GA Web Portal FFS Prior Authorization

Provider User Manual - Version 2.5

ALLIANT GMCF

Revision History

Version	Date	Editor	Description
1.0	9/20/2010	D. Barrett	Initial Draft
1.1	10/21/2010	D. Barrett	Provider IDs and PA IDs redacted.
1.2	11/23/2010	D. Barrett	Updates from Build 2.0.0.2
1.3	8/8/2011	D. Barrett	Updates from build 2.0.0.9
1.4	10/24/2011	D. Barrett	Updates from build 2.0.0.11 and 2.0.0.12
1.5	2/15/2012	D. Barrett	Updates from build 2.0.0.14
1.6	7/18/2012	D. Barrett	Updates from build 2.0.0.15
1.7	8/1/2012	D. Barrett	Updates from build 2.17.00 and SOURCE
1.8	12/10/2012	D. Barrett	Updates from build 2.21.03
1.9	4/2/2013	D. Barrett	Update from build 2.25
2.0	7/1/2013	D. Barrett	Additions associated with CMO PA entry
2.1	8/15/2014	D. Barrett	Updates from build 2.34 and 2.35 and CCSP
2.2	12/12/2014	D. Barrett	Updates from Build 2.39
2.3	7/8/2015	D. Barrett	Added NOW and COMP
2.4	8/17/2015	D. Barrett	Build 2.48 and 2.48.06 updates
2.5	10/5/2015	D. Barrett	Build 2.49 updates and Autism Therapy Services

Document Description and Scope

The *Fee for Service (FFS*) *Prior Authorization (PA)* manual provides step by step instructions for submission of authorization requests via the GA Web Portal for members enrolled in FFS 'regular' GA Medicaid. This manual is not a policy manual but is meant to provide information related to the entry and submission of authorization requests for members in FFS Medicaid. This manual does not cover Care Management Organization (CMO) PA submission. For information on CMO PA submission, refer to the *Web Portal CMO PA Submission* user manual.

Note: Real PA numbers, Provider IDs, and Member IDs are redacted in this manual. Any provider or member information that displays is fictitious

Table of Contents

1.0 Overview

Medicaid providers may submit requests for authorization of services via the GA Web Portal. Once a request is submitted, the request data is added to the Alliant/GMCF PA system and is available for review by Alliant/GMCF staff. Requests for the following review types may be submitted via the web portal.

Review Type	PA Type	Description
Hospital Admissions and Outpatient Procedures (Precertification)	**Z**	Request for inpatient admission or request for certain procedures provided in outpatient hospital setting. Includes dental procedures provided in a hospital.
Practitioner's Office Surgical Procedures	**M**	Request for surgical procedures performed in a practitioner's office.
In-State Transplant Reviews (Precertification – In State Transplants)	**Z**	Request for transplant services provided in Georgia.
Out-of-State Reviews (Precertification – Out of State)	**Z**	Request for specialized medical services that cannot be provided safely in Georgia. A Georgia Physician can submit a request for the member to travel OOS and receive services from a Provider who is capable of providing the service and willing to accept the member.
EPSDT Health Check Dental (under 21 yrs.)	**R**	Request for dental services for members under 21 years of age.
Adult Dental	**T**	Request for certain dental services for members 21 years and older.
Emergency Ambulance Ground Air	 **E** **A**	 Request for emergency ground ambulance services. Request for emergency air transport services.
Non-Emergency Travel	**N**	Request for non-emergency travel and transport.
Vision	**V**	Request for vision case services (glasses and contacts) for members under 21 years of age.
Oral/Maxillofacial Surgery	**OM**	Request for Oral-Maxillofacial procedures.
Durable Medical Equipment	**D**	Request for the purchase, lease, replacement, or repair of durable medical equipment.
Orthotics and Prosthetics	**DP**	Request for the purchase, replacement, or repair of O&P devices.

Review Type	PA Type	Description
Hearing Aide Services	**DH**	Request for hearing aids, accessories, and/or repairs.
Additional Physician Office Visits	**U**	Request for additional physician office visits that are in excess of the annual Medicaid service limits of 12 visits for the fiscal year
Additional Psychiatric Services (under age 21 yrs.)	**PY**	Request for additional psychiatric service office visits for members under age 21 that are in excess of the annual Medicaid service limits of 24 visits for the calendar year.
Additional Psychological Services (under age 21 yrs.)	**PS**	Request for additional psychological service office visits for members under age 21 that are in excess of the annual Medicaid service limits of 24 visits for the calendar year.
Hospital Outpatient Therapy	**ZT**	Request for therapeutic services (PT, OT, and ST) provided in an outpatient hospital.
Radiology PA- Facility Setting	**Z**	Request for certain radiology procedures provided in an outpatient hospital.
Radiology PA-Physician Office	**M**	Request for certain radiology procedures provided in a physician's office.
Medications PA- Facility Setting	**ZD**	Request for certain high cost injectable drug codes provided in an outpatient hospital.
Medications PA-Physician Office	**M**	Request for certain high cost injectable drug codes provided in a physician's office.
PASRR Level I	**L1**	Request for PASRR Level I screening required for nursing home applicants to determine the presence of a mental illness, mental retardation, or a related disorder.
Nursing Facility Mechanical Ventilation Services	**M1**	Request for authorization of mechanical ventilation services provided in a nursing facility.
Swingbed	**SW**	Request for admission/continued stay to a Swingbed facility for adults (DMA6) or children (DMA6A).
Intermediate Care Facility-Mental Retardation	**MR**	Request for the admission/continued stay in an ICF-MR facility for adults (DMA6) or children (DMA6A).

Review Type	PA Type	Description
Children's Intervention Services	**B**	Request for rehabilitative and restorative therapeutic services that are offered to Medicaid eligible children under the Children's Intervention Services program.
Independent Care Waiver (ICWP) DMA6 DMA80	 **I6** **I**	Requests for admission/continued placement in the Independent Care Waiver program; and requests for service authorization.
SOURCE Level of Care and Placement	**S6**	Level of Care and Placement Request for initial admission and continued placement (reassessment) in the Service Options Using Resources in Community Environments program.
Source Services PA	**SC**	SOURCE Services request: **These requests are not reviewed by GMCF staff** but are approved upon submission.
CCSP Level of Care and Placement	**C6**	Request for initial admission and continued placement (reassessment) in the Community Care Services Program.
NOW Level of Care and Placement	**N6**	Requests for initial admission and continued placement in the New Options Waiver Program.
COMP Level of Care and Placement	**CO6**	Requests for initial admission and continued placement in the Comprehensive Supports Waiver Program.
Georgia Pediatric Program (GAPP) DMA6A DMA80	 **G6** **GP**	Request for admission or continued enrollment in the Georgia Pediatric Program; and requests for service authorization.
TEFRA/Katie Beckett DMA6A	**DW**	Request for initial admission and continued placement in the Katie Beckett program.

2.0 Authorization Request Web Entry

2.1 Hospital Admissions and In-State Transplant Requests

Program	Authorization Period
Precertification	90 days
Precertification–Instate Transplants	One Year

Table 1

2.1.1 Description

Precertification requests for inpatient and outpatient hospital services are entered on the *Hospital Admissions and Outpatient Procedures* request template; and precertification requests for instate transplant services are entered on the *In-State Transplants* request template. The table below shows the requesting provider categories of service applicable to precertification and instate transplant requests.

Hospital Admissions and 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
Instate 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

Table 2

The request templates for Precertification and Precertification/Instate Transplants are basically the same. The *Hospital Admissions/Outpatient Procedures* request template, however, may include **Additional Information** questions. The additional questions are system generated 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 *In-State Transplant* requests.

2.1.2 Instructions

2.1.2.1 Inpatient Hospital Admissions

Follow these instructions to enter a request for an inpatient hospital admission:

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. 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.

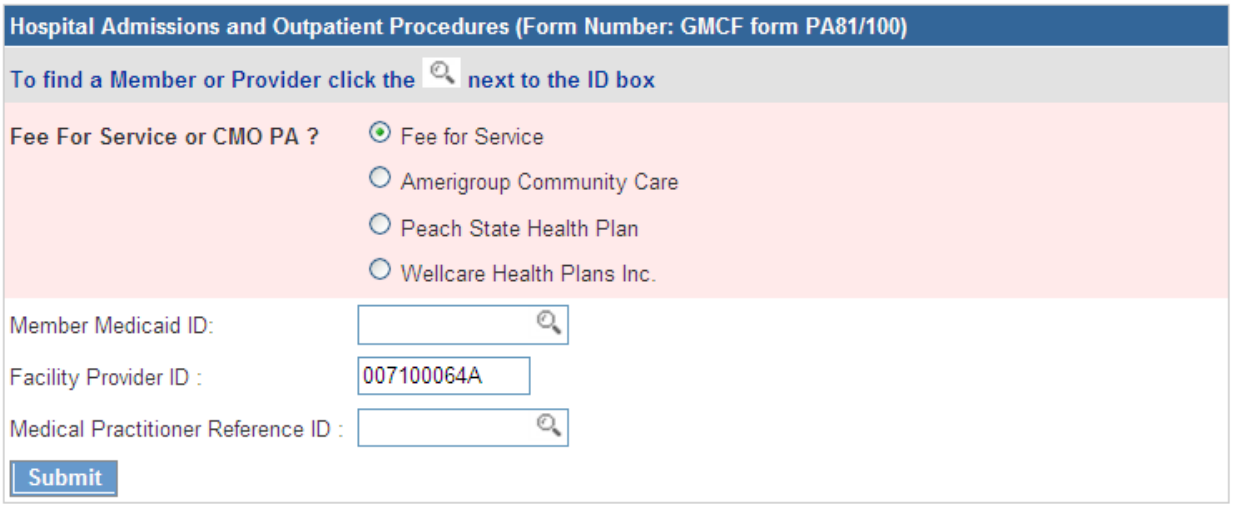


Figure 1

5. The provider ID associated with the user who logged into the portal displays in the appropriate Provider ID box. The figure 1 example shows how this page appears when a facility logs into the portal and requests a hospital admission.

6. Enter the 'Member Medicaid ID'.

7. 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.

Figure 2

8. Click **Submit** to open the request template.

9. 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.

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

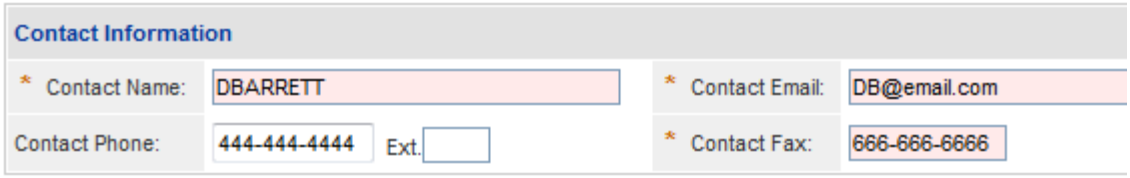


Figure 3

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. Enter manually or use the calendar popup. If the admission date entered is more than 90 days greater than the request date, the case will be system 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.

Figure 4

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:

Figure 5

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'.

Figure 6

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.

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.

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.

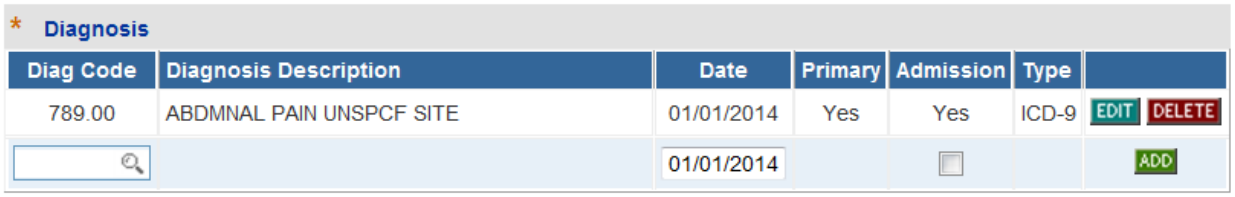


Figure 7

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 (system populated), procedure 'From Date' and 'To Date', units requested, and modifiers (if applicable).

Figure 8

23. For inpatient hospital admissions, a procedure code is not required unless a procedure is rendered that requires prior authorization. If the inpatient admission includes such a procedure, enter the following in the Procedures Table: 'CPT Code', procedure 'From Date'; procedure 'To Date', and requested 'Unit'(s).

24. After entering the procedure information, click **Add** to add the information to the request. For specific instructions on adding procedures, refer to **Section 2.1.2.2**-outpatient hospital requests.

25. If the procedure 'From Date' entered 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.

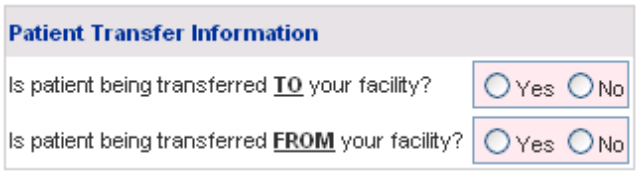


Figure 9

26. Respond to each transfer question by clicking 'Yes' or 'No'.

27. If 'Yes' is selected for either transfer question, additional **required** transfer questions display.

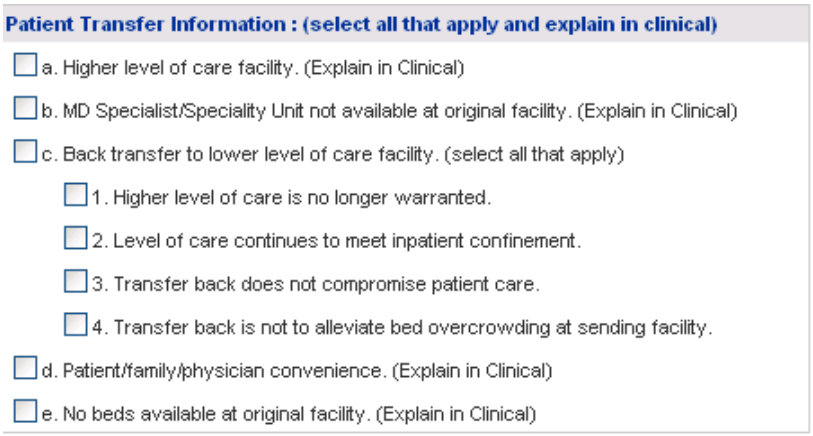


Figure 10

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

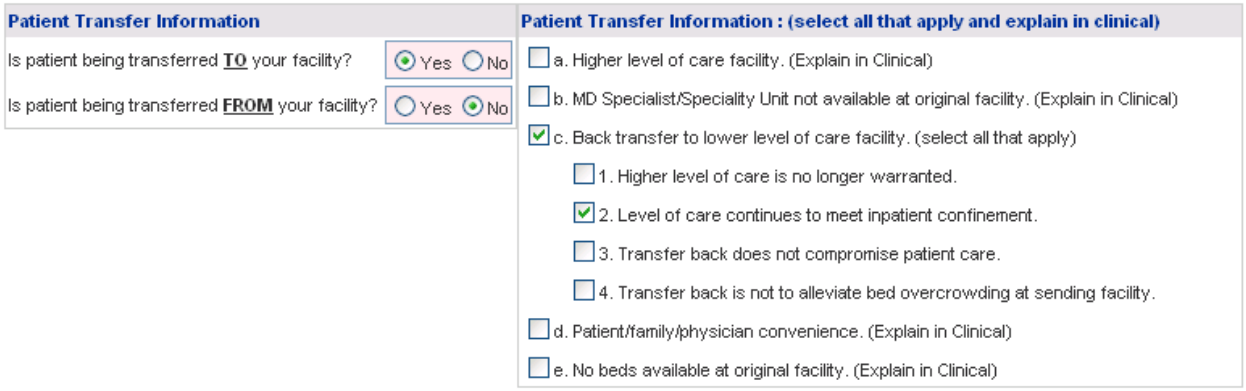


Figure 11

Supporting Information:

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

29. 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.

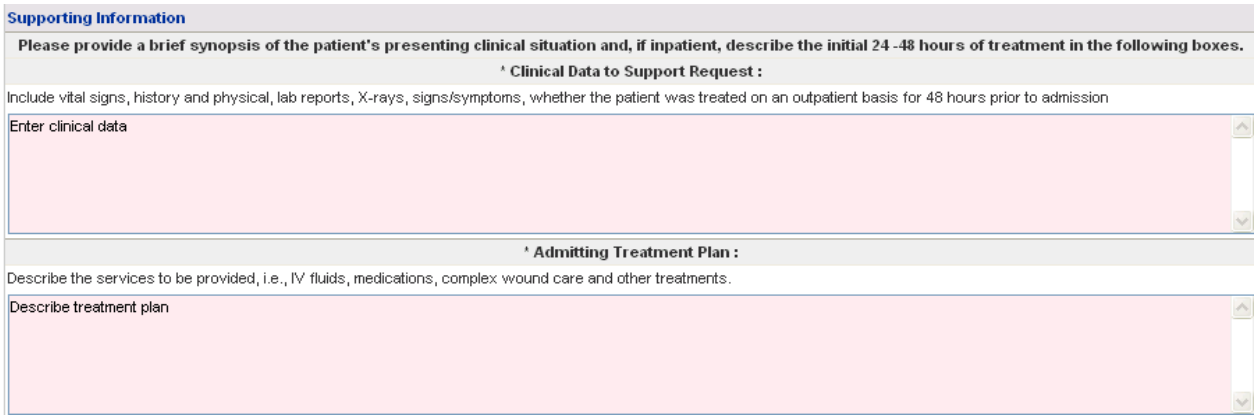


Figure 12

Retro-Eligibility:

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

Figure 13

30. For members with 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'. If 'Critical Care' had been selected as the current location, the questions related to inpatient critical care would display instead.

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

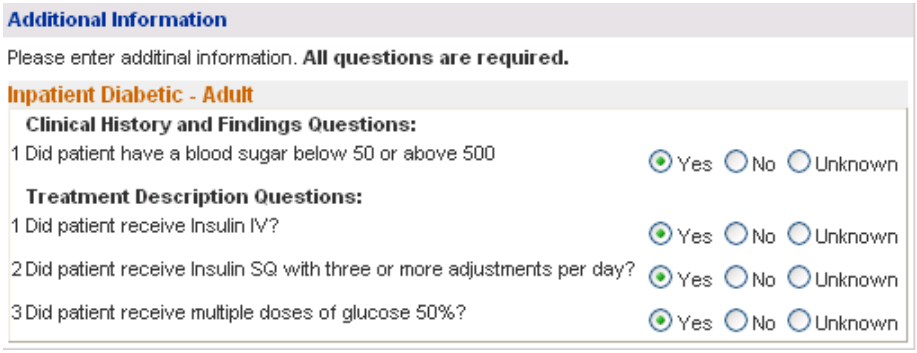


Figure 14

32. 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.

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 page displays.

2.1.2.2 Outpatient Hospital Admission

The process for entering a request for authorization of 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 must be entered**. Additional information questions may be pulled into the request template depending on the procedure code or codes added to the request.

1. Go to the **Georgia Web Portal** at www.mmis.georgia.gov and log in using your assigned user name and password.

2. Follow the same entry process for inpatient admissions as described under **Section 2.1.2.1**.

3. In the **Request Information** section, enter the admission date.

4. Select the 'Admission Type': Elective, Urgent, or Emergency.

5. Select *Outpatient* from the drop list for 'Place of Service'.

Figure 15

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.

6. 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.

7. Enter the date that this diagnosis was established in the 'Date' box.

8. 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'.

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

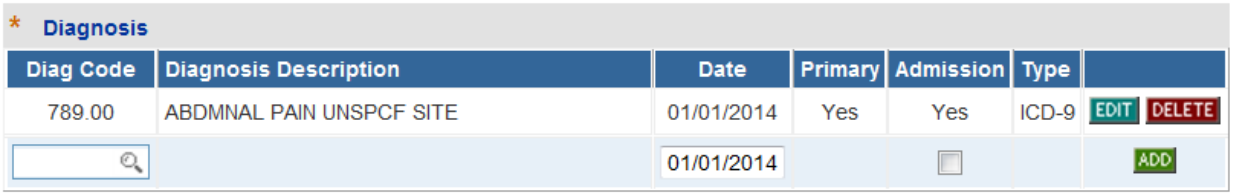


Figure 16

10. 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.

11. 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."

12. Enter the date of service for the procedure in the 'From Date' box; and repeat that date in the 'To Date' box. Use the calendar popup for date insertion, or enter manually.

13. 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.

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

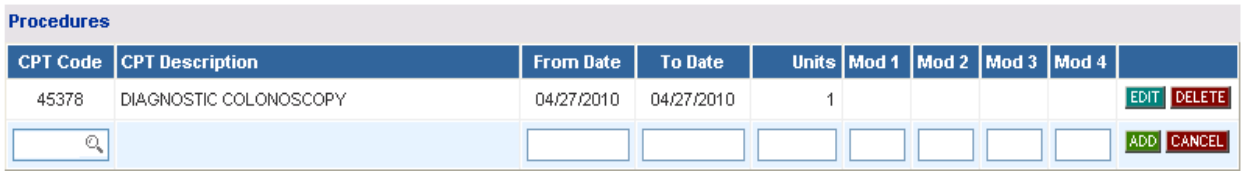


Figure 17

15. Follow the same process to add other procedure codes, if applicable. **Remember to click Add after each procedure line is entered.** When **Add** is clicked the system validates the procedure entry against system edits as follows:

    - If the same procedure code is entered more than once, this message displays when **Add** is clicked: "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".

    - If a 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.

    - If a procedure From Date is before the Admission Date, this message displays when **Add** is clicked: "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.

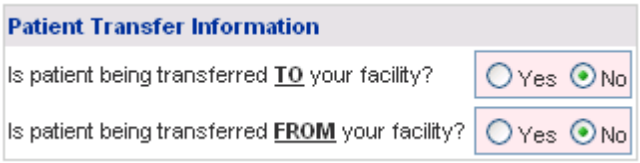


Figure 18

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.

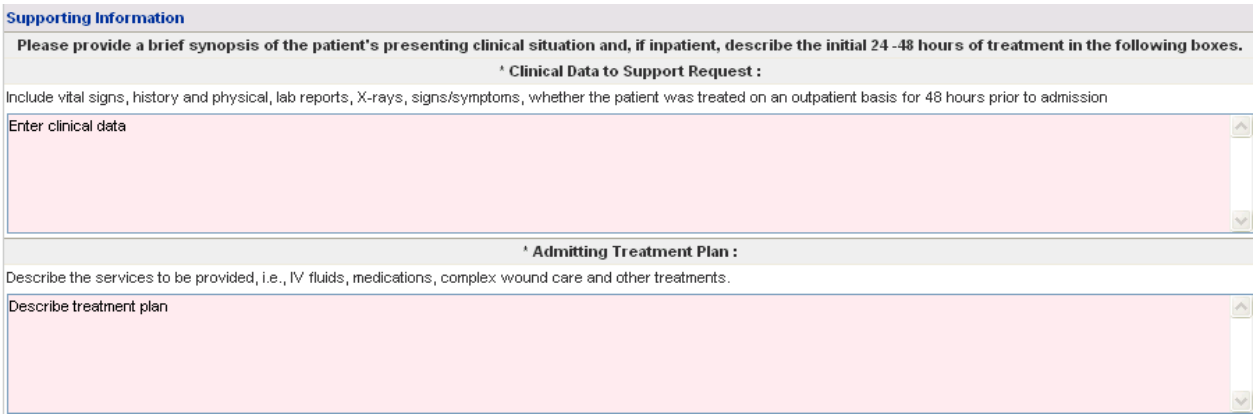


Figure 19

Retro-Eligibility:

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

Figure 20

18. For members with retro eligibility for the dates of service, click 'Yes'.

Additional Information Questions:

The entry of certain procedure codes may trigger additional information questions that display at the bottom of the request template. These questions are required and must be completed in order to submit the request. The next figure shows the additional information questions for an outpatient colonoscopy request.

19. Click 'Yes' or 'No' for each question. If questions #1 through #4 do not apply to the patient's condition; describe the 'other situations' for the colonoscopy in the text box provided next to question #5.

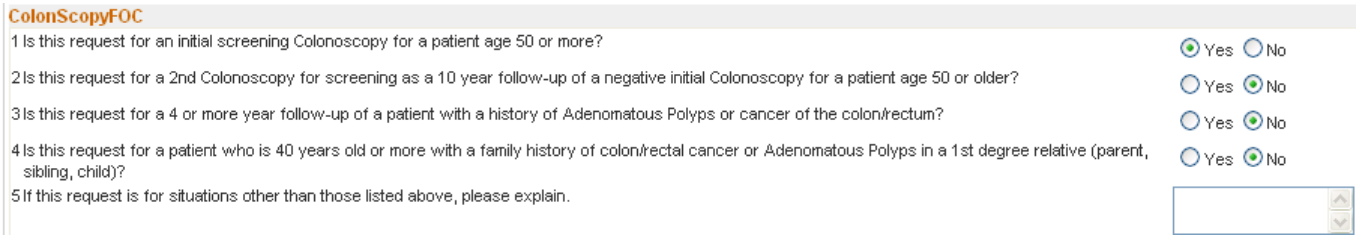


Figure 21

20. When all data is entered on the request form, click **Review Request** at the bottom of the page.

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. Before reviewing the request for accuracy, 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 system displays the pending PA tracking number.

2.1.2.3 In-State Transplant Requests

The process for entering an *In-State Transplant* PA request is the same as entering an inpatient or outpatient PA with procedure codes. There are no additional information questions for transplant requests.

1. Go to the **Georgia Web Portal** at www.mmis.georgia.gov and log in using your assigned user name and password.

2. Follow the same process for request entry as described for inpatient or outpatient admissions.

3. Then, enter the other required data as previously described in **Sections 2.1.2.1** and **2.1.2.2**.

4. Once all data is entered on the template, click **Review Request** at the bottom of the page.

5. 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.

6. Before reviewing the request for accuracy, click **I Agree** in response to the Attestation Statement.

7. Review the request. To change information entered, click **Edit Request**. Otherwise, click Submit Request.

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

2.2 Out of State Services (OOS)

Program	Authorization Period
Precertification – Out of State	90 days unless the PA has a 1 year transplant code

Table 3

2.2.1 Description

Precertification requests for out of state services (OOS) may be submitted via the web portal utilizing the *Out-of-State Services* request template. Submission of requests for out of state services is restricted to providers with the following categories of service:

Out of State Services	010– Inpatient Hospital Services 070 – Outpatient Hospital Services 670 – Ambulatory Surgical Center (ASC) 430 – Physician Services 480 – Nurse Midwifery 490 – Oral Maxillofacial Surgery 550 – Podiatry 740 – Nurse Practitioner

Table 4

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 on the *New Request for Prior Authorization* page. If a hospital/Ambulatory Surgical Center requests the OOS PA, the Reference ID for the patient's medical practitioner is required.

2.2.2 Web Entry Instructions

Follow these instructions to enter a request for out of state services:

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. 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 displays in the appropriate Provider ID box. If the patient's physician is the requestor, the only ID that needs to be entered is the member's Medicaid ID number. A facility provider ID is not needed.

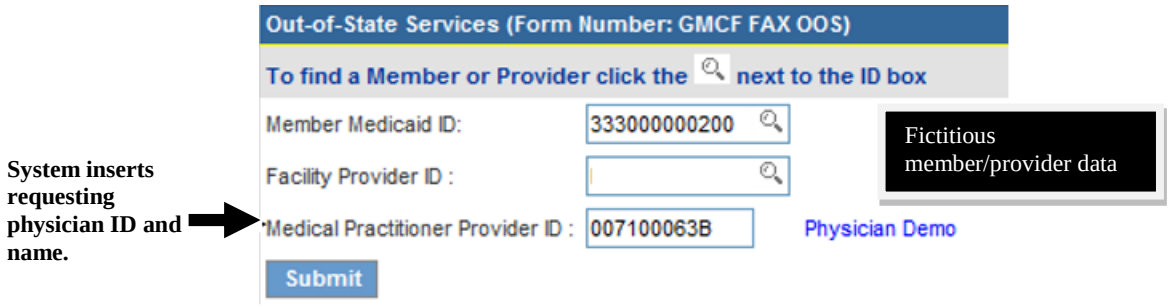


Figure 22 Physician Requestor

Note: When the Facility Provider ID box is left blank, the system auto-populates 'REFGMCFOOS' in the facility box when Submit is clicked.

5. If the hospital is the requestor, enter the member's Medicaid ID and enter the physician's Reference ID number in the 'Medical Practitioner Provider ID' box.

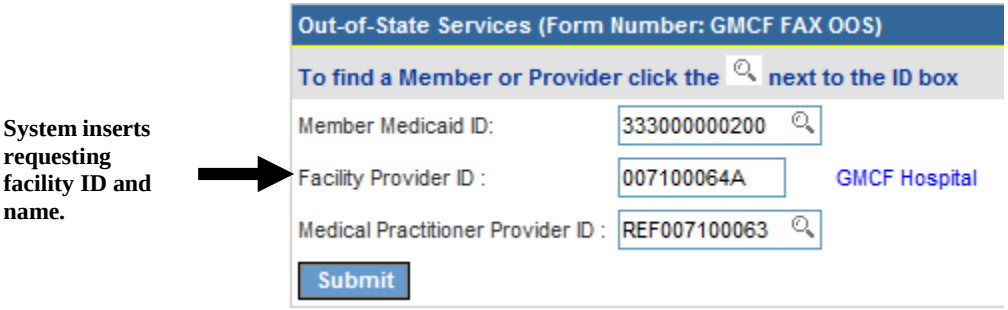


Figure 23 Hospital Requestor

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.

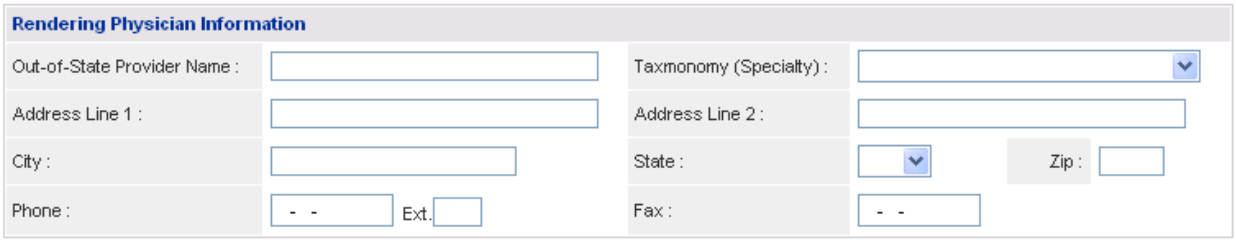


Figure 24

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.

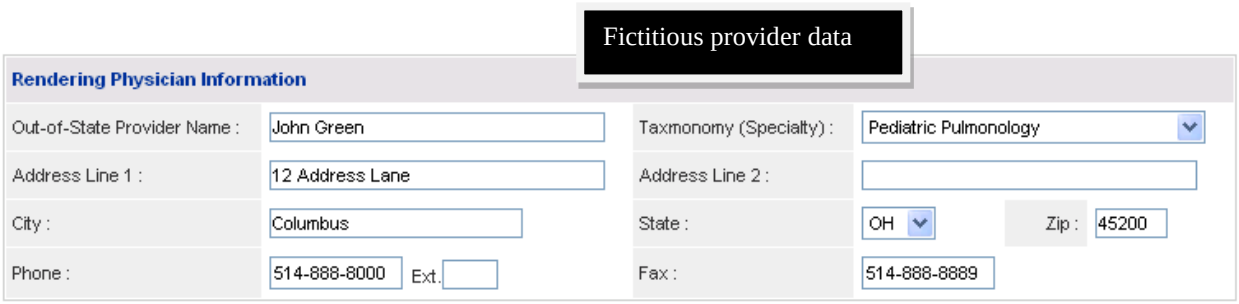


Figure 25

Rendering Facility Information:

This section captures out of state facility information.

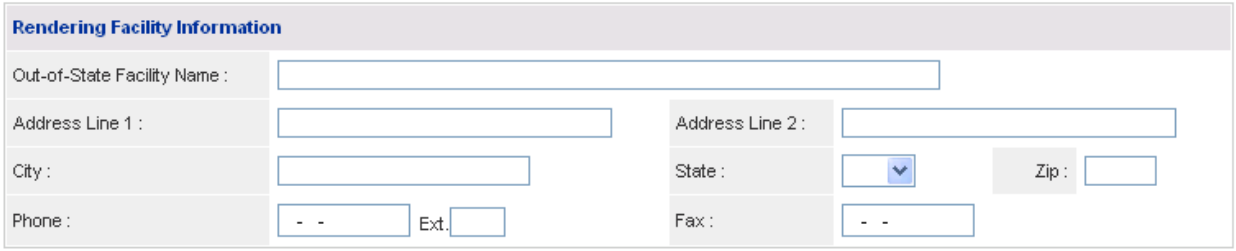


Figure 26

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.

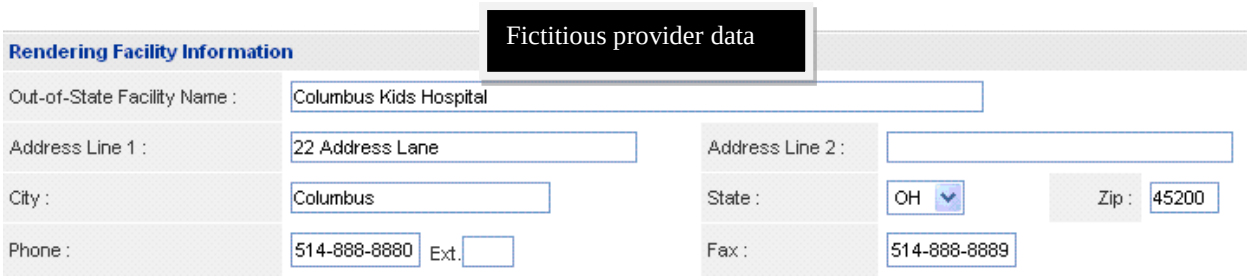


Figure 27

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.

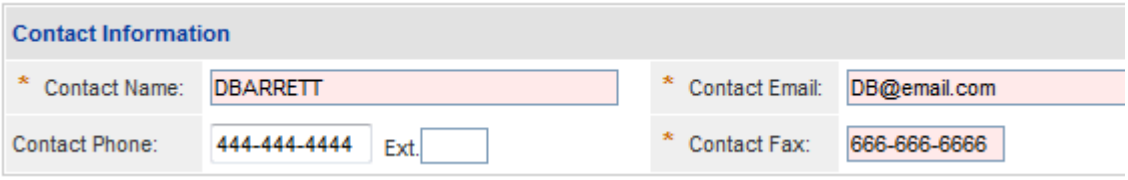


Figure 28

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'.

Figure 29

Diagnosis Table:

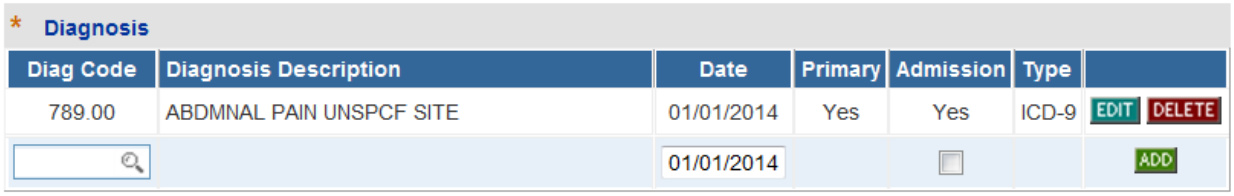
The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, primary diagnosis indicator, admission diagnosis indicator, and diagnosis type for each diagnosis code entered.

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.

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
		01/01/2014				ADD

Figure 30

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.

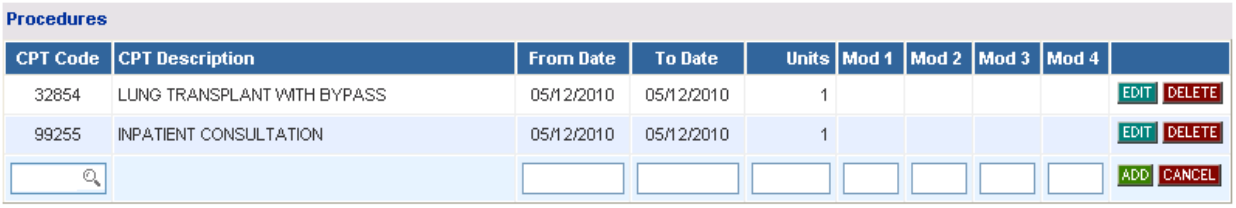
28. Enter the procedure code for the service requested in the 'CPT Code' box; or search for and have system insert the procedure code.

29. Enter the date of service for the procedure in the 'From Date' box; and repeat that date in the 'To Date' box. Use the calendar popup for date insertion, or enter manually.

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
									ADD CANCEL

Figure 31

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.

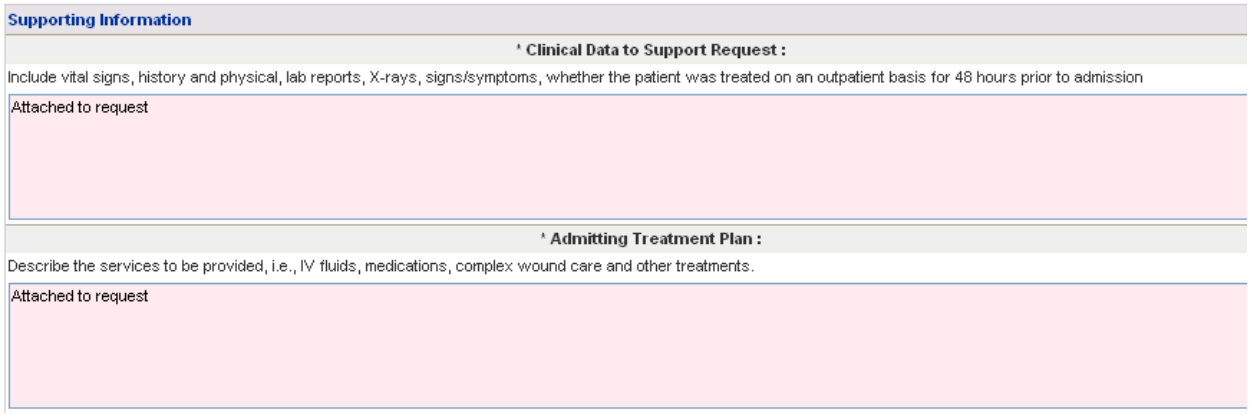


Figure 32

Retro-Eligibility:

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

Figure 33

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*. 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 system displays the pending PA tracking number.

2.3 Hospital Outpatient Therapy Requests

Program	Authorization Period
Hospital Outpatient Therapy	Up to 3 months

Table 5

2.3.1 Description

Requests for therapeutic services provided in an outpatient hospital setting **must be** submitted via web portal utilizing the *Hospital Outpatient Therapies* 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 submission of Hospital Outpatient Therapy requests for members in FFS Medicaid is restricted to providers with an outpatient hospital (070) category of service. The *Hospital Outpatient Therapies* request form includes **Additional Information** questions which are required regardless of the therapeutic services requested. The questions are designed to capture information related to policy requirements for short term rehabilitation services as specified in the Department of Community Health Hospital Services manual.

2.3.2 Web Entry Instructions

Follow these instructions to enter a request for hospital outpatient therapy:

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. 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.

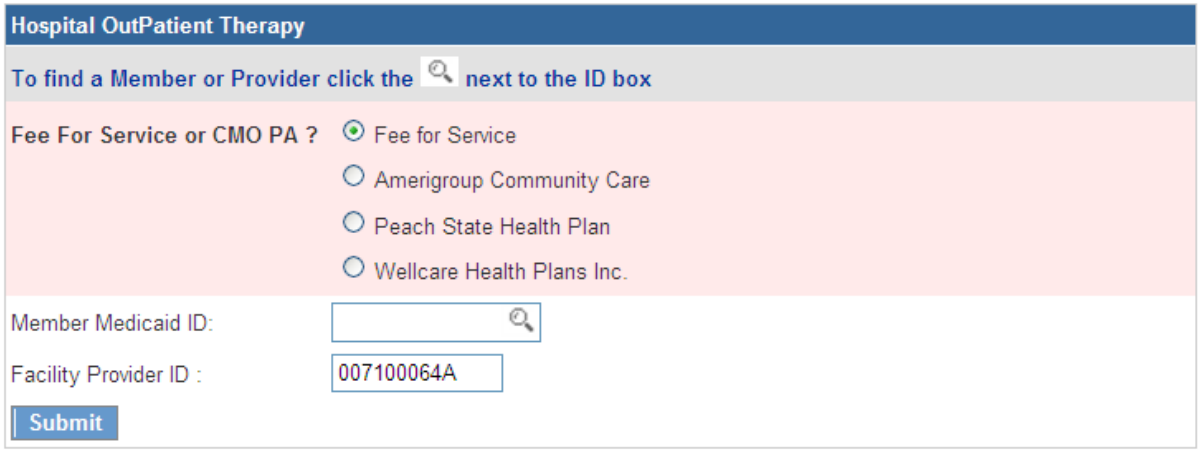


Figure 34

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

Figure 35

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. .

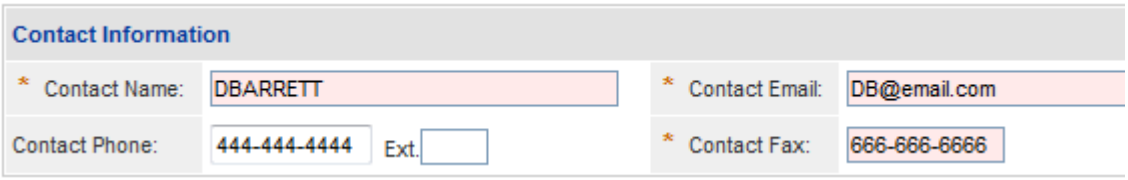


Figure 36

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.

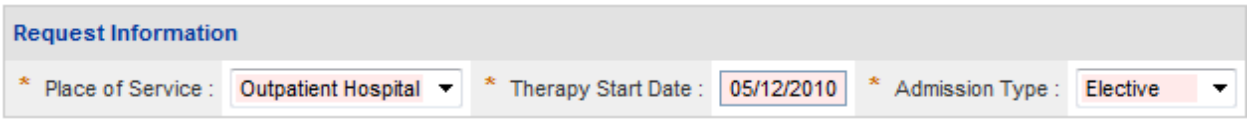


Figure 37

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.

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 this diagnosis was established in the 'Date' box.

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.

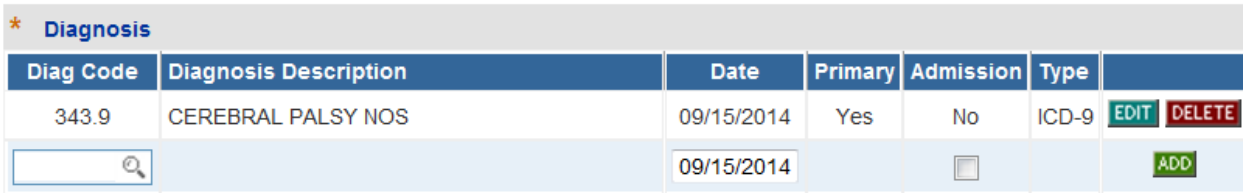


Figure 38

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. Enter the dates manually or use the calendar popup.

