requests is restricted to providers with 080 COS. Swingbeds may be requested by entering a Medicaid ID or a Social Security Number for individuals who do not yet have a Medicaid ID. The process for entering a SW DMA6 and SW DMA6A is the same; and the request templates are very similar. The web entry instructions focus on DMA-6 entry; although differences between the DMA-6 and DMA-6A are noted in the instructions.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Nursing Home (Swingbed) Form DMA-6** if the recipient is an adult, or select **Pediatric Admission to a Nursing Home (Swingbed) Form DMA6A** if the recipient is less than 21 years.
4. On the *New Request for Prior Authorization* page, the requesting Swingbed provider ID is system populated in the ‘Swingbed Provider ID’ box.
5. Enter the member’s Medicaid ID. If the individual does not have Medicaid ID, enter the individual’s Social Security Number. **Do not enter both.**

Nursing Home (Form Number: DMA-6)

To find a member or provider ID click the next to the ID box

Member Medicaid ID:

Social Security Number :

Swingbed Provider ID :

Submit

Figure 321

6. Click **Submit** to open the request form.
7. At the top of the request form, the requesting Swingbed provider information is auto-populated. The patient’s information is also auto-populated when the patient is a Medicaid recipient.

8. When the patient is not a Medicaid recipient, the SSN entered to open the form displays in the ‘Social Security Number’ box. The following information must be added:

- **Name:** Enter the patient’s last name in the ‘Last Name’ box, and the patient’s first name in the ‘First Name’ box. A middle initial and suffix are optional.
- **Date of Birth**
- **Gender:** Select from the drop list.

Member Information					
Member ID :	First Name :	Test	MI :	Last Name :	Member
Date of Birth :	02/25/1940	Social Security Number :	222-33-3444	Gender :	Female

Figure 322

Physician Information:

The only required field in this section is physician name.

9. Enter the physician’s first name and last name in the ‘Physician Name’ box.

Physician Information					
Physician Name :	John Greer	Physician ID :			
Address Line 1 :		Address Line 2 :			
City :		State :		Zip :	
Phone :	- -	Ext. :		Fax :	- -

Figure 323

Contact Information:

The system pulls in the requesting Swingbed provider’s contact information. All contact information is required.

10. Enter or edit any contact information that is missing or incorrect.

Contact Information			
* Contact Name:	DBARRETT	* Contact Email:	DB@email.com
Contact Phone:	444-444-4444	Contact Fax:	666-666-6666

Figure 324

Request Information:

This section captures the following required information: recommendation type (continued placement or initial placement); initial admission date; admission type; and place of service.

Note: Recommendation type is captured in a different section on the DMA-6A form.

11. Enter the type of placement applicable to the request by selecting *Continued Placement* for patients already in a Swingbed; or *Initial Placement* for new admission to Swingbed.
12. **If initial placement selected**, enter the date of admission/anticipated date of admission to the Swingbed in the ‘Initial Admission Date’ box.
OR
13. **If continued placement selected**, enter the start date for continued Swingbed placement in the ‘Continued Placement Start Date’ box.
14. ‘Patient Status’ defaults to *Swingbed*.
15. Enter the type of admission to Swingbed by selecting *Elective*, *Urgent* or *Emergency* from the ‘Admission Type’ drop list.
16. The ‘Place of Service’ defaults to *Skilled Nursing Facility*.

The screenshot shows the 'Request Information' form with the following fields and values:

- Recommendation Type:** Radio buttons for 'Continued Placement' (unselected) and 'Initial Placement' (selected).
- Initial Admission Date:** Text input field containing '06/11/2013'.
- Discharge Date:** Empty text input field.
- Place of Service:** Dropdown menu showing '31 - Skilled Nursing Facility'.
- Patient Status:** Dropdown menu showing 'SwingBed'.
- Admission Type:** Dropdown menu showing 'Emergency'.

Figure 325 - Initial

The screenshot shows the 'Request Information' form with the following fields and values:

- Recommendation Type:** Radio buttons for 'Continued Placement' (selected) and 'Initial Placement' (unselected).
- Continued Placement Start Date:** Text input field containing '07/12/2013'.
- Discharge Date:** Empty text input field.
- Initial Request ID:** Empty text input field.
- Place of Service:** Dropdown menu showing '31 - Skilled Nursing Facility'.
- Patient Status:** Dropdown menu showing 'SwingBed'.
- Admission Type:** Dropdown menu showing 'Elective'.

Figure 326 - Continued

<p>DMA-6A Form Note: In place of the <i>Request Information</i> section, the DMA-6A form has a section related to the child’s status and parental consent. Follow these instructions to complete the section on the DMA-6A:</p>
<ul style="list-style-type: none"> Respond <i>Yes</i> or <i>No</i> to indicate whether or not the child’s caretaker believes that the child would require institutionalization if services were not provided.
<ul style="list-style-type: none"> Respond <i>Yes</i> or <i>No</i> to indicate whether or not the child attends school.
<ul style="list-style-type: none"> Enter the date of Medicaid application. If not known, enter the PA request date.
<ul style="list-style-type: none"> Respond <i>Yes</i> or <i>No</i> to indicate whether or not the parent/legal representative has authorized release of health information.
<ul style="list-style-type: none"> Enter the date that parent/legal representative signed the DMA-6A.

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, primary diagnosis indicator, diagnosis type (ICD9 or ICD10), and admission diagnosis indicator (optional) for each diagnosis code entered.

- Enter the diagnosis code for the patient’s primary diagnosis in the ‘Diag Code’ box; or search for and have system insert the diagnosis. If the diagnosis code includes a decimal point, enter the decimal point with the code.
- Enter the date that this diagnosis was established in the ‘Date’ box, or if not known, enter the Swingbed admission date.
- Click the ‘Primary’ checkbox to indicate that the diagnosis is the primary diagnosis; and click the ‘Admission’ checkbox, if the diagnosis is the Swingbed admission diagnosis.
Note: If only one diagnosis is entered, the system will select that diagnosis as primary.
- Click **Add** at the end of the diagnosis line to add the diagnosis information to the request.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
437.4	CEREBRAL ARTERITIS	01/01/2012	Yes	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	01/01/2012	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 327

- Follow the same process to add other diagnosis information. Remember to click **Add** after each diagnosis is entered.

Retro-Eligibility:

The system defaults the question regarding member retro eligibility to ‘No’.



Does this member have retro eligibility for the submitted dates of service ? Yes No

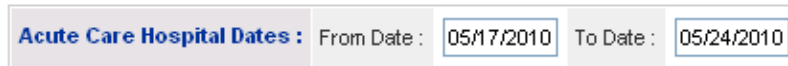
Figure 328

- 22. Click ‘Yes’ if the patient has Medicaid retro eligibility for the requested dates of service.

Acute Care Hospital Dates:

This required section captures the acute hospital admission and discharge date.

- 23. Enter the date that the patient was admitted to the acute care hospital in the ‘From Date’ box; and the date discharged from the hospital in the ‘To Date’ box. Enter the dates manually or use the calendar popup.



Acute Care Hospital Dates : From Date : 05/17/2010 To Date : 05/24/2010

Figure 329

Diagnosis on Admission to Hospital:

This section is optional.



Diagnosis on Admission to Hospital			
Diag Code	Diagnosis Description	Primary	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	ADD

Figure 330

Medications:

The *Medications* table captures the patient’s primary medication including: type, dosage, route and frequency.

- 24. To enter medication information, first select the medication type by selecting a type from the ‘Name’ drop list.
- 25. Enter the dosage for the medication in the ‘Dosage’ box.

26. Enter the method of medication administration by selecting the method of administration from the ‘Route’ drop list (Oral or Parental or Rectal or Topical).
27. Enter the frequency of medication administration by selecting a frequency from the ‘Frequency’ drop list (Regular or PRN: As necessary or Regular & PRN).
28. Click **Add** at the end of the medication line to add the medication information to the request.

Medications				
Name	Dosage	Route	Frequency	
Cardiac	50mg	Oral	Regular	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="ADD"/>

Figure 331

29. Follow the same process to add other medication information. Click **Add** after each entry.

Diagnostic/Treatment Procedures:

The *Diagnostic and Treatment Procedures* table captures diagnostic/treatment procedures ordered as part of the patient’s plan of care.

30. To add diagnostic or treatment procedures, first select the procedure type by selecting a type from the ‘Type’ drop list. Select ‘Other’, if the diagnostic/treatment procedure is not listed.
31. Next, enter the frequency of the diagnostic/treatment procedure in the ‘Frequency’ box.
32. Click **Add** to add the diagnostic/treatment procedure to the request.

Diagnostic and Treatment Procedures		
Type	Frequency	
S&A Accucheck	bid	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text"/>	<input type="text"/>	<input type="button" value="ADD"/>

Figure 332

33. Repeat the process to add other diagnostic/treatment procedures. Click **Add** after each entry.

Treatment Plan:

This section is optional but may be used to capture additional treatment plan information that is not captured in other sections of the request form.

Treatment Plan : Provide the complete treatment plan including medications, level of care requested, other services to be provided to the patient. Add information regarding the treatment plan that is not captured in other sections of this form.

Figure 333

Physician Certification and Signed Date:

This section captures physician certification in regards to communicable diseases, level of care, and management of the patient’s condition.

- 34. Indicate whether or not the patient is free of communicable disease by selecting *Yes* or *No*.
- 35. Indicate whether or not the patient’s condition can be managed by Community Care by selecting *Yes* or *No*.
- 36. Indicate whether or not the patient’s condition can be managed by Home Health services by selecting *Yes* or *No*.
- 37. Indicate whether or not the physician has certified the level of care by selecting *Yes* or *No*.
- 38. The physician license number is optional. Enter the date that the physician signed the DMA6-6A in the ‘Date Signed by Physician’ box.

<input checked="" type="radio"/> Yes <input type="radio"/> No	Is the patient free of communicable diseases?
Can this patient's condition be managed by :	
<input type="radio"/> Yes <input checked="" type="radio"/> No	- Community Care ?
<input type="radio"/> Yes <input checked="" type="radio"/> No	- Home Health Services ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	Has the physician certified that this patient requires the level of care provided by a nursing facility or an intermediate care facility for the mentally retarded ?

