

SOURCE LEVEL OF CARE WEB PROVIDER TRAINING

Presented by DCH & Alliant/GMCF

July 30, 2012 and August 2, 2012

SOURCE ELIGIBLE MEMBERS

- Target population for SOURCE:
 - Physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance (ADLs) or instrumental activities of daily living (IADLs).
 - Must meet the definition for Intermediate Nursing Home Level of Care.

ALLIANT/GMCF'S SCOPE OF WORK

- Initial level of care (LOC) admission determinations:
 - members discharged from services from 10/1/2011 through 7/25/2012 who are requesting readmission to the program
 - applicants who have been approved under Money Follows the Person (MFP)
- Reassessments:
 - members who were assigned a 6 month length of stay (LOS) who are being re-evaluated for continued services
 - a percentage of a statistically valid sample size of annual reassessments to be determined by DCH

ANNUAL REASSESSMENTS

- Most yearly reassessments and service plan approvals will continue to be managed by SOURCE CM sites.
- DCH will select a sample number of reassessments .
- DCH will notify the CM sites of the member sample and request required supporting documentation.
- SOURCE CM agency will submit documentation to GMCF for review.
- GMCF will follow normal decision notification process if LOC approved.
- Should the determination fail to support LOC, DCH will send notification to the waiver participant and CM agency.

GENERAL INFORMATION

- All SOURCE sites will be required to submit LOC requests with the required documentation *only* via the web portal.
- No mailed or faxed documents will be accepted.
- GMCF will not accept a case for review until all required documents are attached.
- Services cannot start until the initial LOC approval is granted.
- Initial approvals can be granted for one year or for a shorter time frame (e.g. 6 months).

REQUIRED DOCUMENTS

- 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 (physician or other appropriate professional notes that support LOC)
- DON-R Screening Tool (initial only)
- New Care Path Evaluation (reassessment)

DECISION NOTIFICATIONS

- GMCF's "*approvals*" will be in the web portal with decisions documented by GMCF to the provider via "Contact Us" which provides a secure environment and is HIPAA compliant; therefore, all inquiries related to protected health information should use this feature."
- All denial letters will be formatted using Appendix Z1 and Z2 and will be sent via certified mail to the member and SOURCE site.

APPROPRIATE TRANSITIONS FOR DENIED LOC FROM GMCF

- Explanation to member
- Provide resources
- Assist with request for hearing
- Only members may request a hearing

TECHNICAL DENIALS

- A technical denial will be implemented for missing documentation.
- Alliant/GMCF will institute an “initial technical denial” if all documents are not received within 5 calendar days from the initial request and will communicate decision via web portal.
- A “final technical denial” will be instituted if all documents are not received within 30 calendar days of the initial request.
- “Final Technical” denials will be communicated via Z1 and Z2 sent to member/SOURCE site.

COMMUNICATIONS TO GMCF

- If the provider has questions about their submitted case they can use the “Contact Us” query section on the web portal.
- Telephone calls will not be accepted.

WAITING LIST

- DCH will manage the wait list process using the DON-R (telephone screening tool) for WL placement.
- SOURCE sites should send DON-R's to Brian Dowd for initial placement requests while waiting list in effect; not GMCF.
- DCH will institute slot allocations.

SOURCE WEB ENTRY PROCESS

- Login to the Georgia Web Portal.
- On the *Secure Home* page, click **Prior Authorization**.
- Select **Submit/View** from the drop list;
OR
- Select *Provider Workspace* and then **Enter a New Request for PA**.

Welcome, [REDACTED]

Search

You have approximately 19 minutes until your session will expire.

Tuesday, February 09, 2010

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide | EDI | Pharmacy

Account | **Providers** | Training | Claims | Eligibility | Health Check | Prior Authorization | Referral | Reports | Trade Files

Home **Secure Home** Demographic Maintenance Rate Information Search [REDACTED] ch EOB Search

Provider Service Location Information

? [REDACTED]

Name [REDACTED]
 Medicaid Provider ID [REDACTED]
 National Provider ID [REDACTED]
 Provider Type HOSPITAL

Submit/View
 Provider V Submit/View

Address 1 [REDACTED] N AVE
 Address 2 [REDACTED]
 City, State [REDACTED]
 Zip [REDACTED]

Messages

? [REDACTED]