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.

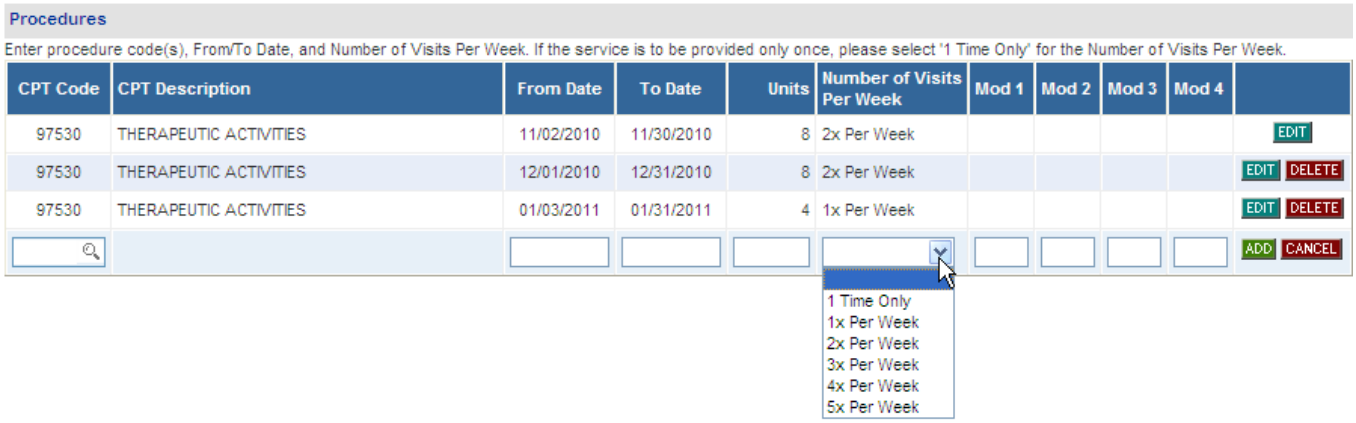


Figure 39

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

Procedure Validation

The system validates procedure codes against the following system edit:

- If the procedure entered is an evaluation code, and more than 1 unit is requested or more than '1 Time Only' is selected as the number of visits per week, the following message displays when **Add** is clicked: "Per DCH policy, only 1 unit per month may be authorized for evaluation codes. System has changed 'Units' to 1 for Procedure 97001".

Figure 40

The system also validates the procedure dates against the following system edits:

- If the procedure From Date and procedure To Date are not within the same month the following message will display when **Add** is clicked: "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.

- If a procedure From Date is more than ninety (90) days in the future, the following 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.

- Up to three consecutive months of service may be entered on one request. If more than three consecutive months are requested, the following 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.

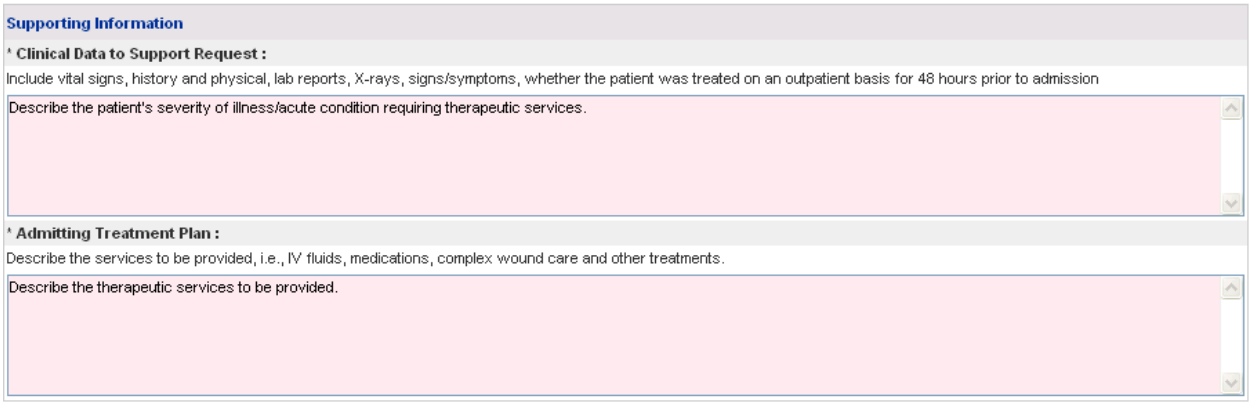


Figure 41

Additional Information Questions:

Additional questions display at the bottom of the request form. All questions are required except for the 'Range of Motion' and 'Strength Evaluation' sections. The range of motion and strength sections should be completed when the information 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 : 359.1

and date of onset(mm/dd/yyyy) : 10/19/2009

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
[ ] Feet/Ankle	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[x] Knee	( ) N/A (•) Both ( ) Left Side ( ) Right Side	25
[x] Hip	( ) N/A (•) Both ( ) Left Side ( ) Right Side	25
[ ] Spine	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Shoulder	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Elbow	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Wrist	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Hand	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Fingers	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[x] Neck	( ) N/A ( ) Both (•) Left Side ( ) Right Side	10
[ ] Other	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	

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
[ ] Feet/Ankle	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[x] Knee	( ) N/A (•) Both ( ) Left Side ( ) Right Side	2
[x] Hip	( ) N/A (•) Both ( ) Left Side ( ) Right Side	2
[ ] Spine	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Shoulder	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Elbow	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Wrist	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Hand	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Fingers	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Neck	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	
[ ] Other	(•) N/A ( ) Both ( ) Left Side ( ) Right Side	

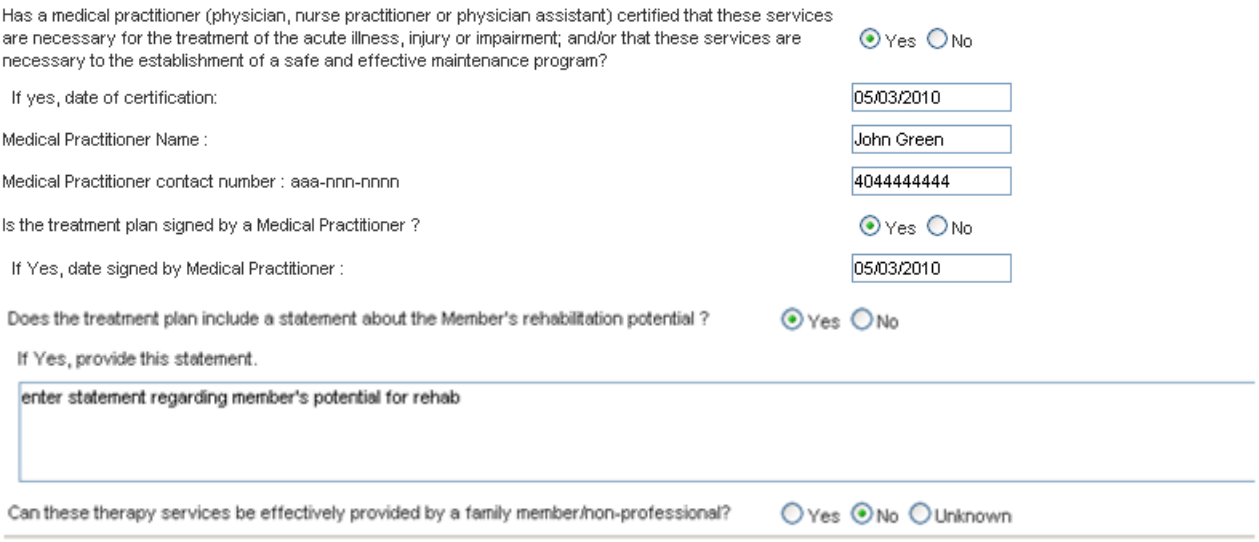


Figure 42

25. 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.

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.

2.4 Radiology Prior Authorization Requests

Program	Authorization Period
Radiology Facility Setting	90 Days
Radiology Physician Office	90 Days

Table 6

2.4.1 Description

Requests for authorization of radiology services provided in an outpatient hospital or physician office **must be** submitted via the web portal utilizing the *Radiology-Facility Setting* and *Radiology-Physician Office* request templates. Submission of requests for prior approval of radiology services is restricted to providers with the following categories of service:

Radiology - Physician	430 – Physician Services 431 – Physician's Assistant Services 480 – Nurse Midwifery 550 – Podiatry 740 – Nurse Practitioner
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

Table 7

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. The request templates for radiology facility and radiology physician office are identical; and the same information is required for submission. The request templates include **Additional Information** questions which are specific to a radiology code group (OB Ultrasound codes; PET Body; and PET Brain) or a family of codes (MRI Brain; MRI Lumbar Spine; CT Head; CT Pelvis; and CT Abdomen).

2.4.2 Web Entry Instructions

2.4.2.1 Radiology Facility Setting Instructions

Follow these instructions to enter a request for request for Radiology Facility Setting:

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. Select **Radiology-Facility Setting** from the list of review types.

4. **If the hospital is the requestor**, the Provider ID for the hospital displays on the *New Request for Prior Authorization* page.

5. Enter the member's Medicaid ID. If a medical practitioner is involved in the service, enter the Reference ID for the medical practitioner; otherwise, leave this box blank.

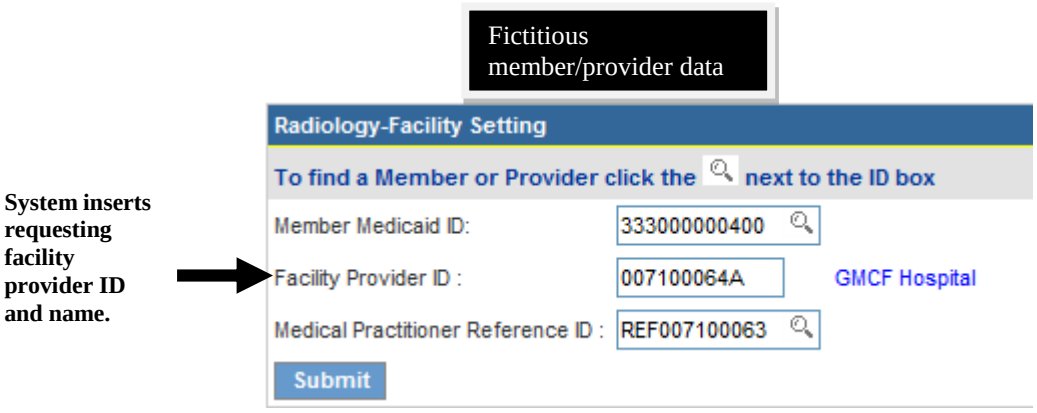


Figure 43

6. **If the medical practitioner is the requestor**, the Provider ID for the practitioner displays on the *New Request for Prior Authorization* page.

7. Enter the member's Medicaid ID and the hospital's Reference ID (required).

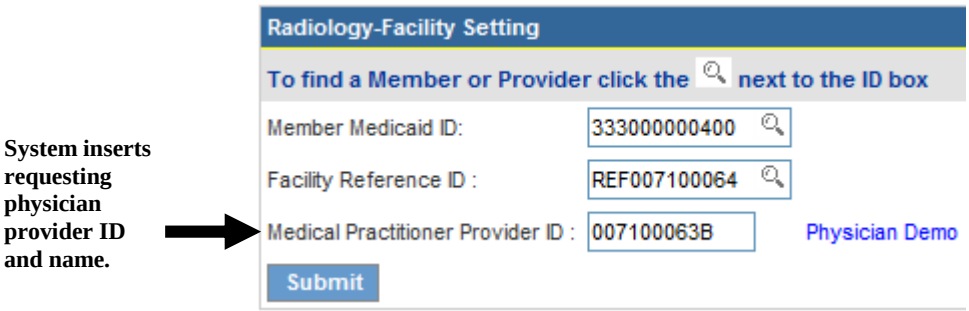


Figure 44

8. 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.

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

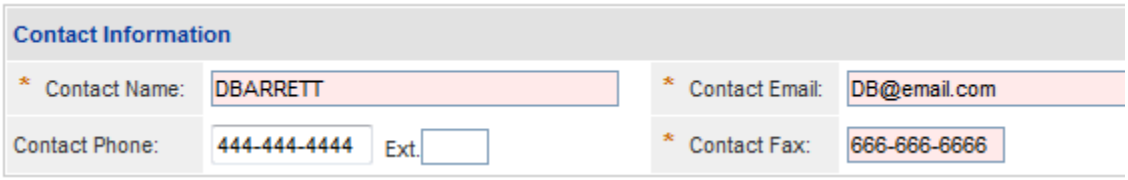


Figure 45

Request Information:

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

10. Enter the date that the radiology service was rendered or is to be provided in the 'Date of Service' box. Enter the date manually or use the calendar popup. If a date of service is entered that is more than 90 days greater than the request date, the case will be system withdrawn/denied with the following decision comment: "Please resubmit request within 90 days of planned procedure date/admission date." This decision is rendered when the PA is submitted and may be viewed via the web portal *Provider Workspace* PA Search.

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

Figure 46

Diagnosis Table:

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

12. 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.

13. Enter the date that this diagnosis was established in the 'Date' box.

14. 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'.

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

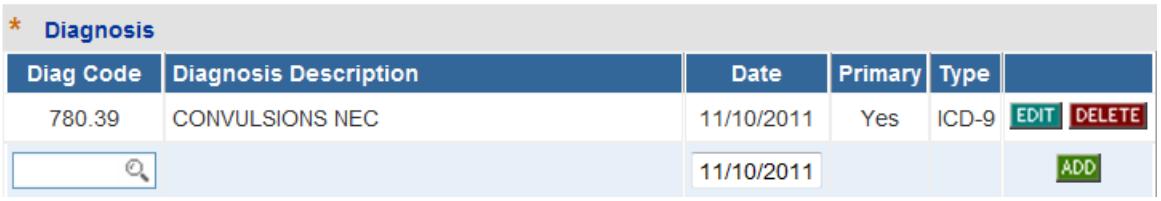


Figure 47

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), Code Description (system populated) and requested Units. Modifiers are not applicable to the procedures requested under this PA type.

17. Enter the CPT code for the requested radiology procedure in the 'CPT Code' box; or search for and have system insert the procedure code.

18. Enter the units requested for the procedure under 'Units'.

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

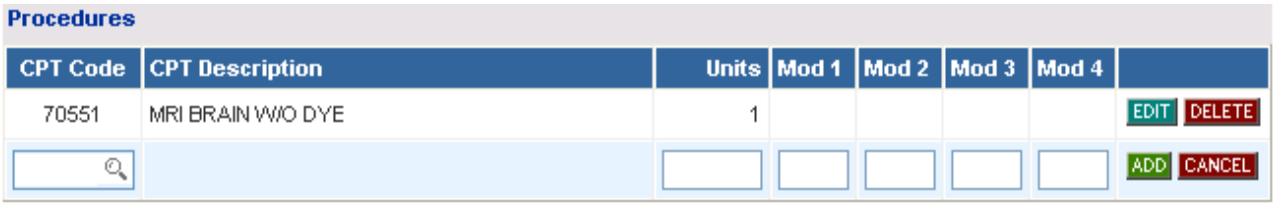


Figure 48

20. 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.

21. 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.

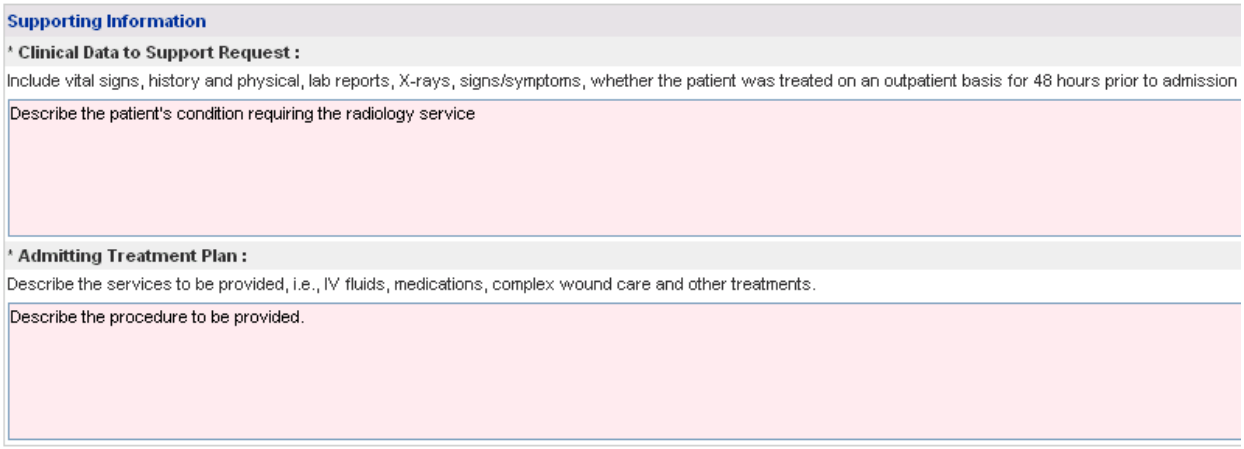


Figure 49

Retro-Eligibility:

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

Figure 50

22. 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. Figure 85 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.

23. 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.

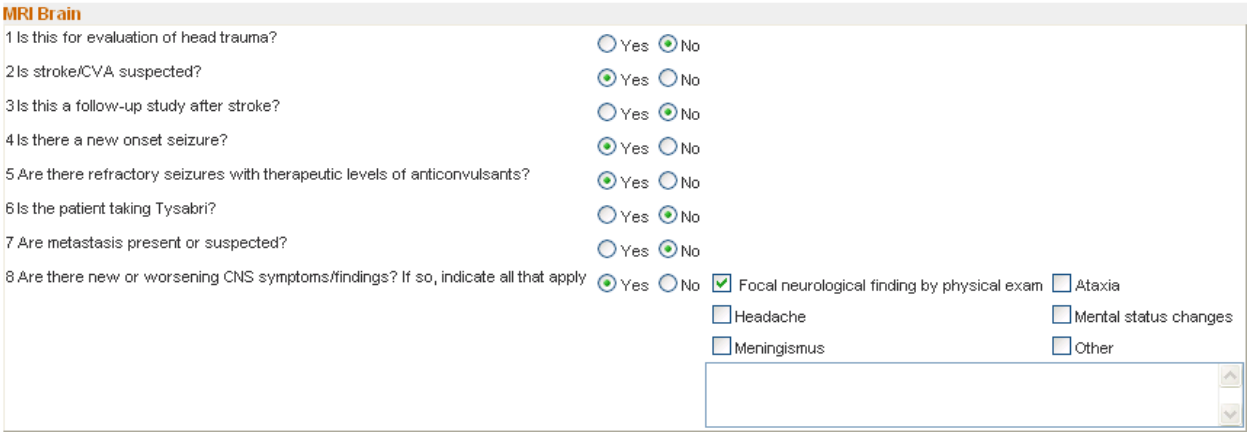


Figure 51

24. 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.

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 system displays the pending PA tracking number.

2.4.2.2 Radiology Physician Office

The web requests forms for Radiology Facility Setting and Radiology Physician Office are identical. The only difference in the web entry for Radiology Facility and Radiology Office is the procedure for accessing the web request forms. Follow these instructions to access the online form for Radiology Physician Office.

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. 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. Enter the member's Medicaid ID.

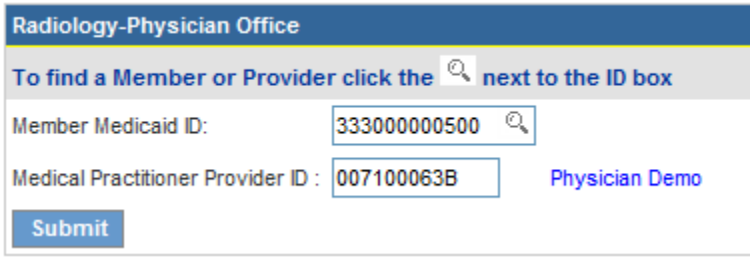


Figure 52

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

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

7. Follow the instructions for entering request information as previously described for Radiology Facility Setting.

2.5 Medications Prior Authorization Requests

Program	Authorization Period
Medications Facility Setting	Synagis – RSV season Other drugs: 6 months or one year.
Medications Physician Office	

Table 8

2.5.1 Description

Requests for prior authorization of drugs administered in an outpatient hospital or physician office must be submitted via the web portal utilizing the *Medications PA Facility Setting* and *Medications PA Physician Office* request templates. Only the drug codes requiring prior authorization can be entered on a Meds PA request. Additionally, the system will not permit the entry of the prior approval drug codes on any other request type. The request templates for Meds Facility and Meds Physician Office are almost identical. There are two exceptions under the **Request Information** section. The Medications Facility template captures the 'Admit Date'; and the system defaults the 'Place of Service' to outpatient hospital. The Medications Physician Office template captures the 'Date of Service' instead of admission date; and the system defaults the 'Place of Service' to office. Both request templates include **Additional Information** questions specific to the drug code requested (not all injectable drug codes trigger additional questions).

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 with one of the following categories of service may request a Medications Physician Office PA.

- Physician Services (430)
- Physician Assistant Services (431)
- Nurse Midwifery (480)
- Podiatry (550)
- Nurse Practitioner (740)

2.5.2 Web Entry Instructions

2.5.2.1 Medications PA Facility Setting Instructions

Follow these instructions to enter a request for Medications PA Facility Setting:

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. 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.

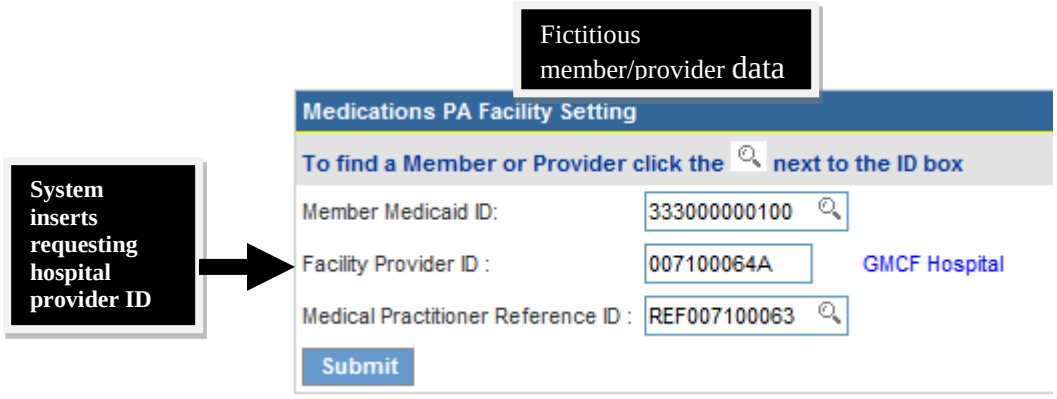


Figure 53

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.

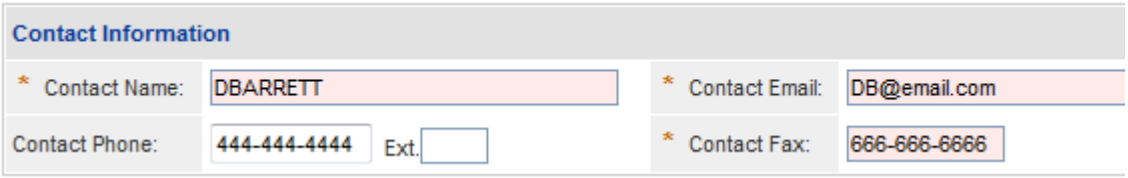


Figure 54

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. Enter the date manually or use the calendar popup.

9. Select the 'Admission Type' (Elective, Emergency or Urgent) from the drop list.

10. The system defaults the 'Place of Service' to outpatient hospital.

Figure 55

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 '0'.

12. Enter the member's weight in the box provided. Only a number value should be entered and it must be greater than '0'.

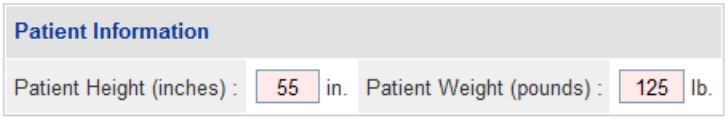


Figure 56

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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.

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.

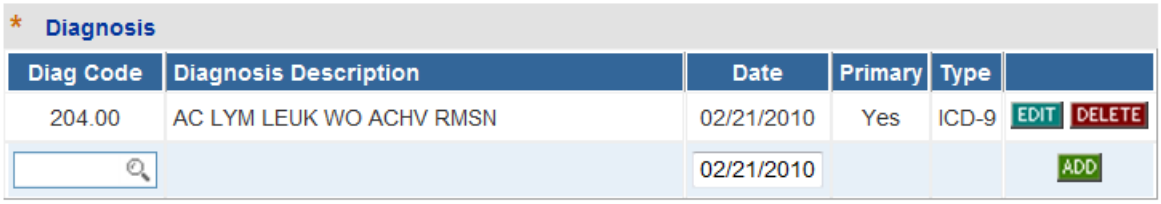


Figure 57

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. Enter the dates manually or insert via the calendar popup.

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.

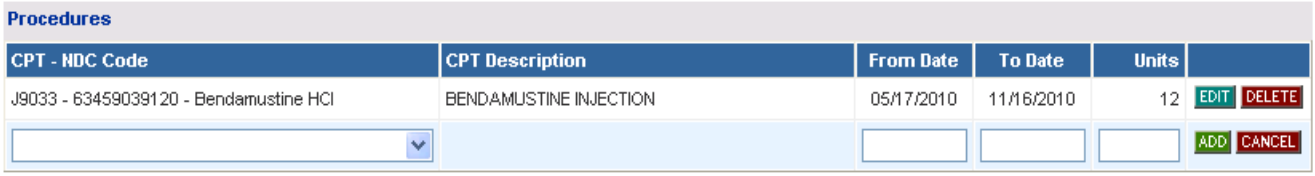


Figure 58

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.

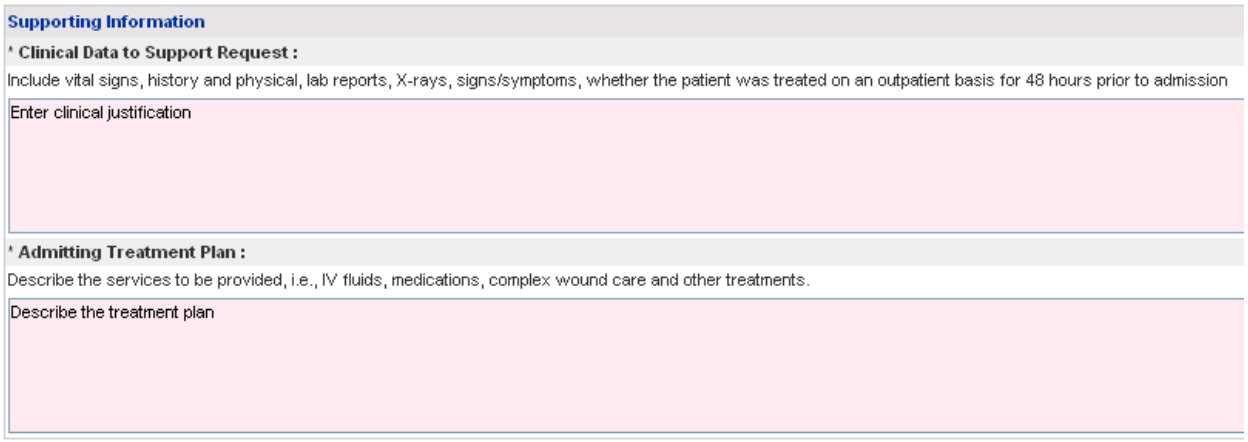


Figure 59

Retro-Eligibility:

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

Figure 60

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

Additional Information Questions:

Certain drug codes trigger additional questions that are related to DCH pharmacy authorization criteria. The system validates the drug code entered and displays the questions at the bottom of the request form. All questions that display are required and must be completed in order to submit the request. The next figure shows the questions for Treanda (J9033) with responses.

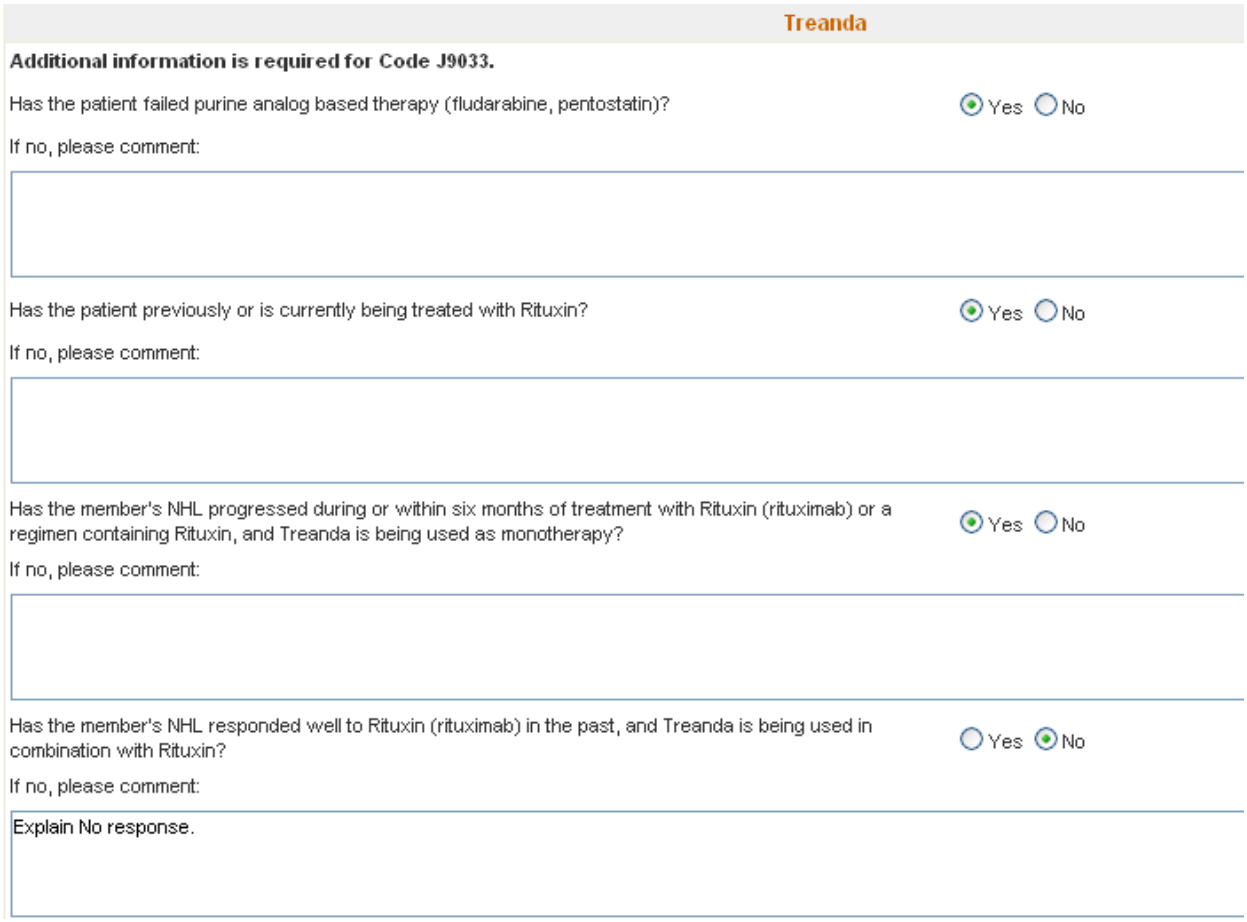


Figure 61

24. 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.

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 system displays the pending PA tracking number.

2.5.2.2 Medications PA Physician Office

As previously noted, the web requests forms for Meds PA Facility and Meds PA Physician Office are almost identical with the exception of the **Request Information** section.

Follow these instructions to access the online form for Medications PA Physician Office.

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. 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.

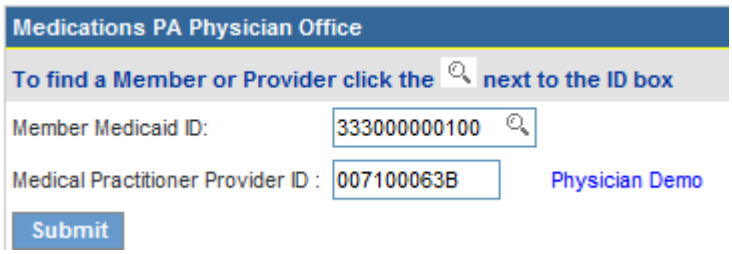


Figure 62

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.

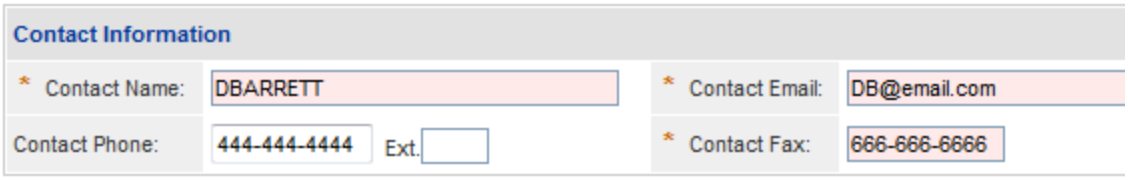


Figure 63

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. Enter the date manually or use the calendar popup.

9. Select the 'Admission Type' (Elective, Emergency or Urgent) from the drop list.

10. The system defaults the 'Place of Service' to office.

Figure 64

11. To complete the form, follow the instructions as previously described for Meds PA Facility Setting.

2.6 Practitioner's Office Surgical Procedures

Program	Authorization Period
Office Surgical Procedures	90 Days

Table 9

2.6.1 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 *Practitioner's Office Surgical Procedures* request template. Submission of Office Surgical requests is restricted to Providers with one of the following categories of service:

- Physician Services (430)
- Physician Assistant Services (431)
- Nurse Midwifery (480)
- Podiatry (550)
- Nurse Practitioner (740)

The Office Surgical Procedures template may include **Additional Information** questions, which are triggered by the system depending on the procedure code entered. Response to the questions is required for PA submission.

2.6.2 Web Entry Instructions

Follow these instructions to enter an Office Surgical Procedures request:

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. 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.

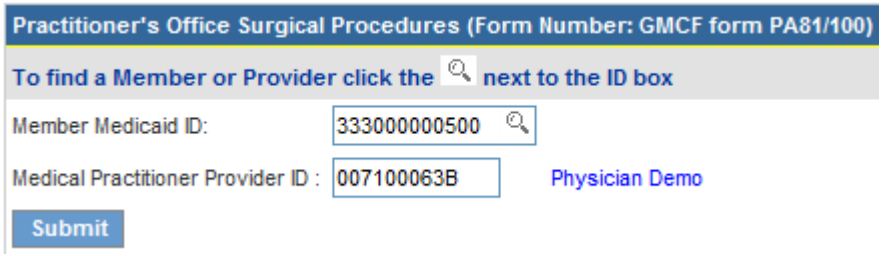


Figure 65

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.

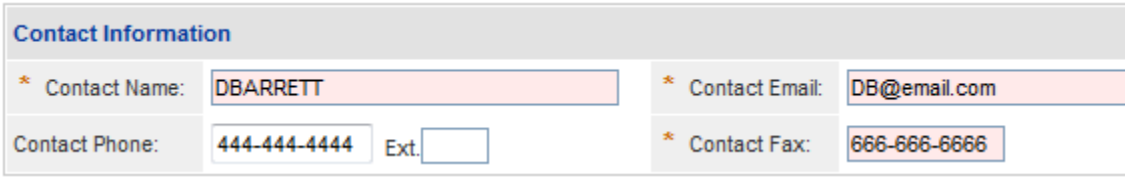


Figure 66

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. Enter the date manually or use the calendar popup. If a date of service is entered that is more than 90 days greater than the request date, the case will be system withdrawn/denied with the following denial decision comment: "Please resubmit request within 90 days of planned procedure date/admission date." The provider will not see this when submitting the PA; but may search for and view the decision and rationale via the web portal search.

9. Select the 'Admission Type' (Elective, Emergency or Urgent) from the drop list.

10. The system defaults the 'Place of Service' to office.

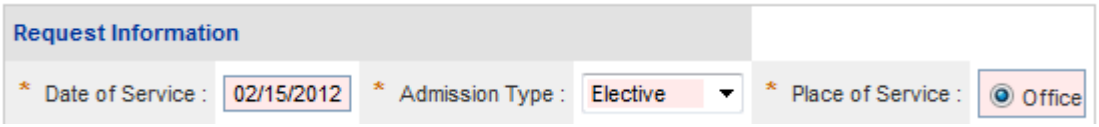


Figure 67

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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.

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.

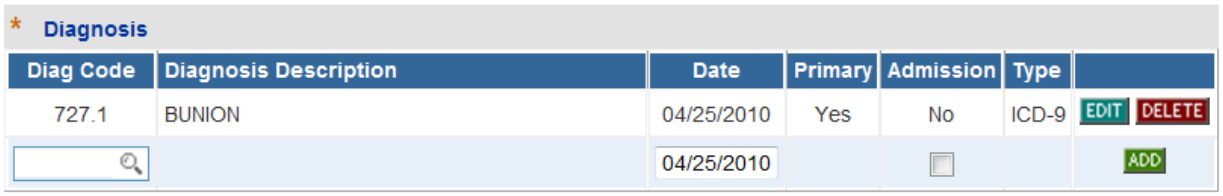


Figure 68

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.

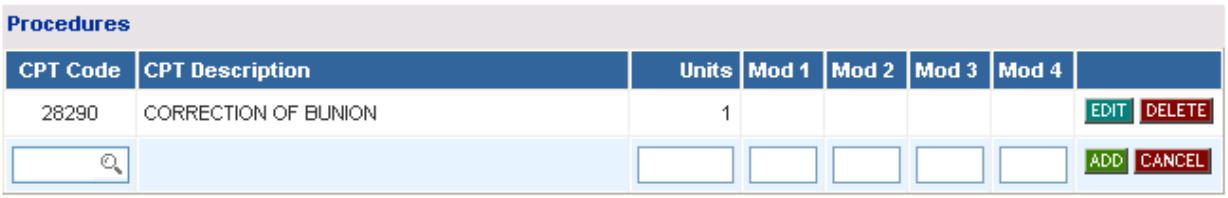


Figure 69

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.

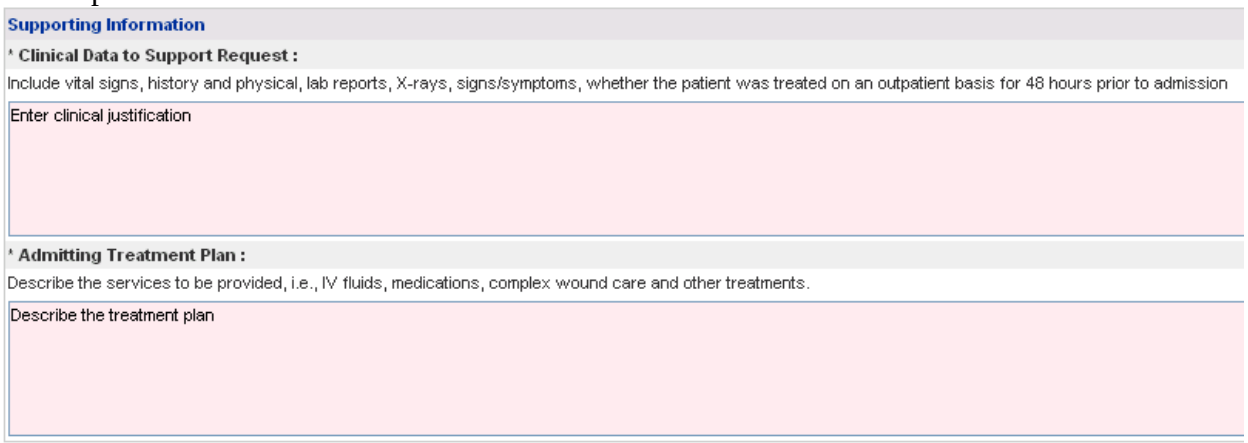


Figure 70

Retro-Eligibility:

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

Figure 71

21. For members with retro eligibility for the dates of service, click 'Yes'.

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.

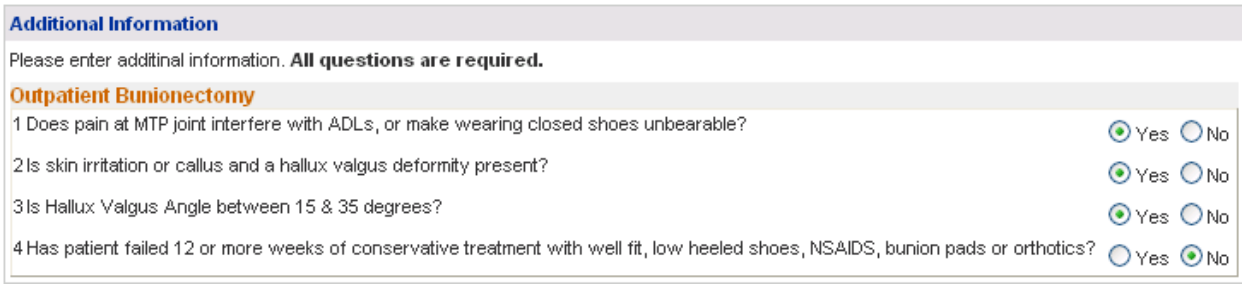


Figure 72

22. 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.

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 system displays the pending PA tracking number.

2.7 Additional Physician Office Visits

Program	Authorization Period
Physician Office Visits	Procedure From Date to 12/31 of Effective Date Year

Table 10

2.7.1 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 *Additional Physician Office Visit* request template. Submission of additional office visit requests is restricted to Providers with one of the following categories of service:

- Physician Services (430)
- Physician Assistant Services (431)
- Nurse Midwifery (480)
- Podiatry (550)
- Oral Max (490)
- Nurse Practitioner (740)

2.7.2 Web Entry Instructions

Follow these instructions to enter an Additional Physician Office Visit request:

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. 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.

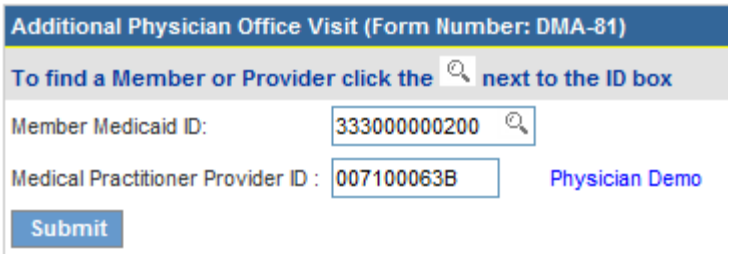


Figure 73 New

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.

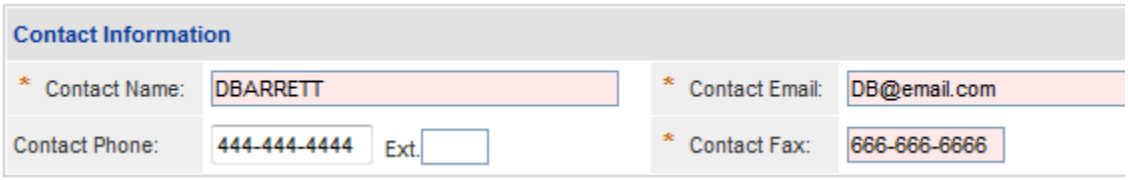


Figure 74

Request Information:

This section captures Place of Service.