Physician License Number : <input type="text"/>	Date Signed by Physician : <input type="text" value="05/24/2010"/>
---	--

Figure 334

<p>DMA-6A Form Note: On the Swingbed DMA-6A, the physician certification questions and physician signed date are captured in a section that also captures the level of care and type of recommendation. Here are some guidelines for completing this section:</p>
<ul style="list-style-type: none"> For the ‘Anticipated Dates of Hospitalization’, enter the Swingbed admission date in the ‘From Date’ box; and the anticipated discharge date in the ‘To Date’ box.
<ul style="list-style-type: none"> Enter the recommended level of care by selecting <i>Nursing Facility</i> from the ‘Level of Care Recommended’ drop list.
<ul style="list-style-type: none"> Enter the type of recommendation (initial or continued placement) by selecting the type from the drop list.
<ul style="list-style-type: none"> Indicate where the patient was transferred from by clicking the <i>Hospital</i> button.
<ul style="list-style-type: none"> Indicate the length of time that care is needed by selecting the <i>Temporary</i> button; and then enter ‘1’ as the estimated temporary length of time.
<ul style="list-style-type: none"> Respond to each of the certification questions by clicking <i>Yes</i> or <i>No</i>.
<ul style="list-style-type: none"> Enter the name of the physician that signed the DMA-6A in the ‘Physician Name’ box.
<ul style="list-style-type: none"> Enter the date that the physician signed the DMA-6A in the ‘Date Signed by Physician’ box.
<ul style="list-style-type: none"> Enter the physician’s license number in the ‘Physician License Number’ box.
<ul style="list-style-type: none"> Enter the physician’s phone number in the ‘Physician Phone’ box.

Patient Condition:

This section consists of four **required** questions that capture information related to the patient’s condition/care, and the appropriateness of Swingbed placement.

39. Respond *Yes* or *No* to each question.

1.	Does the patient's condition require specialized medical intervention not usually provided by a nursing home?	<input type="radio"/> Yes <input checked="" type="radio"/> No
2.	Does a particular aspect of the patient's care or diagnosis present challenges for discharge planning?	<input type="radio"/> Yes <input checked="" type="radio"/> No
3.	Does the patient have functional challenges not usually accepted by nursing homes, e.g. functional impairments related to morbid obesity, severe contractures, etc?	<input checked="" type="radio"/> Yes <input type="radio"/> No
4.	Does the patient present severe behavior challenges requiring atypical intervention?	<input checked="" type="radio"/> Yes <input type="radio"/> No

Figure 335

Evaluation of Care and Treatment:

The next **required** section captures the results of the nursing evaluation; patient’s mental and behavioral status; and the nursing care needed.

Note: The *Evaluation of Care and Therapies* section on the DMA6A is slightly different from the DMA6; but it captures similar information.

40. For each category, select the applicable item(s) by clicking the corresponding checkbox or button.

41. Enter the number of hours/day that the patient is out of bed in the ‘Hours out of the bed per day’ box.

Evaluation of Nursing Care Needed : (check all that apply)					
Diet :	Bladder :	Bowel :	Decubiti :	Restorative Potential :	Overall Condition :
<input checked="" type="checkbox"/> Regular <input checked="" type="checkbox"/> Diabetic <input type="checkbox"/> Formula <input type="checkbox"/> Low Sodium <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Other	<input checked="" type="radio"/> Continent <input type="radio"/> Occasionally Incontinent <input type="radio"/> Incontinent <input type="radio"/> Other	<input checked="" type="radio"/> Continent <input type="radio"/> Occasionally Incontinent <input type="radio"/> Incontinent <input type="radio"/> Colostomy	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Infected <input type="checkbox"/> On Admission <input type="checkbox"/> Surgery Date	<input type="radio"/> Good <input checked="" type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Questionable <input type="radio"/> None	<input type="radio"/> Improving <input type="radio"/> Stable <input checked="" type="radio"/> Fluctuating <input type="radio"/> Deteriorating <input type="radio"/> Critical <input type="radio"/> Terminal
Mental & Behavioral Status : (check all that apply)			Nursing Care and Treatment : (Check all that apply)		
<input checked="" type="checkbox"/> Agitated <input type="checkbox"/> Confused <input type="checkbox"/> Cooperative <input type="checkbox"/> Depressed <input checked="" type="checkbox"/> Forgetful <input type="checkbox"/> Alert	<input type="checkbox"/> Noisy <input type="checkbox"/> Nonresponsive <input type="checkbox"/> Vacillating <input type="checkbox"/> Violent <input type="checkbox"/> Wanders <input type="checkbox"/> Withdrawn	<input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Anxious <input type="checkbox"/> Well Adjusted <input checked="" type="checkbox"/> Disoriented <input type="checkbox"/> Inappropriate Reaction	<input type="checkbox"/> Catheter Care <input checked="" type="checkbox"/> Intake <input checked="" type="checkbox"/> Output <input type="checkbox"/> IV <input type="checkbox"/> N/A	<input type="checkbox"/> Bedfast <input type="checkbox"/> Colostomy Care <input type="checkbox"/> Sterile Dressings <input type="checkbox"/> Suctioning	
Hours out of the Bed Per Day : <input type="text" value="4"/> Hrs.					

Figure 336

Frequency of Therapies:

This section captures the frequency per week of therapies received and needed. This section is not required but should be completed if applicable to the patient’s treatment plan.

42. For each therapy prescribed for the patient, indicate the hours per week received in the ‘Received’ box; and the hours per week that are needed in the ‘Needed’ box.

Indicate Frequency Per Week (in Hours)		
	Received	Needed
Physical Therapy	<input type="text"/>	<input type="text"/>
Occupational Therapy	<input type="text"/>	<input type="text"/>
Remotive Therapy	<input type="text"/>	<input type="text"/>
Reality Orientation	<input type="text" value="5"/>	<input type="text" value="5"/>
Speech Therapy	<input type="text"/>	<input type="text"/>
Bowel and Bladder Retrain	<input type="text"/>	<input type="text"/>
Activities Program	<input type="text" value="5"/>	<input type="text" value="5"/>

Figure 337

Level of Impairment and Activities of Daily Living:

This required section captures the patient’s level of impairment (mild, moderate, none, severe) in regards to sight, hearing, speech, limitation in motion, and paralysis. It also records the patient’s current abilities (dependent, independent, needs assistance, not appropriate) regarding activities of daily living. **Note:** This section is not on the DMA6A.

- 43. Select the appropriate description for each item from the ‘Level of Impairment’ and ‘Activities of Daily Living’ drop lists.

Activities of Daily Living		Level of Impairment	
Eating	Needs Assistance	Sight	Moderate
Wheelchair	Not Appropriate	Hearing	Moderate
Transferring	Needs Assistance	Speech	Moderate
Bathing	Needs Assistance	Limited Motion	Moderate
Ambulating	Needs Assistance	Paralysis	None
Dressing	Dependent		

Figure 338

Justification for Admission or Continued Placement:

This required section captures the rationale for Swingbed placement and any discharge plans to home or nursing facility.

- 44. Enter information to support the medical necessity of the Swingbed placement including discharge plans and the anticipated discharge date to home or nursing facility.

Justification and Circumstances for Admission or Continued Placement :
Provide justification for the services ordered including the rationale for swingbed placement; any discharge plans to home or nursing facility

Enter information to support medical necessity. Include discharge plans and discharge date.

Figure 339

MD or Nurse Signature:

45. Enter the first name and last name of the person who signed the Swingbed request in the 'Name of MD/RN Signing Form' box; and the date signed in the 'Date Signed' box.



The image shows a screenshot of a web form. It contains two input fields. The first field is labeled 'Name of MD / RN Signing Form' and contains the text 'Jane RN'. The second field is labeled 'Date Signed' and contains the date '09/08/2010'. The fields are separated by a vertical line.

Figure 340

46. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*.
47. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
48. Click **I Agree** in response to the *Attestation Statement*.
49. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**. The pending authorization tracking number displays at the top of the page.

2.3.23 Intermediate Care Facility for Mentally Retarded	
Program	Authorization Period
Intermediate Care Facility for Mentally Retarded (DMA6)	One year
Intermediate Care Facility for Mentally Retarded (DMA6A)	One year
Description	
<p>Requests for admission and continued stay in an Intermediate Care Facility for the Mentally Retarded (ICFMR) may be submitted via the web portal using the <i>ICFMR DMA-6</i> for individuals 21 years and older; and <i>ICFMR DMA6A</i> for individuals under 21 years. Submission of ICFMR requests is restricted to providers with 180 COS. Currently, there is only one provider authorized for ICFMR services. ICFMR and Swingbed use the same basic request template with the following differences:</p> <ul style="list-style-type: none"> • Place of Service: For ICFMR, this value defaults to Intermediate Care Facility Mentally Retarded instead of Skilled Nursing Facility. • Evaluation Dates: In place of the Patient Condition questions found on the SW form, the ICFMR form captures the completion dates of the Developmental Care Plan, Social Evaluation, and Psychological Evaluation. 	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Intermediate Care Facility for Mentally Retarded DMA-6** if the recipient is an adult, or select **Intermediate Care Facility for Mentally Retarded Form DMA6A** if the recipient is less than 21 years.
4. On the *New Request for Prior Authorization* page, the requesting ICFMR provider ID is system populated in the ‘ICFMR Provider ID’ box
5. Enter the member’s Medicaid ID in the ‘Member Medicaid ID’ box.

Intermediate Care Facility for Mentally Retarded (Form Number : DMA-6)

To find a member or provider ID click the next to the ID box

Member Medicaid ID:

ICFMR Provider ID :

Submit

Figure 341

6. Click **Submit** to open the request form. The member and provider information are system populated at the top of the form.

7. Follow the same instructions for entering data on the request as described for Swingbed requests, except the following completion dates are required: Developmental Care Plan, Social Evaluation and Psychological Evaluation.