Category	Subject	Sent Date	Effective Date	End Date	Remove
PROVIDER ALERT	Subject	11/02/2009	06/13/2009	06/09/2010	<input type="checkbox"/>
PROVIDER ALERT	Welcome to the New Web Portal	11/02/2009	10/27/2009	06/02/2010	<input type="checkbox"/>
PROVIDER ALERT	More Messaging	11/02/2009	09/02/2009	05/01/2010	<input type="checkbox"/>
PROVIDER ALERT	Additional web functions	11/02/2009	10/02/2009	10/02/2010	<input type="checkbox"/>
PROVIDER ALERT	Testing public messages	11/02/2009	11/02/2009	11/02/2010	<input type="checkbox"/>
PROVIDER ALERT	Hello everyone	09/11/2009	09/11/2009	10/10/2010	<input type="checkbox"/>

Select All

Save

Deselect All

WEB ENTRY - continued

- When **Submit/View** is clicked, a link for the SOURCE Level of Care and Placement web form displays.

New Request for Prior Authorization

[SOURCE Level of Care and Placement](#)

- Click the link to open the form.

REQUEST AUTHORIZATION

- Enter the member's Medicaid ID.
- SOURCE Provider ID is populated by the system based on portal login credentials.
- Click **Submit** to open the online request form.

New Request for Prior Authorization

Source

To find a member or provider ID click the  next to the ID box

Member Medicaid ID: 

Source Provider ID :

LEVEL OF CARE & PLACEMENT

Member/Provider Info

- At the top of the form, member and provider information is populated by the system based on member and provider IDs entered.
- Check to be sure the correct member is noted on the form.

PHYSICIAN INFORMATION

- Enter the physician's first and last name.
- If the physician is the primary physician, select the 'Primary Physician' checkbox.
- If the physician is the SOURCE site Medical Director, select the Medical Director checkbox.
- Enter the physician's phone number.
- Enter the date that the physician signed the LOC Placement Instrument Form (Appendix F).

PHYSICIAN INFORMATION - continued

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="text" value="▼"/>
		Zip :	<input type="text"/>
		County :	<input type="text" value="▼"/>
* 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"/>

CONTACT INFORMATION

- Provider contact information is generally populated by the system.
- Enter or change contact name, phone, fax, or email address if missing or incorrect.

Contact Information			
* Contact Name:	<input type="text" value="Darlene Barrett"/>	Contact Email:	<input type="text" value="dbarrett@comcast.net"/>
Contact Phone:	<input type="text" value="555-555-5555"/> Ext. <input type="text"/>	* Contact Fax:	<input type="text" value="555-555-5554"/>

REQUEST INFORMATION

- Select the Recommendation Type: *Initial or Reassessment*
- Enter the DON-R score only if an initial LOC request.
- Enter the date admitted to the program or the planned admission date.
- Indicate if Member approved/not approved for MFP.

REQUEST INFORMATION - continued

- Select Release of Information type.
- Select *Home* or *Other* as the place of service.

Request Information			
* Recommendation Type :	<input checked="" type="radio"/> Initial <input type="radio"/> Reassessment	* DON-R Telephone Screening Score :	<input type="text" value="14"/>
* Initial Admit Date :	<input type="text" value="06/13/2012"/>	* Approved for Money Follows the Person?	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Release of Info Code :	<input type="text" value="InformedConsent"/> ▼	* Place of Service :	<input type="text" value="Home"/> ▼

DIAGNOSIS

- Enter the member's primary ICD-9 diagnosis code in the 'ICD-9' box. System populates the description.
- Enter the diagnosis date.
- Click the 'Primary' checkbox.
- Click **Add**.

DIAGNOSIS - continued

* Diagnosis

ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	Admission	
331.0 		03/01/2012	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="button" value="ADD"/>



* Diagnosis

ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	Admission	
331.0	ALZHEIMER'S DISEASE	03/01/2012	Yes	No	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text"/> 		<input type="text"/>		<input type="checkbox"/>	<input type="button" value="ADD"/>

ACUTE CARE HOSPITAL ADMISSIONS

- This section is not required but may be entered if applicable to case.

Acute Care Hospital Dates : From Date : 02/01/2012 To Date : 02/05/2012

Diagnosis on Admission to Hospital

ICD-9 Code	ICD-9 Description	Primary	
250	DIABETES MELLITUS	Yes	EDIT DELETE
<input type="text"/>	<input type="text"/>		ADD

MEDICATIONS AND TREATMENT PROCEDURES

- These sections capture medications and specific treatment procedures that are part of the member's treatment plan. In lieu of entering this information, may enter 'See medications (or treatments) attached' in the Treatment Plan textbox.
- Meds: Select the medication type; enter dosage; and select the route and frequency. Click **Add**.
- Treatments: Select the type and enter the frequency. Click **Add**.