8. Click *Office* or *Other* to enter the 'Place of Service'.

Figure 75

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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.

11. 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'.

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

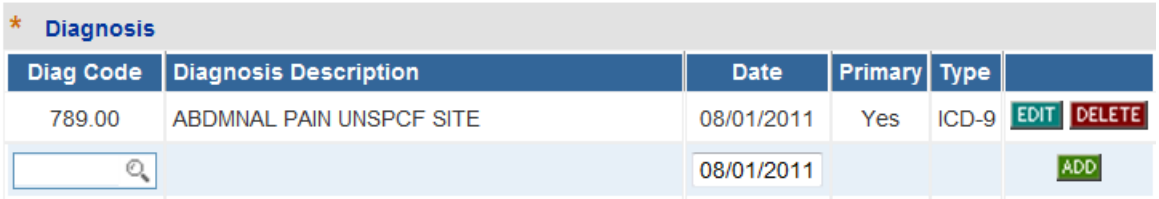


Figure 76

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 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.

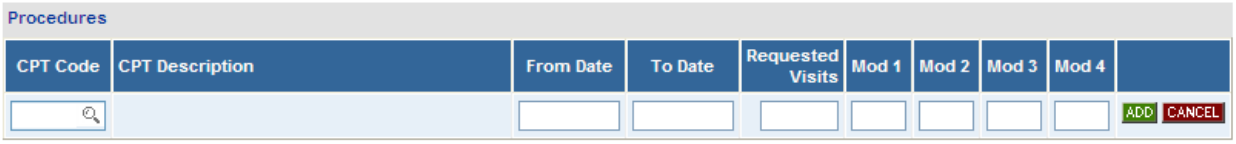


Figure 77

14. Enter the office visit procedure code in the 'CPT Code' box**.** The office visit procedure codes are bundled in three code groups (family of codes): New Patient, Established Patient, and Consults. It is only necessary to **enter one code from a code group** (family of codes) since the entire family is sent to the claims system. **If more than one code from the same family is entered, only the actual code entered is sent to Claims, and not the complete family of codes.**

15. In the 'From Date' box, enter the date of the first visit related to the request. In the 'To Date' box, enter the date of the last visit related to the request. Enter the dates manually or use the calendar popup. If a procedure From Date is entered that is more than ninety (90) days in the future, the following 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.

16. In the 'Requested Visits' box, enter the number of additional visits requested for the request period.

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

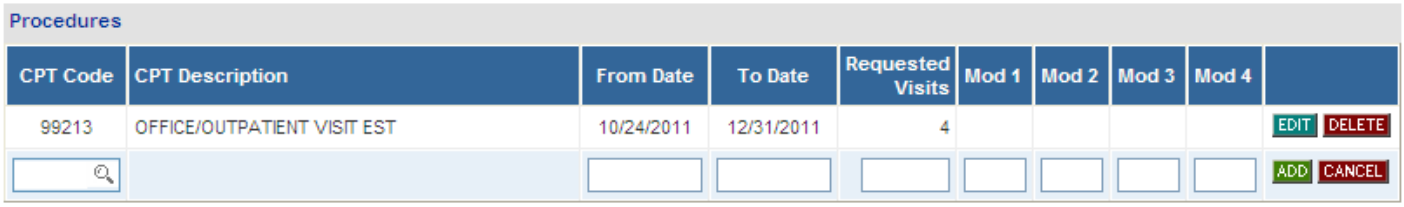


Figure 78

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. Enter manually or insert via the calendar popup.

19. Enter the date of the patient's most recent office visit in the 'Date of Most Recent Visit' box.

Figure

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.

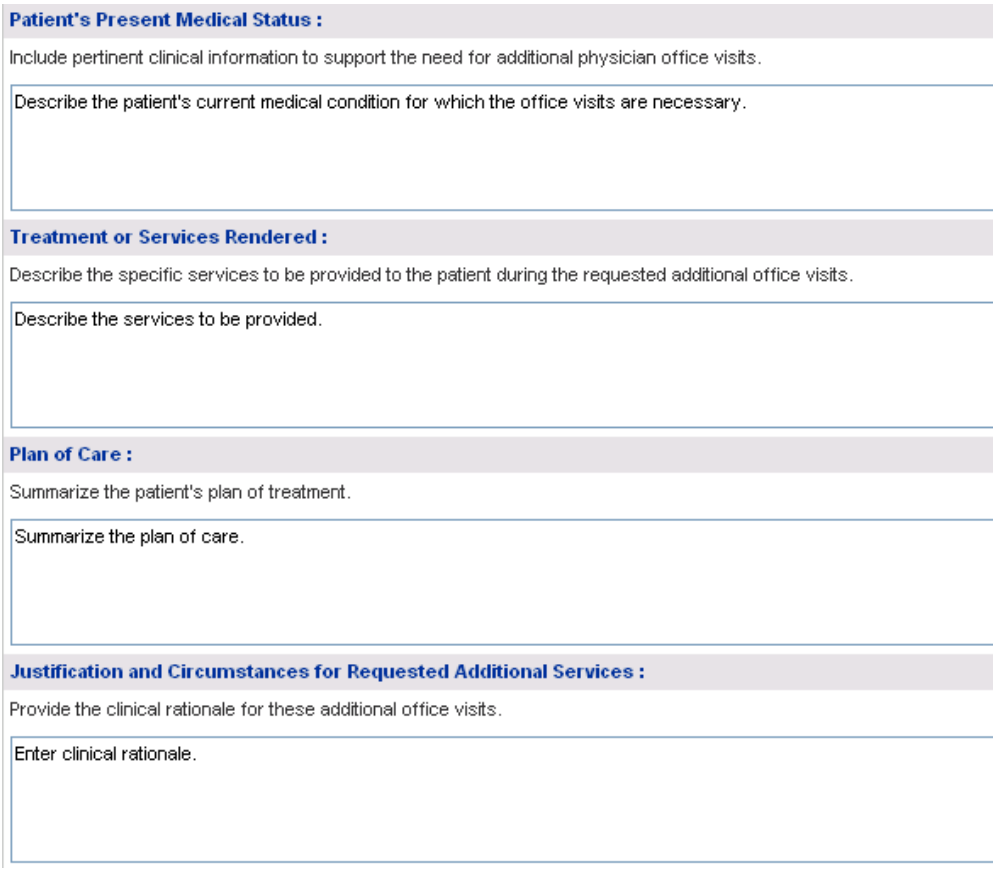


Figure 79

21. 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.

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 system displays the pending PA tracking number.

2.8 Additional Psychological/Psychiatric Services and Autism Therapy Services

Program	Authorization Period
Psychiatry	6 months/end of month or until 12/31 of effective date year
Psychology	
Autism Therapy Services	Three months

Table 11

2.8.1 Description

Additional Psychiatric and Psychological Services:

Requests for authorization of psychological or psychiatric services, in excess of the twenty-four (24) visits allowed per year without PA, may be submitted via web portal utilizing the *Additional Psychiatric/Psychological Services* request template. 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. Although the PA type for each program is different, the same template is used to request psychiatric and psychological services. The system derives the PA type based on the requesting provider category of service (COS).

Autism Therapy Services:

Requests for Autism Therapy Services must be submitted via the web portal utilizing the *Autism Therapy Services* request template. Only Providers with a 570 category of service that have been credentialed by the Department of Community Health may request Autism Therapy Services.

2.8.2 Additional Psychiatric and Psychological Services Web Entry Instructions

Follow these instructions to enter a request for additional psychiatric or psychological services via the web portal:

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. 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.

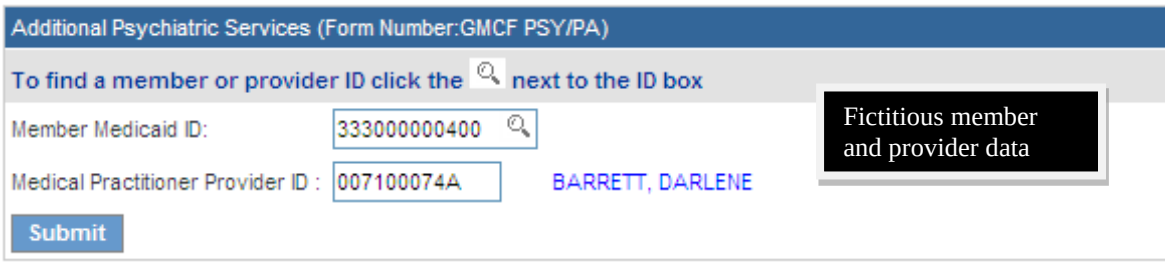


Figure 80

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.

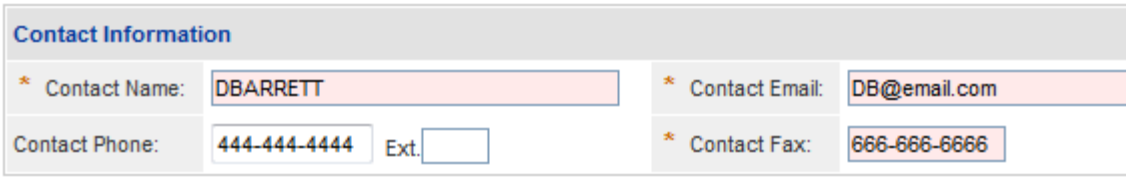


Figure 81

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.**

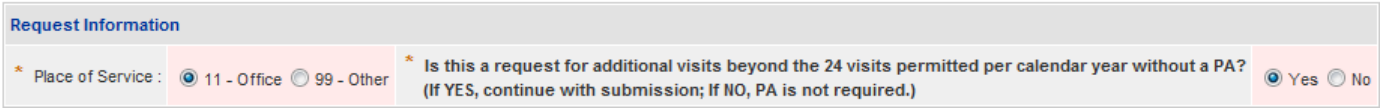


Figure 82

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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. Enter the date manually, or use the calendar popup.

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.

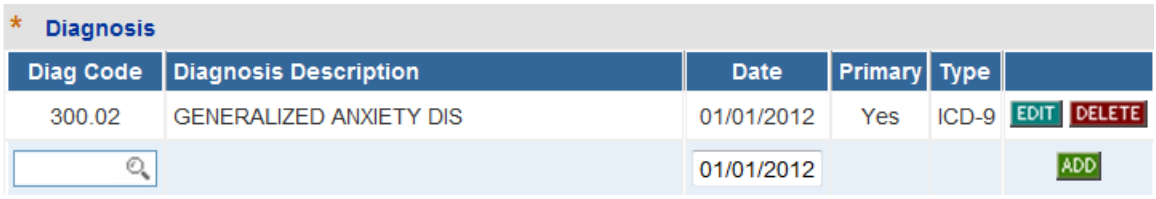


Figure 83

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 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.

15. Enter the procedure code for the psychological/psychiatric service requested in the 'CPT Code' box**.** Only the following codes may be entered: 96101, 90832, 90837, and 90853.

16. 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 dates manually or use the calendar popup.

17. 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'.

18. 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*.

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

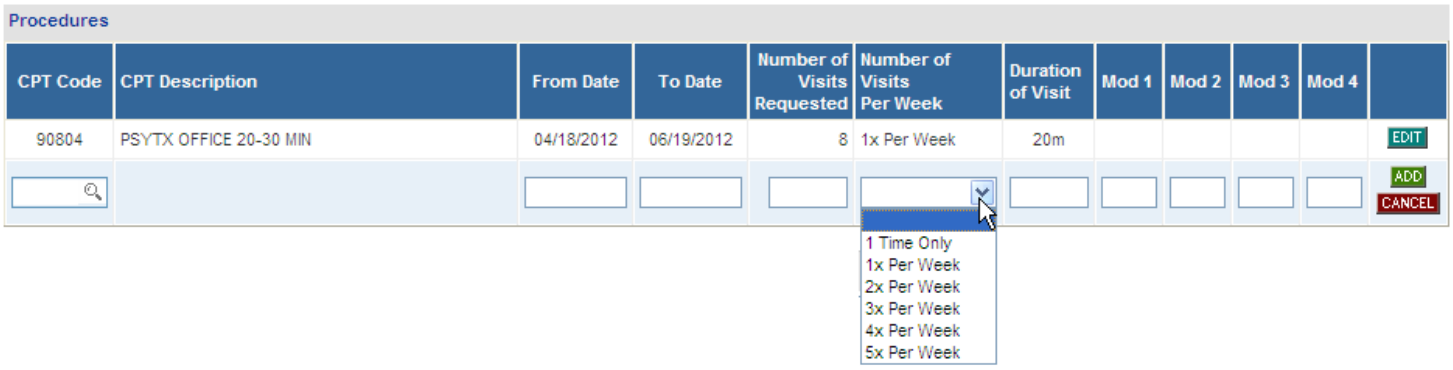


Figure 84

20. Follow the same process to add another procedure code, if applicable. **Remember to click Add after each procedure line is entered.** When the procedures are added, the system validates the procedure dates against the following edits. If the procedure date fails validation, the procedure date must be corrected before the PA can be submitted.

    - If a procedure From Date is entered that is more than ninety (90) days in the future, the following 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."

    - If the user enters a procedure 'To Date' that is beyond 12/31 of the current calendar year, this message displays: "You cannot request additional visits on this PA beyond 12/31 <<current year>>. Please correct the 'To Date."

Retro-Eligibility:

Figure 85

21. The system defaults the question regarding member retro eligibility to 'No'. If the member has retro eligibility for the dates of service, click 'Yes'. If the 'No' indicator is not changed, and a procedure 'From Date' was added that is before the '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.

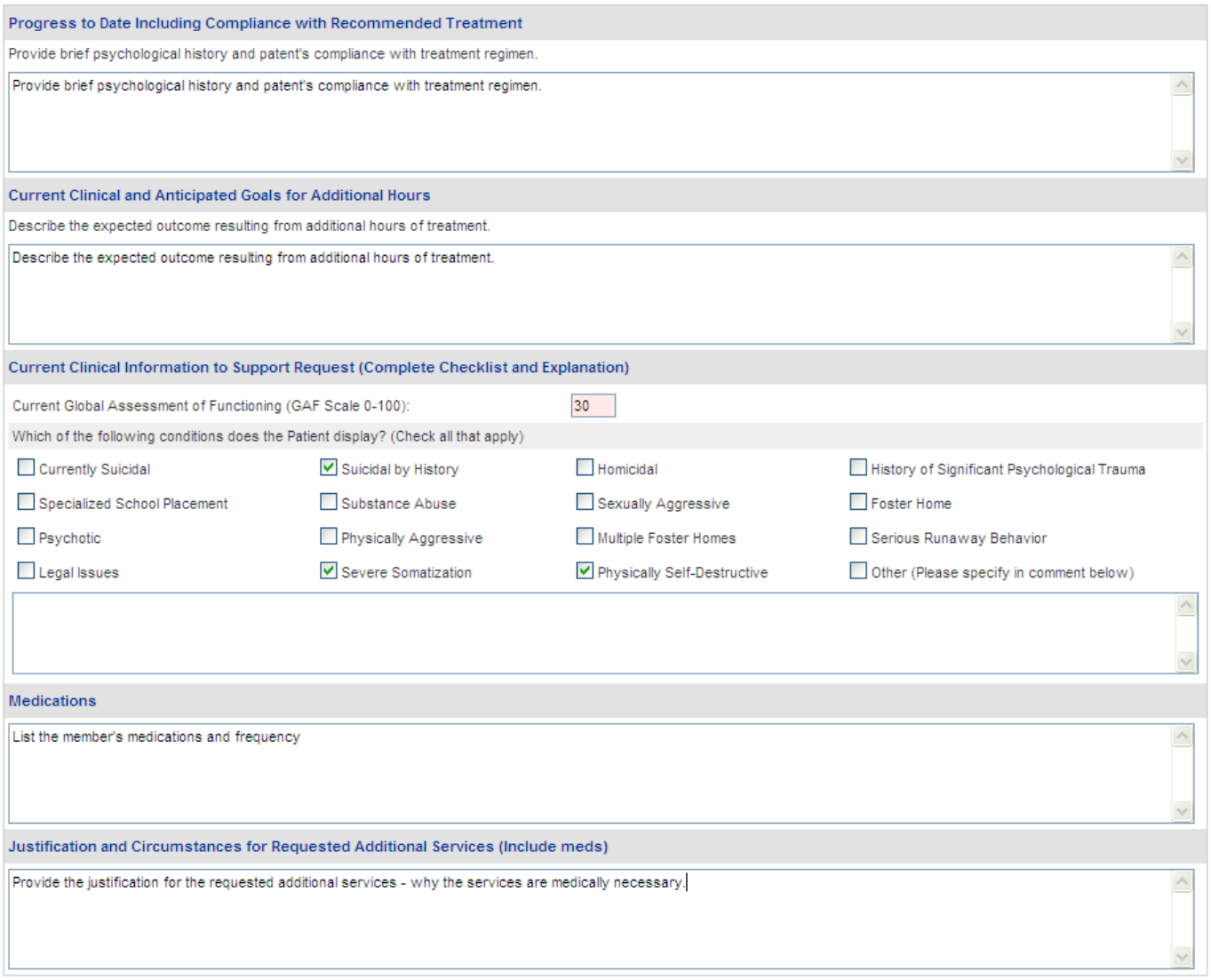


Figure 86

28. 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.

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

30. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.

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

2.9 Dental Services

Program	Authorization Period
Health Check Dental	One Year/Month End
Adult Dental	

Table 12

2.9.1 Description

Requests for authorization of dental services for children and adults may be submitted via the web portal utilizing the *Early Periodic Screening Diagnosis and Treatment Dental (EPSDT)/Adult Dental* request template. 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.

2.9.2 Web Entry Instructions

Follow these instructions to enter a request for Adult Dental or Health Check Dental:

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. 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.

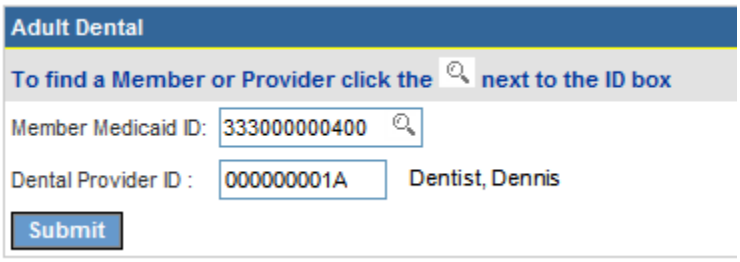


Figure 87

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.

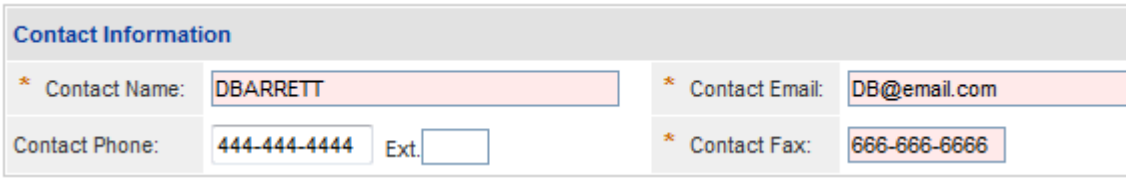


Figure 88

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.

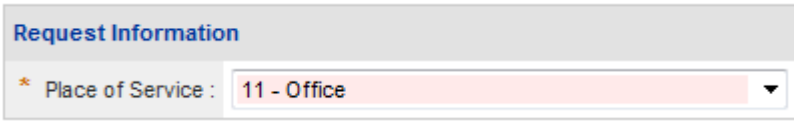


Figure 89

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. Enter the dates manually or use the calendar popup.

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.

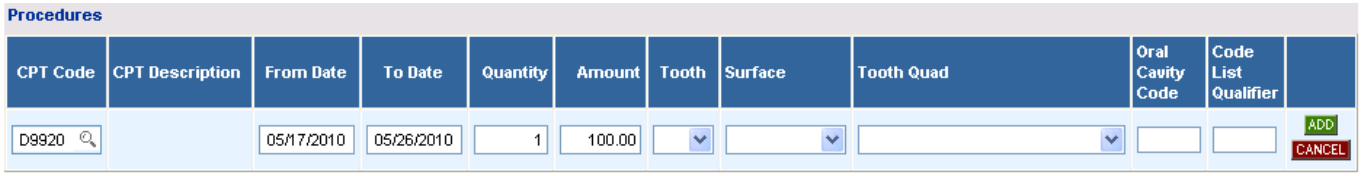


Figure 90

17. Click **Add** to add the procedure code to the request. The system validates the procedure code entry.

    - If a procedure ‘From Date’ is added that is more than ninety (90) days in the future, the following 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.
    - If the same procedure code is entered more than once, the following 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 delete the duplicate procedure.

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

Retro-Eligibility:

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

Figure 91

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

Missing Teeth:

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

20. Select the applicable tooth identifiers under both categories.

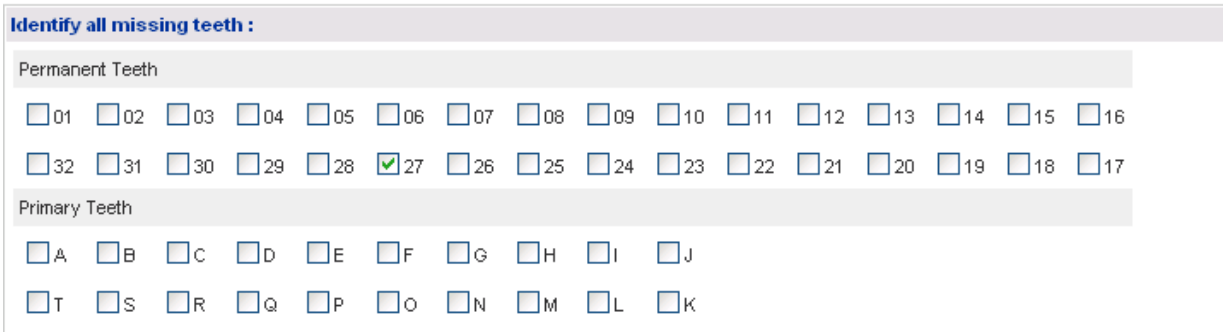


Figure 92

Justification for Services:

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

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

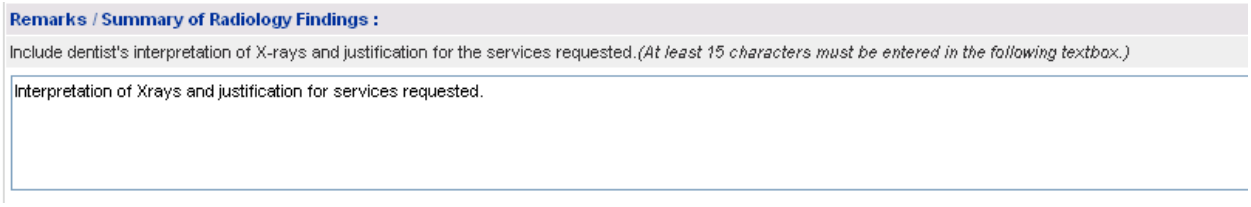


Figure 93

Additional Information Questions:

Additional questions may display at the bottom of the request form depending on system validation of the dental PA type and the dental service requested. For example, Figure 102 shows the additional questions that are triggered when dental service code D9920 is entered on a Health Check Dental request.

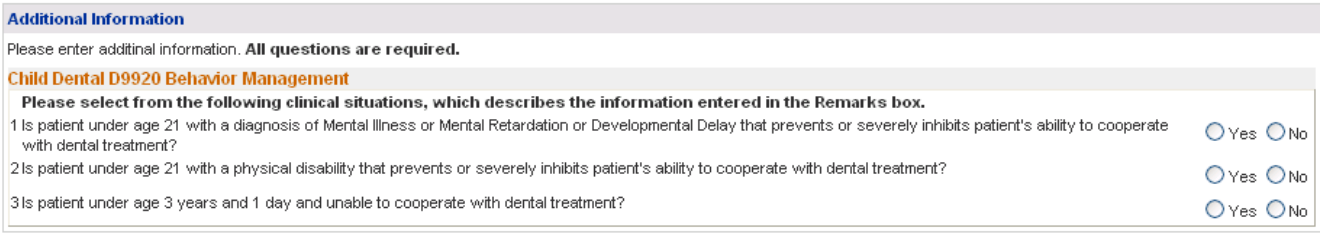


Figure 94

22. Click Yes or No for each question. All are required.

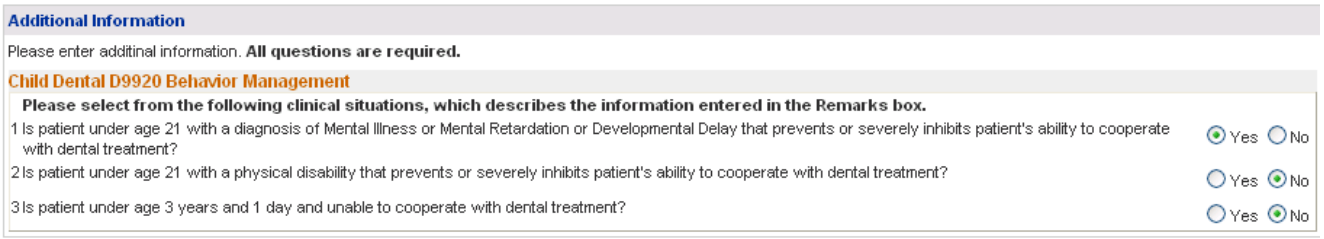


Figure 95

23. 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.

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 system displays the pending PA tracking number.

2.10 Oral Maxillofacial Surgery Requests

Program	Authorization Period
Oral/Maxillofacial Surgery	90 Days

Table 13

2.10.1 Description

Requests for authorization of Oral Maxillofacial surgery services may be submitted via the web portal utilizing the *Oral Max (Form Number: DMA-81)* request template. Providers with any one of the following categories of service may request this PA type: 430, 450, 460 and 490.

2.10.2 Web Entry Instructions

Follow these instructions to enter a request for Oral Maxillofacial surgery services:

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. 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.

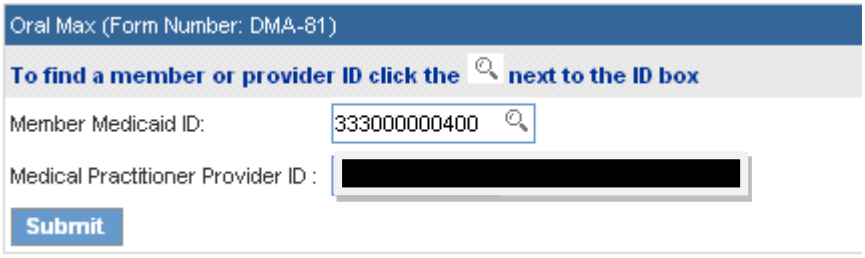


Figure 96

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.

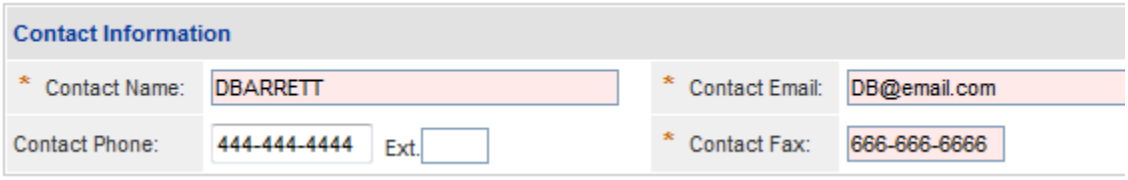


Figure 97

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.

Figure 98

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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.

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.

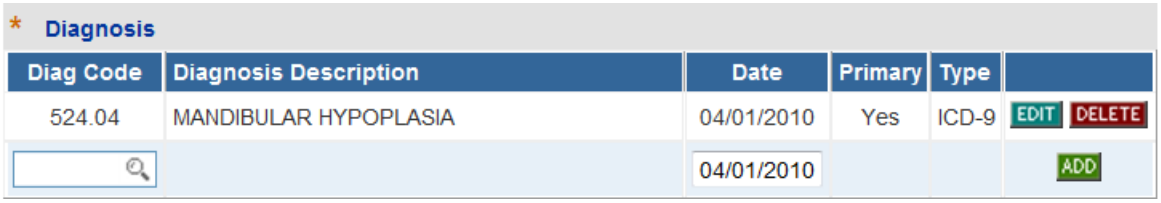


Figure 99

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. The system will calculate a 90 day span for the request.

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

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

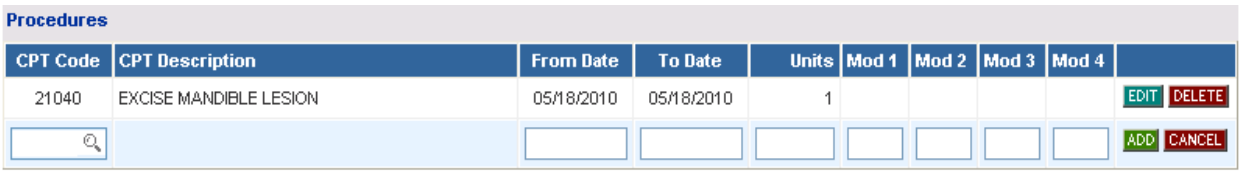


Figure 100

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.

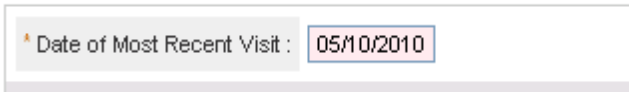


Figure 101

Supporting Information:

This section captures information to support the request for oral max surgery services including: current medical status, treatment/services rendered, plan of care and justification for services requested.

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

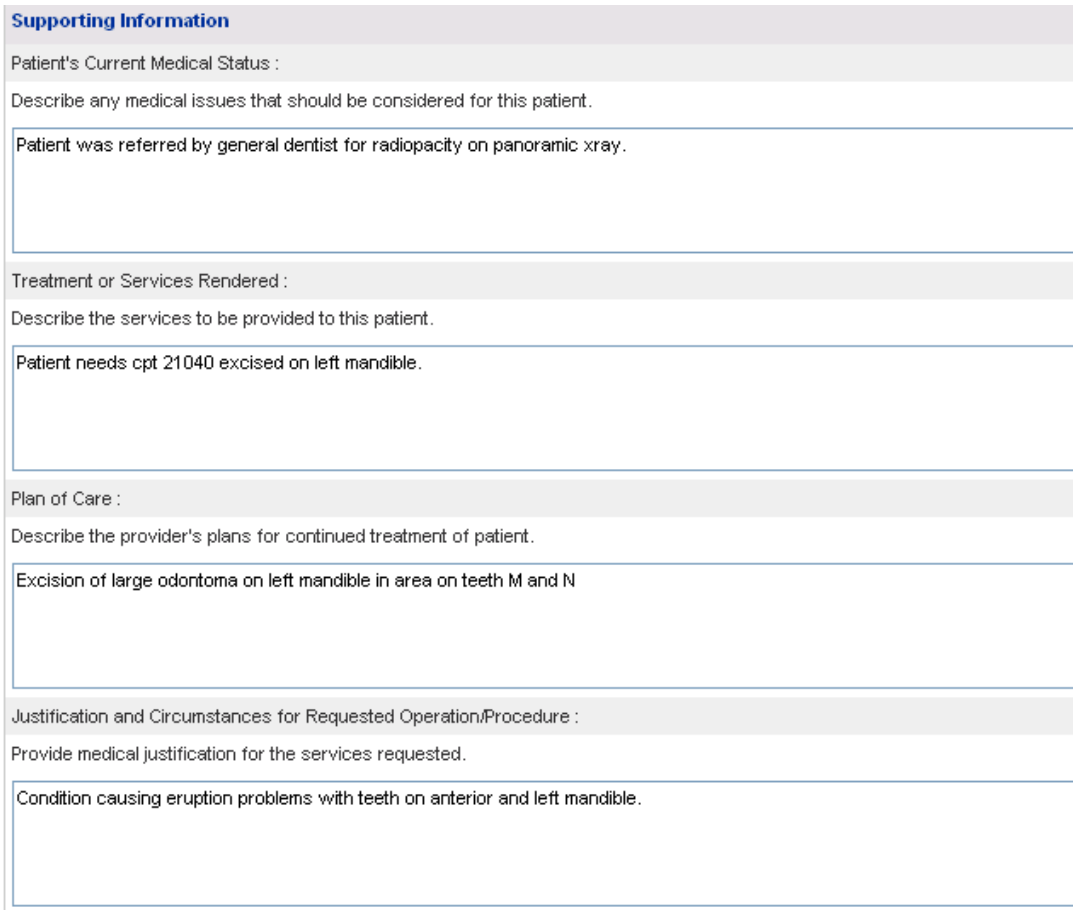


Figure 102

Retro-Eligibility:

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

Figure 103

22. For members with 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*. 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 system displays the pending PA tracking number.

2.11 Transport Services

Program	Authorization Period
Emergency Air Ambulance Service	One day
Emergency Ground Ambulance Service	One day
Non-Emergency Travel Services	Same as service date span

Table 14

2.11.1 Description

Requests for authorization of air, ground and exceptional (non-emergency) transport services may be submitted via the web portal utilizing the *Emergency Air Ambulance*, *Emergency Ground Ambulance* and *Exceptional Transport* (Non-Emergency Ground) request templates. Providers with a 370 category of service (COS) may request emergency ground transport PAs; providers with a 371 COS may request an emergency air transport PAs; and providers with a 380 COS may request exceptional transport PAs. The same basic request template is used for each program with the following differences:

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

Table 15

2.11.2 Web Entry Instructions

Follow these instructions to enter a request for air, ground or exceptional transport services:

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. 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.

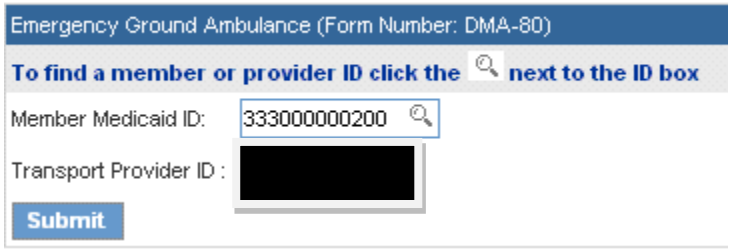


Figure 104

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.

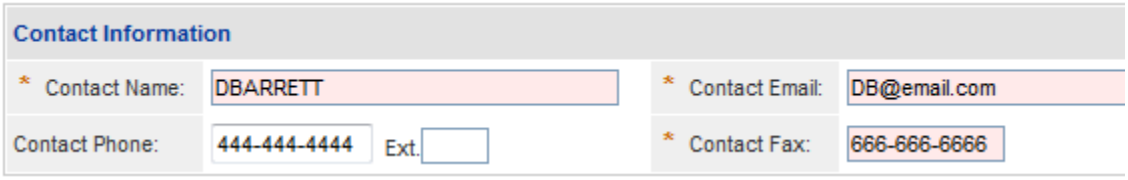


Figure 105

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.

Figure 106

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.

Figure 107

Transport Type and Miles:

11. The system populates the 'Mode of Transportation' and 'Emergency Transportation' indicator based on the request type selected.

12. Enter the total miles the patient was transported in the 'Total Miles' box.

Figure 108

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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. The date of transport may be entered for the diagnosis 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.

Figure 109

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 codes A0428, A0426 and A0425 may be entered on 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. If the request is for ground transport and the code requested is not one of A0428, A0426 or A0425, this message displays when **Add** is clicked: "<<transport code>> does not require prior authorization for ground transport, please remove from this request."

Figure 110

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.

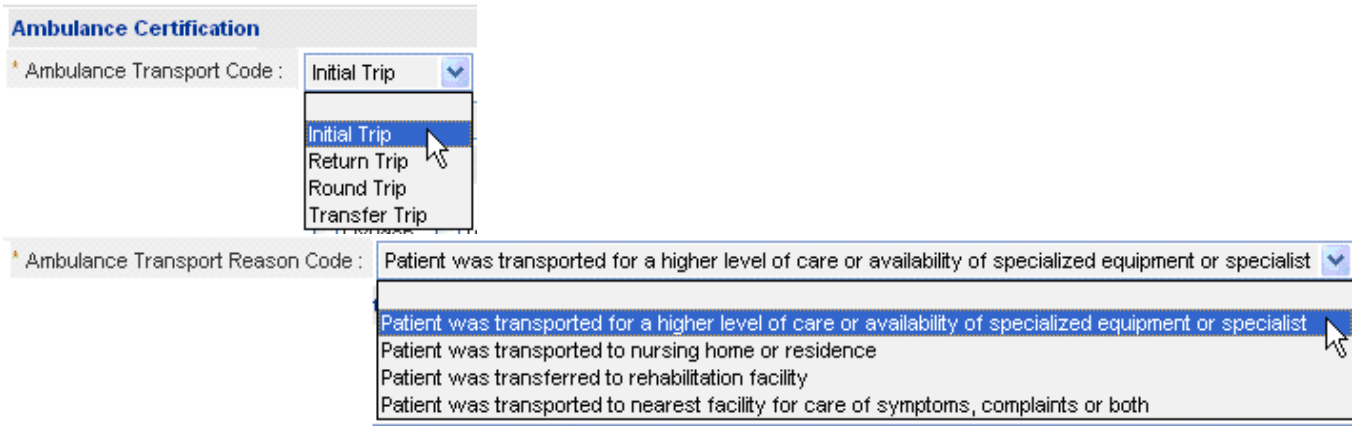


Figure 111

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.

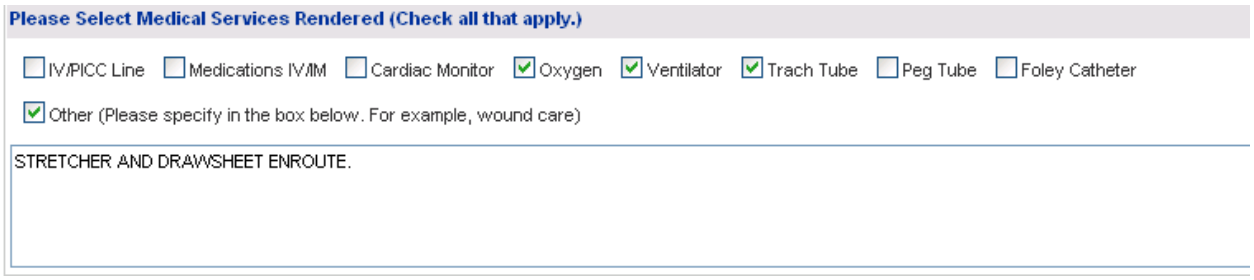


Figure 112

Supporting Information:

This section captures a description of services provided and why the services were necessary.

28. Enter information in each required textbox.

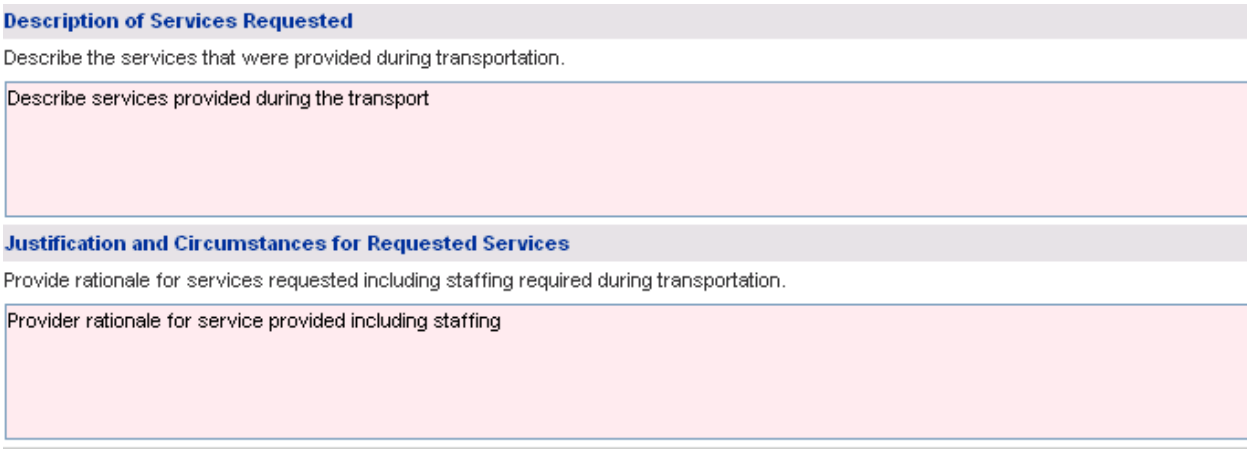


Figure 113

29. 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.

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 system displays the pending PA tracking number.

2.12 Durable Medical Equipment Requests

Program	Authorization Period
Durable Medical Equipment	4 months to one year depending on procedure code and modifier

Table 16

2.12.1 Description

Requests for authorization of Durable Medical Equipment (DME) may be submitted via the web portal utilizing the *Durable Medical Equipment* request template. Submission of this PA type is restricted to Providers with a DME 320 or 321 category of service. The DME template may include required **Additional Information** questions which are triggered by the system depending on the procedure code or codes entered. The questions are specific to an equipment procedure code or group of equipment codes, and mirror the certification requirements in the DCH Medicaid Provider Manual for Durable Medical Equipment Services.

2.12.2 Web Entry Instructions

Follow these instructions to enter a Durable Medical Equipment request:

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. 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.

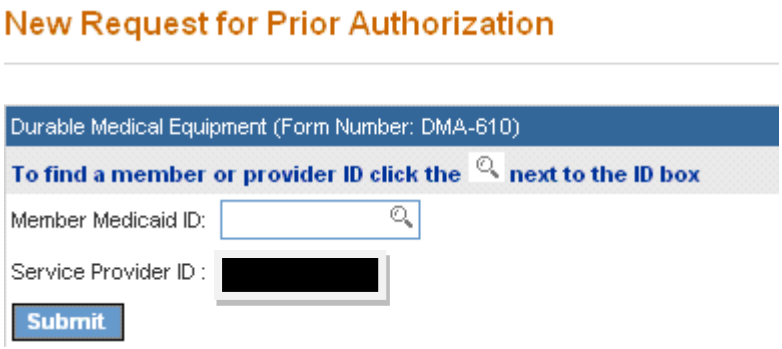


Figure 114

5. Enter the member's Medicaid ID.

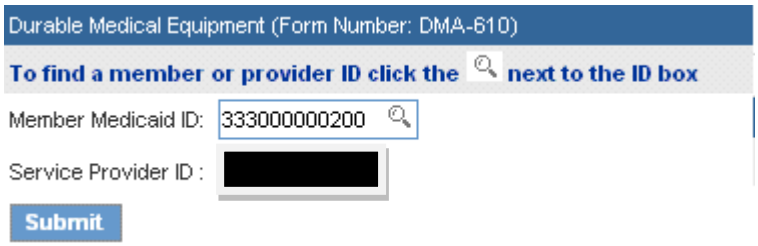


Figure 115

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.