Developmental Care Plan Date :	<input type="text" value="05/17/2010"/>	Social Evaluation Date :	<input type="text" value="05/17/2010"/>	Psychological Evaluation Date :	<input type="text" value="05/17/2010"/>
--------------------------------	---	--------------------------	---	---------------------------------	---

Figure 342

2.3.24 Nursing Facility Mechanical Ventilation Services	
Program	Authorization Period
Nursing Facility Mechanical Ventilation Services	Initial Placement 90 days; Continued Placement 90 days
Description	
Requests for authorization of mechanical ventilation services provided in a nursing facility are submitted via the web portal utilizing the <i>Nursing Facility Mechanical Ventilation Services</i> online form. A Vent PA can be entered using the applicant’s Medicaid ID number; or, if the applicant is not a Medicaid recipient, the applicant’s Social Security Number (SSN). In order to request authorization for mechanical ventilation services, Providers must have a category of service of 110 or 160, and be approved as a mechanical ventilation service provider by the Department of Community Health.	

Web Submission Instructions:

1. Log into the UAT Portal.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Nursing Facility Mechanical Ventilation Services**.
4. On the *New Request for Prior Authorization* page, the requesting Nursing Facility provider ID is system populated in the ‘Vent Provider ID’ box.
5. Enter the member’s Medicaid ID. If the individual does not have Medicaid ID, enter the individual’s Social Security Number (SSN). **Do not enter both**.

New Request for Prior Authorization

The Requesting Provider ID is a unique value assigned to identify a provider performing a service for a prior auth from the ‘Find Provider ID’ link.

The screenshot shows a web form titled "Nursing Facility Mechanical Ventilation Services". Below the title is a blue bar with the text "Please enter the Member's ID or the SSN. Do not enter both." Below this is a grey bar with the instruction "To find a member or provider ID click the [magnifying glass icon] next to the ID box". There are three input fields: "Member Medicaid ID" with the value "333000000300" and a magnifying glass icon; "Social Security Number" with a placeholder "___-__-____"; and "Vent Provider ID" with a blacked-out value and a magnifying glass icon. A blue "Submit" button is located at the bottom left of the form.

Figure 343

6. Click **Submit** to open the request form.

7. The system populates the requesting provider information on the form; and, if the patient is a Medicaid recipient, the patient's Medicaid ID, Last Name, First Name, Date of Birth, Gender and SSN are also populated.
8. If the patient is not a Medicaid recipient, the SSN previously entered displays in the 'Social Security Number' box; and the following information must be entered:
 - **Name:** Enter the patient's last name in the 'Last Name' box, and the patient's first name in the 'First Name' box. A middle initial and suffix are optional.
 - **Date of Birth:** Enter manually or use the calendar popup
 - **Gender:** Enter the gender of the patient by selecting the gender type from the drop list.

Physician Information:

This section captures information about the resident's physician including the date that the DMA-6 was signed.

9. Enter the Physician's first and last name in the 'Physician Name' box (required).
10. Address information is not required but may be entered.
11. Enter the Physician's phone number (required).
12. Enter the date that the physician signed the DMA-6 (required).

The screenshot shows a form titled "Physician Information" with the following fields and values:

- Physician Name:** Doctor John Test
- Address Line 1:** (empty)
- Address Line 2:** (empty)
- City:** (empty)
- State:** (dropdown menu)
- Zip:** (empty)
- County:** (dropdown menu)
- Phone:** 444-444-4444
- Ext.:** (empty)
- Fax:** - -
- Date DMA6 Signed by Physician:** 02/03/2012

A note below the Physician Name field states: "The DMA6 must be attached to this request. After submitting the request, go to Create an Attachment and attach the DMA6."

Figure 344

Contact Information:

The system pulls in the nursing facility provider’s contact information.

13. Enter contact information that is required (name, phone, email and fax) but is missing.

The screenshot shows a form titled "Contact Information" with a light gray header. Below the header, there are four input fields arranged in a 2x2 grid. The top-left field is labeled "* Contact Name:" and contains the text "DBARRETT". The top-right field is labeled "* Contact Email:" and contains "DB@email.com". The bottom-left field is labeled "Contact Phone:" and contains "444-444-4444", followed by an "Ext." label and an empty input box. The bottom-right field is labeled "* Contact Fax:" and contains "666-666-6666". All input fields have a light pink border.

Figure 345

Request Information:

This section captures recommendation type, admission date, place of service, admission type, and PASRR Level I information.

14. Select the ‘Recommendation Type’ by clicking the *Initial Placement* or *Continued Placement* button.
15. If initial placement is selected, a box for the ‘Initial Admission Date/Planned Admission Date’ displays. Enter the date of initial admission to the nursing facility, or the date the admission is planned to the mechanical ventilation unit.
16. If continued placement is selected, a box for the ‘Continued Placement Start Date’ displays. Enter the date that begins the continued placement stay for mechanical ventilation services.
17. The ‘Place of Service’ defaults to *Skilled Nursing Facility*. No action is required.
18. Select the applicable ‘Admission Type’ from the drop list: *Elective*, *Emergency* or *Urgent*. If *Urgent* or *Emergency* is selected, explain why the admission is an emergency or is urgent in the ‘Justification for Services’ box located at the bottom of the request form.
19. If the resident has an approved Level I PASRR, enter the 12 digit authorization number in the ‘Level I PASRR Approval Number’ box, and then enter the approval date in the ‘Level I PASRR Approval Date’ box.

Request Information	
* Recommendation Type :	<input type="radio"/> Continued Placement <input checked="" type="radio"/> Initial Placement
Initial Admission Date/Planned Admission Date :	05/05/2013
* Place of Service :	31 - Skilled Nursing Facility
* Admission Type :	Elective
Level I PASRR Approval Number :	113050199999
Level I PASRR Approval Date :	05/01/2013

Figure 346

Request Information	
* Recommendation Type :	<input checked="" type="radio"/> Continued Placement <input type="radio"/> Initial Placement
Continued Placement Start Date :	01/23/2013
Initial Admission Date :	01/23/2012
* Place of Service :	31 - Skilled Nursing Facility
* Admission Type :	Elective
Level I PASRR Approval Number :	112012399999
Level I PASRR Approval Date :	01/22/2012
Initial Request ID :	

Figure 347

Continued Placement – Vent Weaning:

If continued placement is selected as the recommendation type, two questions regarding vent weaning display. Responses to these questions are required.

20. Click *Yes* or *No* to indicate whether or not at least two vent weaning attempts have been made in the last 90 days.
21. If *No* selected, indicate whether or not weaning is feasible at this time by clicking *Yes* or *No*.
22. If *No* selected, describe in the box provided, the reason or reasons that vent weaning is not possible at this time

Have at least two vent weaning attempts been made in the last 90 days?

Yes No

If No, is vent weaning feasible at this time?

Yes No

If No, describe why patient is currently unsuitable for vent weaning.

Describe why vent weaning is not feasible at this time.

Figure 348

Diagnosis on Admission to Mechanical Ventilation Unit:

This table captures the diagnosis code (or codes) associated with the patient’s condition which necessitates mechanical ventilation services. At least one diagnosis code must be entered.

- 23. Enter the diagnosis code in the ‘Diag Code’ box. If the diagnosis code includes a decimal point, enter the decimal point with the code. If you do not know the diagnosis code, it is possible to search for the code by using the search function (spy glass) and entering the diagnosis description. Select the diagnosis from the search results and the system will insert the code.
- 24. The system populates the diagnosis description when the diagnosis is added.
- 25. Enter the date that the diagnosis was determined in the ‘Date’ box. If not known, enter the nursing facility admission date or the planned ventilation unit admission date. Enter the date manually or select from the calendar popup.
- 26. Click the ‘Primary’ checkbox to indicate that the diagnosis is the primary diagnosis; and click the ‘Admission’ checkbox to indicate that the diagnosis is the admission diagnosis. **Note:** If only one diagnosis is entered, the system will select that diagnosis as primary.
- 27. Click **Add** at the end of the diagnosis line. **You must click Add to add the diagnosis information to the request.**

* Diagnosis on Admission to Nursing Facility Mechanical Ventilation Unit						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
769	RESPIRATORY DISTRESS SYN	02/01/2012	Yes	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 349

- 28. Repeat the same process to add other diagnosis codes, if necessary. Remember to click **Add** after each addition.

Admission and Continued Stay Criteria:

This section consists of a series of questions related to mechanical ventilation services admission and continued stay policy. **A response to each question is required.**

- 29. Respond *Yes* or *No* to each question.

Admission/Continued Stay Criteria :
 (All questions are required)
 Supporting Documentation for each criterion may be reflected on the DMA-6 section noted in the parentheses or through attached documents as indicated.

- * Health condition requires close medical supervision, 24 hours a day of licensed nursing care, and specialized services or equipment (Section B12 on DMA-6). Yes No
- * Requires mechanical ventilation greater than six (6) hours a day per day for greater than twenty one (21) days. (Section B Diagnostic and Treatment Procedures on DMA-6). Yes No
- * Has a tracheostomy with the potential for weaning but require mechanical ventilation for a portion of each day for stabilization. Yes No
- * Admission from hospitalization or other location shall demonstrate two (2) weeks clinical and physiologic stability including applicable weaning attempts prior to transfer. (Section B Diagnostic and Treatment Procedures on DMA-6). Yes No
- * Requires pulse oximetry monitoring to check stability of oxygen saturation levels. (Section B Diagnostic and Treatment Procedures on DMA-6). Yes No
- * Requires respiratory assessment and documentation daily by a Licensed Respiratory Therapist or Registered Nurse. (Section B Diagnostic and Treatment Procedures on DMA-6). Yes No
- * Have a physician order for respiratory care to include suctioning as needed. (Section B Diagnostic and Treatment Procedures on DMA-6). Yes No
- * Requires tracheostomy care at least daily. (Section B Diagnostic and Treatment Procedures on DMA-6). Yes No

Figure 350

Hospital Admissions and Diagnosis at Discharge from Most Recent Admission

This section captures the patient’s recent hospitalizations/admissions. If the request is for an initial placement, information about the most recent discharging facility is required. This could be a hospital or another facility, such as a nursing facility. If the request is for a continued placement, enter any acute hospitalizations since the last vent authorization period.

30. Enter the name of the hospital or facility in the ‘Hospital/Facility’ box.
31. Enter the date admitted in the ‘Admit Date’ box.
32. Enter the date discharged in the ‘Discharge Date’ box.
33. Explain the reason for admission in the ‘Reason for Hospitalization’ box.
34. Click **ADD** to add the information to the request.
35. Repeat the process to add other hospitalizations/admissions.