MEDS/TREATMENTS - continued

Medications				
Name	Dosage	Route	Frequency	
Antihypertensive	30mg	Oral	Regular	EDIT DELETE
Sed/hypnotic	50mg	Oral	Regular	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

Diagnostic and Treatment Procedures		
Type	Frequency	
Medication Regulation	Daily	EDIT DELETE
<input type="text"/>	<input type="text"/>	ADD

SOURCE SERVICES

- Select a service type from the ‘Services’ drop list.
- Enter the unit of service requested.
- Enter the service frequency. If service only provided one time, enter *one time*.
- Enter the duration of the service. If only provided once, enter *one time*.
- Click **Add**.

SOURCE SERVICES - continued

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

TREATMENT PLAN

- Summarize the treatment plan to include information not otherwise specified on the request, such as: name of specific medications, level of care requested, residential history, and other services to be provided.

Treatment Plan :

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.

CERTIFICATION QUESTIONS

- Indicate whether or not the member is free of communicable diseases.
- Indicate whether or not the member's condition is manageable by SOURCE.
- Indicate whether or not the member's condition is manageable by Home Health Services.
- Indicate whether or not the physician has certified that the member requires intermediate level of care provided by a nursing facility.
- Indicate whether or not the physician has certified that the attached plan of care addresses the client's needs for Community Care.

CERTIFICATION - continued

Yes No

Is the patient free of communicable diseases?

Can this patient's condition be managed by :

Yes No

- Source ?

Yes No

- Home Health Services ?

Yes No

Has the physician certified that this patient requires the intermediate level of care provided by a nursing facility?

Yes No

Has the physician certified that the attached plan of care addresses the client's needs for Community Care?

EVALUATION OF NURSING CARE

- For each nursing evaluation category, select the nursing need item(s) necessary for the member's care.
- Enter the number of hours that the member is usually out of bed per day (this is optional).

EVALUATION OF NURSING CARE - continued

- May select more than one checkbox.

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="checkbox"/> Continent <input type="checkbox"/> Occasionally Incontinent <input checked="" type="checkbox"/> Incontinent <input type="checkbox"/> Other	<input type="checkbox"/> Continent <input type="checkbox"/> Occasionally Incontinent <input type="checkbox"/> Incontinent <input checked="" type="checkbox"/> 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="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Questionable <input type="checkbox"/> None	<input type="checkbox"/> Improving <input type="checkbox"/> Stable <input checked="" type="checkbox"/> Fluctuating <input type="checkbox"/> Deteriorating <input type="checkbox"/> Critical <input type="checkbox"/> 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 : Hrs.

THERAPIES, ADLS, LEVEL OF IMPAIRMENT

- **Therapies:** If applicable to the member's plan of treatment, enter the hours per week of therapy received and the hours needed.
- **Activities of Daily Living:** For each ADL category, select the level of assistance needed from the drop list.
- **Level of Impairment:** For each category of impairment, select the level impairment from the drop list.

ADLs & LEVEL OF IMPAIRMENT - continued

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"/>

JUSTIFICATION FOR SERVICES

- In the 'Justification and Services' textbox, explain why SOURCE services are necessary for the member's care.
- Enter the first name and last name of the RN who signed the *Level of Care and Placement*.
- Enter the date that the form was signed.

JUSTIFICATION - continued

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 : Jane Doe

Date Signed : 06/15/2012

SUBMIT REQUEST

- Click **Review Request** to display the *Attestation Statement*.
- Click **I Agree** in response to the *Attestation Statement*.
- Click **Submit Request**. The **pending Request ID** displays at the top of the page.

ATTACH DOCUMENTS

- When the request is submitted, required documents may be attached.
- Go to **Create an Attachment**. This section includes checkboxes for each required document type.
- Click a checkbox or checkboxes; click **Browse**; find the file; and then click **Attach File**.

ATTACHMENTS - continued

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".

Until all required documents are attached, GMCF will not accept this case for review and the turn-around-time for the review will not begin.