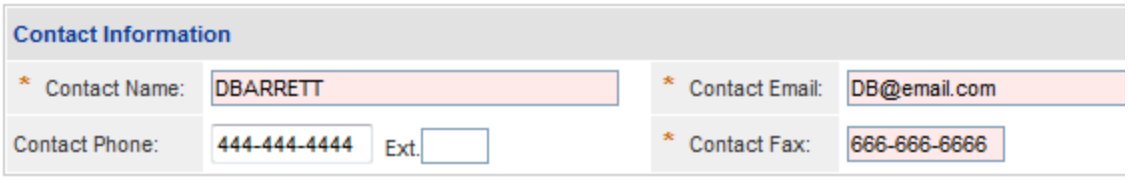


Figure 116

Request Information:

This section captures the Place of Service.

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

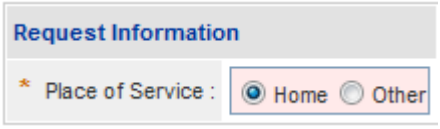


Figure 117

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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.

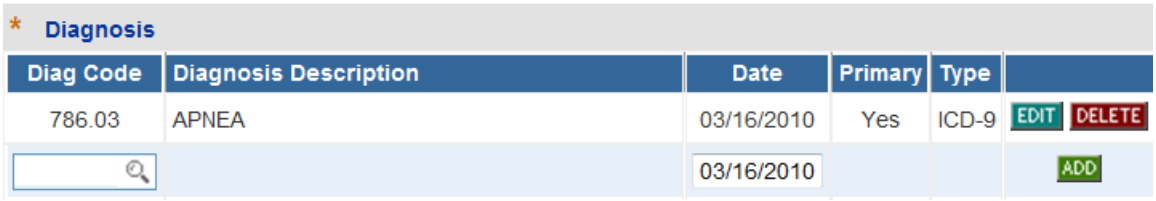


Figure 118

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. Enter manually or use the calendar popup.

16. For rental equipment, enter the rental end date in the 'To Date' box. A 'To Date' is not required for purchase.

17. 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**.

18. Enter the price per unit for the equipment in the 'Requested Price/Unit' box.

19. Enter the procedure modifier in the 'Mod 1' box. A modifier is required.

20. 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.

21. Click **Add** at the end of the procedure table to add the procedure code information to the request. If a 'From Date' is entered that is more than ninety (90) days in the future, the following message displays when **Add** is clicked: "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.

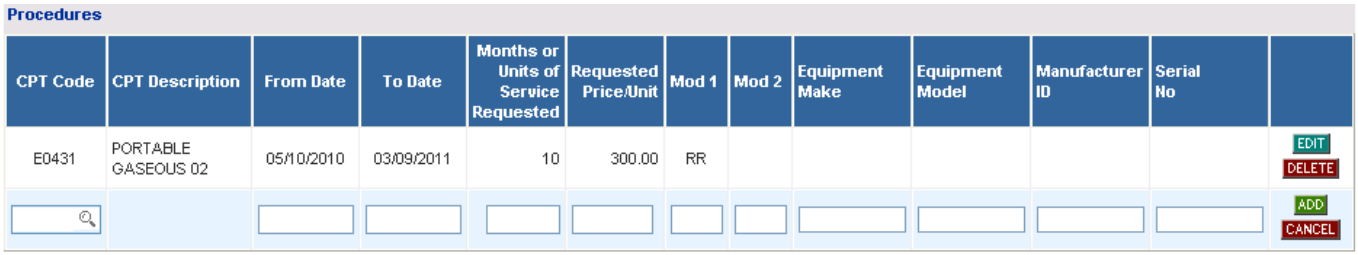


Figure 119

22. 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'.

Figure 120

23. 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

Figure 121

24. 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.

25. 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.

26. Enter the therapist/service provider name and the license or certification number in the boxes provided. **Note**: **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).

27. Enter the member's height in inches and weight in pounds (required) in the boxes provided. Enter a number value that is greater than '0'.

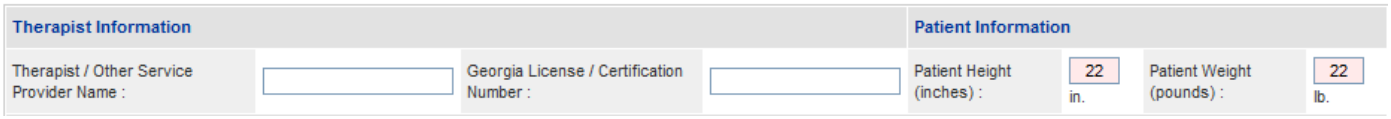


Figure 122

Justification for Services Requested:

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

28. Enter the justification in the textbox provided.

Figure 123

Physician Prescription and Encounter Information:

This section validates there is a signed physician prescription or Certificate of Medical Necessity (CMN) on file, and documents that the patient had a face to face encounter with the physician.

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

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

31. If *Yes* to encounter, enter the date of the face to face encounter with the physician.

32. Enter the ordering physician's last name and first name in the boxes provided.

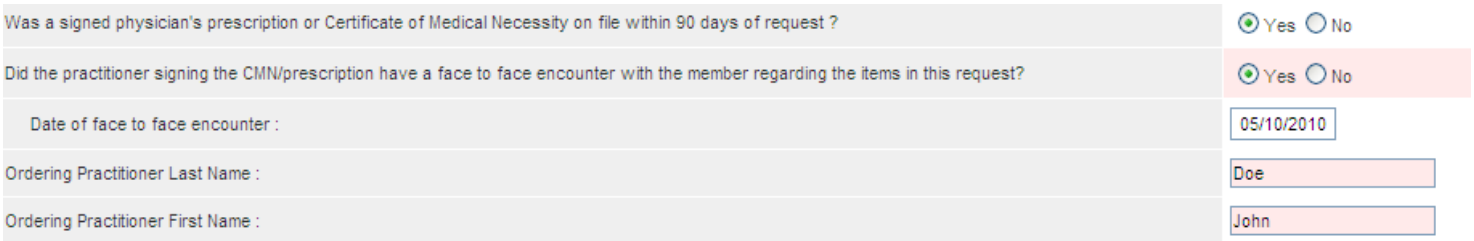


Figure 124

Additional Information Questions:

Additional information questions may be pulled into the request template depending on the procedure codes added to the request. The next figure shows the questions that are triggered when oxygen codes E0431RR or E1390RR are entered on the request.

33. Provide the information requested by selecting Yes or No; or entering the information in the boxes provided.

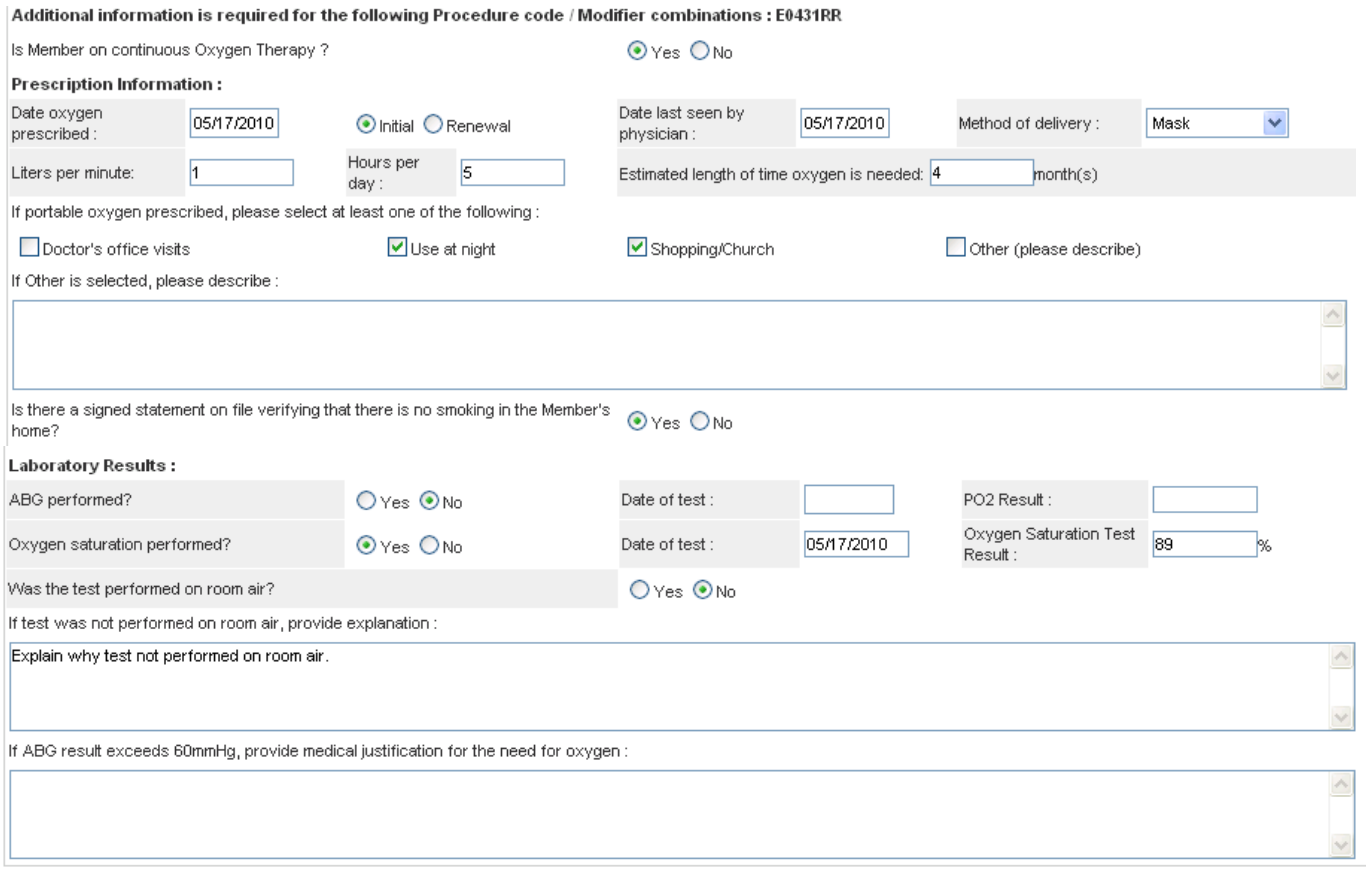


Figure 125

34. 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.

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 system displays the pending PA tracking number. On this page, the provider may attach additional required documentation via **Create an Attachment**.

Create an Attachment:

For some DME codes, attachment 'type' checkboxes are available in the **Create an Attachment** 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.

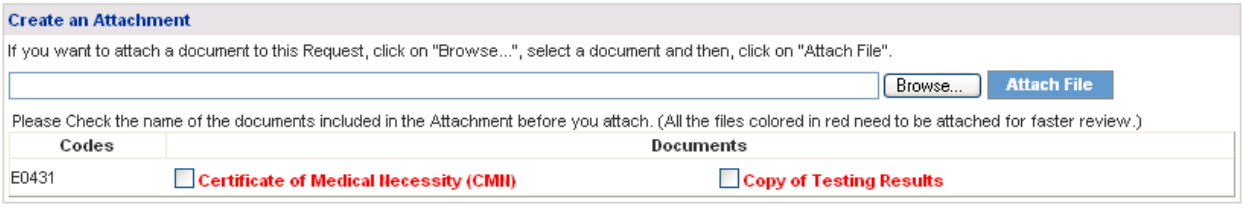


Figure 126

38. To attach a file: Check the applicable document type boxes that describe the file to be attached. Click **Browse**; find the file; select the file; and then click **Attach File**. Once the file or files are attached, the file or files are associated with the document 'type' in the **Attached Files** table.

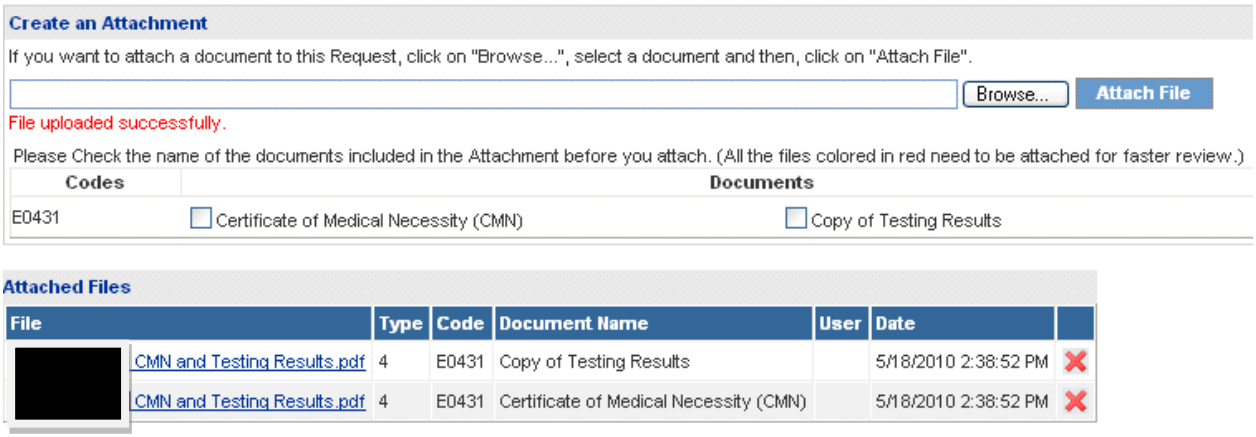


Figure 127

2.13 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

Table 17

2.13.1 Description

Requests for authorization of Orthotics/Prosthetics or Hearing Services may be submitted via the Web Portal utilizing the *Orthotics and Prosthetics* request template and *Orthotics and Prosthetics/Hearing* request template, respectively. Submission is restricted to Providers with an orthotics/prosthetics 330 category of service. When certain orthotics/prosthetic procedure codes are added to an O&P request, 'additional information' questions are pulled into the online form. Response to these additional questions is required in order to submit the PA.

2.13.2 Web Entry Instructions

Follow these instructions to enter an Orthotics/Prosthetics **or** Hearing Services requests:

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. 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.

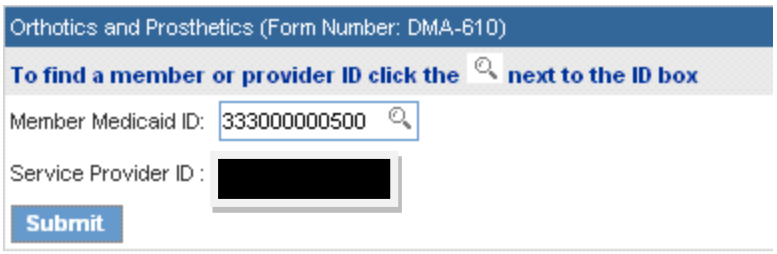


Figure 128

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.

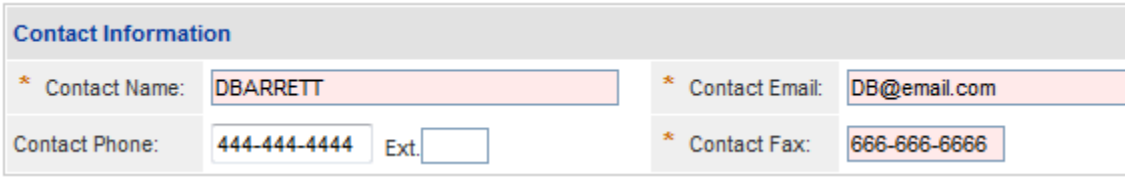


Figure 129

Request Information:

This section captures the Place of Service.

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

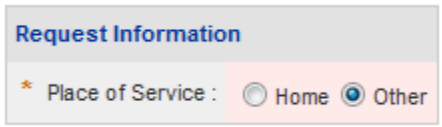


Figure 130

Figure 131

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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.

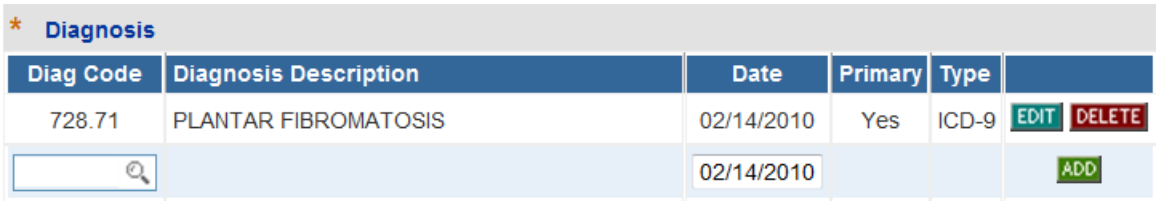


Figure 132

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. Enter manually or use the calendar popup.

16. The procedure 'To Date' box may be left blank since it is not required for orthotics/prosthetics or hearing services.

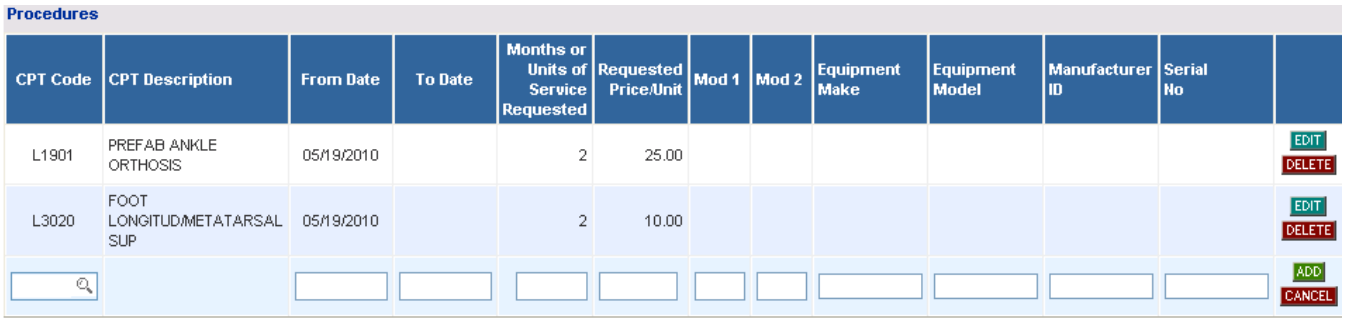
17. Enter the total units of service requested in the 'Months or Units of Service Requested' box.

18. Enter the price per unit for the item requested in the 'Requested Price/Unit' box.

19. The modifier box may be left blank unless the request is for certain orthotics/prosthetics and hearing aid supply codes that require a modifier to distinguish left (LT) and right (RT). For hearing aid supply codes, the same procedure code but different modifier is entered on two separate procedure lines (see Figure 177 for an example).

20. Click **Add** at the end of the procedure table to add the procedure code information to the request. If a 'From Date' is entered that is more than ninety (90) days in the future, the following message displays when **Add** is clicked: "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.

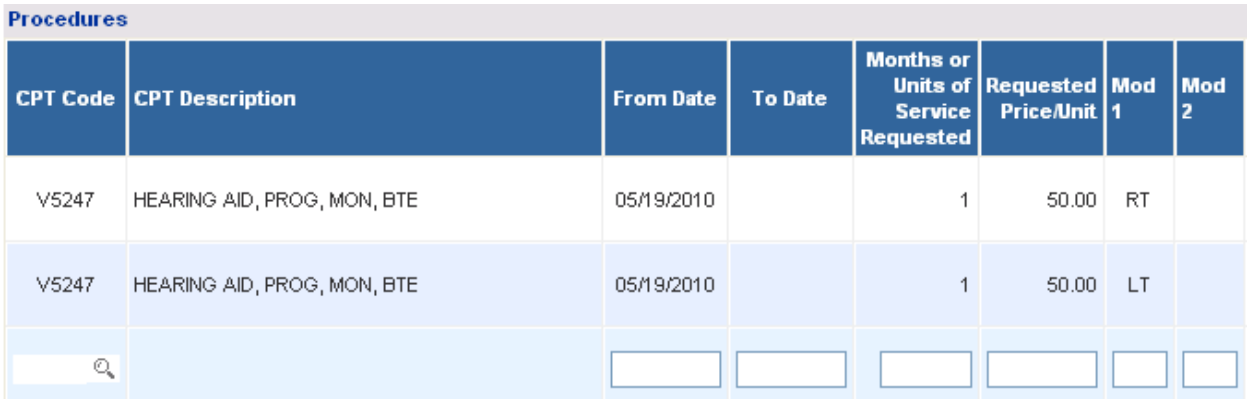
21. Follow the same process to add other procedure codes, as applicable. **Remember to click Add after each procedure line is entered.**



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
												ADD CANCEL

Figure 133 Orthotics



Procedures

CPT Code	CPT Description	From Date	To Date	Months or Units of Service Requested	Requested Price/Unit	Mod 1	Mod 2
V5247	HEARING AID, PROG, MON, BTE	05/19/2010		1	50.00	RT	
V5247	HEARING AID, PROG, MON, BTE	05/19/2010		1	50.00	LT	

Figure 134 Hearing Aide Services

Retro-Eligibility:

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

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.

Figure 135 Rep

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. For Orthotics and Prosthetic requests, the certification type is also captured.

25. For 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. Enter a number value that is greater than '0'.

Figure 136 Therapist/Certification and Type – Orthotics/Prosthetics

26. For 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.

Figure 137 Therapist/Certification – 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.

Figure 138

Physician Prescription:

This section 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.

Figure 139

Additional Information Questions:

Additional information questions are pulled into the template for Orthotics/Prosthetics requests 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.

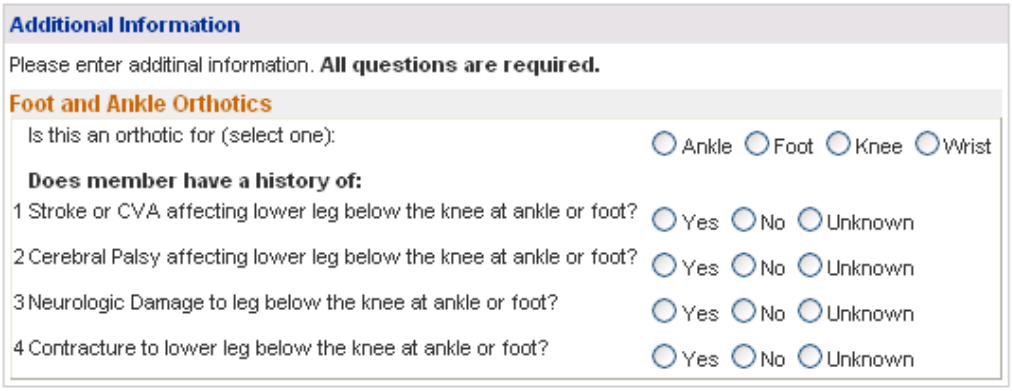


Figure 140

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.

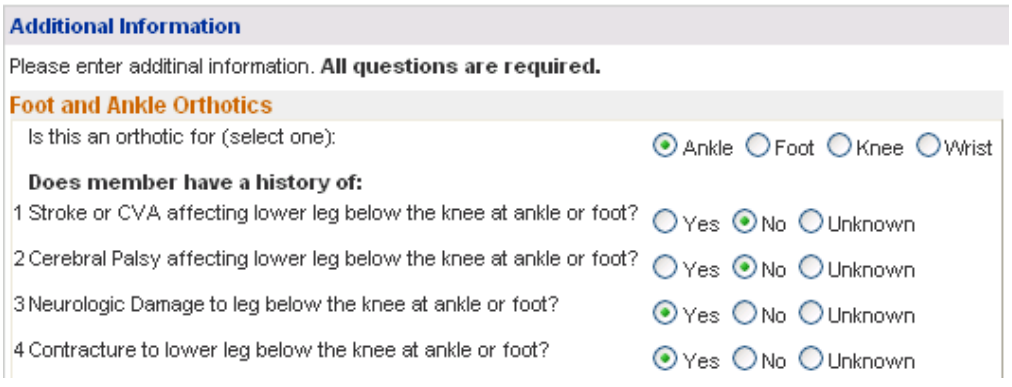


Figure 141

31. 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.

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

33. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.

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

2.14 Vision Services Requests

Program	Authorization Period
Vision Care Services	90 Days

Table 18

2.14.1 Description

Requests for authorization of glasses and contacts for members under 21 years may be submitted via the web portal utilizing the *Vision Services* request template. Submission of requests for vision services is restricted to Providers with a 470 category of service.

2.14.2 Web Entry Instructions

Follow these instructions to enter a Vision Services request:

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. 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.

Figure 142

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.

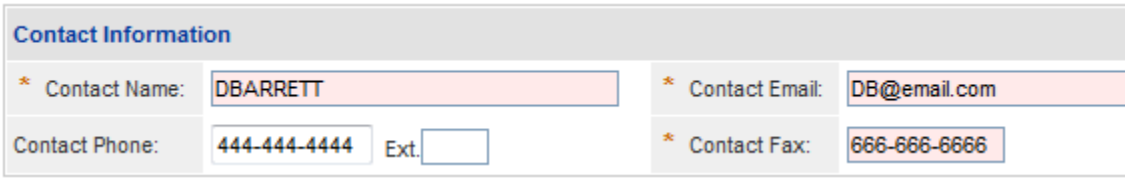


Figure 143

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.

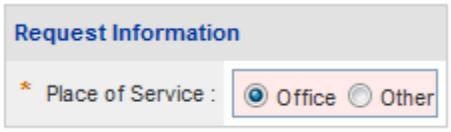


Figure 144

Diagnosis Table:

The Diagnosis table captures diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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 diagnosis 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.

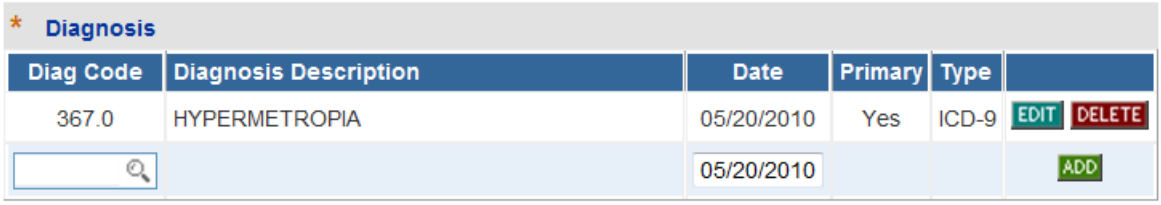


Figure 145

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. Enter manually or use the calendar popup.

16. In the 'To Date' box, enter the same date as entered in the 'From Date' box. The system will calculate the applicable authorization span.

17. Enter the total units requested for the service in the 'Units' box. Enter whole numbers only.

18. Enter the unit price for the service requested in the 'Requested Price/Unit' box.

19. Click **Add** at the end of the procedure table to add the procedure code information to the request. If a 'From Date' is added that is more than ninety (90) days in the future, the following message displays when **Add** is clicked: "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.

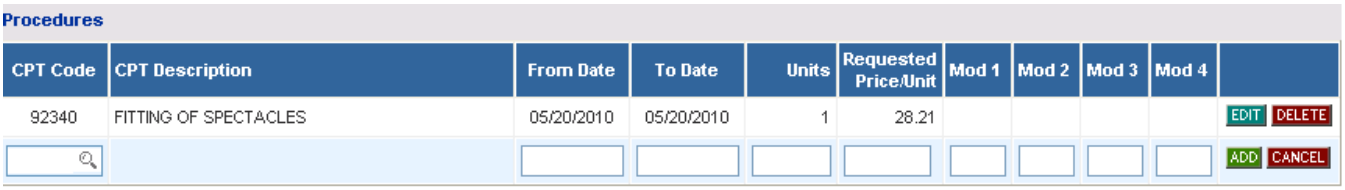


Figure 146

20. 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'.

Figure 147

21. 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.

22. 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. Enter manually or use the calendar popup

Figure 148

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.

23. Enter the information in each applicable textbox. When data has been entered to the bottom of a visible text box, the scroll bar will activate. Click the up or down arrow on the scroll bar to navigate up or down in the text box.

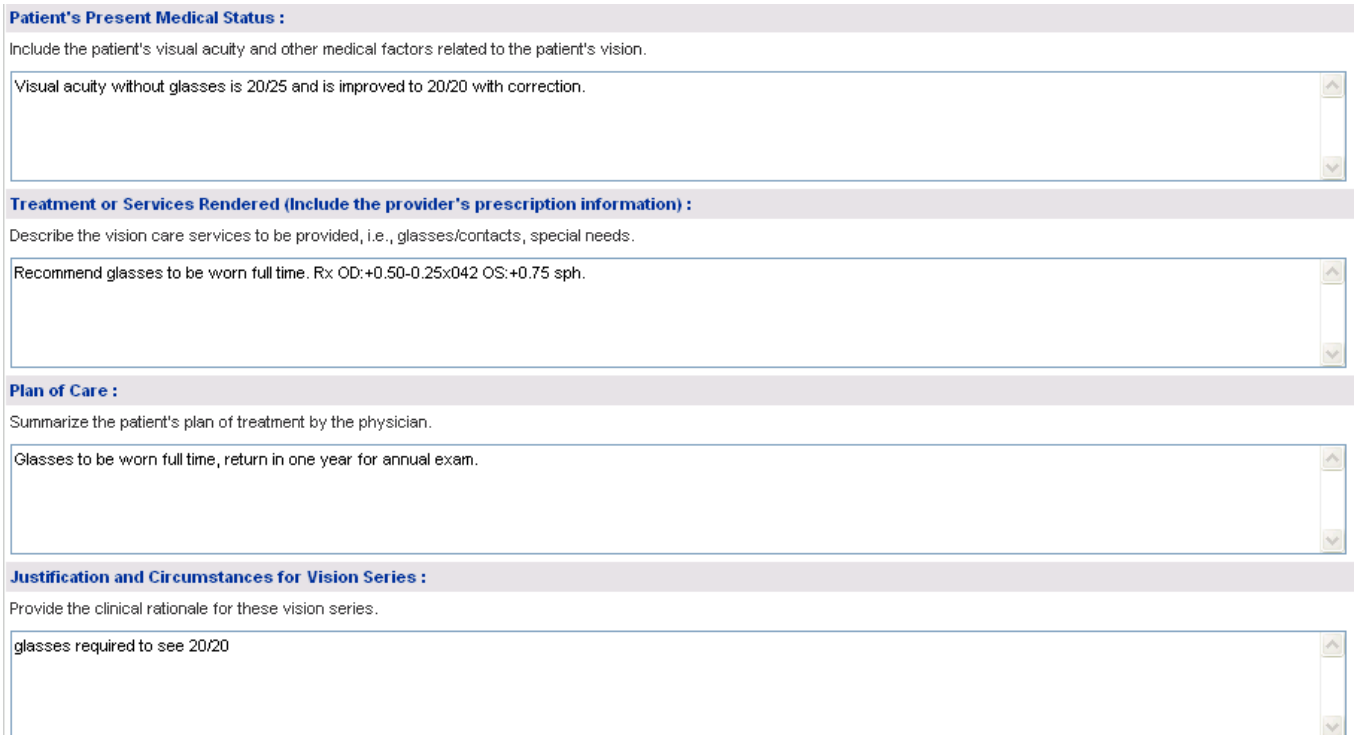


Figure 149

Prescription:

This section documents that there is a signed prescription on file.

24. The system defaults the answer to this question to *No*. Click *Yes* to confirm that a prescription is on file.

Figure 150

25. 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.

26. 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 system displays the pending PA tracking number.

2.15 Children's Intervention Services

Program	Authorization Period
Children's Intervention Services	Up to 180 days

Table 19

2.15.1 Description

Requests for therapeutic services provided under the Children's Intervention Services (CIS) program may be submitted via the web portal utilizing the *Children's Intervention Services* request template. The submission of CIS requests is restricted to providers with an 840 category of service. The request template captures the services requested, justification for services, and the type and dates of required additional documentation that is attached to the PA request. Up to six (6) consecutive months of service may be entered on one request. Procedure dates entered are validated to prevent submission of 'retro' requests.

2.15.2 Web Entry Instructions

Follow these instructions to enter a request for Children's Intervention Services:

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. 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.

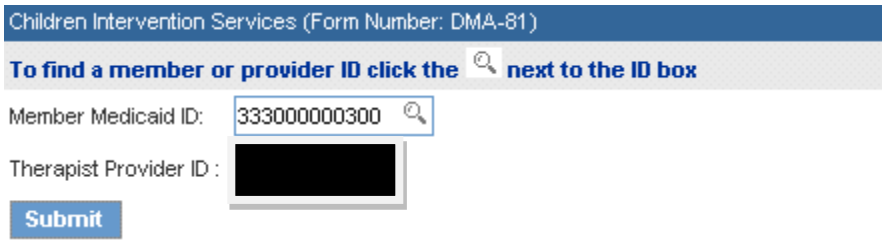


Figure 151

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.

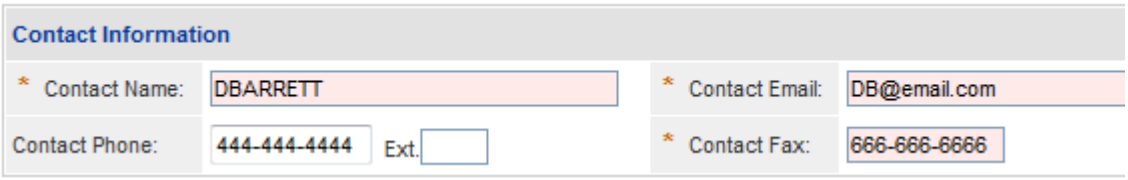


Figure 152

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.

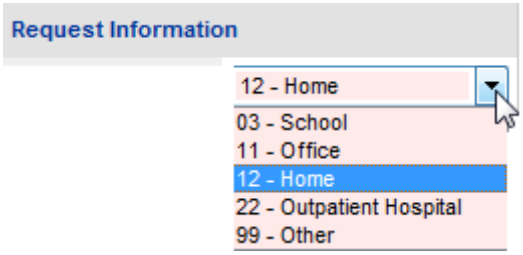


Figure 153

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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.

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.

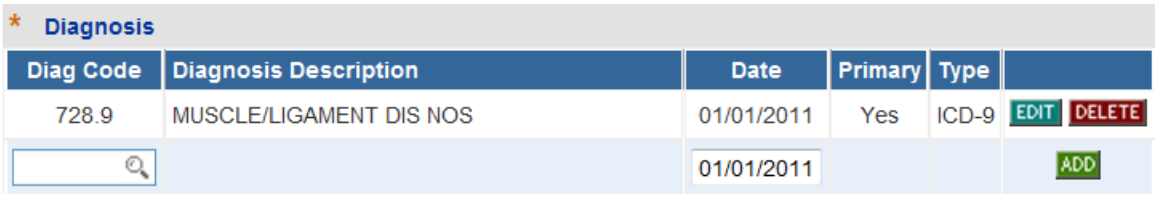


Figure 154

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 must be within the same month. Enter the dates manually or use the calendar popup.

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. When the procedure is added, the system validates the procedure dates against the following edits:

    - If a procedure 'From Date' is entered that is before the PA request date, this message displays: "A Children's Intervention Services request cannot be entered that starts before the request date." The date must be correct in order to submit the request.

    - If the procedure 'From Date' and procedure 'To Date' are not within the same month, this message displays: "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.

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

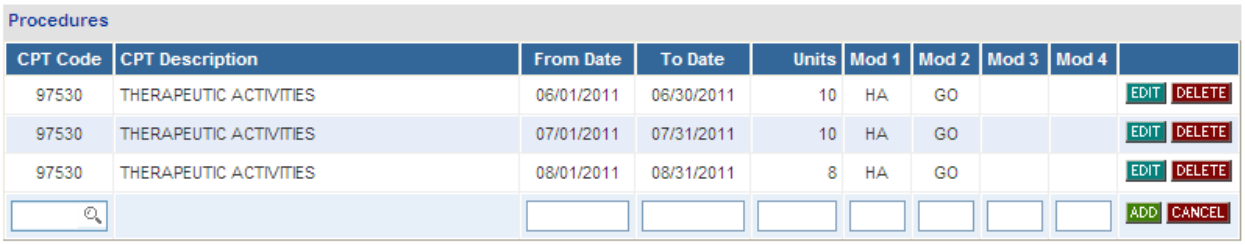


Figure 155

20. Up to six (6) consecutive months of service may be entered on one request. If more than six consecutive months are requested, the following 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 or months must be removed in order to submit the request.

Retro-Eligibility:

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

21. 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 needed services.

22. Enter the date that the child was admitted to the CIS program in the 'Date admitted to program' box. Enter manually or user the calendar popup.

23. 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.

Figure 156

24. In the 'Justification and Circumstances for Required Services' textbox, explain why the requested services are medically necessary.

25. Enter the first and last name of the patient's physician in the 'Primary Care Physician Name' box.

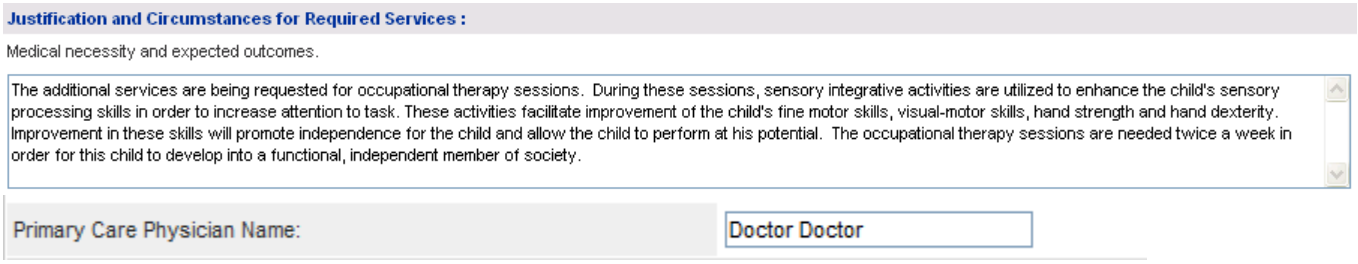


Figure 157

Outcomes:

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

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

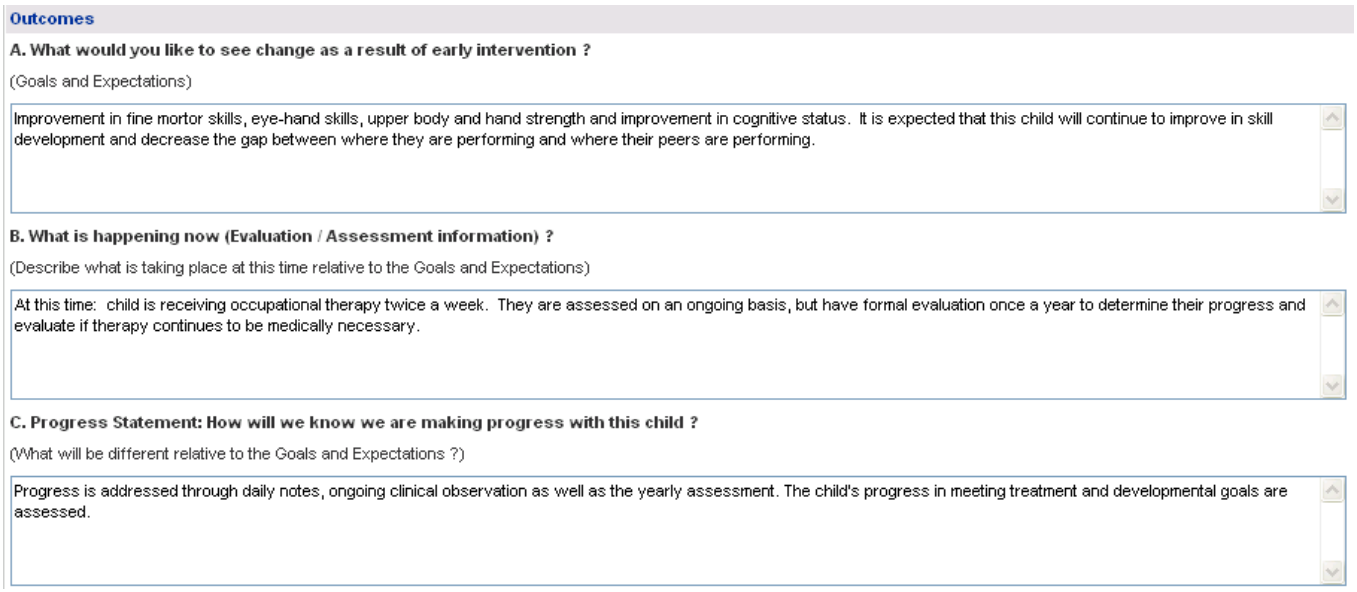


Figure 158

CIS Request Submission Requirements:

This final required section documents the type and dates of additional information that is required for CIS PA submission.

27. 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.

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

Figure 159

29. 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.

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 system displays the pending PA tracking number. On this page, additional required documents may be attached under **Create an Attachment.**

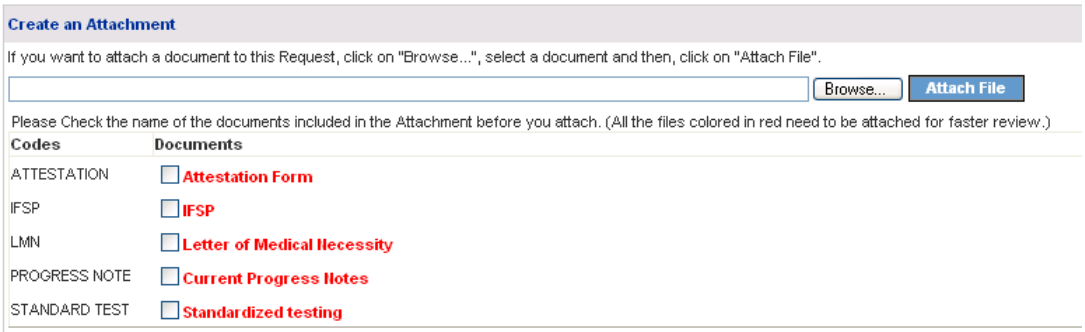


Figure 160

2.16 Independent Care Waiver Program (ICWP)

Program	Authorization Period
Independent Care Waiver Program	Up to one year

Table 20

2.16.1 Description

Requests for level of care and service authorizations under the Independent Care Waiver Program may be submitted via the web portal utilizing the ICWP DMA-6 and ICWP DMA-80 request templates, respectively. Submission of requests for ICWP services is restricted to providers with a 660 category of service. The ICWP DMA-6 must be approved before a DMA-80 can be entered.

2.16.2 Web Entry Instructions

DMA-6:

Follow these instructions to enter an Independent Care Waiver Program DMA-6:

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. 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.

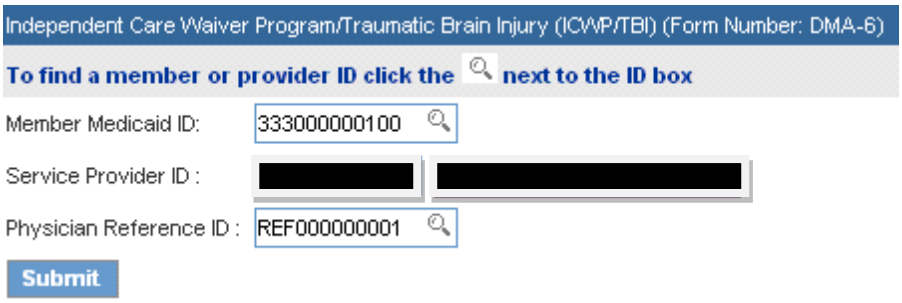


Figure 161

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

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. If the physician Reference number was entered, the physician information is also system populated.