Hospital Admissions
 If initial placement requested, enter the most recent hospitalization. If continued placement requested, list any acute hospitalizations since last vent authorization period began.

Hospital/Facility	Admit Date	Discharge Date	Reason for Hospitalization	
Test Hospital	01/24/2012	01/27/2012	Severe respiratory distress	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

Figure 351

36. To document the diagnosis at discharge from the most recent admission, enter the diagnosis code for the discharge diagnosis in the ‘Diag Code’ box (optional).
37. Select the diagnosis as primary, if applicable.
38. Click **ADD** to add the discharge diagnosis to the request. The system inserts the ‘Diagnosis Description’.

Diagnosis at Discharge from Most Recent Hospital Stay			
Diag Code	Diagnosis Description	Primary	
769	RESPIRATORY DISTRESS SYN	Yes	EDIT DELETE
<input type="text"/>	<input type="text"/>		ADD

Figure 352

Medications and IVFs:

This section records the patient’s medications including intravenous fluids.

39. Select a drug category from the ‘Name’ drop list.
40. Enter the dosage for the medication in the ‘Dosage’ box.
41. Select the administration route from the ‘Route’ drop list.
42. Select the frequency of administration from the ‘Frequency’ drop list.
43. Click **ADD** to add the drug information to the request.
44. Repeat the same process to add other medications.

Medications and IVFs				
Name	Dosage	Route	Frequency	
Anti-inflammatory	10mg	Oral	Regular	EDIT DELETE
Bronchodilator	10mg	Oral	Regular	EDIT DELETE
Antihypertensive	20mg	Oral	Regular	EDIT DELETE
Sed/hypnotic	10mg	Oral	PRN: As Necessary	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

Figure 353

Vent Use and Other Treatment Procedures

This section captures mechanical ventilation services information. Six service types are pre-populated on the treatment table: O2 Continuous, Trach Care, Respiratory Therapy, Pulse Oximetry, Ventilator and O2 PRN. The frequency of these services must be entered. In addition, other treatment procedures may be selected and added.

Follow this process, to enter the frequency for the required services and add other the treatment information:

45. Click the **EDIT** button for the first treatment.

Vent Use and Other Treatment Procedures

A frequency must be added for each of the treatments displayed. Click Edit on the treatment line and the treatment will display at the bottom of the table. Enter the frequency in the box provided and then click Save.

Type	Frequency	
O2 Continuous		EDIT
Trach Care		EDIT
Respiratory Therapy		EDIT
Pulse Oximetry		EDIT
Ventilator		EDIT
O2 PRN		EDIT
<input type="text"/>	<input type="text"/>	ADD

Figure 354

46. When edit is clicked, the treatment type displays at the bottom of the table. Enter the frequency for the treatment and then click **SAVE**.

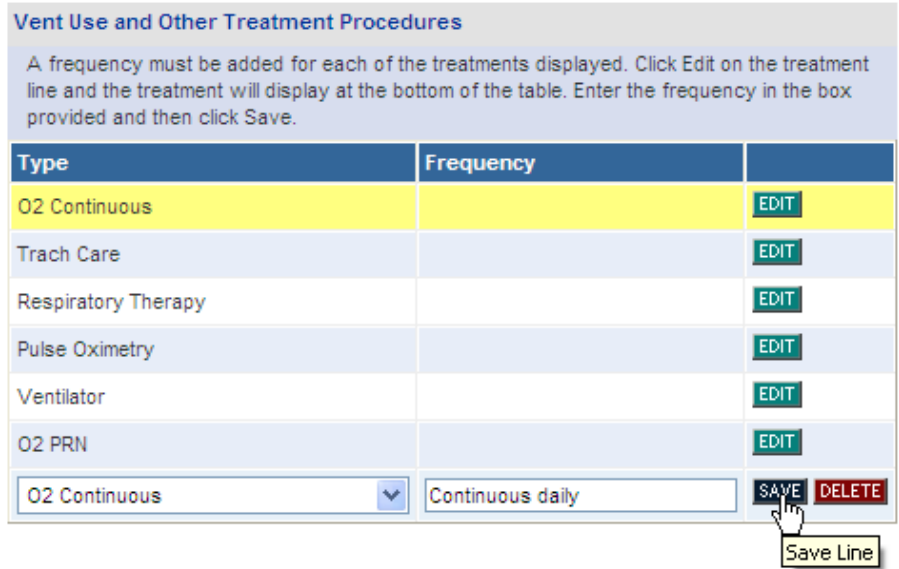


Figure 355

47. The treatment and frequency are saved and added to the request.

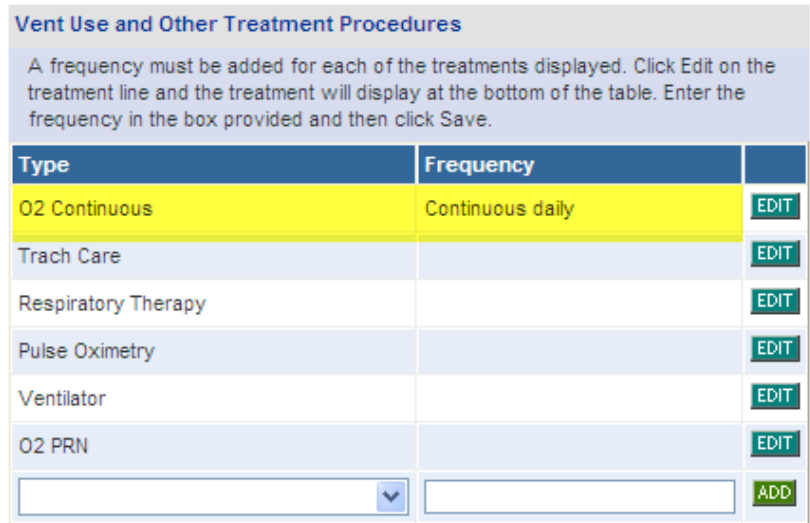


Figure 356

48. Click the **Edit** button for the next treatment and follow the same process to add a frequency for the treatment and save. Continue with the same process for each required treatment.

49. Other treatment procedures, which are part of the patient’s plan of care, may be added to the request. At the bottom of the table, below O2 PRN, click the down arrow to display the treatment procedures drop list. Select a treatment procedure; enter the frequency of the treatment; and then click **Add**.

Vent Use and Other Treatment Procedures

A frequency must be added for each of the treatments displayed. Click Edit on the treatment line and the treatment will display at the bottom of the table. Enter the frequency in the box provided and then click Save.

Type	Frequency	
O2 Continuous	Continuous daily	EDIT
Trach Care	Bid	EDIT
Respiratory Therapy	Once a day	EDIT
Pulse Oximetry	Twice a week	EDIT
Ventilator	10 hours a day	EDIT
O2 PRN	PRN	EDIT
Foley Catheter Care	Daily	EDIT DELETE
Intake & Output	Continuous	EDIT DELETE
<input type="text"/>	<input type="text"/>	ADD

Figure 357

Ventilator Settings:

50. For each ventilator setting, enter the numerical amount in the boxes provided. The box for FiO2 includes a decimal point; and the system inserts a '0' if only two digits are entered.

O2% : Peep : FiO2 : Resp Rate Setting :

Figure 358

Treatment Plan:

This text box captures a summary of the patient's treatment plan.

51. Summarize the plan of care including medications and treatments not previously noted, and any other services to be provided to the patient.

Treatment Plan :

Provide the complete treatment plan including medications, level of care requested, other services to be provided to the patient.

Provide the complete treatment plan including medications, level of care requested, other services to be provided to the patient.

Figure 359

Justification and Circumstances for Admission or Continued Placement

This textbox captures the justification for the mechanical ventilation services. Explain why the services are medically necessary. In addition, if urgent or emergency was selected as the admission type, provide clinical justification supporting the need for urgent or emergency admission.

- 52. Enter the justification and circumstances for the admission or continued placement in the box provided.
- 53. Enter the name of the RN who completed the DMA-6 in the 'Name of MD/RN Signing Form' box; and then enter the date signed in the 'Date Signed' box.

Justification and Circumstances for Admission or Continued Placement :

Provide justification for the services ordered.

Provide justification for the services ordered.

Name of MD / RN Signing Form : Date Signed :

Figure 360

- 54. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click **Review Request** again.
- 55. Click **I Agree** in response to the *Attestation Statement*.
- 56. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**. A page displays with the authorization ID in pending status.

2.3.25 PASRR Level I Requests	
Program	Authorization Period
PASRR Level I Screening	N/A
Description	
<p>Requests for Pre-Admission Screening Resident Review (PASRR) Level I are submitted via the web portal using the DMA-613 (PASRR) Level I form. The PASRR Level I form may be accessed from the public web portal via the Provider Information tab, or from the portal secure home page via the Provider Workspace. A Level I may be entered using the applicant’s Medicaid ID number; or, if the applicant is not a Medicaid recipient, the applicant’s Social Security Number (SSN). Upon submission of the Level I, the provider receives the Level I tracking number and notification of the Level I decision. The system determines the decision based on validation of the responses to the Level I screening questions and other form data. The following decisions are returned depending on the validation:</p> <ul style="list-style-type: none"> • Approved: A decision of ‘Approved’ indicates that all Level I criteria were met. No further action is needed and the applicant is approved for admission to a nursing facility. The Level I tracking number is now the Level I authorization number. • Pending: A decision of ‘Pending’ indicates that some or all criteria were not met. In general, most pending cases are referred for Level II assessment. • Withdrawn: If the system returns a decision of ‘Withdrawn’, it means that a response on the form reflects that the applicant’s physician anticipates the nursing facility stay will be less than 30 days. In this situation, no prior authorization is required. 	

Web Submission Instructions:

1. Log into the UAT Portal.
2. Select **Provider Information** and then **PASRR Request**; **OR** click **Prior Authorization** and then **Provider Workspace**.
3. On the Provider Workspace, click **Enter a New PASRR Request**.
4. On the next window that displays, enter the applicant’s Medicaid ID **OR** the applicant’s Social Security Number. **Do not enter both numbers.**

PreAdmission Screening/Resident Review(PASRR) Level I Assessment (Form : DMA-613)

The screenshot shows a web form with two input fields: 'Member Medicaid ID:' and 'Social Security Number:'. The Social Security Number field contains the text '222-23-2323'. Below the fields is a blue 'Submit' button. To the right of the form is a black box with the text 'Fictitious SSN' in white.