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
SOURCE-INITIAL	<input type="checkbox"/> Appendix F- Level of Care and Placement Instrument Form
	<input type="checkbox"/> Appendix I – Level of Care Justification for Intermediate Nursing Facility Care
	<input type="checkbox"/> Appendix S-MDS-HC Form
	<input type="checkbox"/> Appendix C-SOURCE Assessment Addendum
	<input type="checkbox"/> Medication Record
	<input type="checkbox"/> Case Notes
	<input type="checkbox"/> DON-R Screening Tool

Attached Files

File	Type	Code	Document Name	Size	User	Date	
SOURCE_test_attachment.Tif	Web Upload	SOURCE-INITIAL	Appendix C-SOURCE Assessment Addendum	425 KB		2/21/2012 3:12:54 PM	DELETE
SOURCE_test_attachment.Tif	Web Upload	SOURCE-INITIAL	Appendix F- Level of Care and Placement Instrument Form	425 KB		2/21/2012 3:12:54 PM	DELETE
SOURCE_test_attachment.Tif	Web Upload	SOURCE-INITIAL	Appendix I – Level of Care Justification for Intermediate Nursing Facility Care	425 KB		2/21/2012 3:12:54 PM	DELETE
SOURCE_test_attachment.Tif	Web Upload	SOURCE-INITIAL	Appendix S-MDS-HC Form	425 KB		2/21/2012 3:12:54 PM	DELETE
SOURCE_test_attachment.Tif	Web Upload	SOURCE-INITIAL	Case Notes	425 KB		2/21/2012 3:12:54 PM	DELETE
SOURCE_test_attachment.Tif	Web Upload	SOURCE-INITIAL	DON-R Screening Tool	425 KB		2/21/2012 3:12:54 PM	DELETE
SOURCE_test_attachment.Tif	Web Upload	SOURCE-INITIAL	Medication Record	425 KB		2/21/2012 3:12:54 PM	DELETE

ATTACHMENTS - continued

- Documents may also be attached to previously submitted pending or initial tech denied PAs.
- Go to the *Provider Workspace* and search for the PA.
- On the *Review Request* page, click the **Attach file** button.
- Go to **Create an Attachment**, find the file(s), and attach.

Prior Authorization - Review Request

Request Information

Request ID : [REDACTED] Case Status : **Pending** Case Status Date : 07/19/2012

Member ID : [REDACTED]

Provider ID : [REDACTED]

Admission Date : 07/18/2012 Discharge Date :

Effective Date : 07/19/2012 Expiration Date : 07/18/2013

Denial Reason :

Diagnosis

ICD-9 Code	ICD-9 Description	ICD-9 Date	Primary
331.0	ALZHEIMER'S DISEASE	06/24/2012	Yes

- [Edit Request](#)
- [Withdraw Request](#)
- [Attach File](#)
- [Return To Search Results](#)
- [Return to Provider Workspace](#)
- [Contact Us](#)



SYSTEM GENERATED PROVIDER NOTIFICATIONS

- Provider receives a 'no reply' email when a SOURCE PA is initially approved, or initially tech denied for missing information.
- The email notification directs the provider to check the web portal *Provider Workspace* for notification details.
- If the initial decision is a tech denial for missing information, the email will specify what information was missing.

NOTIFICATION DETAILS

- To access notification details: Log into the portal; select **Prior Authorization**; select **Provider Workspace**.
- Last ten notifications display at top of page.
- To view a PA notification, select the PA number and click **Show**.

NOTIFICATIONS - continued

Provider Workspace

Last 10 Requests : [Redacted] [v] [Show] Messages : [Redacted] [v] [Show] PA Notifications : [Redacted] [v] [Show]

Enter and Edit Authorization Requests

[Enter a New Authorization Request](#) - Use this link to enter a new prior authorization request. [More...](#)

[Search, Edit or Attach Documentation to Requests](#) - Use this link to search, edit or attach documentation to authorization requests.

[Member Medicaid ID Updates](#) - Use this link to Search, Edit, and modifying Member Medicaid IDs for SwingBed or Katie.

[Redacted] [v] [Show]

- Approved
- Approved
- Denied
- Approved
- Approved
- Approved
- Approved
- Approved
- Denied
- Denied
- Denied
- Approved

PA Change and Reconsideration Requests

[Submit/View PA Change Requests](#) - Use this link to request a change to existing authorization requests. [More...](#)

[Submit Reconsideration Requests](#) - Use this link to request a reconsideration to a denied case except CIS request. [More...](#)

PA NOTIFICATIONS - continued

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 : 133000000500
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](#)

END OF PRESENTATION