9. If the physician Reference number was not entered, enter the name of the physician in the **Physician Information** section.

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.

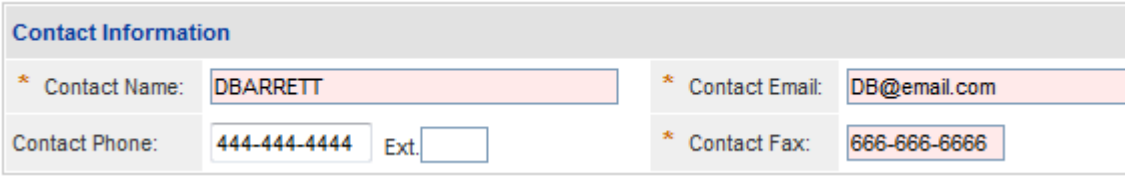


Figure 162

Request Information:

This section captures the following required information: Recommendation Type and Place of Service.

11. 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'.

12. The system defaults the 'Place of Service' to *Home*.

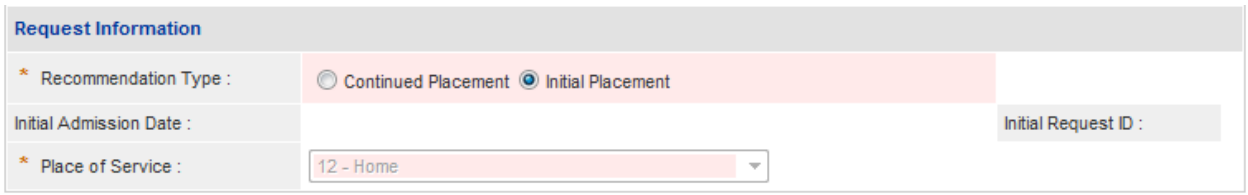


Figure 163

Diagnosis Table:

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

13. 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.

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. Enter the date manually or select from the calendar popup.

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 the **Add** at the end of the diagnosis line to add the diagnosis code to the request.

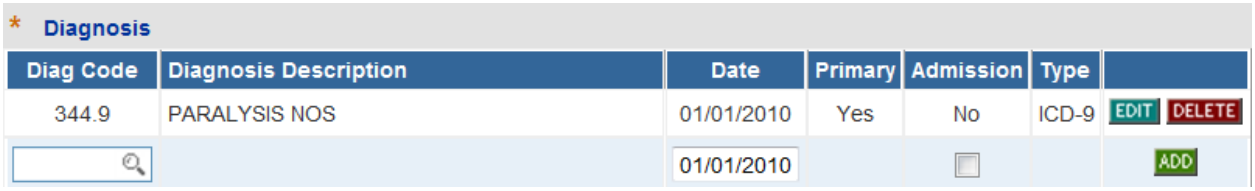


Figure 164

17. 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.

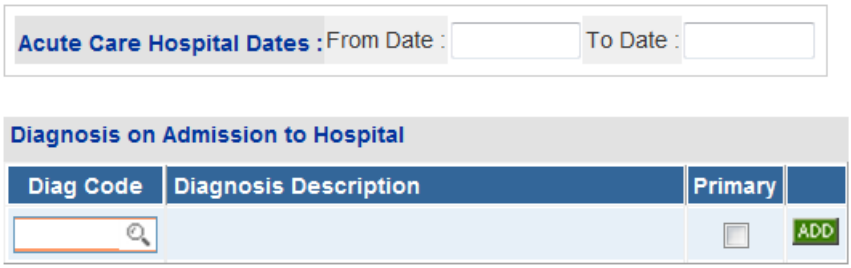


Figure 165

Medications and Diagnostic/Treatment Procedures:

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.

18. To enter medication information, first select the medication type by selecting a type from the 'Name' drop list.

19. Enter the dosage for the medication in the 'Dosage' box.

20. Enter the method of medication administration by selecting the method of administration from the 'Route' drop list (Oral or Parental or Rectal or Topical).

21. Enter the frequency of medication administration by selecting a frequency from the 'Frequency' drop list (Regular or PRN: As necessary or Regular & PRN).

22. Click **Add** at the end of the medication line to add the medication information to the DMA-6.

23. Follow the same process to add other medication information. **Remember to click Add after each entry.**

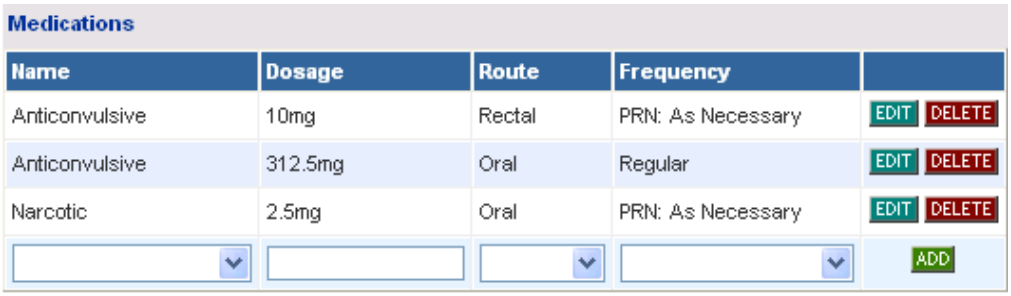


Figure 166

24. 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.

25. Next, enter the frequency of the diagnostic/treatment procedure in the 'Frequency' box.

26. Click **Add** to add the diagnostic/treatment procedure to the DMA-6.

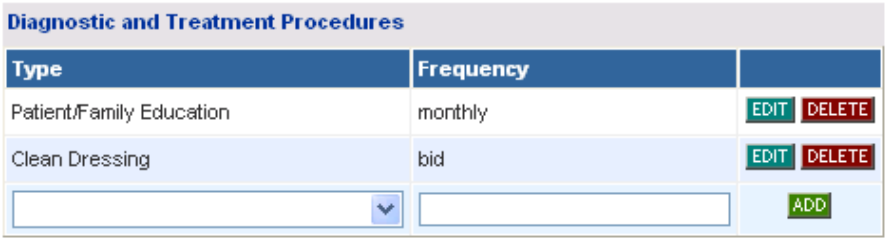


Figure 167

27. Repeat the process to add other diagnostic/treatment procedures. **Remember to click Add after each entry**.

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.

28. Enter the information in the textbox. When data has been entered to the bottom of the visible text box, the scroll bar will activate. Click the up or down arrow on the scroll bar to navigate up or down in the text box.

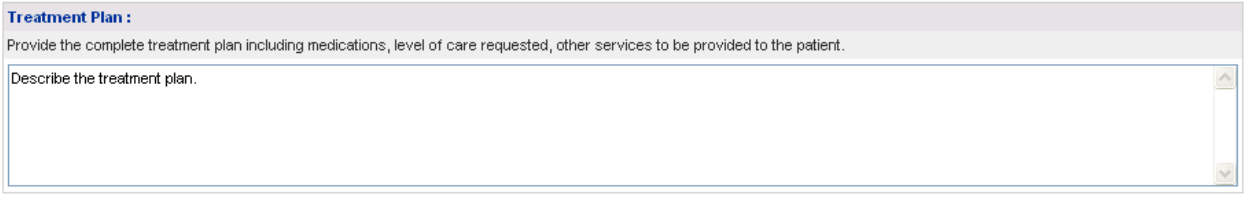


Figure 168

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.

29. Select **Yes** to indicate that the Member is free of communicable diseases.

30. Select **Yes** to indicate that the Member's condition can be managed by Community Care.

31. Select **Yes** to indicate that the Member's condition can be managed by Home Health services.

32. Select **Yes** to indicate that the physician has certified the level of care.

33. Enter the date that the DMA-6 was signed by the member's physician in the 'Date Signed by Physician' box.

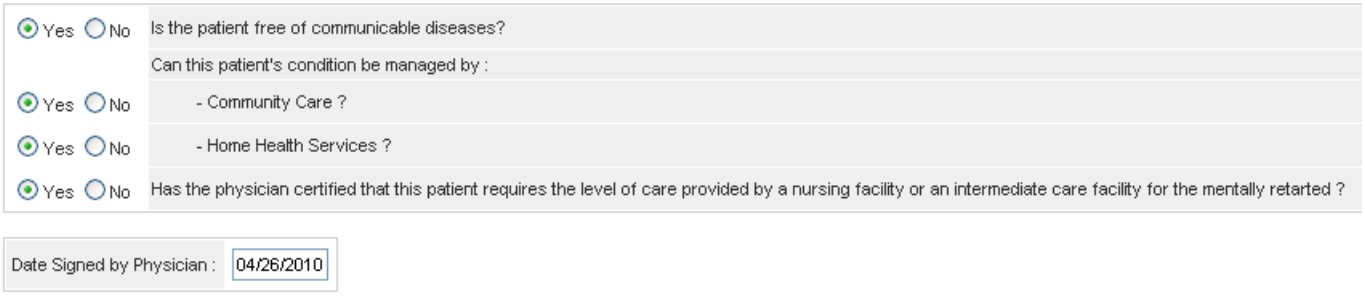


Figure 169

Evaluation of Nursing Care Needed:

This section documents the results of the nursing care evaluation.

34. Under each main category, select the applicable item(s) by clicking the corresponding checkbox or button. This section is required.

35. If applicable, enter the number of hours 'out of bed' per day in the 'Hours out of the bed per day' box.

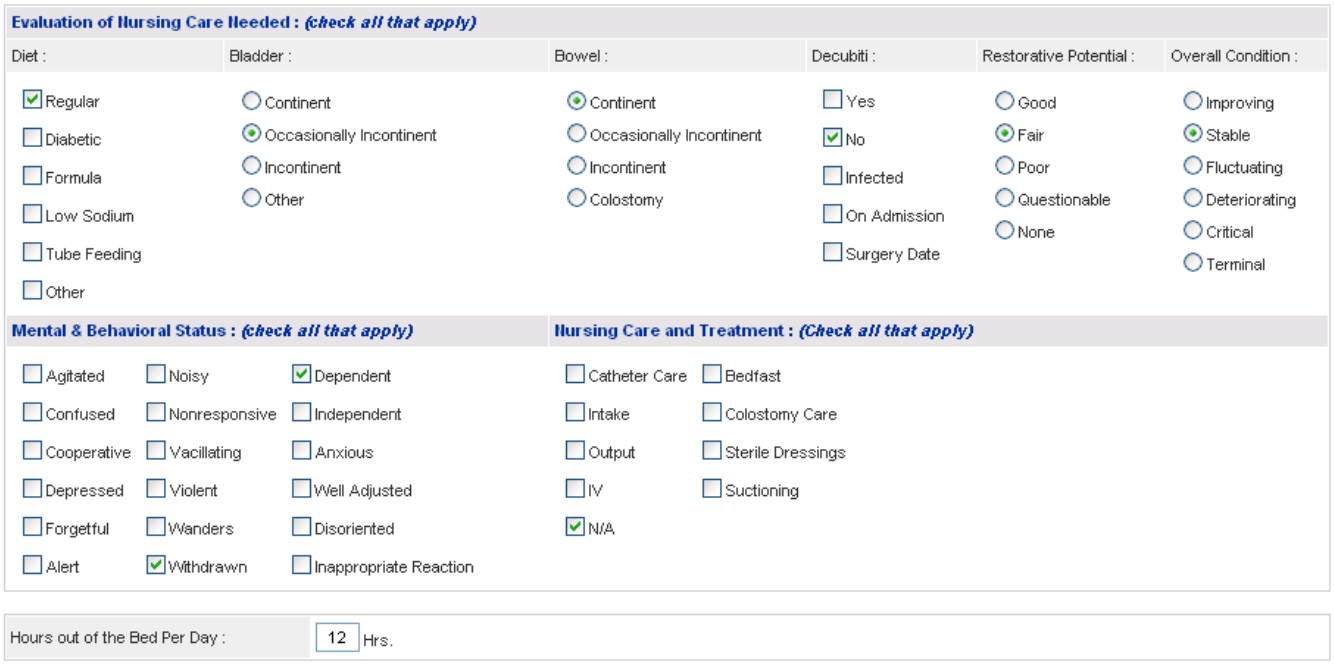


Figure 170

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.

36. 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.

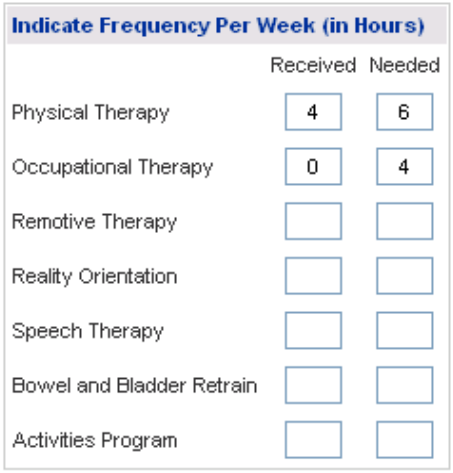


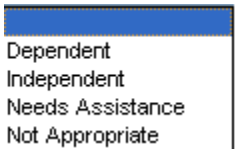
Figure 171

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 records the Member's current abilities regarding activities of daily living. The figures below show the drop list choices for 'Level of Impairment' and for 'Activities of Daily Living'.

Figure 172 Level of Impairment Choices/I6

Figure 173 ADLs Choices/I6



37. Select the appropriate description for each item from the 'Level of Impairment' and 'Activities of Daily Living' drop lists.

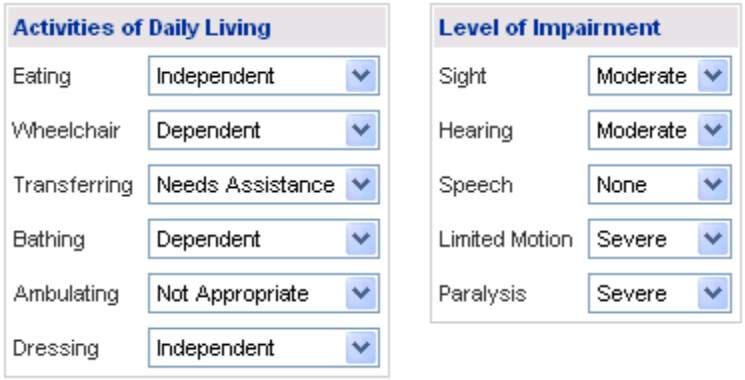


Figure 174

Justification and Circumstances:

This required section captures information related to the member's condition that justifies the need for the services and supports the level of care requested.

38. Enter the information in the textbox provided. When data has been entered to the bottom of the visible text box, the scroll bar will activate. Click the up or down arrow on the scroll bar to navigate up or down in the text box.

39. 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. Enter the date that the form was signed in the 'Date Signed' box.

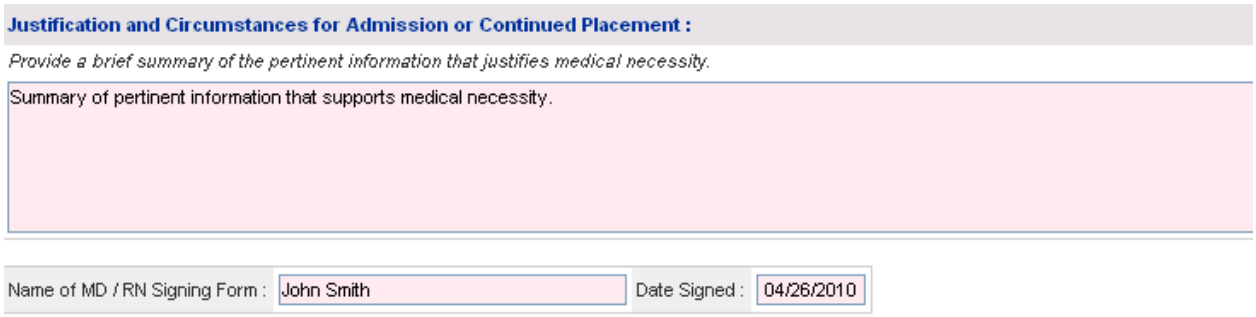


Figure 175

40. 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.

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 system displays the pending PA tracking number.

ICWP DMA-80

Follow these instructions to enter an Independent Care Waiver DMA-80:

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. 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

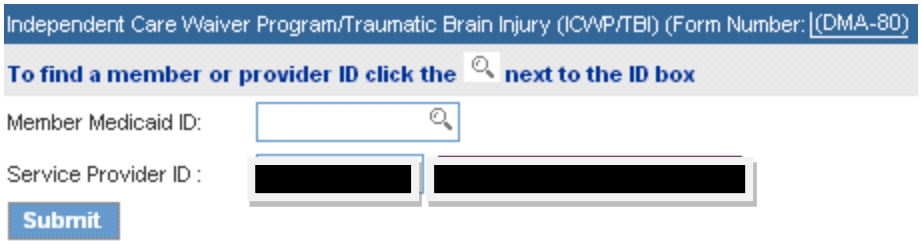


Figure 176

5. Enter the member's Medicaid ID.

6. Click **Submit** to open the *DMA-6 Confirmation* page.

7. Enter the approved DMA-6 authorization number in the 'DMA-6 Prior Authorization Confirmation Number' box.

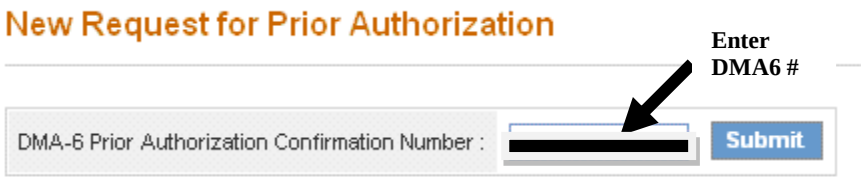


Figure 177

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

9. At the top of the DMA-80 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.

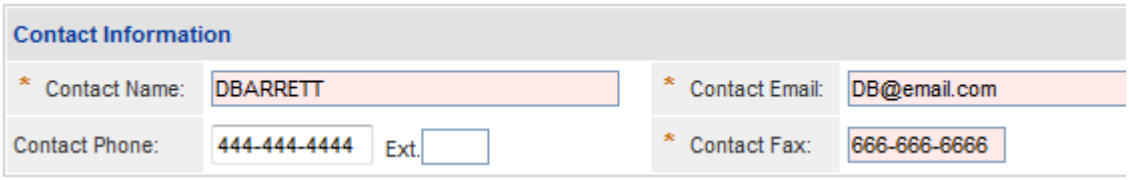


Figure 178

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. Indicate if the member is a consumer directed participant by clicking the *Yes* button (the system defaults this question to No).

Figure 179

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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. Enter the date manually or select from the calendar popup.

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.

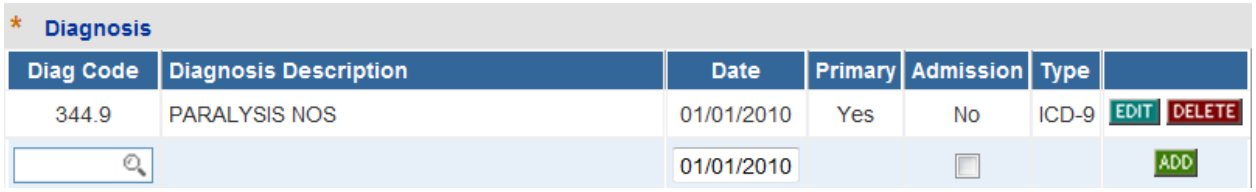


Figure 180

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 date when the service is to start in the 'From Date' box. Enter the date manually or select from the calendar popup.

20. Enter the date when the service is to end in the 'To Date' box. Enter the date manually or select from the calendar popup.

21. Enter the total number of units requested for the entire service period in the 'Units' box. Enter whole numbers only.

22. Enter '0' for 'Requested Units/Day'.

23. Enter the number of units to be provided each month in the 'Requested Units/Month' box.

24. Enter the total cost of the service requested for service period in the 'Requested Amount' box.

25. Enter the 'Cost Sharing Amount' in the box provided if the member shares the cost of the service.

26. Next, add the appropriate modifier or modifiers if applicable to the service requested. Enter the modifiers in correct order in the 'Mod 1', 'Mod 2', and 'Mod 3' boxes, as applicable.

27. Click **Add** at the end of the procedure line to add the service information to the request.

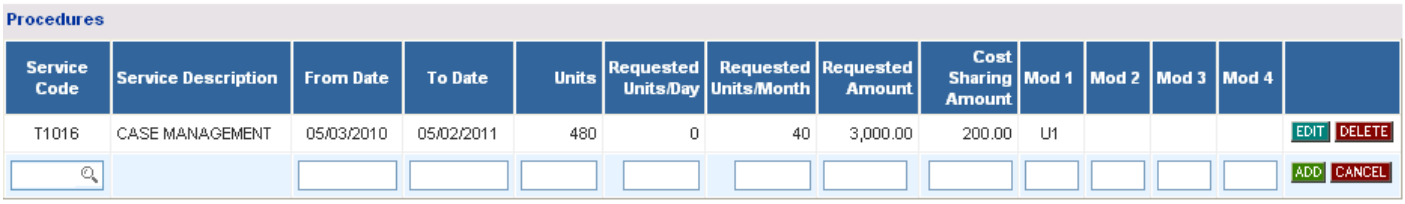


Figure 181

28. 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.

29. Enter the date that the member was **initially** admitted to the ICWP in the 'Program Admit Date' box. Enter manually or select from the calendar popup.

31. 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.

32. **If 'Renewal' is selected**, also enter the date of the last annual care plan in the 'Date Last Certified' box. Enter manually or use the calendar popup.

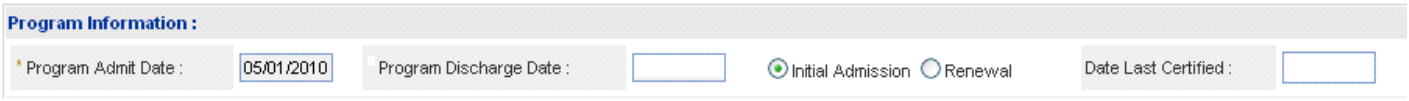


Figure 182

Supporting Information:

This section captures a description of the services ordered for the member; and the medical justification for providing the services.

33. Describe the services and frequency of services that have been ordered in the 'Description of Services Requested' textbox. When data has been entered to the bottom of the visible text box, the scroll bar will activate. Click the up or down arrow on the scroll bar to navigate up or down in the text box.

34. 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. When data has been entered to the bottom of the visible text box, the scroll bar will activate. Click the up or down arrow on the scroll bar to navigate up or down in the text box.

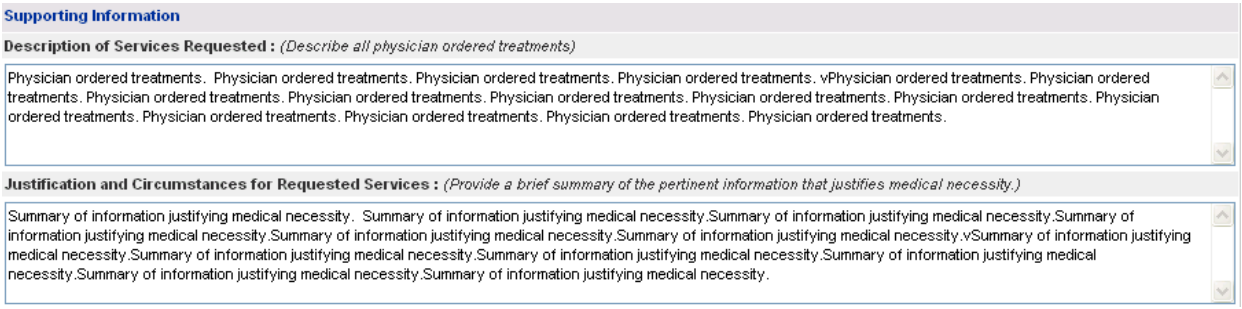


Figure 183

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.

35. Enter the required information in each textbox. When data has been entered to the bottom of the visible text box, the scroll bar will activate. Click the up or down arrow on the scroll bar to navigate up or down in the text box.

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.**

36. 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.

37. 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.

38. 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.

39. 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.

40. If the member is receiving other waiver services, click *Yes*.

Figure 184

41. 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.

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

43. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.

44. When the request is successfully submitted, the system displays the pending PA tracking number. On this page, additional required documents may be attached under **Create an Attachment.**

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2.17 Service Options Using Resources in Community Environments (SOURCE)

Program - SOURCE	Authorization Period
Level of Care and Placement	Initials/Reassessments: 3 months to one year
Services PA	Up to one year

Table 21

2.17.1 Description

SOURCE *Level of Care and Placement* (LOC) requests for initial admission and reassessment are submitted by providers via the Georgia 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

SOURCE Services PA are submitted by SOURCE case managers via the Georgia 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

2.17.2 SOURCE LOC Entry Instructions

Follow these instructions to enter a SOURCE Level of Care and Placement request:

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. Select the **SOURCE** 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.

Figure 185

5. Click **Submit** to open the *Level of Care and Placement* request form.

6. 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.

7. Enter the physician's first name and last name in the 'Physician Name' box (required).

8. If the physician name relates to the member's primary physician, select the 'Primary Physician' checkbox. If the physician name relates to the SOURCE Site Medical Director, then select the 'SOURCE Site Medical Director' checkbox. Both checkboxes may be selected if the physician is the primary physician and the Medical Director.

9. Enter the physician's phone number in the 'Phone' box (required). The system auto formats the phone number.

10. Enter the date that the physician signed the Level of Care and Placement in the 'Date LOC Signed' box (required). The date may be entered manually or selected from the calendar popup.

11. Although not required, physician address information and license number can be provided.

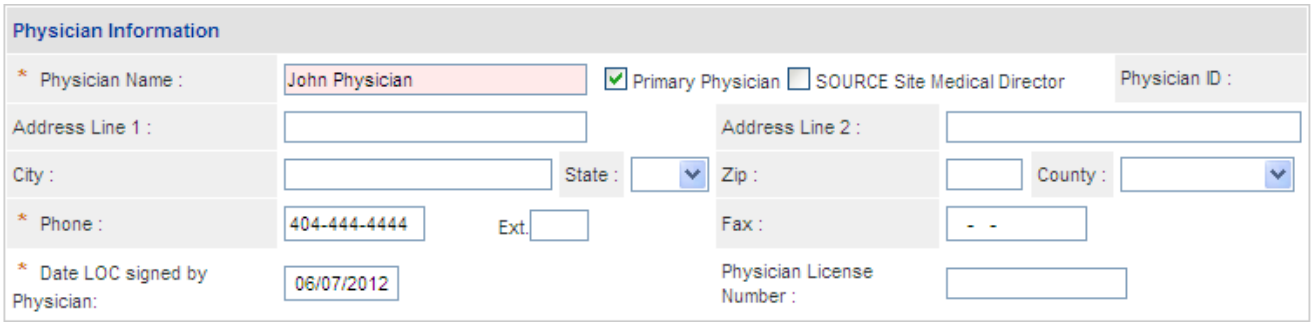


Figure 186

Contact Information:

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

12. 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.

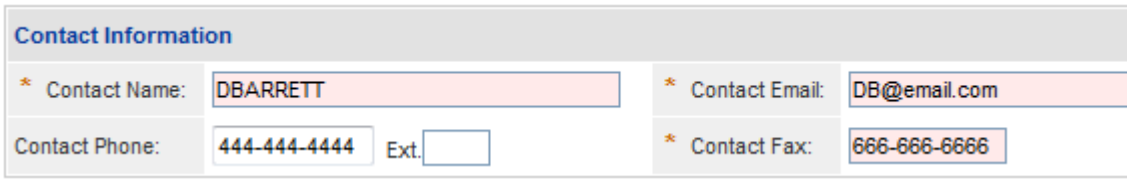


Figure 187

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 Follow 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. 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 the request is an initial request, enter the date admitted to the program or the planned admission date in the 'Initial Admit Date' box. If the request is a reassessment, enter the date that the member was **initially** admitted to SOURCE.

16. Indicate whether or not the member is approved for *Money Follows the Person* by selecting *Yes* or *No*.

17. From the 'Place of Service' drop list, select the location where services, related to this request, are provided. The choices are *Home* or *Other*.

Figure 188

Diagnosis:

This table captures the diagnosis code (or codes) associated with the patient's condition. At least one diagnosis code is required.

18. 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. 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 or first word of the description. Select the diagnosis from the search results and the system will insert the code.

19. 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. Enter the date manually or select from the calendar popup.

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**.

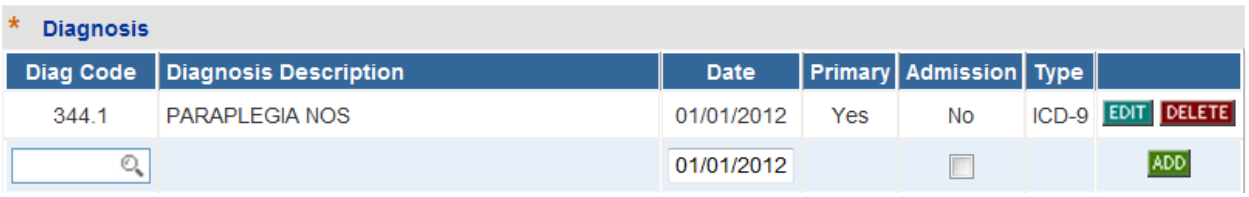


Figure 189

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**.

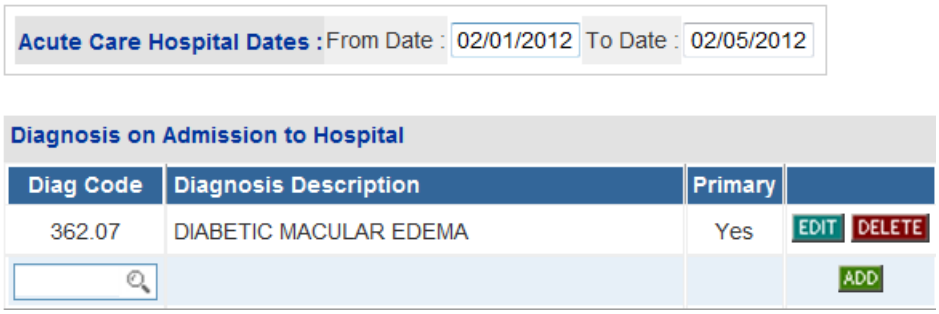


Figure 190

Medications and Diagnostic/Treatment Procedures:

This section captures medications and treatment procedures applicable to the member's plan of care. This information is not required but should be entered to support the need for SOURCE services. In lieu of 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.

Medications

27. Click the down arrow from 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.

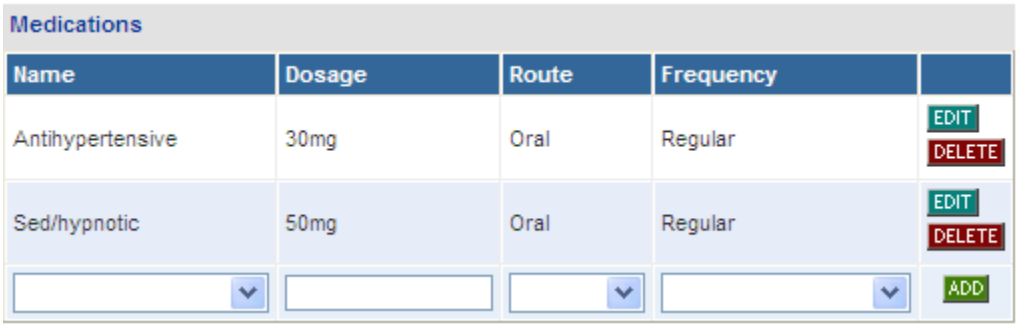


Figure 191

Diagnostic and Treatment Procedures

32. From the 'Type' drop list, select a diagnostic/treatment procedure.

33. Enter the frequency for the treatment procedure in the 'Frequency' box.

34. Click **Add**.

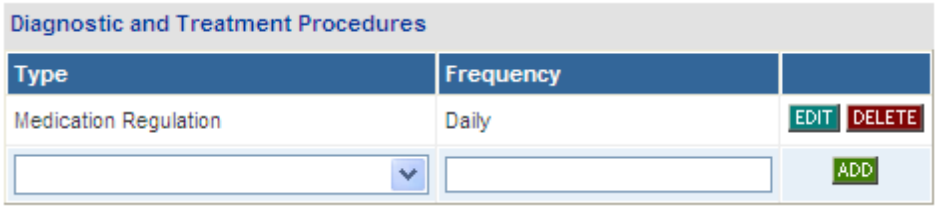


Figure 192

35. Follow the same process to add other treatments.

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.

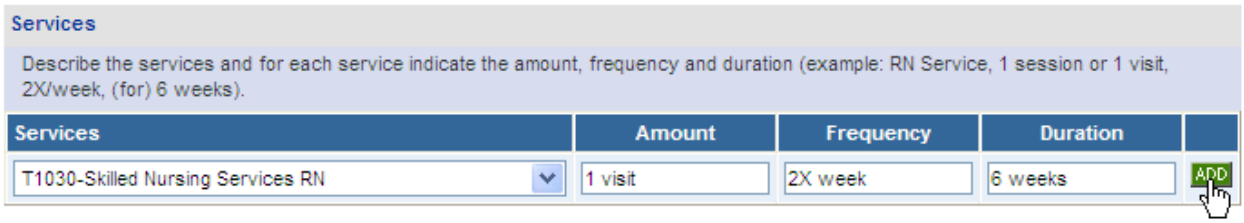


Figure 193

41. Follow the same process to add other services. Remember to click **Add** after entering each line of service information.

Figure 194 S

Treatment Plan:

This textbox captures a description of the member's treatment plan. This information is required.

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. You may also attach this information to the request – enter "See Attached Treatment Procedures or Medications" in the text box.

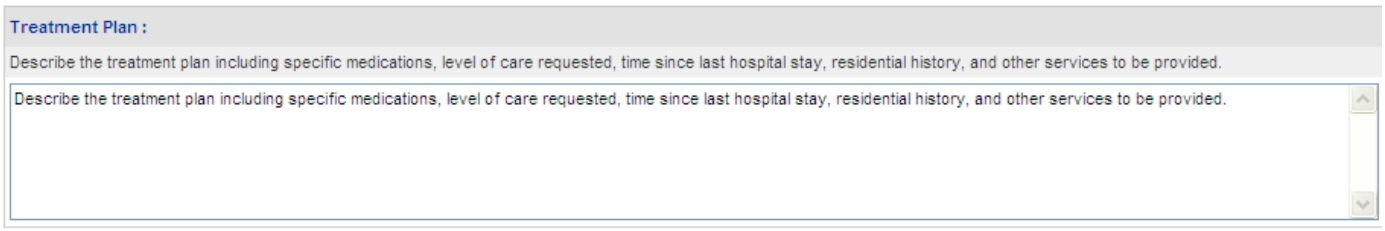


Figure 195

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.

◉ 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?

Figure 196

Evaluation of Nursing Care Needed:

This section captures the member's nursing needs identified in the nursing care evaluation.

48. For each nursing evaluation category, select the nursing need item(s) necessary for the member's care (required). 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. 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 (optional).

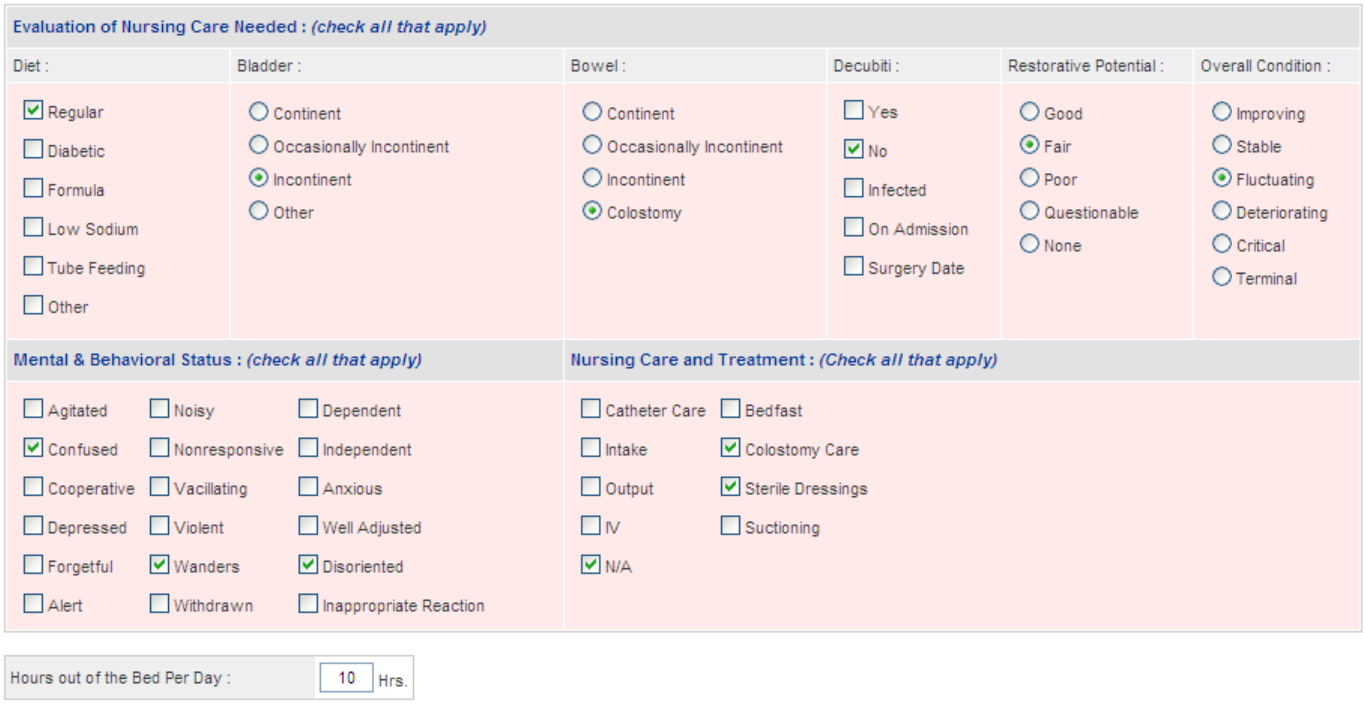


Figure 197

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, click the down arrow and select the level of assistance needed from the drop list.

52. **Level of Impairment**: For each category of impairment, click the down arrow and select the level impairment from the drop list.

Figure 198

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.

Figure 199

56. 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.

57. Click ***I Agree*** in response to the *Attestation Statement* to confirm that all information entered is true and in accordance with Department of Community Health policy.

58. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.

59. When the request is successfully submitted, the system displays the pending PA tracking number at the top of the page. Additional supporting documents required for SOURCE requests can be attached to the pending PA at this point.

60. Go to **Create an Attachment.** This section includes checkboxes for each document type required for Initial or Reassessment (depending on which Recommendation type was selected on the request).

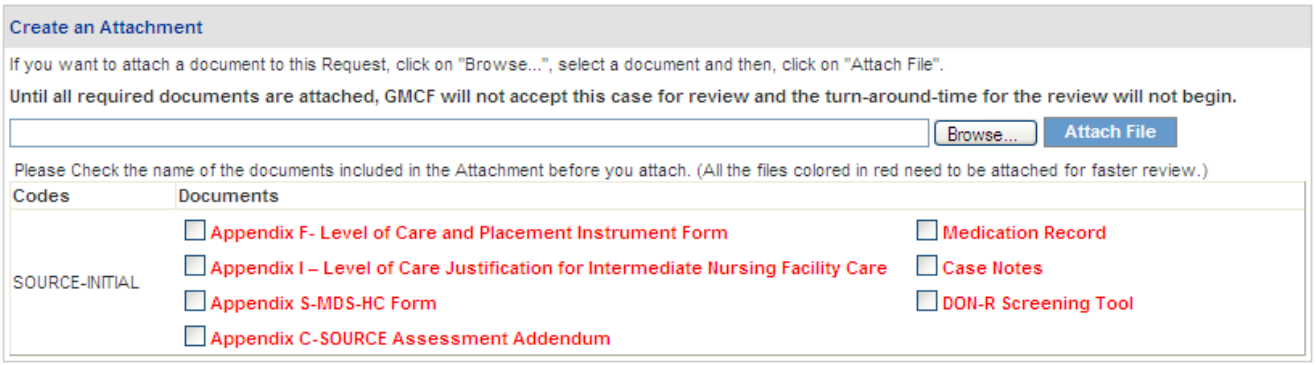


Figure 200

61. One file or multiple files may be attached. Each file attached must have a different name. The following file types may be attached: DOC, DOCX, JPG, PDF, TIF, and TXT. For complete attachment criteria, please refer to the *Attach Files to a PA Request* manual located on the Provider Workspace/Education and Training/User Manuals.