Figure 361

5. Click **Submit** to open the Level I screening form. At the top of the form, the following warning displays: **“DO NOT PROCEED IF PHYSICIAN HAS NOT CERTIFIED A DMA-6 FOR A LEVEL OF CARE.”** The intent of this warning is to remind the user to make sure that a physician has officially certified the DMA-6 before submitting the Level I request.

Member Information:

This section captures member demographic information; member’s current location and situation; and out of state contact information (if applicable).

6. If the applicant’s Medicaid ID was entered or the SSN entered corresponds to an individual with a Medicaid ID, the system will populate the Medicaid ID, social security number, Member name, date of birth and gender in the applicable boxes.
7. If the applicant is not a Medicaid recipient, the member information **except for Member ID** must be entered. Enter the applicant’s ‘Last Name’, ‘First Name’, ‘Middle Initial’ (if applicable), ‘Date of Birth’ (manually or using the calendar popup), and select a ‘Gender’ from the drop list. The system inserts the SSN entered on the Level I entry page.
8. Enter the applicant’s current location by selecting the location from the ‘Current Location’ drop list.

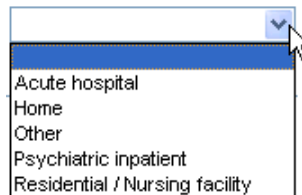


Figure 362

9. If ‘Other’ is selected as the current location, provide an explanation for this choice in the text box provided.
10. Under **‘Check all that applies to the applicant/resident’**, check each box related to the applicant’s situation. If ‘Other’ is selected, enter an explanation in the text box provided.
11. If ‘Out of State resident’ is selected, enter the OOS contact person’s ‘Last Name’, ‘First Name’ and ‘Phone Number’ in the ‘Resident’s OOS PASRR Contact Information’ section.

Question 1b: Is there current and accurate data in the patient record to indicate that there is a **severe physical illness** so severe that the patient could not be expected to benefit from ‘specialized services’?

If ‘Yes’ to question 1b, click a checkbox to specify the severe illness. If ‘Other’ selected for the illness, provide an explanation in the textbox provided.

Question 1c: Does the individual have a **terminal illness** as defined for hospice purpose under 42 CFR 483.130 which includes medical prognosis that his/her life expectancy is 6 months or less?

Question 1d: Does the individual applying for admission, **directly from hospital discharge, require NF services for the condition received while in the hospital** and whose attending physician has certified that the nursing facility stay is likely to require **less than 30 days**?

1. Does the individual have a suspected mental illness, mental retardation, developmental disability or related condition? Yes No

a. Does the individual have a primary (Axis I) diagnosis of dementia based on DSM IV criteria? Yes No

If Yes, check the type of dementia, due to:

Alzheimer's Disease Vascular Changes HIV Head Trauma Huntington's Disease Creutzfeldt-Jakob (ABE)

Parkinson's Disease Pick's Disease Other Dementia Diagnosis Code :

If 'Other' is selected, please explain.

b. Is there current and accurate data found in the patient record to indicate that there is a **severe physical illness** that is so severe that the patient could not be expected to benefit from *specialized services? Yes No

* Specialized Services under Georgia's PASRR Program are services in combination with nursing facility services results in the implementation of an individualized plan of care that is developed and supervised by an interdisciplinary team, prescribes specific therapies and activities which necessitates supervision by trained mental health personnel and is directed toward stabilization and restoration. The services include crisis intervention, training/counseling, physician assessment & care, In-Service training services, Skills training with Rehab supports & therapy, day/community support for adults, and case management which involves assertive community treatment. For more information, see Nursing Facility Part II Medicaid Policy Manual, Appendix H.

If Yes, specify the physical illness :

Coma, Functioning at a brain stem level Congestive Heart Failure Chronic Obstructive Pulmonary Disease Ventilator dependence Delirium

Parkinson's Disease Huntington's Disease Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) Other

If 'Other' is selected, please explain.

c. Does the individual have a **terminal illness** as defined for hospice purpose under 42 CFR 483.130 which includes medical prognosis that his/her life expectancy is 6 months or less? Yes No

d. Does the individual applying for admission, **directly from hospital discharge, require NF services for the condition received while in the hospital** and whose attending physician has certified that the NF stay is likely to require **less than 30 days**? Yes No

Figure 364

Mental Illness/Mental Retardation/Developmental Disability Questions:

13. Respond **Yes** or **No** to the following questions. If a response is ‘Yes’, additional information may be required.

Question 2: Does the individual have a primary (Axis I) diagnosis of mental illness based on DSM-IV criteria?

If ‘Yes’ to question #2, click a checkbox to indicate the applicable psychiatric illness. If ‘Other Psychotic Disorder’ or ‘Anxiety Disorder’ is checked, explain in the textboxes provided. The comments box is optional but can be used to note additional information regarding the patient’s psychiatric disorder.

Question 2a: Does the treatment history indicate the individual has experienced **at least ONE of the following?** (Respond Yes or No to (1) and (2) below).

(1) In-patient psychiatric treatment more than once in the past 2 years.

(2) Within the last 2 years experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Question 2b: **Within the past 3 to 6 months** the disorder results in functional limitations of major life activities that would normally be appropriate for the individual's developmental stage. The individual typically has **AT LEAST ONE of the following** characteristics on a continuing or intermittent basis:

(Respond Yes or No to (1), (2) and (3) below).

(1) **Interpersonal functioning.** The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation.

(2) **Concentration, persistence, and pace.** The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks

(3) **Adaptation to change.** This individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

Question 3: The individual has an Axis II diagnosis of mental retardation based on DSM IV criteria (diagnosed prior to age 18) or developmental disability (manifested before the person reaches age 22). The following **disabilities** MAY indicate a **RELATED CONDITION:** Autism, Blind/Severe Visual Impairment, Cerebral Palsy, Cystic Fibrosis, Deaf/Severe Hearing Impairment, Head Injury, Epilepsy/Seizure Disorder, Multiple Sclerosis, Spina Bifida, Muscular Dystrophy, Orthopedic Impairment, Speech Impairment, Spinal Cord Injury, Deafness/Blindness.

2. Does the individual have a primary (Axis I) diagnosis of mental illness based on DSM IV criteria? Yes No

If Yes, specify the physical illness :

<input type="checkbox"/> Schizophrenia, Paranoid Type	<input type="checkbox"/> Schizophrenia, Disorganized Type	<input type="checkbox"/> Schizophrenia, Catatonic Type	<input type="checkbox"/> Schizophrenia, Undifferentiated Type
<input type="checkbox"/> Schizophrenia, Residual Type	<input type="checkbox"/> Bipolar Disorder	<input checked="" type="checkbox"/> Depressive Disorder	<input type="checkbox"/> Somatoform Disorder
<input type="checkbox"/> Other Psychotic Disorder	<input type="text"/>	<input type="checkbox"/> Anxiety Disorder	<input type="text"/>

Comments :

a. Does the treatment history indicate the individual has experienced at least ONE of the following?

(1) In-patient psychiatric treatment more than once in the past 2 years. Yes No

(2) Within the last 2 years experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. Yes No

b. Within the past 3 to 6 months the disorder results in functional limitations of major life activities that would normally be appropriate for the individual's developmental stage. The individual typically has AT LEAST ONE of the following characteristics on a continuing or intermittent basis:

(1) Interpersonal functioning. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation. Yes No

(2) Concentration, persistence, and pace. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks. Yes No

(3) Adaptation to change. This individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system. Yes No

3. The individual has an Axis II diagnosis of mental retardation based on DSM IV criteria (diagnosed prior to age 18) or developmental disability (manifested before the person reaches age 22). Yes No

Figure 365

Nursing Facility Information:

This section captures nursing facility information. It must be completed if yes is the response to the first question in this section regarding admission to the nursing facility.


14. Respond *Yes* or *No* to indicate whether or not the patient has been admitted to the nursing facility.
15. **If No is the response**, go to the **Physician Information** section.
16. **If Yes is the response**, enter the date of admission to the nursing facility in the ‘Date of Admission to Nursing Facility’ box.
17. To enter the name of the nursing facility and nursing facility provider ID, follow this procedure:
 - a. Click the spy glass  next to the ‘Nursing Facility Provider ID’ box to display the *Nursing Facility Search* page.



Figure 366

- b. The *Nursing Facility Search* page displays the Referral (Reference) Provider ID and names of fifteen nursing facilities listed in alphabetical order. The other facilities are listed on the next search results pages accessed by clicking the page links below the list.

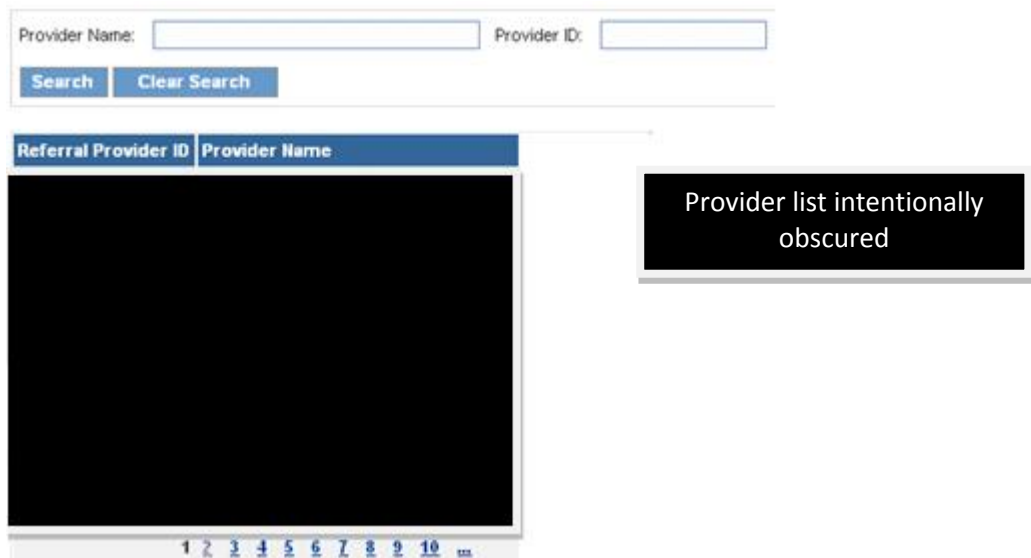


Figure 367

- c. Select the applicable Referral Provider ID from the lists, or use the search function to find the specific nursing facility
- d. To search, enter the nursing facility name in the 'Provider Name' box or nursing facility provider ID in the 'Provider ID' box, and then click **Search**.
- e. On the list of facilities that display, click the Referral Provider ID number. When this is done, the system inserts the facility name and Referral provider ID in the 'Name of Nursing Facility' and 'Nursing Facility Provider ID' boxes on the Level I form.