To attach one file for all document types:

62. Click each document type checkbox.

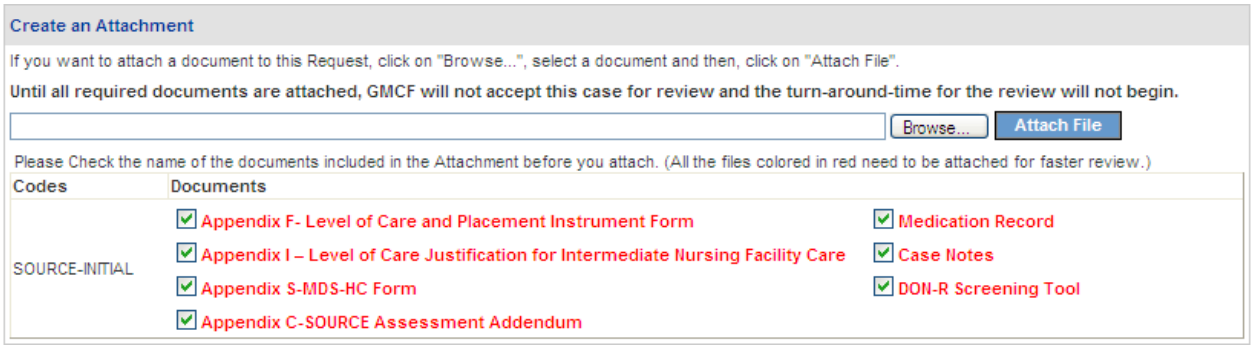


Figure 201

63. Click **Browse** to open the file directory

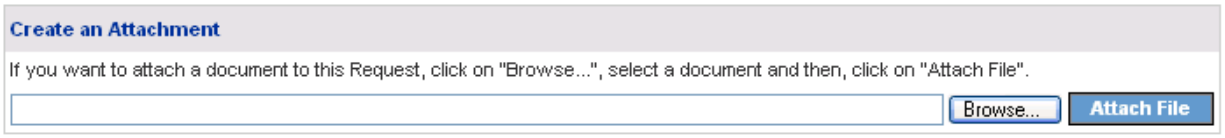


Figure 202

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

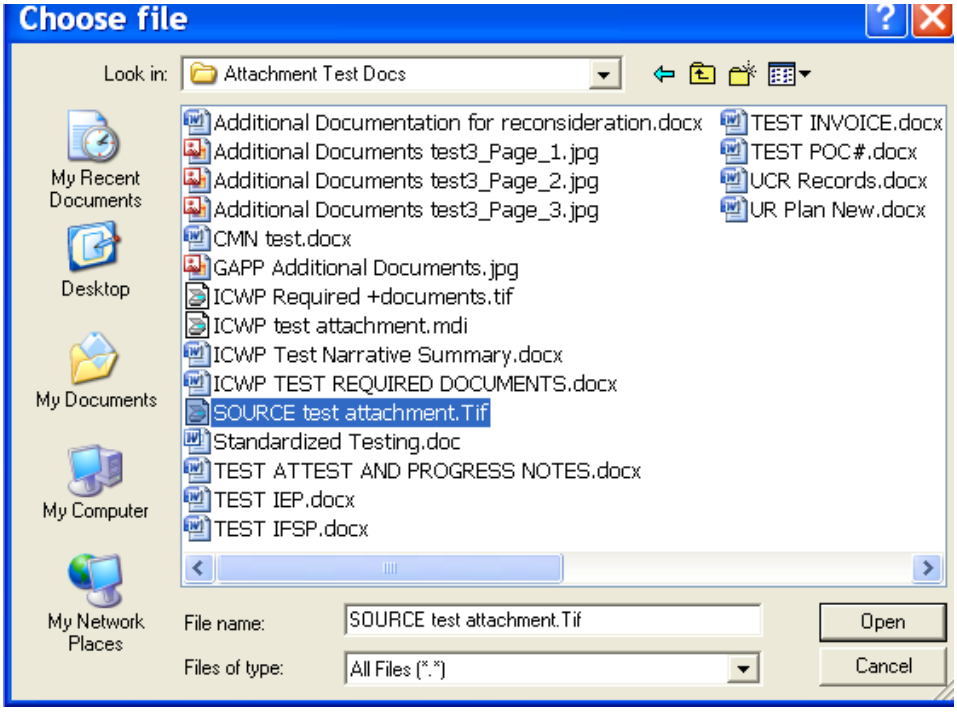


Figure 203

65. Once the file is selected, the file name will display in the box next to browse.

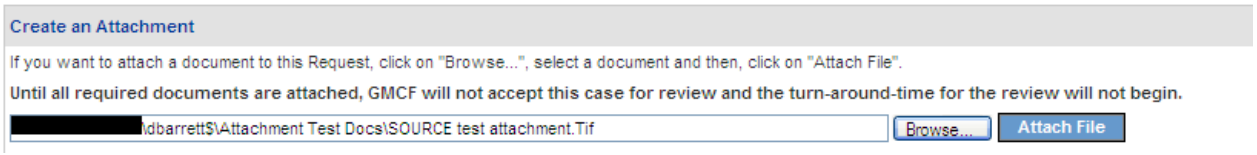


Figure 204

66. Click the **Attach File** button. If the file is uploaded, the 'File uploaded successfully' message displays, and t**he file is associated with each document type** in the **Attached Files** table. The document types are no longer red indicating that each document has been attached.

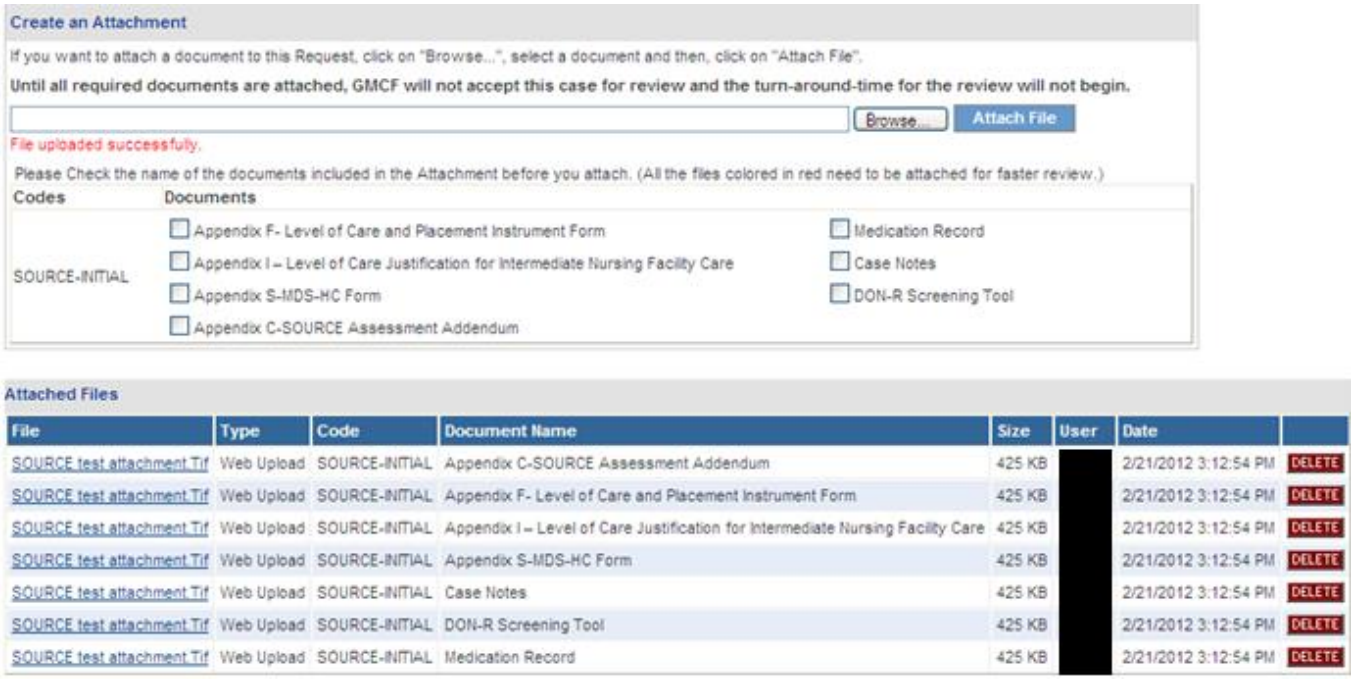


Figure 205 A

<u>To attach more than one file related to different document types</u>:

67. 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.

68. Select another checkbox or other checkboxes. Click **Browse** and find the next file to be attached. Click **Attach File**.

69. Repeat this process until all checkboxes have been selected

2.17.2.1 LOC System Notifications

When a LOC 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.

PA Notifications on the Workspace

Providers have access to PA Notifications via the *Provider Workspace*. There are two ways to view notification details:

- '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:

Follow this process to see the last ten 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.

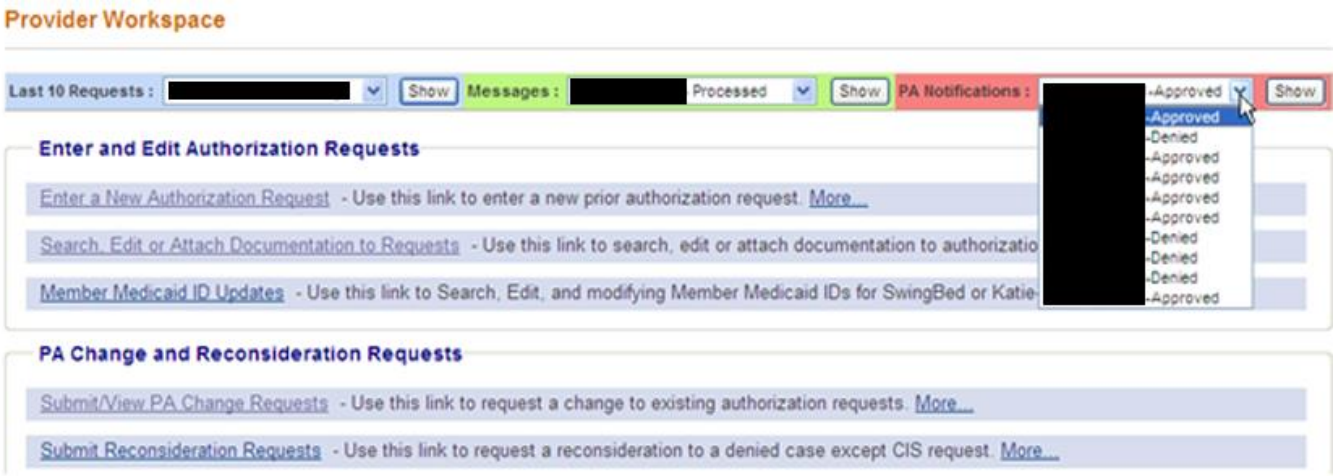


Figure 206

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.

5. 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. Below this section, denial notification information displays; and the letters sent to Members are attached in the **Letter Information** section.

6. If the case was tech denied initially and then approved later, this page shows both the denial and approval notifications by date.

2.17.3 SOURCE Services PA Entry Instructions

Follow these instructions to enter a SOURCE Services PA request:

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**.

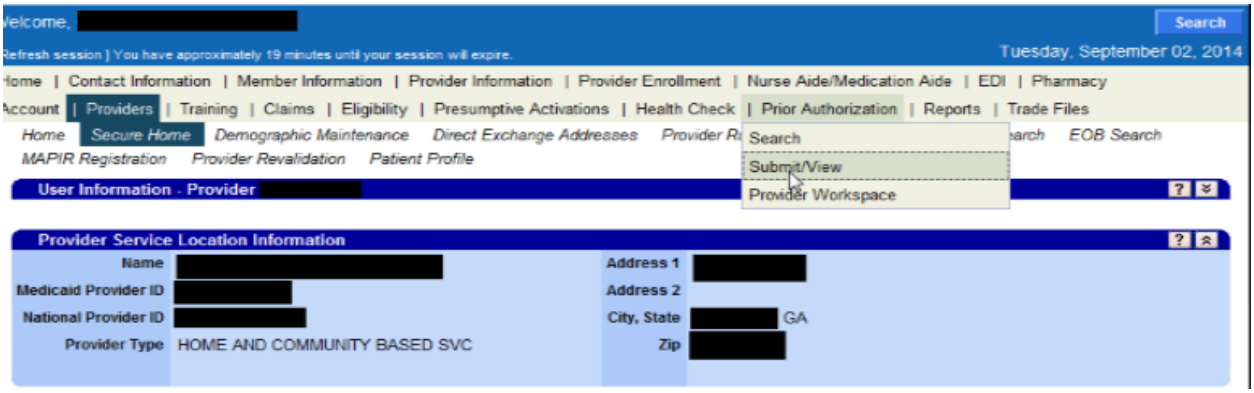


Figure 207

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.

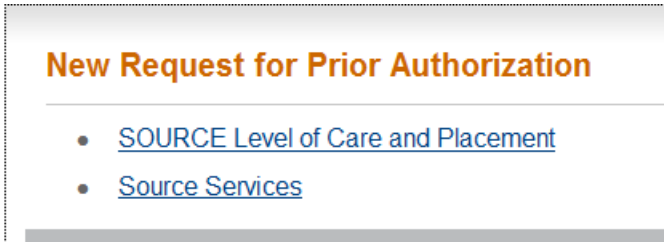


Figure 208

5. On the next screen, the case manager's provider ID is prepopulated based on portal login credentials. Enter the member's Medicaid ID and click **Submit**.

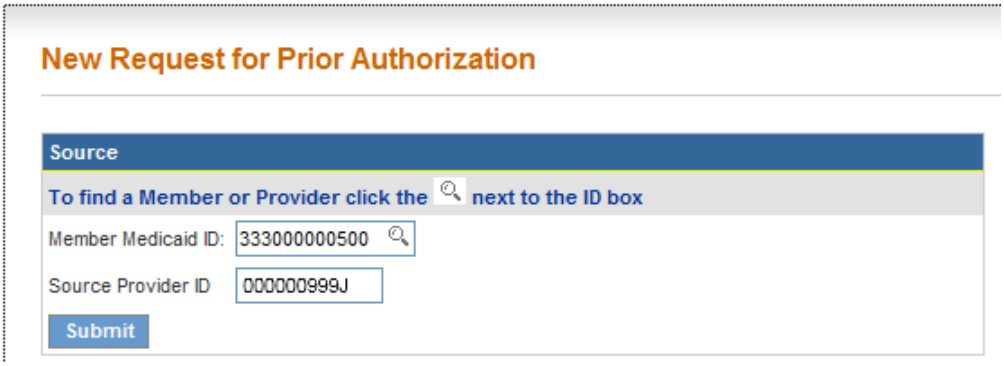


Figure 209

6. 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.

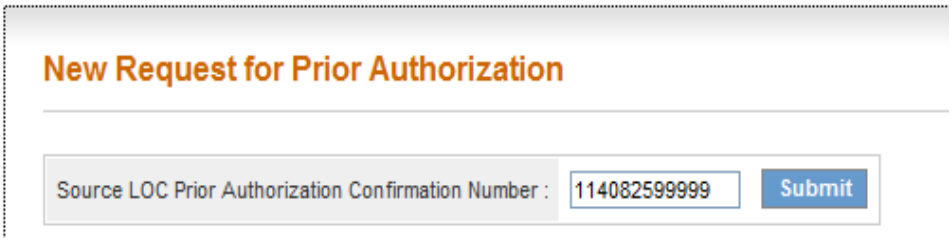


Figure 210

7. 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:

8. 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:

9. 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.

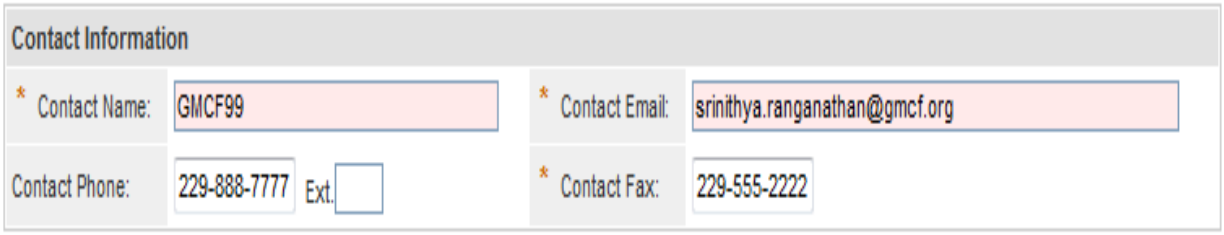


Figure 211

Request Information:

10. The 'Place of Service' defaults to *Home*.

11. Click 'Yes' if the member is consumer directed; otherwise leave as 'No'.

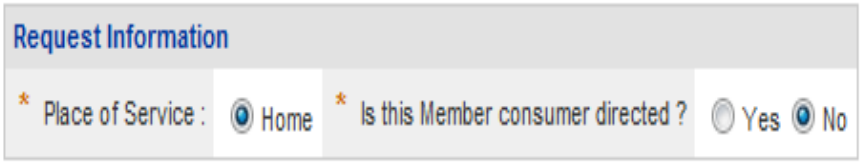


Figure 212

Diagnosis:

At least one diagnosis code is required.

12. 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.

13. Enter the date that the diagnosis was established; if not known, enter the date that the member started in SOURCE.

14. 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.

15. Click **Add** to add the diagnosis information to the request. When **Add** is selected, a blank diagnosis line becomes available for adding another diagnosis.

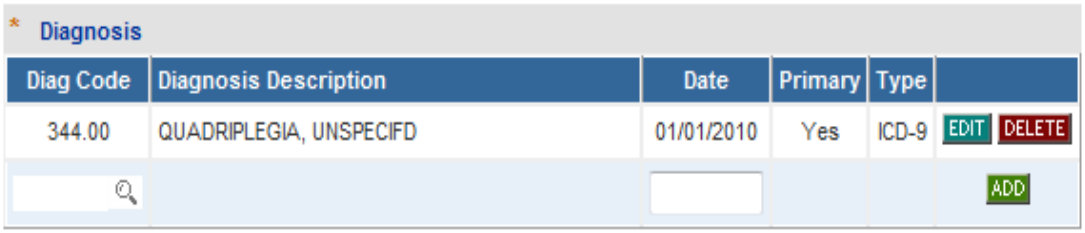


Figure 213

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.

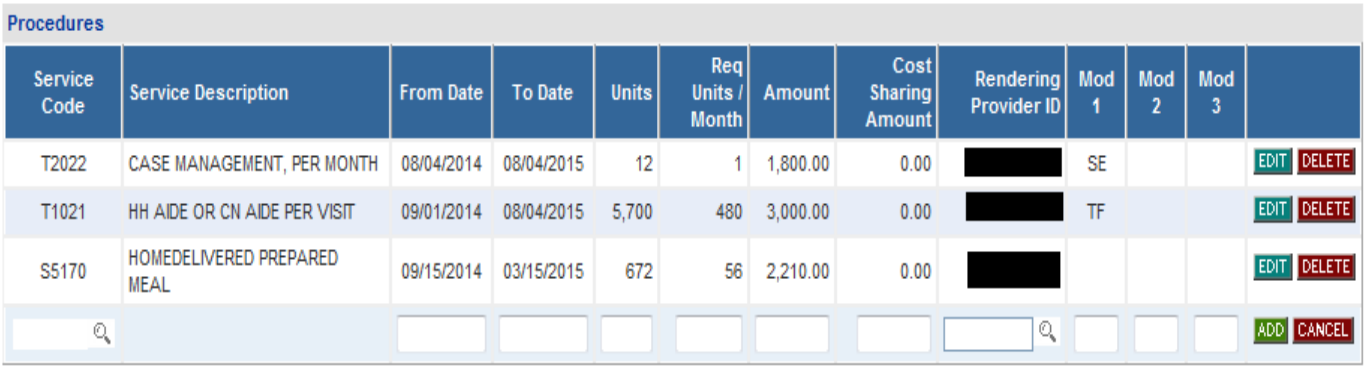
21. If applicable, enter the amount of cost sharing for the service in the 'Cost Sharing Amount' box.

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	[redacted]	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	[redacted]	TF			EDIT DELETE
S5170	HOMEDELIVERED PREPARED MEAL	09/15/2014	03/15/2015	672	56	2,210.00	0.00	[redacted]				EDIT DELETE
												ADD CANCEL

Figure 214

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.

Figure 215

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, however, 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.

Figure 216

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

2.17.3.1 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**.

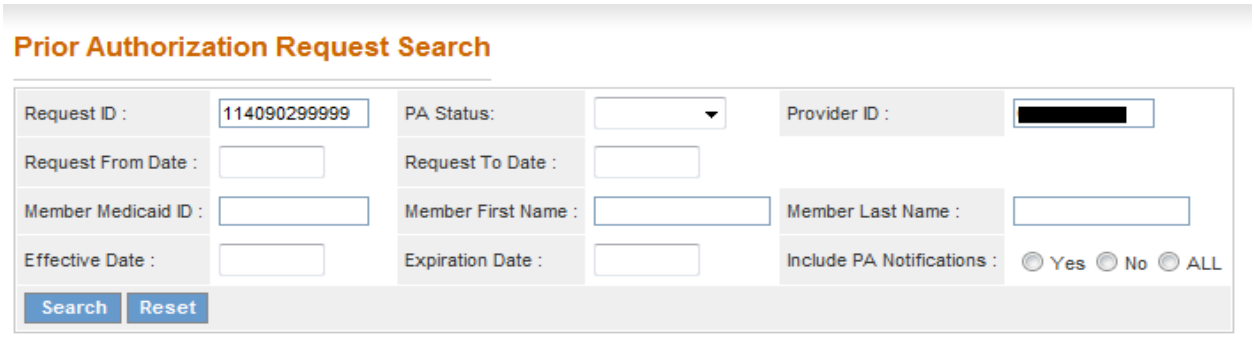


Figure 217

3. Click the 'Request ID' that displays in the search results. The PA *Review Request* page opens which provides a summary of the PA information.

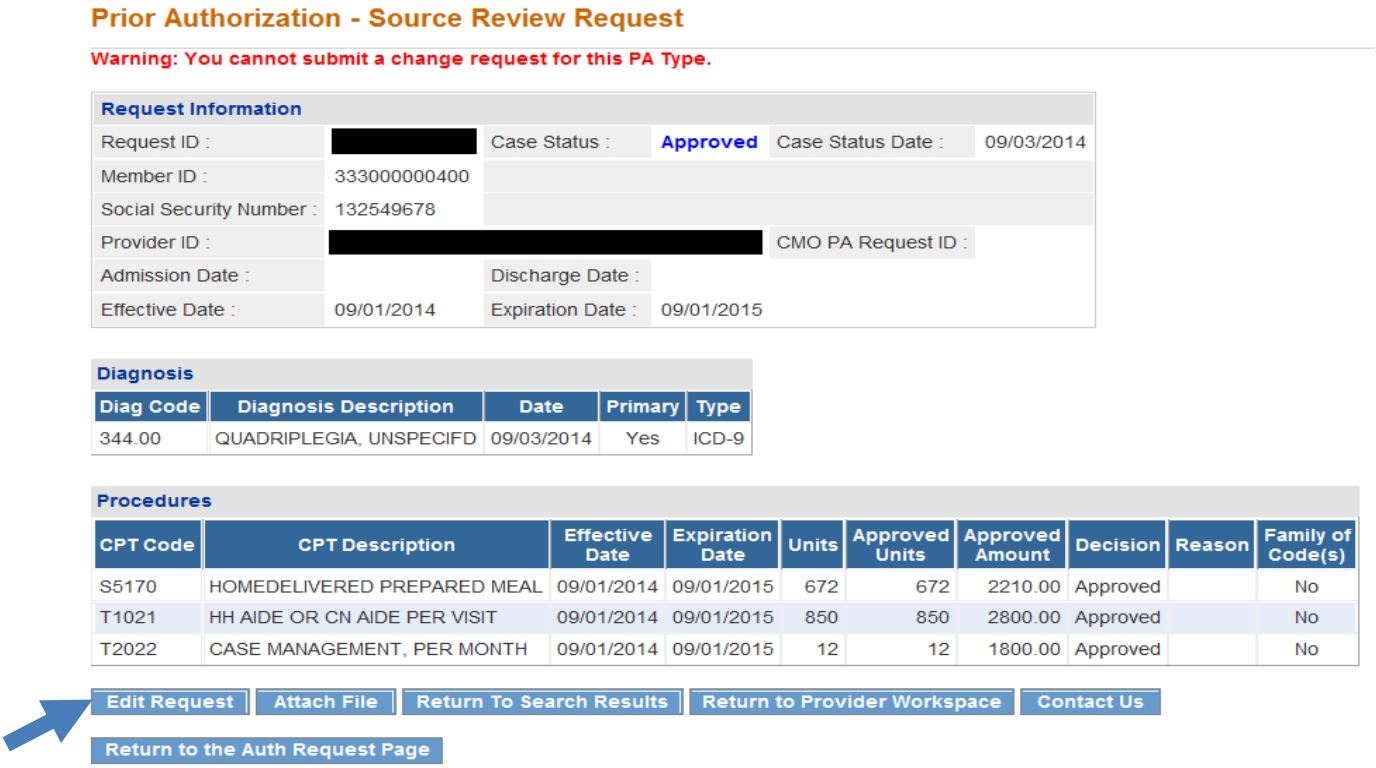
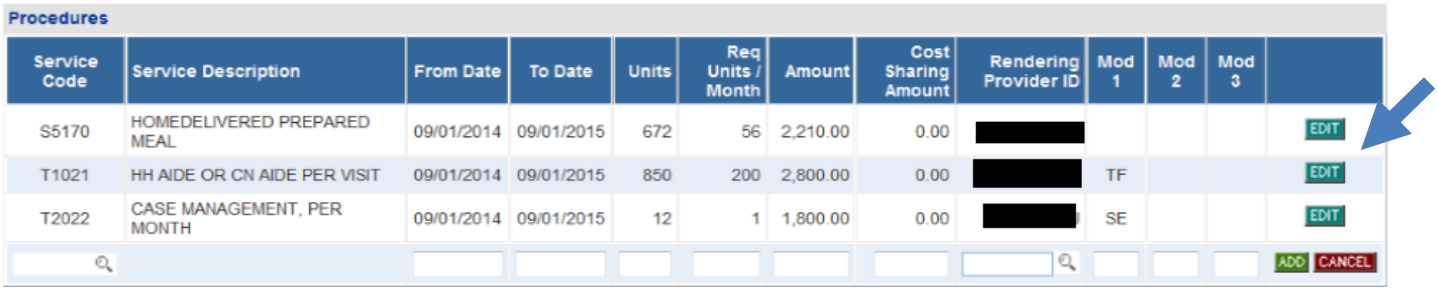


Figure 218

4. To edit the PA, click **Edit Request** at the bottom of the page.

5. On the next page, go to the **Procedures** table and click **Edit** at the end of the procedure line that needs to be modified.



Procedures

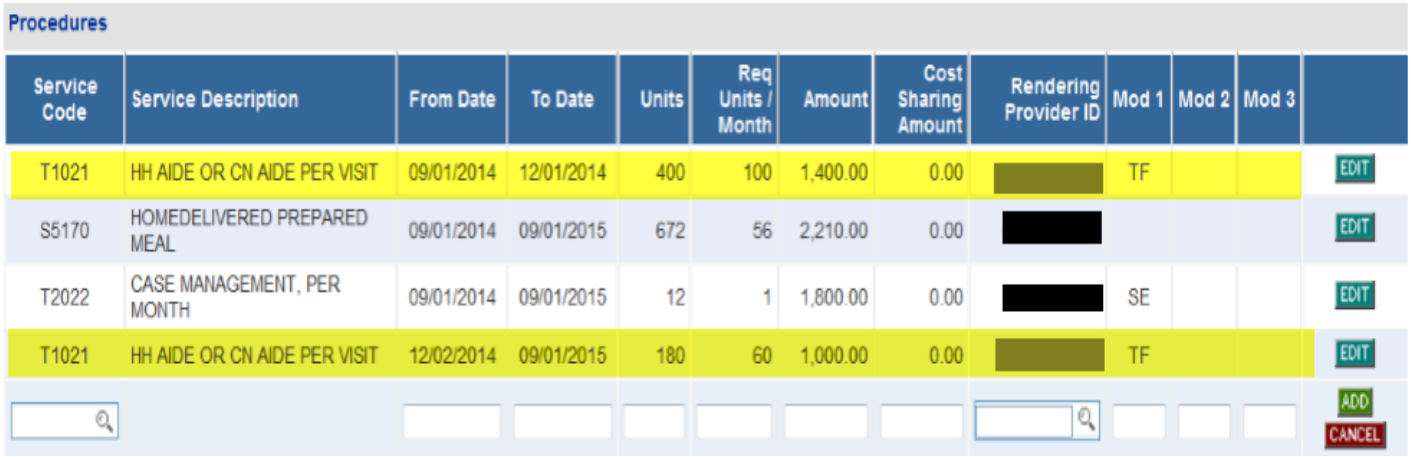
Service Code	Service Description	From Date	To Date	Units	Req Units / Month	Amount	Cost Sharing Amount	Rendering Provider ID	Mod 1	Mod 2	Mod 3	
S5170	HOMEDELIVERED PREPARED MEAL	09/01/2014	09/01/2015	672	56	2,210.00	0.00	[redacted]				EDIT
T1021	HH AIDE OR CN AIDE PER VISIT	09/01/2014	09/01/2015	850	200	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
												ADD CANCEL

Figure 219

6. The following data may be modified:
   - Procedure start and end dates
   - Units
   - Units per Month
   - Amount
   - Cost Sharing

7. After modifying data, click **Save** at the end of the procedure line.

8. 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.



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	
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
												ADD CANCEL

Figure 220

9. To submit the changes made to the PA, go to the bottom of the page and click **Review Request**.

10. Then click **I Agree** to the *Attestation Statement* again, and then **Submit Request**. **The PA is modified but the authorization ID remains the same.**

2.18 Community Care Services Program (CCSP) Level of Care

Program - CCSP	Authorization Period
Level of Care and Placement	Initial and Reassessment: Up to one year

Table 22

2.18.1 Description

Level of Care (LOC) and Placement requests for initial admission and reassessment under the Community Care Services Program (CCSP) are submitted via the Georgia 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.

2.18.2 CCSP LOC Instructions

Follow these instructions to enter CCSP Level of Care and Placement request:

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 **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**.

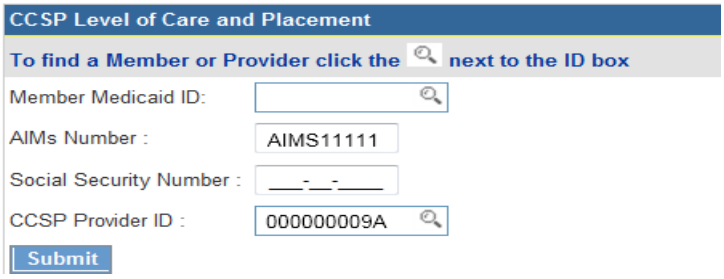


Figure 221

6. Click **Submit** to open the *Level of Care and Placement* request form.

Provider/Member Information:

When the request form opens, the requesting provider information is auto-populated. Member information is also populated according to these guidelines:

7. 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.

8. 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.

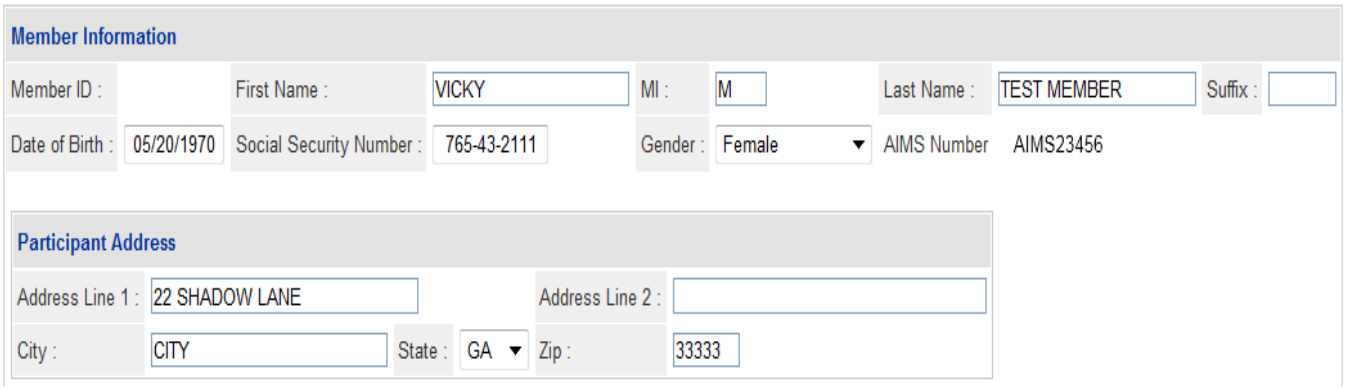


Figure 222

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.

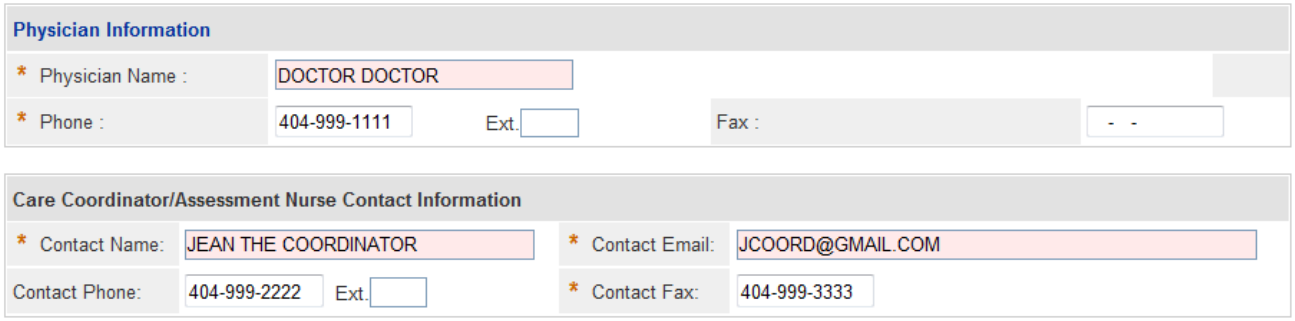


Figure 223

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.

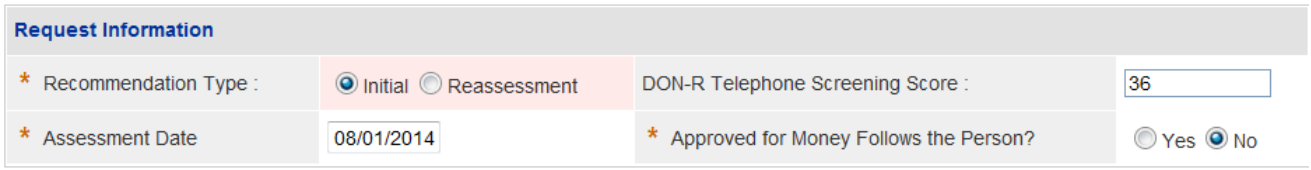


Figure 224

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**.

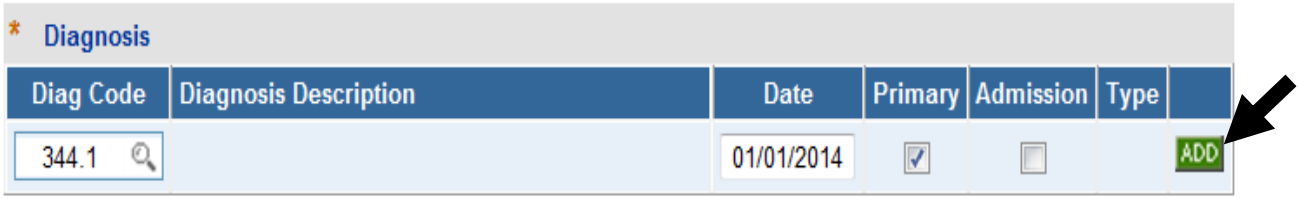


Figure 225

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.

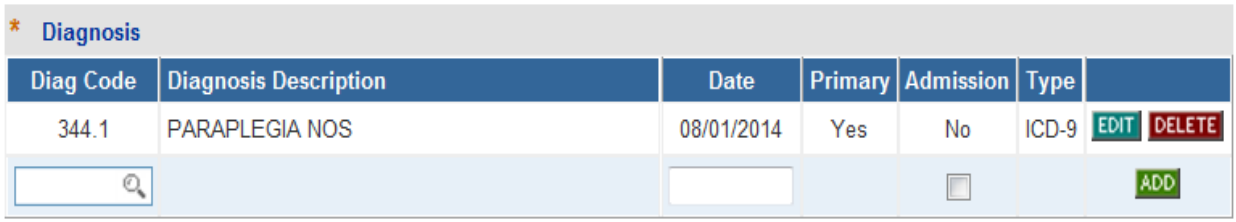


Figure 226

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.

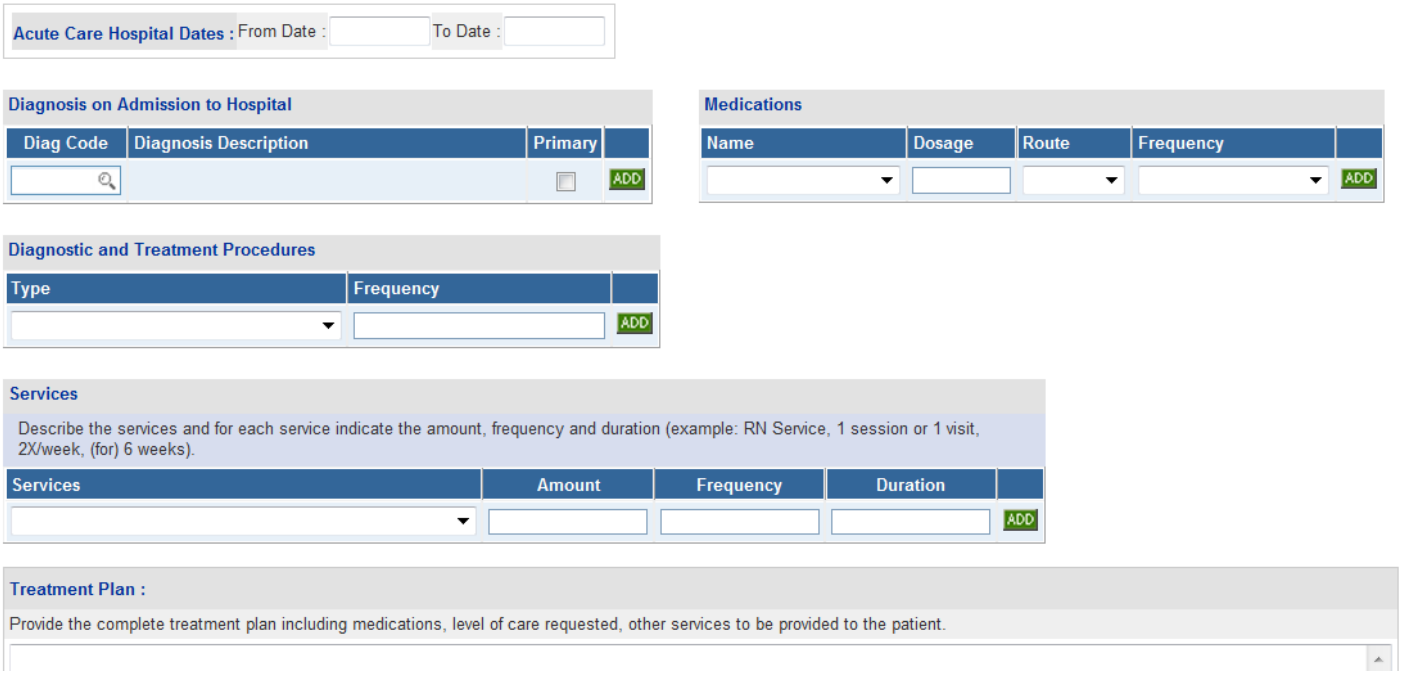


Figure 227

24. 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*.

25. Click **I Agree** in response to the *Attestation Statement.* This must be done before the request can be submitted.

26. Next, click **Submit Request**.

27. 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:

To attach documents, go to **Create an Attachment** (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.

29. To attach a file related to a specific required document or documents, first click the document type checkbox or checkboxes.

30. Click **Browse** and find the file saved to your directory.

31. 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.

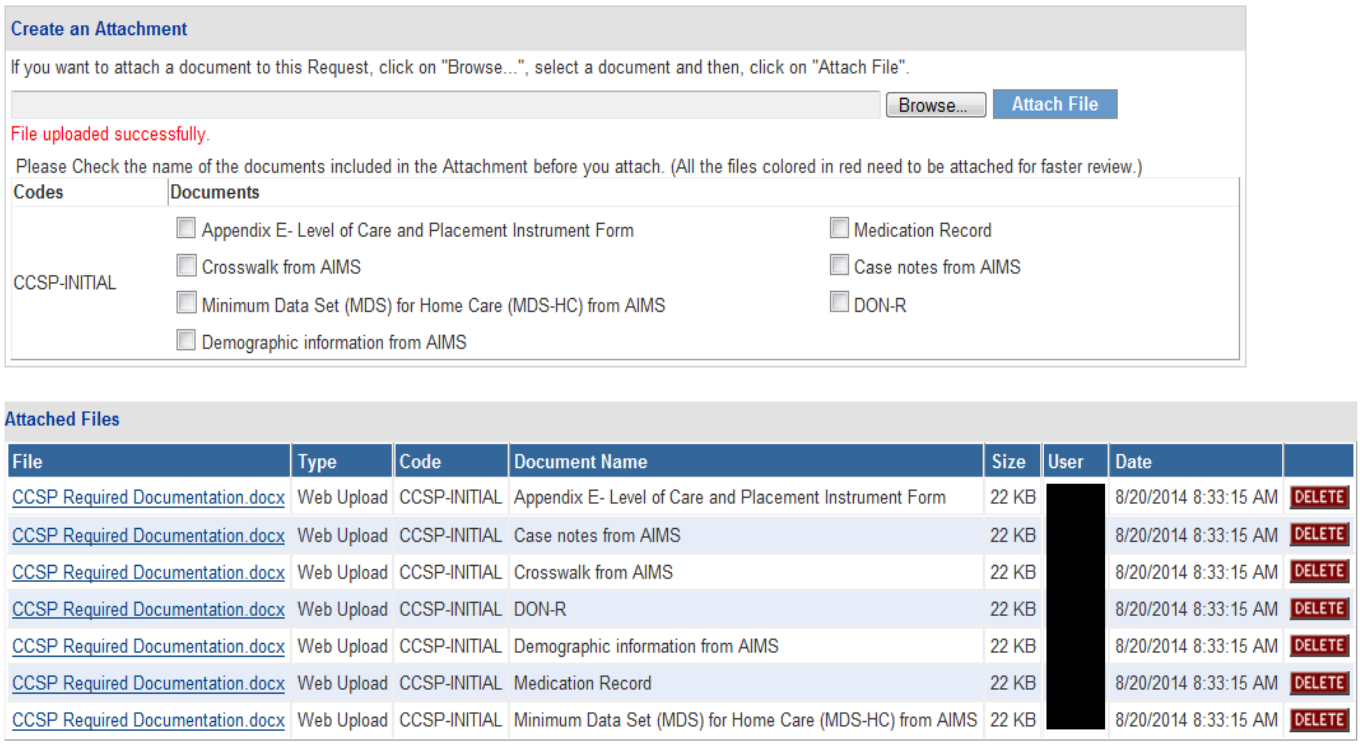


Figure 228

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.

2.18.3 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**.

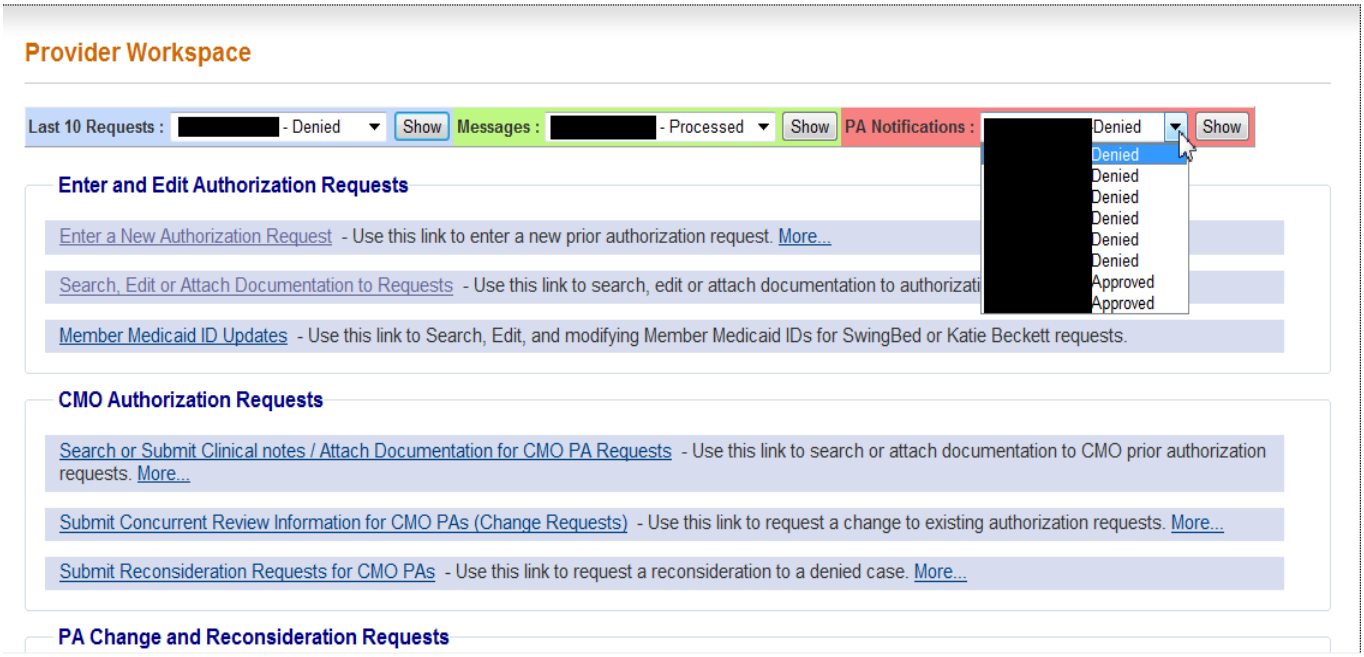


Figure 229

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. **Note:** This section is missing from the screen shot below.

- **Request Information:** This section shows the specific type of decision and decision date.

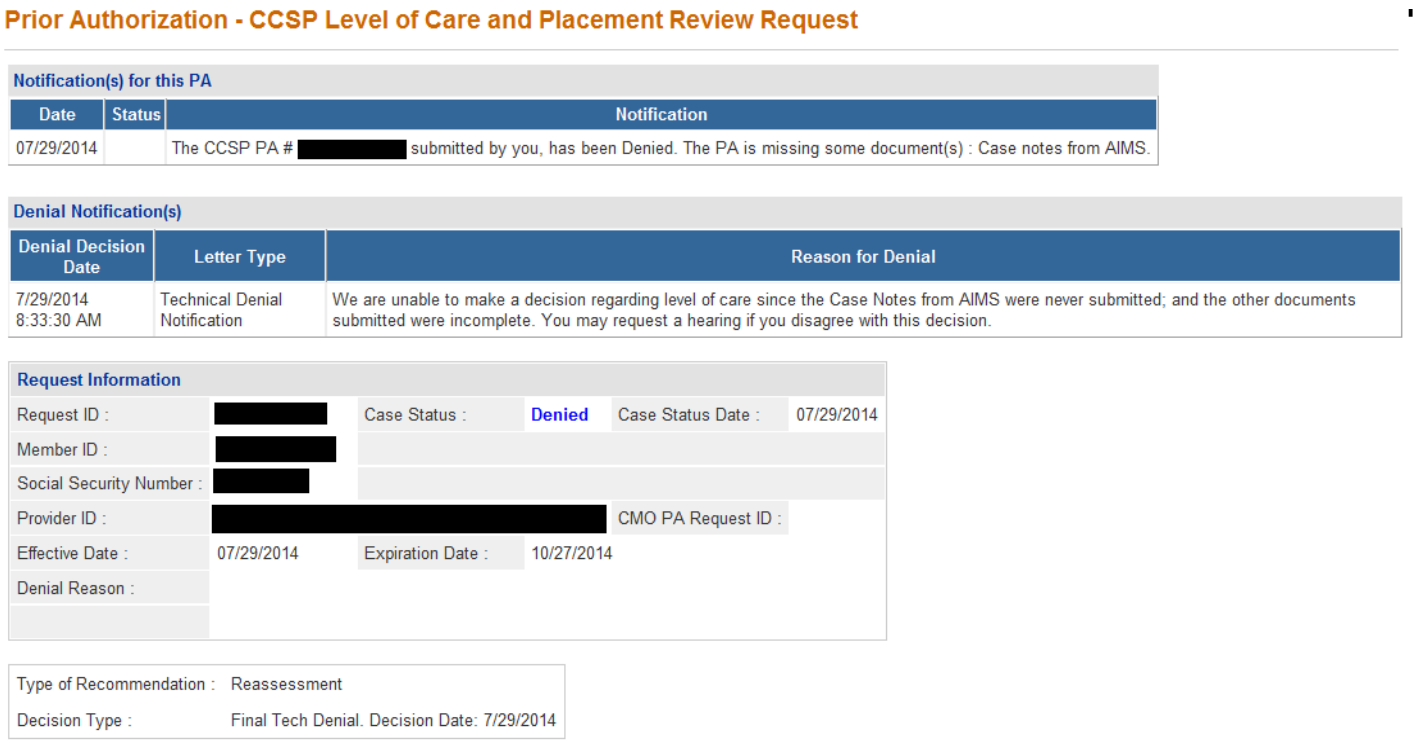


Figure 230

2.19 NOW and COMP Level of Care and Placement

Program - CCSP	Authorization Period
Level of Care and Placement	Initial and Reassessment: Up to one year

Table 23

2.19.1 Description

Level of Care (LOC) and Placement requests for initial placement and reassessment under the Comprehensive Supports Waiver Program (COMP) and the New Options Waiver (NOW) are submitted via the Georgia Web portal by the DBHDD regional offices (the regional office is referred to as the 'provider' in these instructions). Although NOW and COMP are two separate PA types, the process used to submit a NOW LOC is the same process used to submit a COMP LOC. In addition to the LOC online form, additional supporting documentation must be attached. 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.

2.19.2 NOW and COMP LOC Instructions

Follow these instructions to enter a NOW or COMP Level of Care and Placement request:

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.

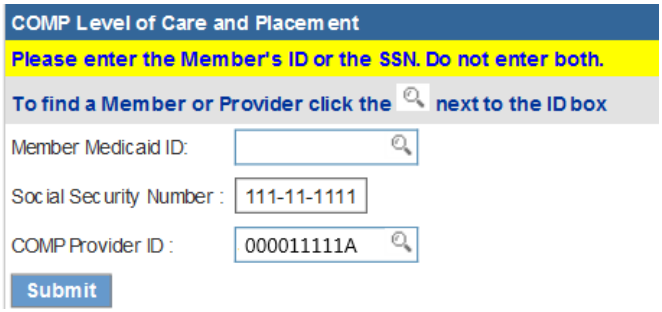


Figure 231

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.

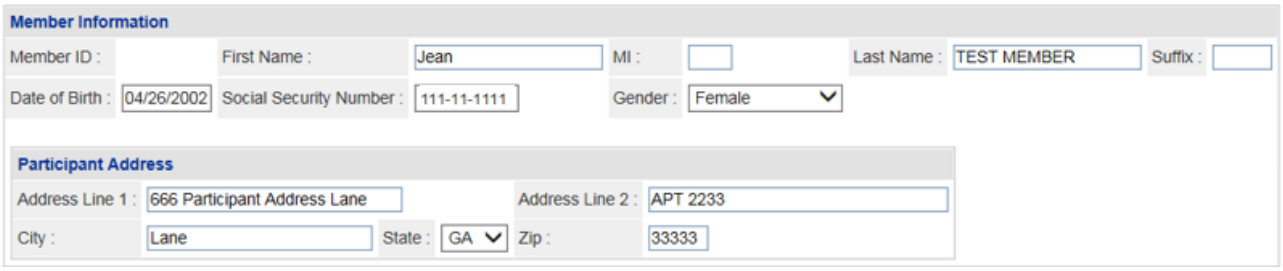


Figure 232

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.

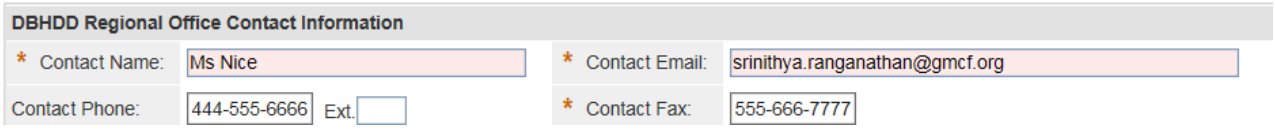


Figure 233

Request Information:

10. Select *Initial* (initial placement) or *Reassessment* (continued placement) as the 'Recommendation Type'. This is required.

11. 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.

12. If known, select *Yes* or *No* for MFP approval. Otherwise, leave blank – this is an optional field.

Figure 234

Diagnosis:

This section captures the participant's primary diagnosis or diagnoses related to NOW or COMP participation. At least one diagnosis is required.

13. Enter the diagnosis code for the participant's primary diagnosis in the 'Diagnosis Code' box. System populates the description.

14. Enter the date that the diagnosis was established. If not known, enter today's date.

15. Click the 'Primary' checkbox.

16. Click **Add**.

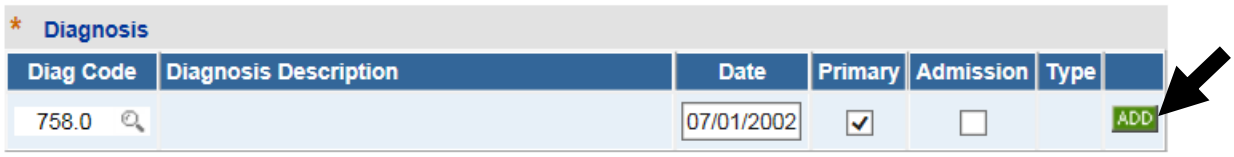


Figure 235

17. 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.

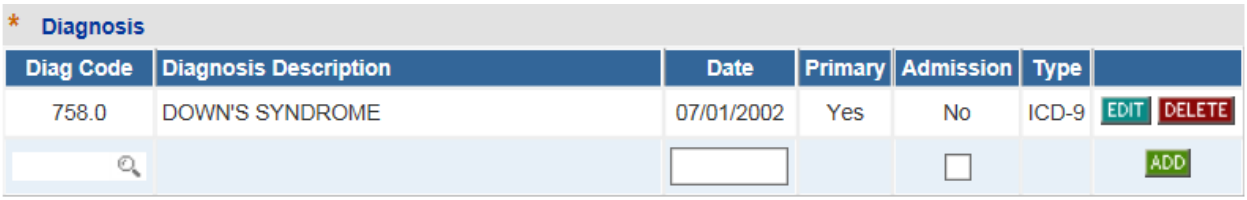


Figure 236

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.

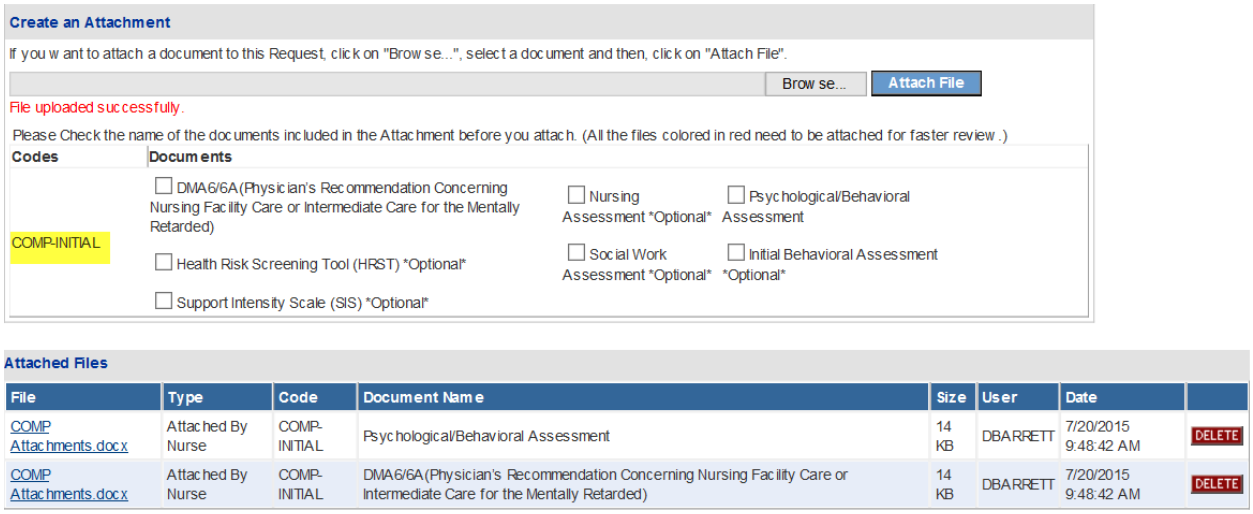


Figure 237

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.

2.19.3 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:

18. To view decision details, open the *Provider Workspace* and click **Search, Edit or Attach Documentation to Requests**.

19. Search for the LOC by entering the 'Request ID' and clicking **Search**. Then, click the PA that displays in the search results.

    -OR-

20. 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**.

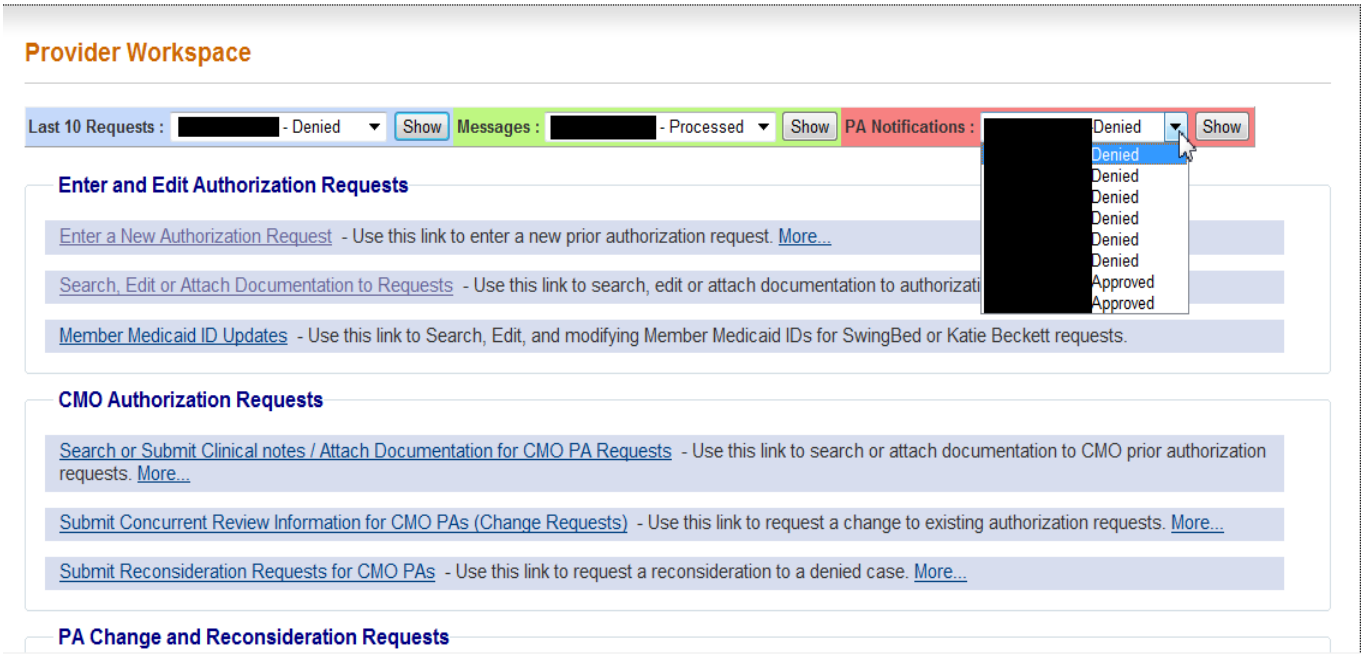


Figure 238

21. 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.

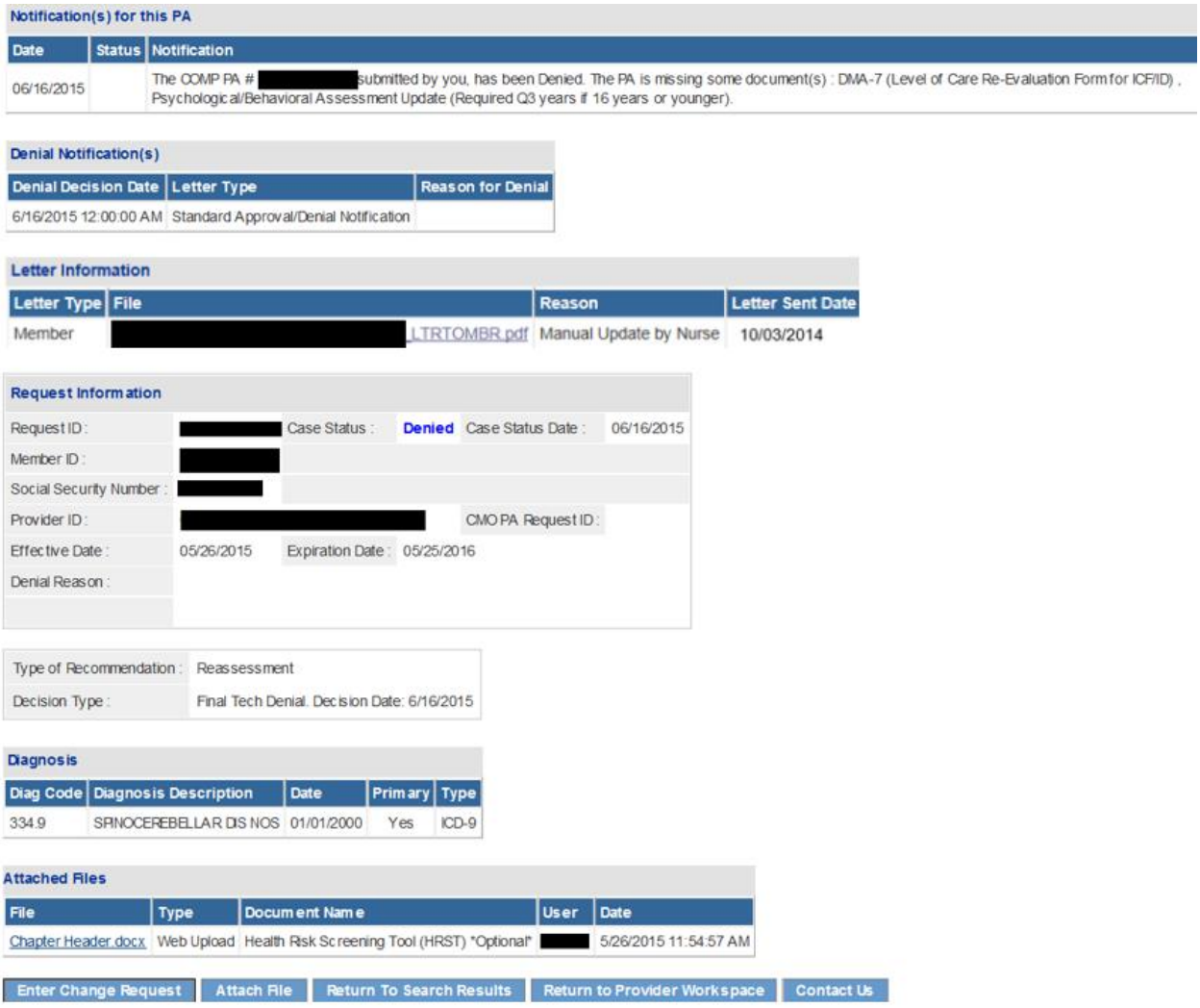


Figure 239

2.20 Georgia Pediatric Program (GAPP)

Program	Authorization Period
Georgia Pediatric Program DMA6A	One year
Georgia Pediatric Program DMA80	Up to six months

Table 24

2.20.1 Description

Requests for level of care and service authorizations under the Georgia Pediatric Program may be 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 970 GAPP COS; a 971 GAPP In-Home Private Duty Nursing COS; or a 972 Medically Fragile Daycare COS. There must be an approved GAPP DMA-6A in the system before a DMA-80 may be entered.

2.20.2 Web Entry Instructions

GAPP DMA-6:

Follow these instructions to enter a Georgia Pediatric Program DMA-6A:

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. 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.**

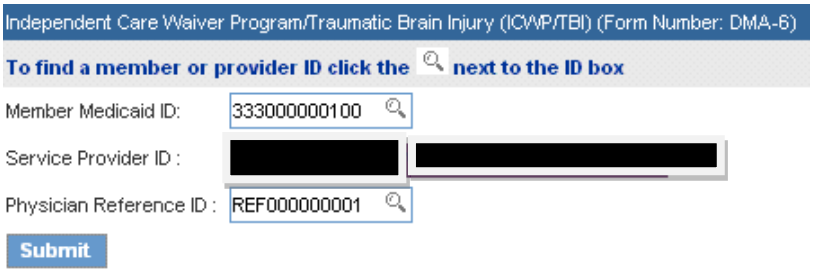


Figure 240

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

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. If the physician Reference number was entered, the physician information is also system populated.

9. If the physician Reference number was not entered, enter the name of the physician in the **Physician Information** section.

Contact Information:

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.

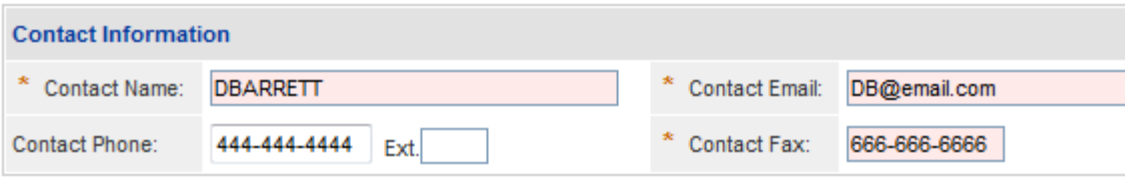


Figure 241

Request Information:

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

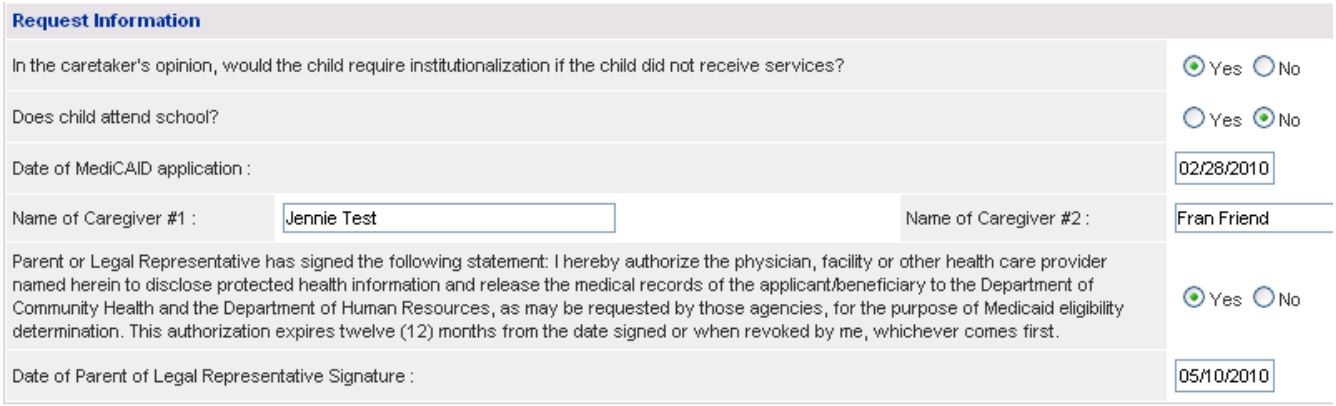


Figure 242

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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. Enter the date manually or select from the calendar popup.

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.

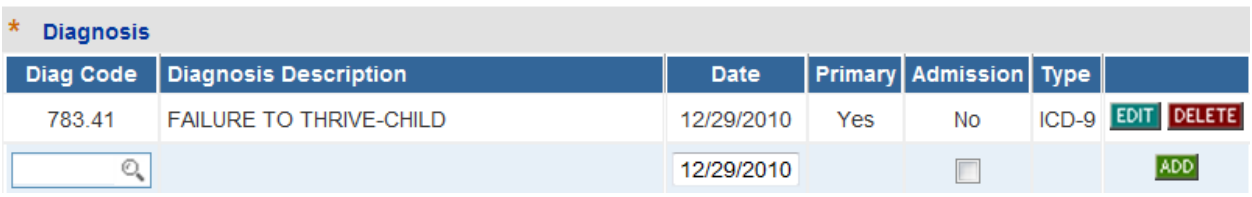


Figure 243

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

Diagnosis on Admission to Hospital:

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

Figure 244

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

Medications and Diagnostic/Treatment Procedures:

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. **Remember to click Add after each entry.**

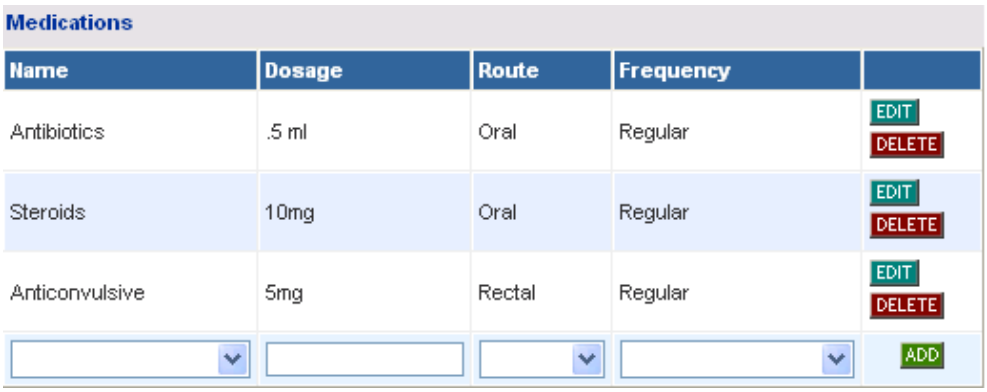


Figure 245

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.

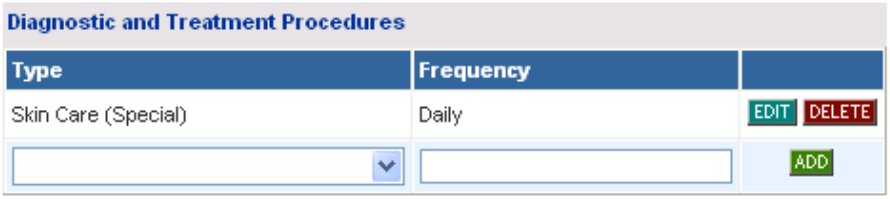


Figure 246

31. Repeat the process to add other diagnostic/treatment procedures. **Remember to click Add after each entry**.

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.

32. Enter the information in the textbox. When data has been entered to the bottom of the visible text box, the scroll bar will activate. Click the up or down arrow on the scroll bar to navigate up or down in the text box.

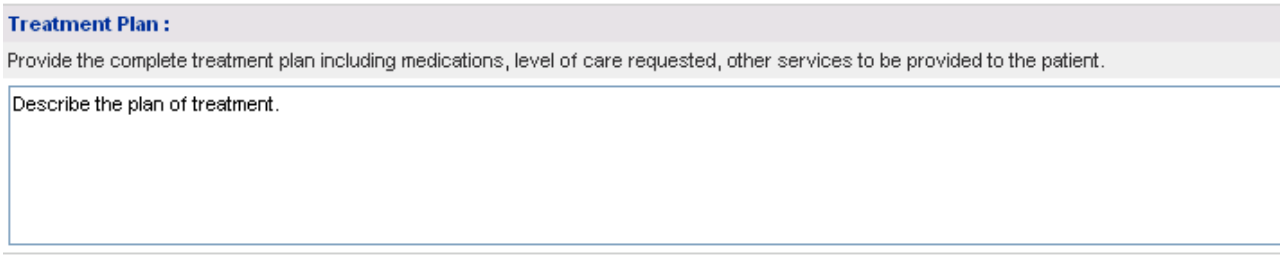


Figure 247

Level of Care and Care Recommendations:

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. Enter manually or user the calendar popup.

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; and, **if *Temporary* selected**, enter the estimated months of temporary care in the box provided.

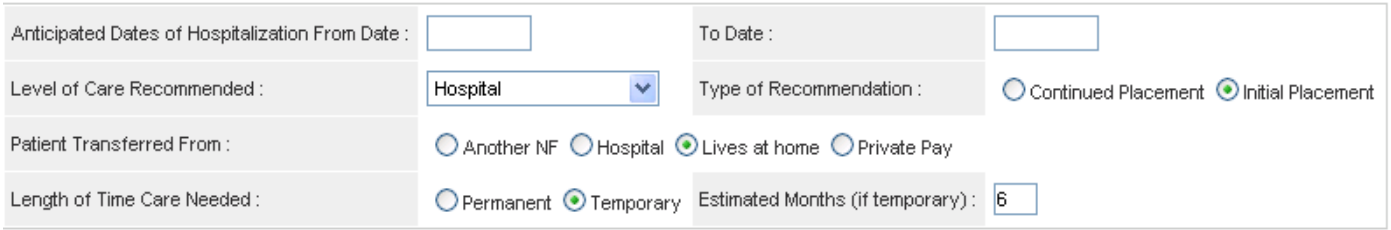


Figure 248

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.

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 are system populated based on the physician's Reference number entered on the *New Request for Prior Authorization* page. Enter the date that the DMA-6A was signed by the member's physician in the 'Date Signed by Physician' box.

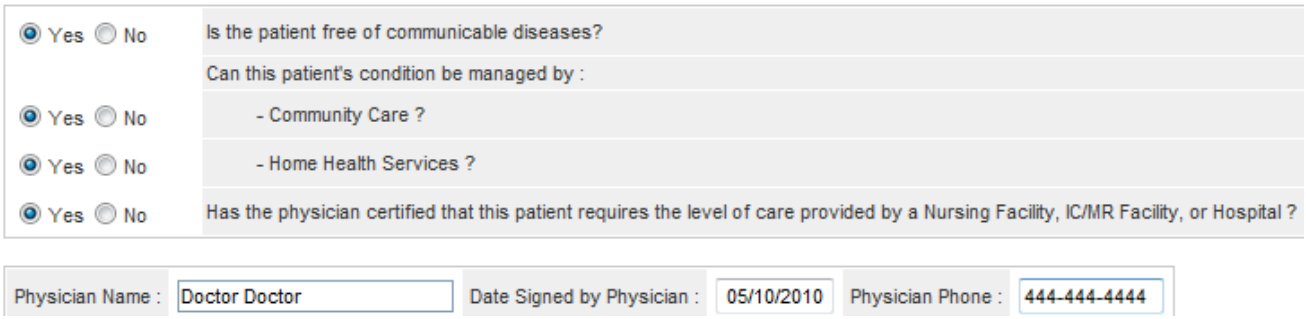


Figure 249

Evaluation of Nursing Care Needed:

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

43. 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.

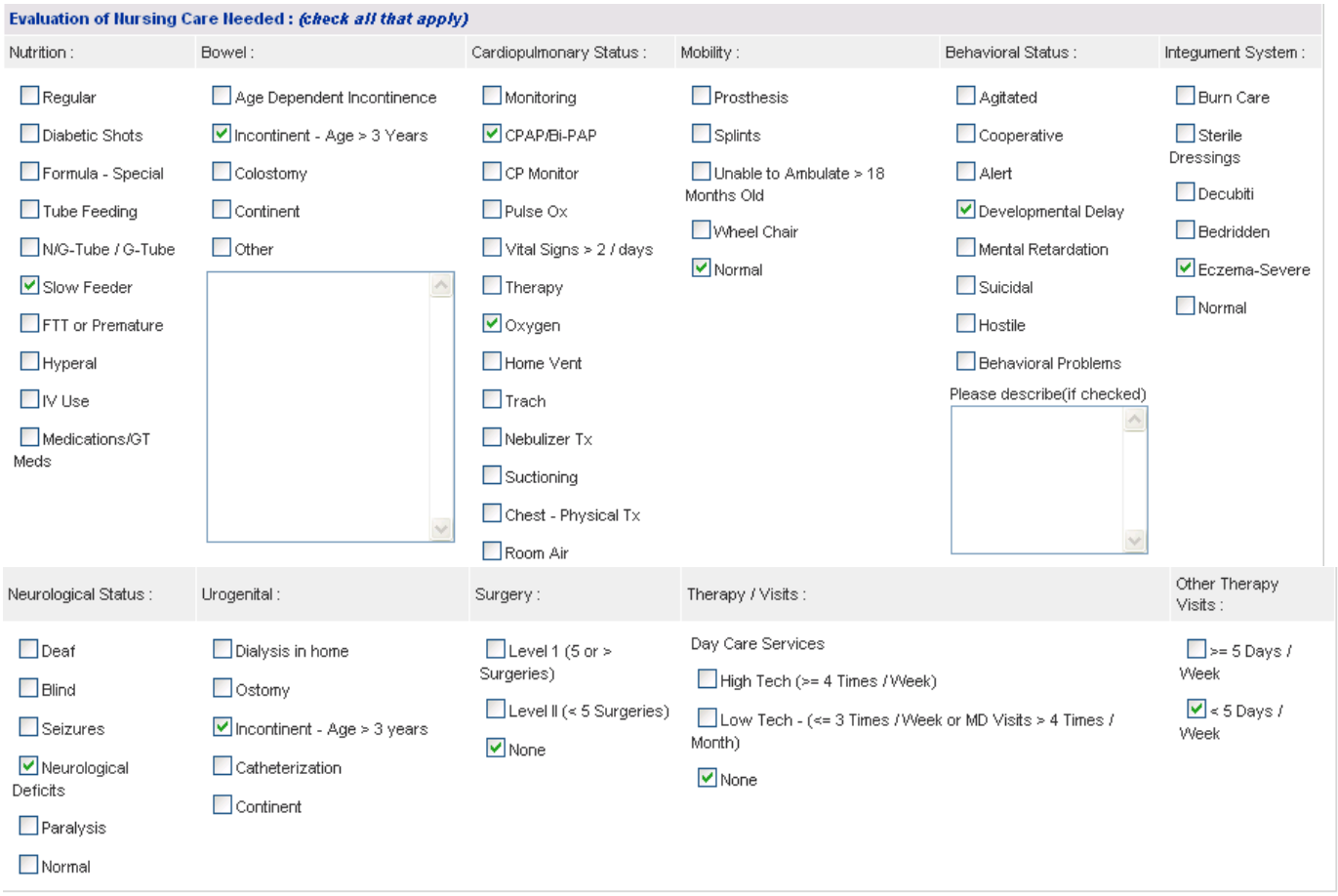


Figure 250

Remarks:

Additional information or explanations regarding the nursing care, medications, diagnostic and treatment procedures or services needed may be entered in the 'Remarks' text box. When data has been entered to the bottom of the visible text box, the scroll bar will activate. Click the up or down arrow on the scroll bar to navigate up or down in the text box.

Signature:

44. Enter the first name and last name of the physician or nurse who signed the DMA-6A in the box provided; and the date signed in the 'Date Signed' box. Enter manually or use the calendar popup.

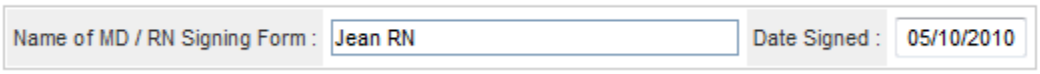


Figure 251

45. 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.

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

47. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.

GAPP DMA-80:

Follow these instructions to enter a Georgia Pediatric Program DMA-80:

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. 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.

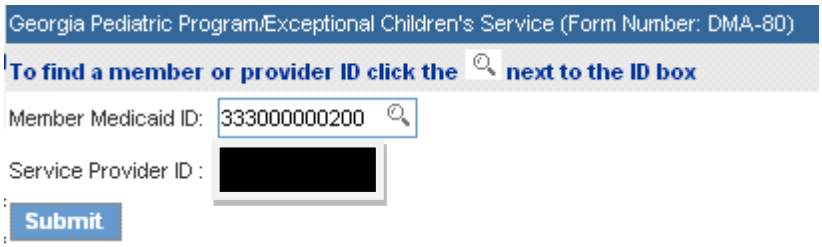


Figure 252

6. Click **Submit** to open the *DMA-6A Confirmation* page.

7. Enter the approved DMA-6A authorization number in the 'DMA-6 Prior Authorization Confirmation Number' box.

Figure 253

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.

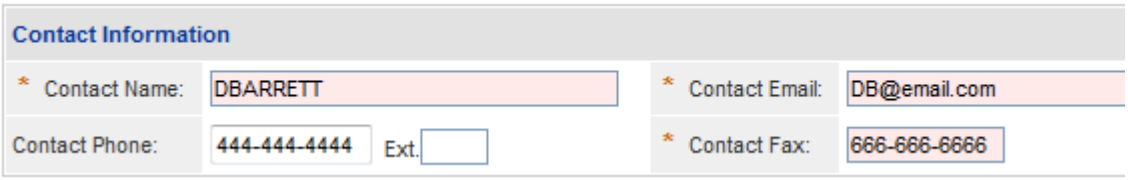


Figure 254

Request Information:

This section captures the location where GAPP services are to be provided, and the 'GAPP Member ID' (system populated).

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.

Figure 255

Diagnosis Table:

The Diagnosis table captures the diagnosis code, code description (system populated), diagnosis date, diagnosis type, 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. Enter the date manually or select from the calendar popup.

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.

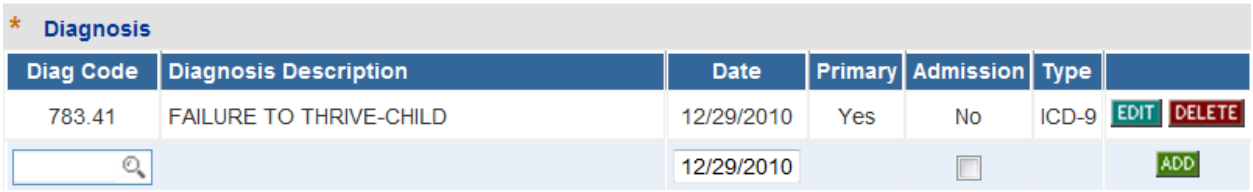


Figure 256

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 line in the *Procedures Table* represents one month (or part of a month).

16. Enter the code for the service requested in the 'Service Code' box.

17. 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. Enter the date manually or select from the calendar popup. The start and end dates should be within the same month.

18. Enter the units of service to be provided each week in the 'Requested Units/Week' box.

19. Enter the units of service to be provided each day in the 'Requested Units/Day' box.

20. Enter the number of units of service to be provided each month in the 'Requested Units/Month' box.

21. Enter a modifier in the 'Mod 1' box if applicable to the service requested. The following GAPP services require a modifier: High Tech Level II daycare – T2027 TG; One way transport up to 20 miles – T2002 TN; and Round trip transport up to 40 miles – T2003 TN.

22. Click the **Add** at the end of the procedure line to add the service information to the request.

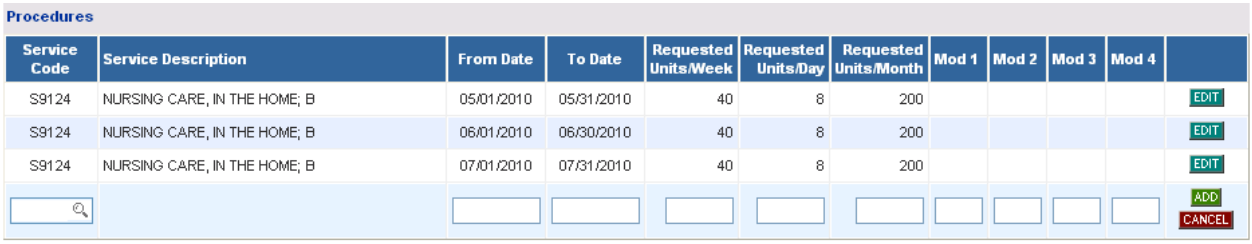


Figure 257

Program Information:

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

23. **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'.

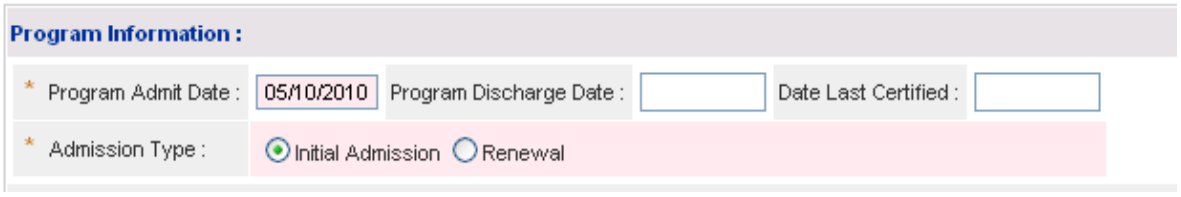


Figure 258 GP-80 Admission Type/Initial

24. **Renewals**: 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 *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.

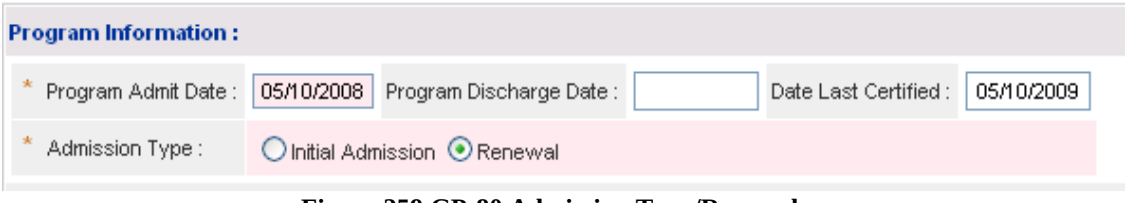


Figure 259 GP-80 Admission Type/Renewal

***Initial or Renewal Comments*:**

25. 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.

26. Describe the services and frequency of services that have been ordered in the 'description of Services' box. When data has been entered to the bottom of the visible text box, the scroll bar will activate. Click the up or down arrow on the scroll bar to navigate up or down in the text box.

27. Describe why the ordered services are medically necessary in the 'Justification and Circumstances' box. When data has been entered to the bottom of the visible text box, the scroll bar will activate. Click the up or down arrow on the scroll bar to navigate up or down in the text box.

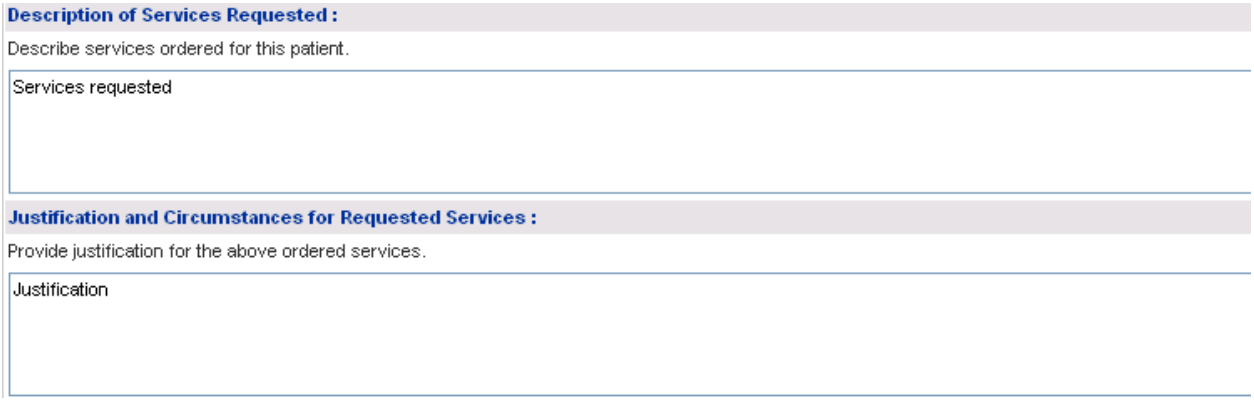


Figure 260

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.