Nursing Facility Information

Has the patient been admitted to the nursing facility? Yes No

Date of Admission to Nursing Facility : Name of Nursing Facility : Nursing Facility Provider ID :

Figure 368

Physician Information:

This required section captures contact and other information for the physician noted on the applicant's DMA-6.

20. Enter the name of the physician who signed the DMA-6 in the 'Physician's Name' box.
21. Indicate if the physician is associated with an office or hospital by selecting from the drop list.
22. Enter the physician's contact phone number in the 'Phone' box.
23. Enter the physician's address in the 'Address 1' box. If additional space is needed for address, the 'Address 2' box may be used.
24. Enter the city and state where the physician is located by selecting from the 'City' and 'State' drop lists.
25. Enter the five-digit zip code in the 'Zip' box; and enter the county by selecting from the drop list.
26. Indicate whether or not the physician signed the DMA-6 by selecting *Yes* or *No*. **If Yes is selected**, enter the date that the physician signed the DMA-6.

Physician Information					
Physician's Name on DMA-6 :	<input type="text" value="Doctor Doctor"/>	Office or Hospital :	<input type="text" value="Office"/>	Phone :	<input type="text" value="444-444-4444"/>
Address 1 :	<input type="text" value="1 Address"/>	Address 2 :	<input type="text"/>	City :	<input type="text" value="City"/>
Zip :	<input type="text" value="30003"/>	County :	<input type="text" value="DeKalb"/>	Physician Signed?	<input checked="" type="radio"/> Yes <input type="radio"/> No
				Date Signed :	<input type="text" value="04/05/2010"/>

DO NOT PROCEED IF PHYSICIAN HAS NOT CERTIFIED A DMA-6 FOR A LEVEL OF CARE

Figure 369

Contact Information:

This required section captures contact information and is important for notifications.

27. Enter the contact person 'First Name' and 'Last Name'. This is usually the person who is requesting the Level I.
28. Enter the name of the contact facility in the 'Name of Contact Facility' box.
29. Select the type of facility from the drop list.
30. Enter the date that the Level I is requested in the 'Date Level I Requested' box.
31. Enter the contact person's phone number in the 'Phone' box. The contact person's Fax and E-mail are optional fields.
32. Enter the contact facility's street address and city in the boxes provided.
33. Select the state where the contact facility is located from the 'State' drop list.
34. Enter the 5-digit zip code in the 'Zip Code' box.

Contact Information					
Contact First Name :	<input type="text" value="First Name"/>	Last Name :	<input type="text" value="Last Name"/>	Name of Contact Facility :	<input type="text" value="Hospital"/>
Date Level I Requested :	<input type="text" value="04/05/2010"/>	Phone :	<input type="text" value="555-555-5555"/>	Fax :	<input type="text" value="- -"/>
Address :	<input type="text" value="Hospital St"/>	City :	<input type="text" value="city"/>	State :	<input type="text" value="Georgia"/>
				Contact Facility Type :	<input type="text" value="Hospital"/>
				E-mail :	<input type="text"/>
				Zip Code :	<input type="text" value="30030"/>

Figure 370

35. After all Level I questions are answered and all data entered, click **Review Request** at the bottom of the form. The page may temporarily 'gray' out as the system validates data.

36. If all required data is entered correctly, an attestation statement displays at the bottom of the *Review Request* page. Click **I Agree**.
37. When 'I agree' is selected, the *Review Request* page is refreshed and two new links display at the bottom: **Edit Request** and **Submit Request**.
38. Select **Submit Request**. The Level I is submitted; and the tracking number and Level I decision (pending, approved, or withdrawn) display at the top of the page as shown in the figure below.

PreAdmission Screening/Resident Review(PASRR) Level I Assessment (Form : DMA-613) Request

Thank you for submitting your Medicaid Prior Authorization request online. You may check the case status of your request online after 24 hours of submission. If you have any questions regarding your request or the prior authorization process, please click the "Contact Us" feature in the upper right-hand corner of this page, or call the toll-free number (800)766-4456.

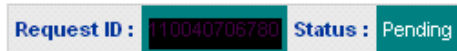


Figure 371

3.0 Production PA System

DCH program directors and program specialists are given ‘read only’ rights to the PA production system via the *DCH Workspace*. The rights are based on the user’s area of responsibility. This means that permission to find/view PA data is only granted for those PA types that are applicable to the user’s area of interest, unless the user is identified as a ‘super user’.

3.1 Screen Layout Overview

The *DCH Workspace* provides DCH users with access to the search pages and to PA detail/decision information. Each PA search page and information page is identified by name, and includes navigational/functional links for initiating searches and viewing PA information. The following examples provide an illustration of the search screen and PA information screen layouts.

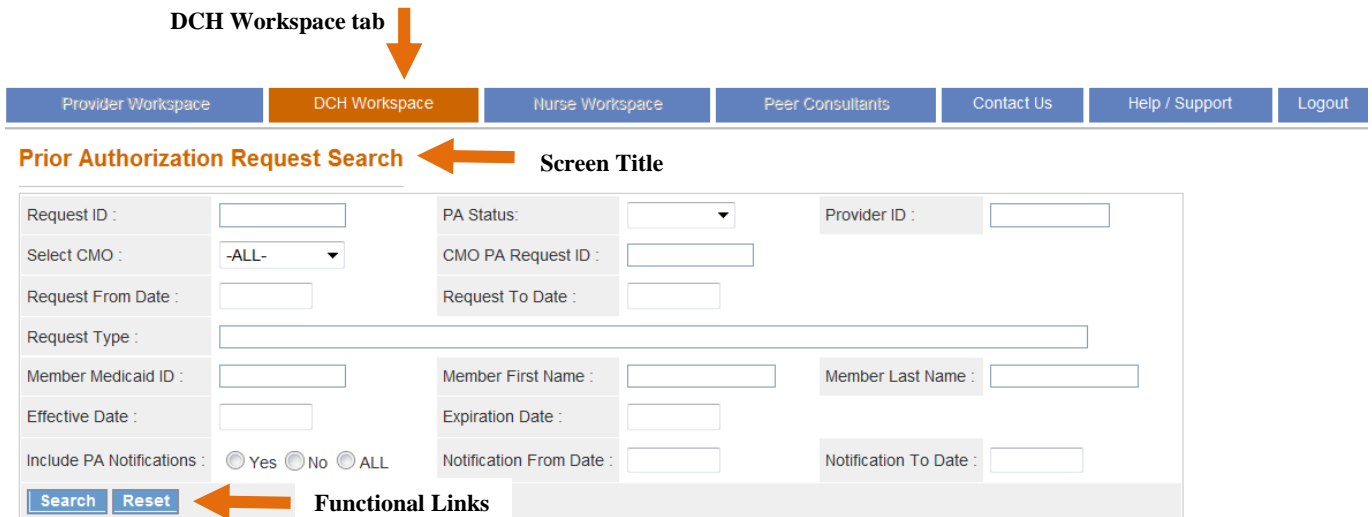


Figure 372

Prior Authorization - Radiology Physician Office Review Request ← **Screen Title**

This PA cannot be edited. Either the PA is currently under process or the decision is taken or this PA type cannot be edited once it is submitted.

Request Information					
Request ID :	██████████	Case Status :	Denied	Case Status Date :	12/15/2014
Member ID :	██████████				
Social Security Number :	██████████				
Provider ID :	██████████	CMO PA Request ID :			
Admission Date :	12/15/2014	Discharge Date :			
Effective Date :	12/15/2014	Expiration Date :	03/15/2015		

Diagnosis				
Diag Code	Diagnosis Description	Date	Primary	Type
V23.87	PREG W INCON FETL VIABIL	12/15/2014	Yes	ICD-9

Procedures									
GPT Code	GPT Description	Effective Date	Expiration Date	Units	Approved Units	Approved Amount	Decision	Reason	Family of Code(s)
76817	TRANSVAGINAL US OBSTETRIC	12/15/2014	03/15/2015	1	1		Withdrawn	PAN	No

↑ **Functional Link**

Clinical Data to Support Request

76817 is requested for date of service 12/15/14 for uncertain viability. Patient is unsure of last period. EDD is 7/28/15.

← **Return To Search Results** **Navigational Link**

Figure 373

3.2 System Access

DCH users access the PA production system utilizing Citrix. A Citrix account and PA system permissions are established for each user by the Alliant/GMCF IT department. DCH personnel request PA system permissions by completing and submitting a *PA System Access Request Form* (Appendix B) that captures the following information:

- Email Address
- DCH user name
- Associated PA type(s)
- User Phone Number

All requests for access are first approved by the designated DCH MMC contract manager before permissions are established. The approved requests are submitted via email to the Alliant/Georgia Medical Care Foundation (GMCF) Information Systems (IS) department at service@allianthealth.org. To ensure that access permissions are kept current, the designated DCH contact provides verification of current users on a quarterly basis, and notifies GMCF when a DCH user is terminated so that access may be removed.

Follow these instructions for accessing Citrix and the PA application:

1. Open the Citrix login page by going to: <http://atl-citrixweb.gmcf.org/>



Figure 374

2. Enter your assigned user name and password, and click **Log On**.
3. On the Citrix main page, click the **PA system** shortcut to open the *DCH Workspace* page. The *DCH Workspace* page displays a link to the PA search functionality.

3.3 Prior Authorization Request Search

DCH users have access to PA search functionality in order to find/view PAs related to their areas of responsibility. Users have ‘read only’ access to the prior authorization request information and decision information for their applicable PA types.

1. Click **Search for Authorization Requests** from the *DCH Workspace* page.

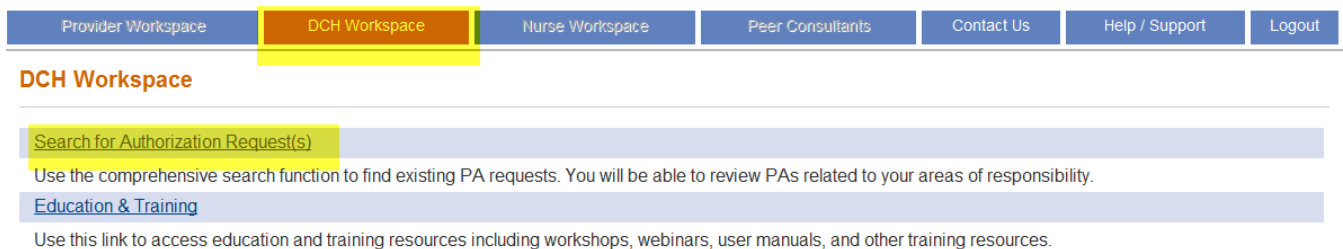


Figure 375

2. The *Prior Authorization Request Search* page opens. Search functionality allows the user to search for PAs using a single search parameter or by combining search parameters.

Figure 376

The following table provides a description of the search parameter options.

Parameter	Description
Request ID	PA ID - The 12 digit number assigned by the system when a FFS PA is entered.
Provider ID	The Medicaid Provider ID associated with the request. Some PA types such as precertification may have two different provider IDs. A search may be conducted using either provider ID.
PA Status	The overall PA status, which may be Pending, Approved, or Denied.
Select CMO	This search option permits a search for FFS PAs only, Wellcare PAs only Amerigroup PAs only, Peach State PAs only OR ALL.
CMO PA Request ID	The tracking number assigned to the CMO PA when entered.
Request Type	Same as PA Type or Review type. The PA types applicable to the DCH user will display.
Request From Date and To Date	Request Date is the date that the PA was entered into the PA system. To search for cases entered on a specific day, enter a 'From Date', and then enter the same date as the 'To Date'. To find cases entered on and after a specific date, enter a 'From Date' only. To find cases entered during a specific time span, enter a 'From Date' and 'To Date'.
Member Medicaid ID	The member's Medicaid ID number. This could be the 12-digit Member ID; or another Medicaid ID cross-referenced with the Member ID.
Member First Name	The member's first name. This name field is not case sensitive.
Member Last Name	The member's last name. This name field is not case sensitive.
Effective Date	The start date for the PA request.
Expiration Date	The end date for the PA request.
Include PA Notifications	This search option only applies to SOURCE and CCSP LOC PAs. Select Yes to search for PAs with notifications; Select No to search for PAs with no notifications; and select All to search for both.
Notification From and To Dates	This search option only applies to SOURCE and CCSP LOC PAs. Enter from/to dates to find PAs with notifications sent during a specific period of time.

Table 2

- To find a specific FFS PA, enter the 12 digit authorization ID in the ‘Request ID’ box. Do not enter any other information. Click **Search**. Since the ‘Request ID’ is a unique number, the search will return only one result. **This is the preferred method for finding a specific PA.**

Prior Authorization Request Search

The screenshot shows a search form with the following fields: Request ID (114123099999), PA Status (dropdown), Provider ID (text), Select CMO (-ALL-), CMO PA Request ID (text), Request From Date (text), Request To Date (text), Request Type (text), Member Medicaid ID (text), Member First Name (text), Member Last Name (text), Effective Date (text), Expiration Date (text), Include PA Notifications (radio buttons: Yes, No, ALL), Notification From Date (text), Notification To Date (text). At the bottom are Search and Reset buttons. An orange arrow points to the Search button.

Figure 377

- To find PAs requested during a specified period of time, search by a ‘From’ and ‘To’ Date. This type of search will pull in all PAs **requested** during a specific period of time.
 - To limit the PAs returned in a search to only certain PA type or types, use the ‘Request Type’ search parameter.
- To select a request type or types, click the ‘Request Type’ box to display the request type list. **Note: Only the request types related to the DCH user’s area(s) of responsibility will display – this may be one PA type or multiple types.**

Prior Authorization Request Search

The screenshot shows the same search form as Figure 377, but with the Request Type dropdown menu open. The menu lists various request types with checkboxes: Adult Dental, Hospital OutPatient Therapy, Precertification, Children's Intervention School Services, Independent Care Waiver Program (DMA-6), Precertification - Instate Transplants, Children's Intervention Services, Independent Care Waiver Program (DMA-80), Precertification - Out Of State, Durable Medical Equipment, Intermediate Care Facility for Mentally Retarded (Form DMA-6), Psychiatry, Emergency Air Ambulance Service, Medications PA Facility Setting, Psychology, Emergency Ground Ambulance Service, Medications PA Physician Office, Radiology Facility Setting, Exceptional Transportation Services, Oral/Maxillofacial Surgery, Radiology Physician Office, Georgia Pediatric Program (DMA-6A), Orthotics and Prosthetics, Swingbed (DMA-6), Georgia Pediatric Program (DMA-80), Practitioners Office Surgical Procedures, Swingbed (DMA-6A), Health Check Dental Program, Preadmission Screening (Form Number: DMA-613), and a Select Checked button at the bottom.

Figure 378

- Next, click the checkbox next to the desired request type. More than one type may be selected. Then, click **Select Checked**. The PA type or types selected are inserted into the ‘Request Type’ box on the search page.
6. To search for a specific PA when the request ID is not available, conduct a search by combining search criteria, such as ‘Request Type’, ‘Provider ID’, ‘Member ID’ and ‘From Date’. Combining search criteria will limit the search results.
 7. To find all PAs submitted by a specific provider during a certain period of time, enter the Provider ID and enter a ‘From Date’ and ‘To Date’. To further limit the PAs returned for this search, add the ‘Request type’ as a search parameter.
 8. After selecting/entering the desired search parameters, click **Search**. A list of PAs matching any of the search criteria is returned.

Request ID :	<input type="text"/>	PA Status:	Pending ▾	Provider ID :	<input type="text"/>	
Select CMO :	-ALL- ▾	CMO PA Request ID :	<input type="text"/>			
Request From Date :	12/22/2014	Request To Date :	12/30/2014			
Request Type :	Medications PA Facility Setting					
Member Medicaid ID :	<input type="text"/>	Member First Name :	<input type="text"/>	Member Last Name :	<input type="text"/>	
Effective Date :	<input type="text"/>	Expiration Date :	<input type="text"/>			
Include PA Notifications :	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ALL		Notification From Date :	<input type="text"/>	Notification To Date :	<input type="text"/>
<input type="button" value="Search"/> <input type="button" value="Reset"/>						

Request ID	Member ID	Last Name	First Name	Request Date	Effective Date	Expiration Date	Status	CMO	CMO Request ID
				12/26/2014 10:19:32 AM	02/04/2015	08/04/2015	Pending	FFS	
				12/26/2014 2:57:48 PM	12/30/2014	01/30/2015	Pending	FFS	
				12/29/2014 10:02:21 AM	12/12/2014	12/12/2015	Pending	FFS	

Figure 379

9. The search results list shows the following information per request: Request ID, PA Type, Member ID, Member Last Name and First Name, Request Date, PA Effective/ Expiration Dates, and Status. Each search results list displays up to 15 cases. If the search returns more than 15 cases, the other search results pages may be accessed by clicking the numbers at the bottom of the page as shown in the example below.

3.4 View PA Data

DCH users have access to the following PA data:

- Request information
 - Decision information
 - PA attachments
 - Notifications (SOURCE/CCSP)
 - Letter data (SOURCE/CCSP)
 - Change request and reconsideration request information
1. To view PA data: search for a PA or PAs and then select a **Request ID** (underlined and in blue) from search results to open the *Review Request* page.

The figure below show the *Review Request* page for a DME PA. The next figure shows a hospital PA.

Prior Authorization - Review Request

Request Information

Request ID : [REDACTED] Case Status : **Pending** Case Status Date : 06/09/2010
 Member ID : [REDACTED]
 Requesting Provider ID : [REDACTED] Rendering Provider ID : [REDACTED]
 Admission Date : [REDACTED] Discharge Date : [REDACTED]

Diagnosis

ICD-9 Code	ICD-9 Description	ICD-9 Date	Primary
111	DERMATOMYCOSIS NEC/NOS	06/01/2010	Yes

Procedures

CPT Code	CPT Description	From Date	To Date	Units	Approved Units	Approved Amount	Decision	Reason
E1390	OXYGEN CONCENTRATOR	06/01/2010	06/02/2010	4			Pending	
E0619	APNEA MONITOR W RECORDER	07/01/2010	07/01/2010	3			Pending	
B9998	ENTERAL SUPP NOT OTHERWISE C	07/01/2010	07/01/2010	1			Pending	
E1340	REPAIR FOR DME, PER 15 MIN	07/01/2010	07/01/2010	1			Pending	
E1390	OXYGEN CONCENTRATOR	07/01/2010	07/01/2010	1			Pending	

Attached Files

File	Type	Document Name	User	Date	
pasrrmaster.docx	Web Upload	Certificate of Medical Necessity (CMN)	LUMA2	6/9/2010 8:26:37 AM	DELETE

[Return To Search Results](#)

[Return To Search Results](#)

Figure 380

Provider Workspace | **DCH Workspace** | Nurse Workspace | Peer Consultants | Contact Us | Help / Support | Logout

Prior Authorization - Review Request

Request Information

Request ID : ██████████ Case Status : **Denied** Case Status Date : 07/20/2010
 Member ID : 333000000300
 Requesting Provider ID : ██████████ Rendering Provider ID : ██████████
 Admission Date : 07/21/2010 Discharge Date :

Diagnosis

ICD-9 Code	ICD-9 Description	ICD-9 Date	Primary
255	ADRENAL GLAND DISORDERS	07/06/2010	Yes

Procedures

CPT Code	CPT Description	From Date	To Date	Units	Approved Units	Approved Amount	Decision	Reason
62311	INJECT SPINE L/S (CD)	07/21/2010	07/21/2010	1			Peer Consultant Denied	DMM

Clinical Data to Support Request

test - DBARRETT, 07/20/2010

Return To Search Results

Figure 381

- If the PA has a denied code or codes, hold the mouse pointer over the denial reason code at the end of the procedure line to display the denial reason description and the reviewer's decision comments.

Request Information

Request ID : ██████████ Case Status : **Denied** Case Status Date : 07/20/2010
 Member ID : 333000000300
 Requesting Provider ID : ██████████ Rendering Provider ID : ██████████
 Admission Date : 07/21/2010 Discharge Date :

Diagnosis

ICD-9 Code	ICD-9 Description	ICD-9 Date	Primary
255	ADRENAL GLAND DISORDERS	07/06/2010	Yes

Procedures

CPT Code	CPT Description	From Date	To Date	Units	Approved Units	Approved Amount	Decision	Reason
62311	INJECT SPINE L/S (CD)	07/21/2010	07/21/2010	1			INADEQUATE DOC MED MGMT	DMM

Clinical Data to Support Request

test - DBARRETT, 07/20/2010

INADEQUATE DOC MED MGMT
 test - Peer Reviewer, 07/20/2010;

Hold pointer over denial reason code.

Figure 382

- To view the PA detail information, click the **Request ID** in bold blue font. This opens a detail page that shows all the data entered on the request.

Request ID : ██████████ Status : **Denied**

Member Information

Member ID	Last Name	First Name	MI	Suffix	DOB	Gender
333000000000	TEST	JOHNNY	A	SR	07/17/1958	M

Service Provider Information

Provider ID	Name and Address	Phone	Taxonomy (Specialty)
██████████	██████████	██████████	- Disproportionate Share Hospital - Hospital, Regular General - Swingbed Hospital - Prescriptive Eligibility

Reference Provider Information

Physician ID	Name and Address	Phone	Taxonomy (Specialty)
██████████	██████████	██████████	- Cardiovascular Disease

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

██████████

Contact Information

Contact Name:	Darlene Barrett	Contact Email:	JANE.SIRMAN@SGMC.ORG
Contact Phone:	229-259-4930	Contact Fax:	229-866-5432

Request Information

Admission Date:	07/21/2010	Admission Type:	Elective
Discharge Date:		SBI in Facility:	No
Place of Service:	OutPatient Hospital	Release of Info Code:	InformedConsent

Diagnosis

ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	Admission
255	ADRENAL GLAND DISORDERS	07/06/2010	Yes	No

Procedures

CPT Code	CPT Description	From Date	To Date	Units	Mod 1	Mod 2	Mod 3	Mod 4
62311	INJECT SPINE L/S (CD)	07/21/2010	07/21/2010	1				

Comments / Messages

Patient Transfer Information

Patient Transfer Information	Patient Transfer Information : (select all that apply and explain in clinical)
Is patient being transferred TO your facility? No	a. Higher level of care facility. No
Is patient being transferred FROM your facility? No	b. MD Specialist/Specialty Unit not available at original facility. No
	c. Back transfer to lower level of care facility. No
	1. Higher level of care is no longer warranted. No
	2. Level of care continues to meet inpatient confinement. No
	3. Transfer back does not compromise patient care. No
	4. Transfer back is not to alleviate bed overcrowding at sending facility. No
	d. Patient/family/physician convenience. No
	e. No beds available at original facility. No

Supporting Information

* **Clinical Data to Support Request:**
(Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission)
 test - DBARRETT, 07/20/2010

* **Admitting Treatment Plan:**
(Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments)
 test - DBARRETT, 07/20/2010

Does this member have retro eligibility for the submitted dates of service ? No

Request Submitted Via:

Figure 383

- To return to *Review Request* page, click **Back** at the bottom of the page.

5. To return to the search results, click [Return to Search Results](#) at the bottom of the *Review Request* page.

OR

6. To initiate another search, click *DCH Workspace* at the top of the page to access the workspace menu.



Figure 384

4.0 Appendices

4.1 Appendix A: Categories of Service per Review Type

Review Type	Allowable Requesting Provider COS Codes	Reference ID Need for Web Submission?
Additional Physician Office Visits	430 – Physician Services 431 – Physician’s Assistant Services, 480 – Nurse Midwifery 490 – Oral Maxillofacial Surgery 550 – Podiatry 740 – Nurse Practitioner	None
Additional Psychiatric Services	430 – Physician Services	None
Additional Psychological Services	570 – Psychological Services	None
Children Intervention Services	840 – Children’s Intervention Services	None
Dental Treatment - Pediatric	450 – Health Check Dental Program (under 21) 490 - Oral Maxillofacial Surgery	None
Dental Treatment – Adult	460 – Adult Dental Program 490 - Oral Maxillofacial Surgery	None
Durable Medical Equipment	320 – Durable Medical Equipment 321 – Pharmacy DME Supplies	None
Emergency Air Ambulance	371 – Emergency Air Ambulance	None
Emergency Ground Ambulance	370 – Emergency Ground Ambulance	None
Non-emergency Travel	380 – Non Emergency Travel Services/Exceptional Transportation	None
Hearing Services	330 – Orthotics/Prosthetics and Hearing	None

Review Type	Allowable Requesting Provider COS Codes	Reference ID Need for Web Submission?
Hospital Admissions/Hospital Outpatient Procedures	010– Inpatient Hospital Services 070 – Outpatient Hospital Services 670 – Ambulatory Surgical Center 430 – Physician Services 431 – Physician’s Assistant Services, 450 – Health Check Dental Program 460 – Adult Dental Program 480 – Nurse Midwifery 490 – Oral Maxillofacial Surgery 550 – Podiatry 740 – Nurse Practitioner	Hospital or Practitioner REF Number
Hospital In-State Transplants	010– Inpatient Hospital Services 070 – Outpatient Hospital Services 670 – Ambulatory Surgical Center 430 – Physician Services 480 – Nurse Midwifery 490 – Oral Maxillofacial Surgery 550 – Podiatry 740 – Nurse Practitioner	Hospital or Practitioner REF number
Out-Of-State Services (Out of State rendering provider)	010– Inpatient Hospital Services 070 – Outpatient Hospital Services 670 – Ambulatory Surgical Center 430 – Physician Services 480 – Nurse Midwifery 490 – Oral Maxillofacial Surgery 550 – Podiatry 740 – Nurse Practitioner	None
Intermediate Care Facility - MR	180 – Intermediate Care Facility/MR	None
Nursing Home Swingbeds	080 – Swingbed Hospital Services	None
Office Surgical Procedures	430 – Physician Services 431 – Physician’s Assistant Services 480 – Nurse Midwifery 550 – Podiatry 740 – Nurse Practitioner	None
Oral Maxillofacial Surgery	430 – Physician Services 490 – Oral Maxillofacial Surgery 450 – Health Check Dental 460 – Adult Dental	None
Orthotics and Prosthetics	330 – Orthotics/Prosthetics and Hearing	None

Review Type	Allowable Requesting Provider COS Codes	Reference ID Need for Web Submission?
Vision Services	470 – Vision Care	None
Hospital Outpatient Therapy	070 – Outpatient Hospital Services	None
Radiology - Physician Office	430 – Physician Services 431 – Physician’s Assistant Services, 480 – Nurse Midwifery 550 – Podiatry 740 – Nurse Practitioner	None
Radiology - Facility Setting	070 – Outpatient Hospital Services 670 – Ambulatory Surgical Center 430 – Physician Services 480 – Nurse Midwifery 490 – Oral Maxillofacial Surgery 550 – Podiatry 740 – Nurse Practitioner	If Hospital requestor, Practitioner REF # is optional. If Practitioner is requestor, Hospital REF # is required.
Medications PA - Physician Office	430 – Physician Services 431 – Physician’s Assistant Services 480 – Nurse Midwifery 550 – Podiatry 740 – Nurse Practitioner	None
Medications PA - Facility Setting	070 – Outpatient Hospital Services	Practitioner REF number is optional.
Georgia Pediatric Program	971 – In Home Private Duty Nursing 972 – Medically Fragile Daycare	None
Independent Care Waiver Program	660 – Independent Care Waiver Services	None
TEFRA Katie Beckett	380 – Non Emergency Travel Services	None
SOURCE Level of Care and Placement	930 and Case Mgt Specialty 030 Service Options Using Resources in the Community	None

Review Type	Allowable Requesting Provider COS Codes	Reference ID Need for Web Submission?
CCSP Level of Care and Placement	590 and Case Mgt Specialty 030 Community Care Services Program	None
NOW Level of Care and Placement COMP Level of Care and Placement	680 - New Options Waiver Level of Care 681 – Comprehensive Supports Waive Level of Care	None None
Level I PASRR	110 – Skilled Care in a Nursing Facility 160 – Intermediate Care Nursing Facility	None

4.2 Appendix B: DCH PA Access Request Form

In order to ensure that DCH staff are given ‘read only’ access to their specific PA types and/or programs within GMCF’s PA administrative pages, each DCH staff member who requires access will need to complete this DCH PA access form.

It is expected that the DCH MMC Program Manager will approve all access requests. All requests should be emailed to GMCF at the following email address: service@allianthealth.org

Request Date:
Name:
Email Address:
Phone Number:

Select the appropriate program type(s) for viewing by entering an ‘X’ in the column to the left of the PA type/form name:

	PA Type/Form
	Adult Dental
	Children's Intervention Services
	Durable Medical Equipment
	Emergency Air Ambulance Service
	Emergency Ground Ambulance Service
	GAPP
	Health Check Dental Program
	Vision Services
	Hospital Outpatient Therapy
	ICWP
	Intermediate Care Facility for Mentally Retarded
	SOURCE
	CCSP
	NOW and COMP
	Katie Beckett
	Medications PA Facility
	Medications PA Physician Office
	Non-Emergency Travel Services
	Oral/Maxillofacial Surgery
	Orthotics and Prosthetics/Hearing
	PASRR
	Practitioners Office Surgical Procedures
	Precertification
	Precertification - Instate Transplants
	Precertification - Out Of State
	Psychiatry
	Psychology
	Radiology Facility Setting
	Radiology Physician Office
	Swingbed
	Unlimited Physician Office Visits