28. 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.

29. 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.

30. Indicate whether or not there is a signed letter of Notification on file by clicking *Yes* or *No*.

31. Indicate whether or not there is a completed Private Duty Summation Sheet by clicking *Yes* or *No.*

32. Indicate whether or not there is a signed Caregiver Competency Checklist for the primary caregiver by clicking *Yes* or *No*.

33. Indicate whether or not there is a signed Caregiver Competency Checklist for the secondary caregiver by clicking *Yes* or *No*.

34. 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.

35. 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.

36. Indicate whether or not the child is in foster care by clicking *Yes* or *No*.

37. 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.

38. Enter the date that the child was evaluated for services in the 'Assessment Date' box.

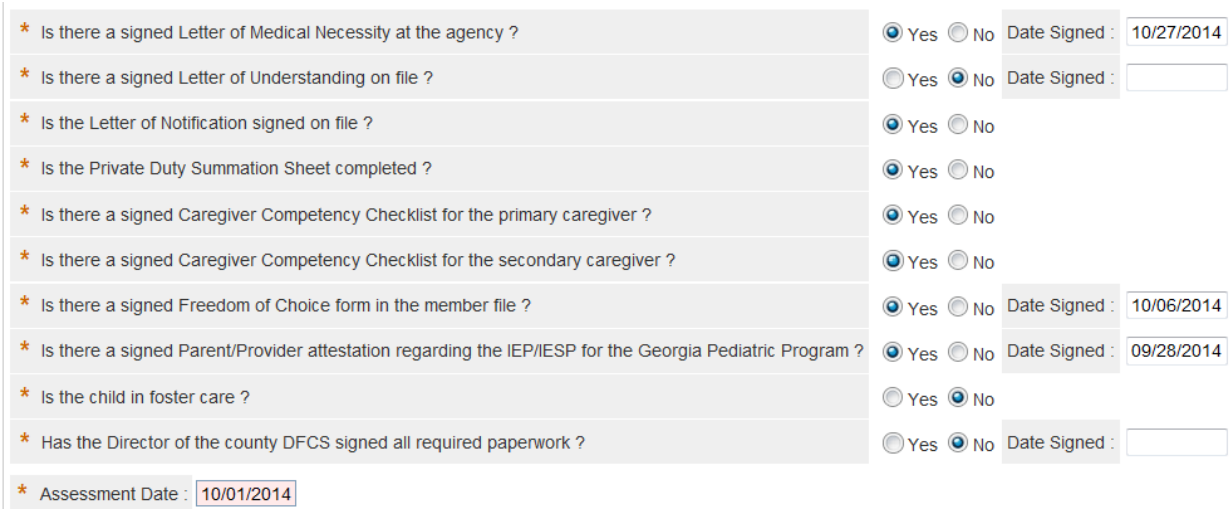


Figure 261

Medications Table:

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

39. To enter medication information, first select the medication type by selecting a type from the 'Name' drop list.

40. Enter the dosage for the medication in the 'Dosage' box.

41. 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. **Remember to click Add after each entry.**

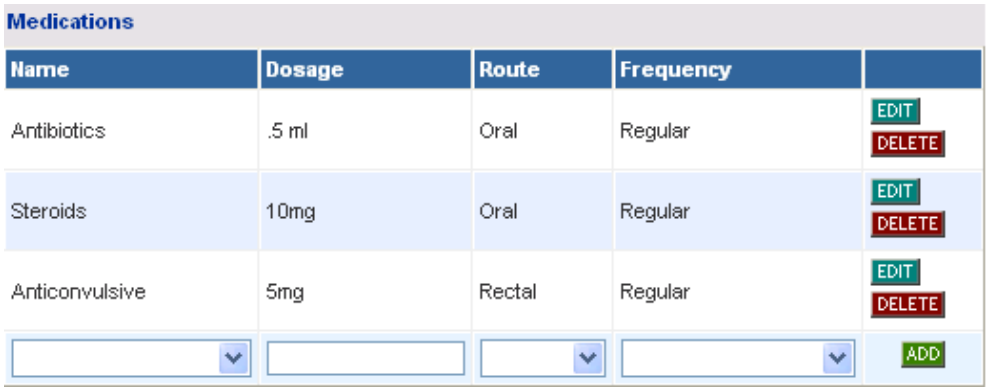


Figure 262

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).

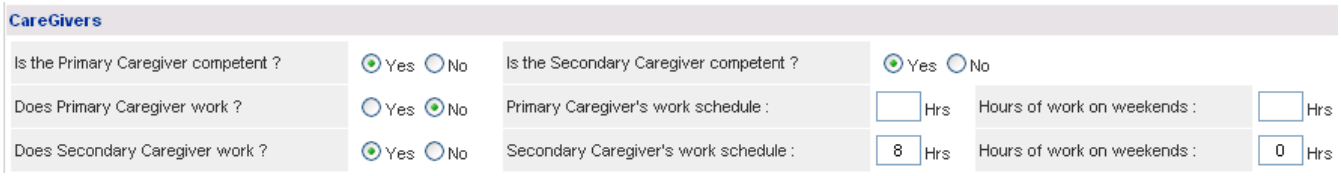


Figure 263

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'.

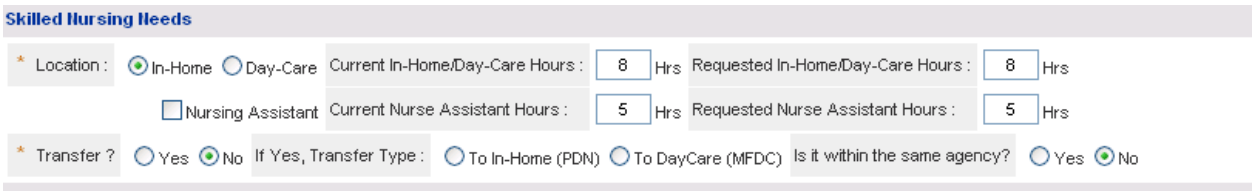


Figure 264

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.

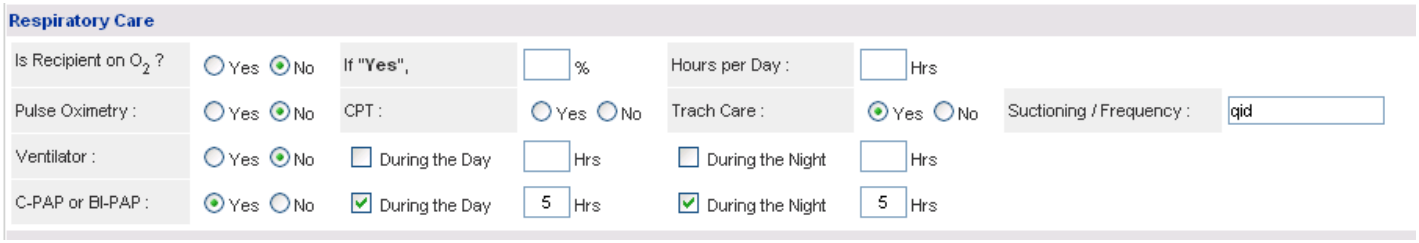


Figure 265

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. If there are no special precautions, enter *None*.

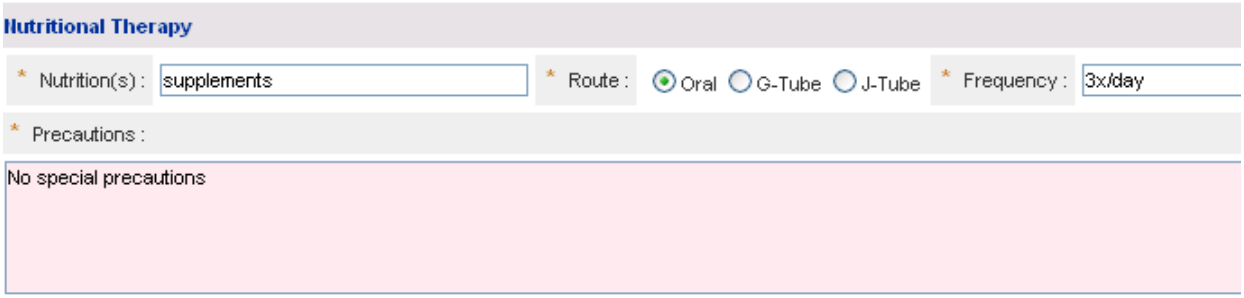


Figure 266

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.

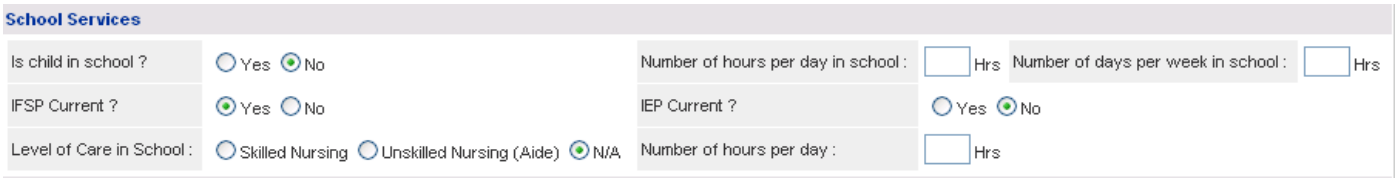


Figure 267

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.

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.

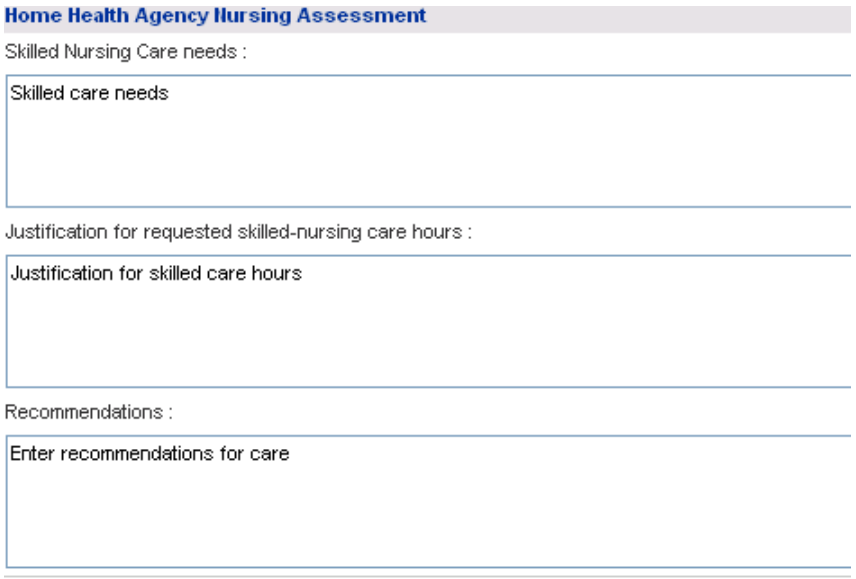


Figure 268

82. 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.

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

84. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.

85. On the page that displays the pending PA ID when the request is submitted, the user may attach required documents under **Create an Attachment;** and associate the file attached to the document type.

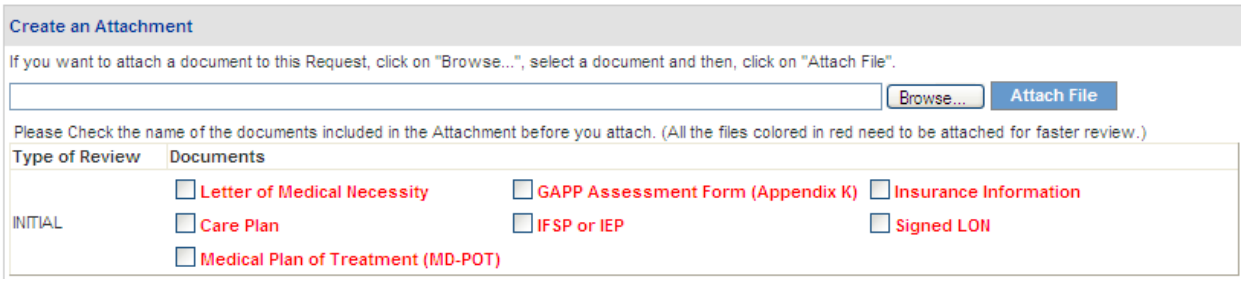


Figure 269

2.21 TEFRA/Katie Beckett DMA6A

Program	Authorization Period
Katie Beckett DMA6A	Generally one year but may be approved for up to 3 years

Table 25

2.21.1 Description

TEFRA/Katie Beckett waiver packets and DMA6As are enter via the web by the RSM Medicaid Unit. The submission process consists of two components:

- Participant/packet entry for new and existing participants
- DMA6A request entry

2.21.2 Web Entry Instructions

1. Log into the **Georgia Web Portal.**
2. On the portal *Secure Home* page, select **Prior Authorization** from the links at the top of the page.

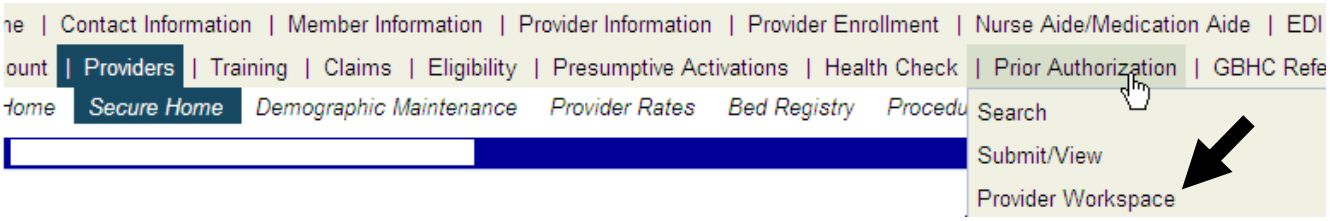


Figure 270

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** to open a search page.

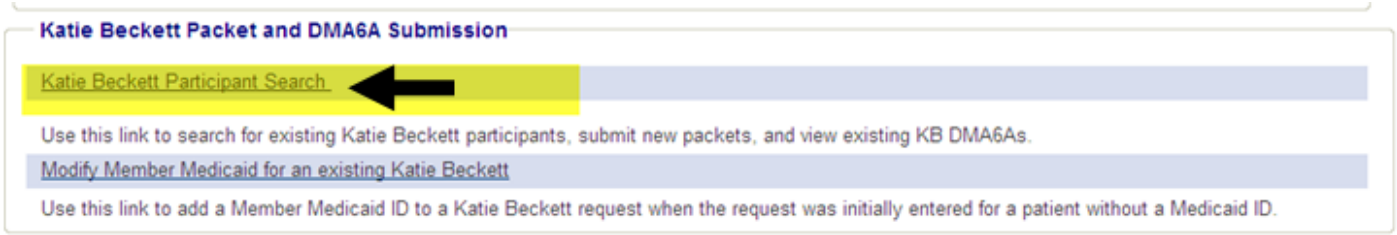


Figure 271

22. Search for the participant first to avoid entering duplicate information. 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.

23. **First, attempt a search by using the SSN only**. Enter the 9 digit SSN in the box provided. Then, click **Search**.

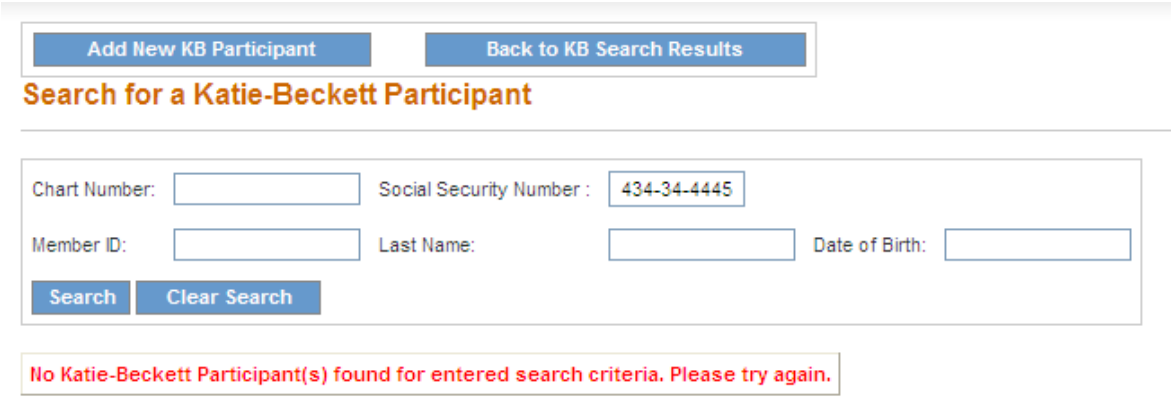


Figure 272

24. 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**.

25. 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 using the calendar popup or enter manually as mm/dd/yyyy**.**

26. 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 exist, do not enter a new participant but notify GMCF using 'Contact Us'.

Add a New Participant/Packet

1. On the search page, click **Add New KB Participant**.

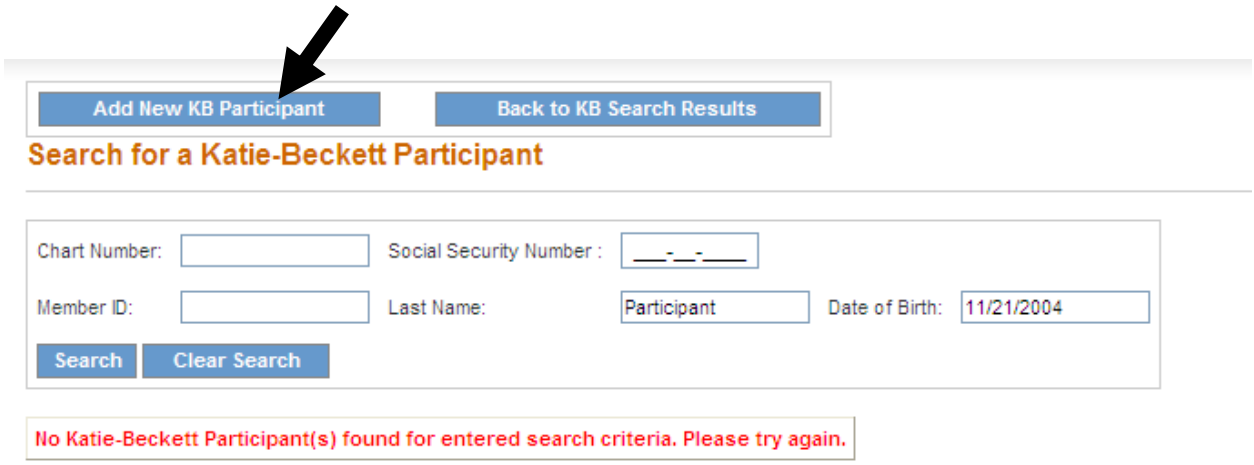


Figure 273

2. The *Katie Beckett Participant Entry* page opens. This page is used to capture and track participant information and packet information.

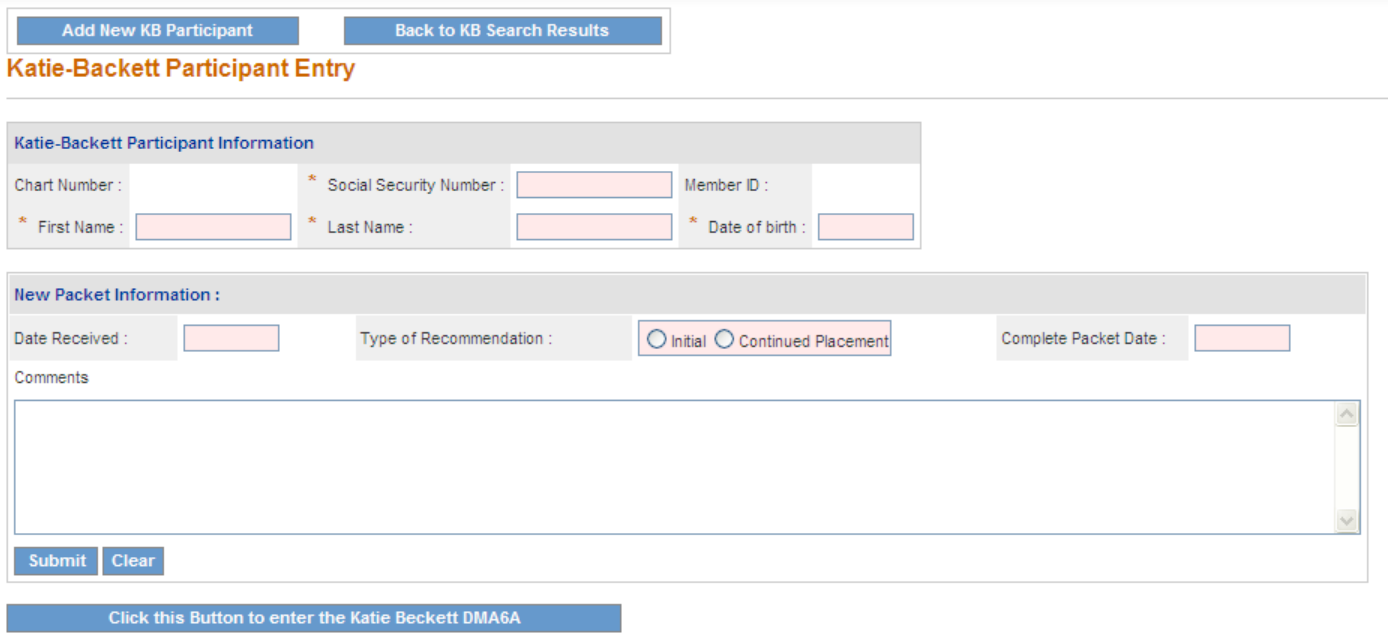


Figure 274

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 by selecting the date from the calendar or manually entering the date as mm/dd/yyyy.

6. In the *New Packet Information* section, enter the date that the packet information was received. Enter the date manually or use the calendar.

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' field is read only**. Once the nurse enters the complete packet date when the case is reviewed, the date will display in this box.

9. Additional information regarding the participant or packet may be entered in the 'Comments' box but this is optional.

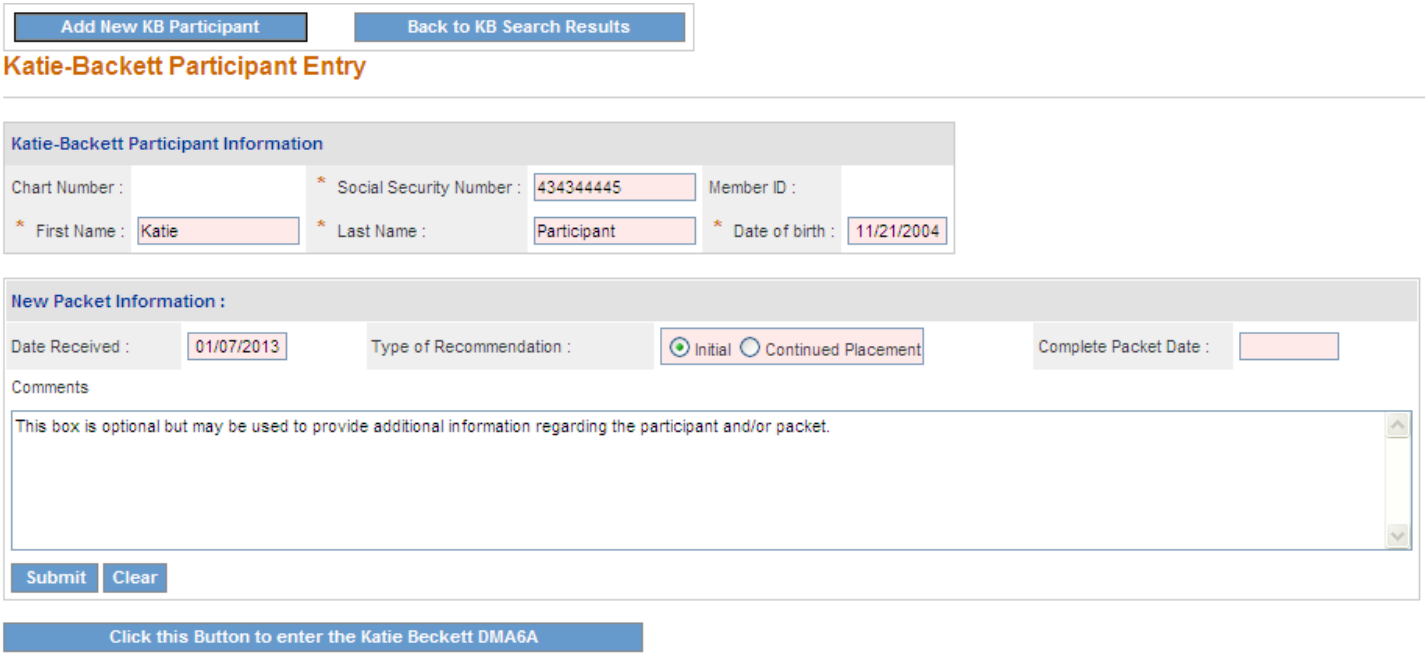


Figure 275

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.

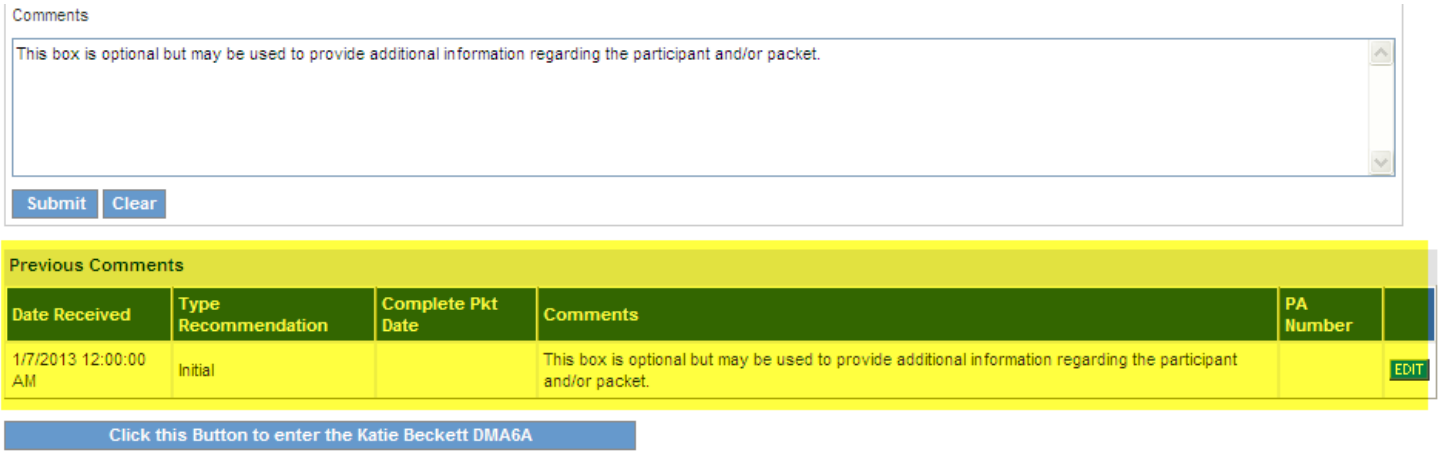


Figure 276

Add a 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.

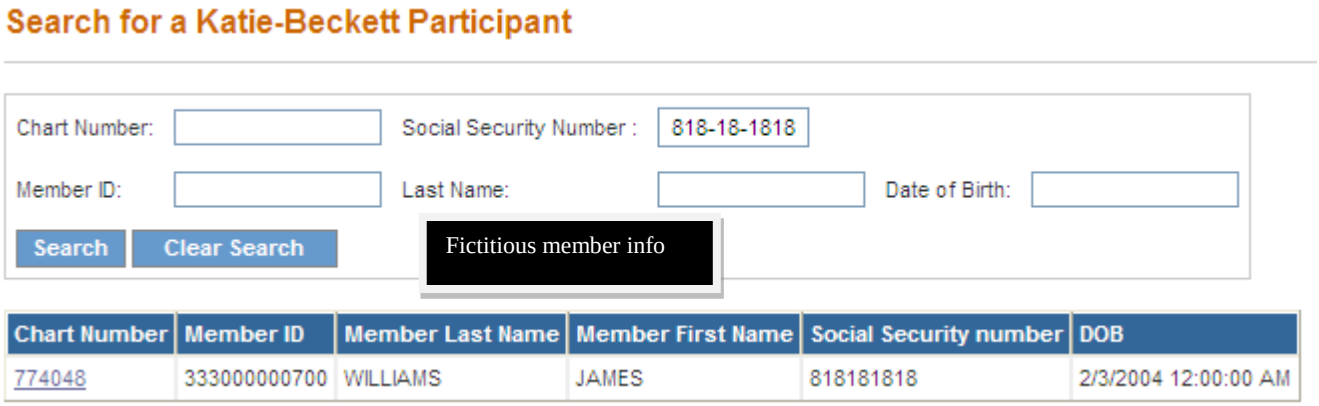


Figure 277

2. Click the **Chart Number** (see previous figure) 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.

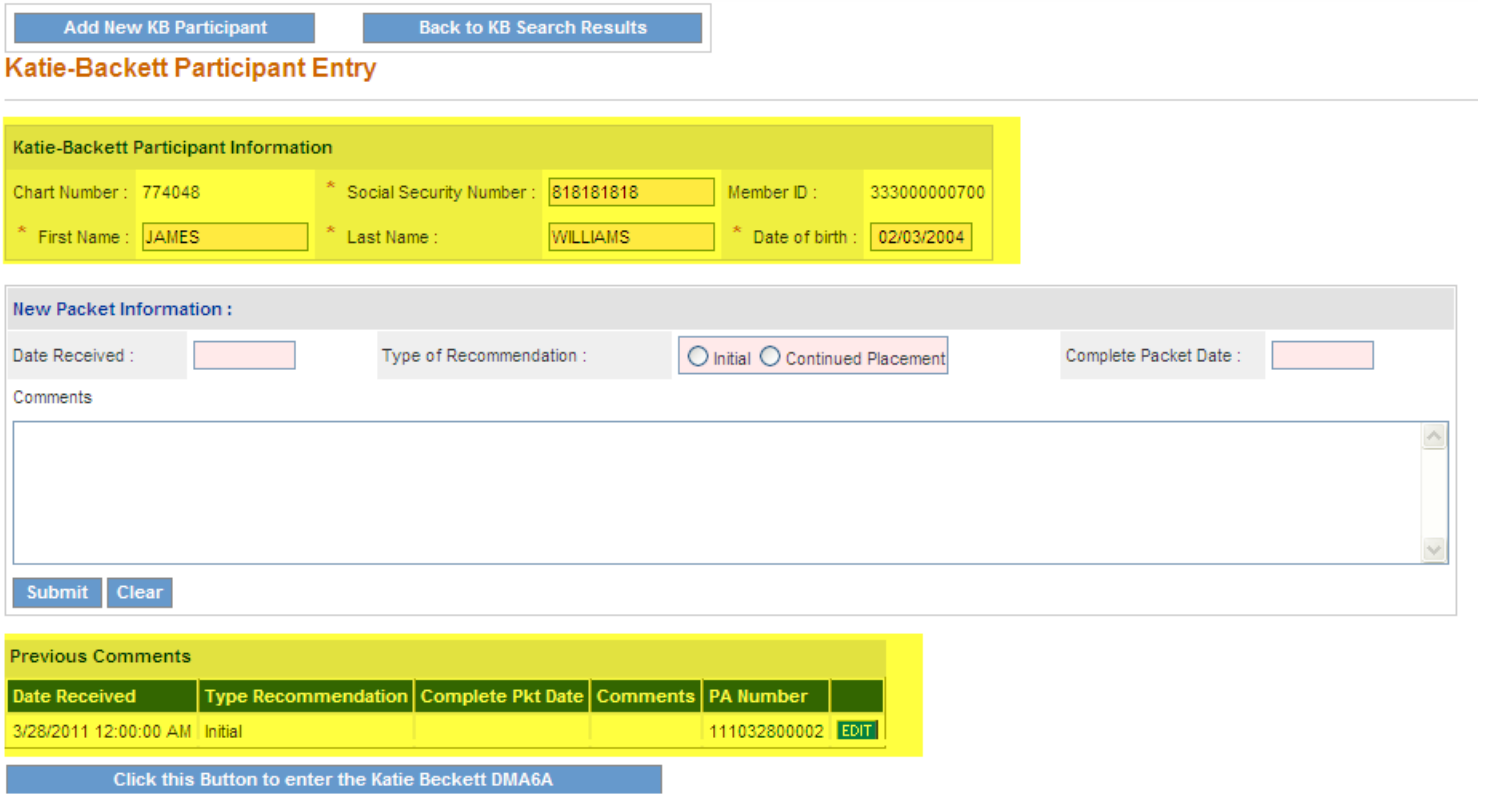


Figure 278

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.

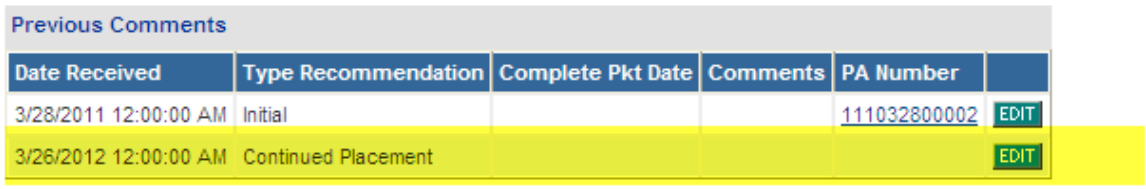


Figure 279

Enter the DMA6A

Enter the DMA6A 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 may 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.

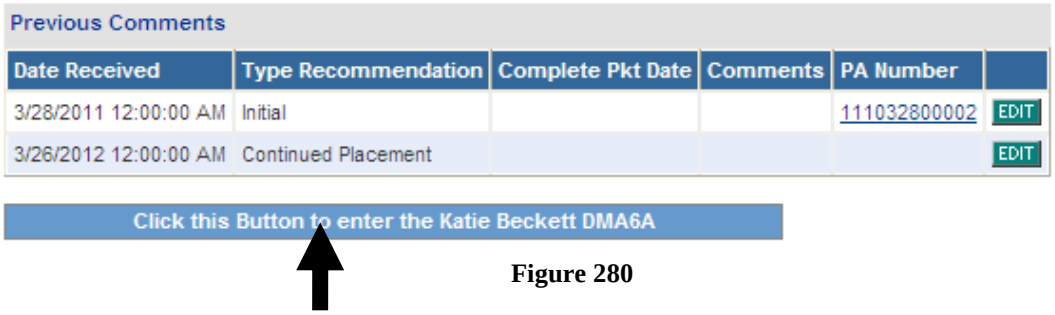


Figure 280

2. On the next screen, click **TEFRA/Katie Beckett (Form DMA-6A)**.

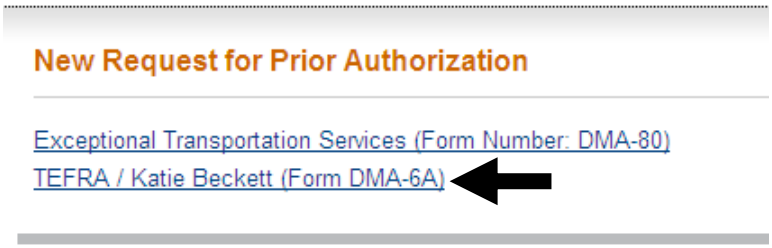


Figure 281

3. The *New Request for Prior Authorization* page opens, which displays the RSM Unit requesting provider ID (provider who logged into the portal). **However, the provider ID may be changed to any DFCS office provider ID with a 380 COS** if the plan is to associate the DMA6A with a specific DFCS office.

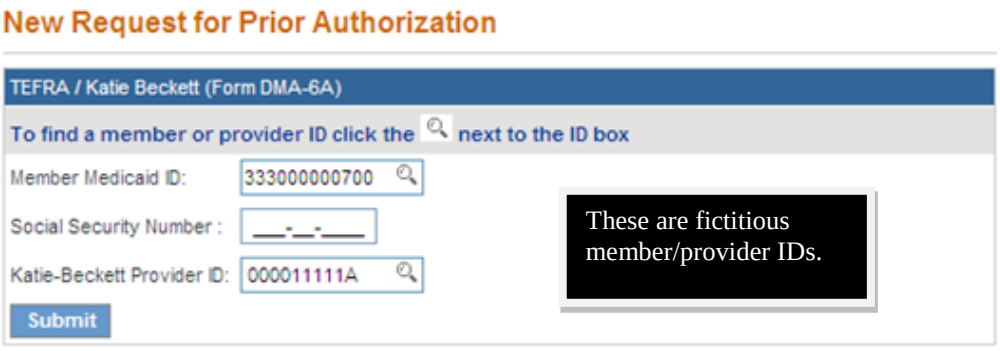


Figure 282

4. This page also displays the participant's SSN (if they are not yet a Medicaid member) **OR** the participant's Member Medicaid ID.

5. **No other member data needs to be entered on this page**. Click **Submit**.

6. 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 as shown in the figure below.

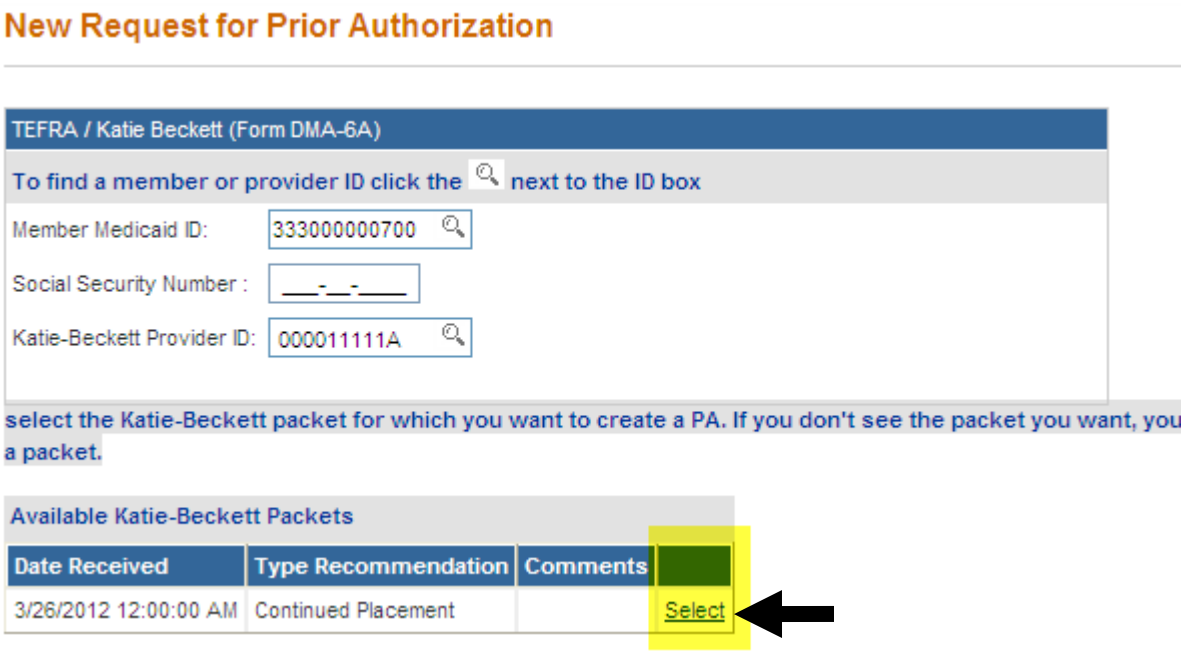


Figure 283

7. Once the packet is selected, the Katie Beckett online form opens. At the top of the form the participant and provider information displays. **The only sections of the form that are required are:**

   - Participant Address (if not system populated based on the Member's Medicaid ID).
   - Contact Information
   - Diagnosis

Participant Address:

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.

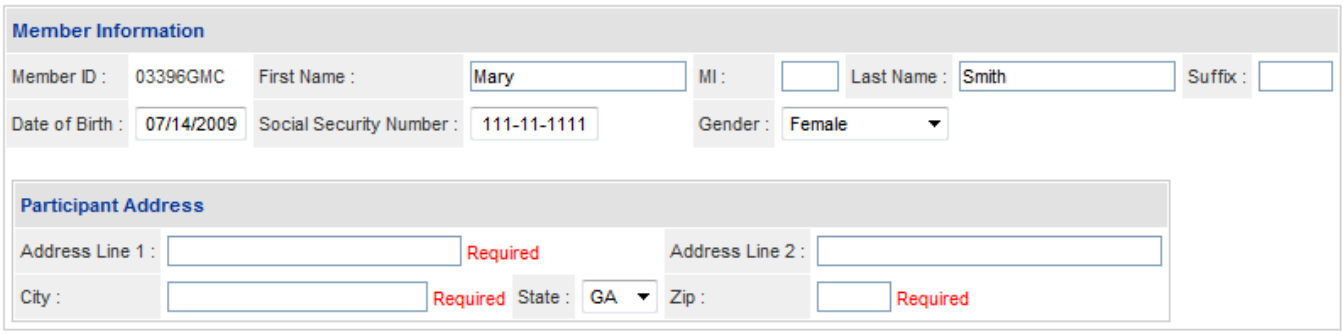


Figure 284

8. 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.

9. Enter the 'City' in the box provided.

10. The 'State' defaults to Georgia.

11. Enter the five (5) digit zip code in the 'Zip' box.

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; but the **information can be edited if not correct.**

Figure 285

12. Review the information carefully and 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.**

Diagnosis Information:

At least one Diagnosis code is required.

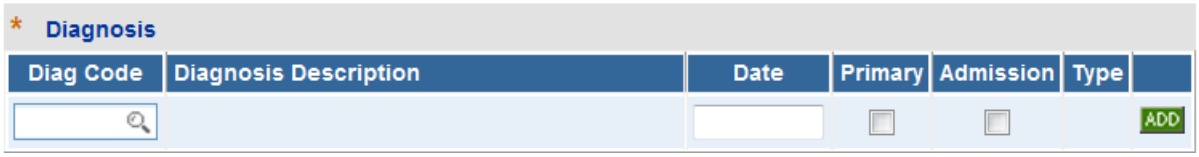


Figure 286

13. 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 such as 343.9.

14. Enter the date that the diagnosis was determined in the 'Date' box. If not known, enter the date that the physician signed the DMA6A.

15. Click the 'Primary' checkbox to indicate that the diagnosis is the primary diagnosis.

16. 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.**

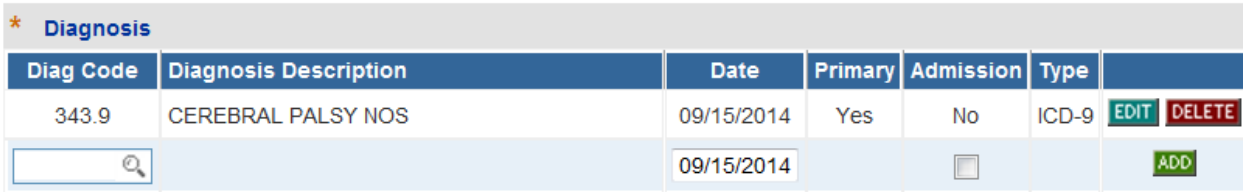


Figure 287

17. Other diagnosis codes may be entered, following the same procedure just described.

18. After the contact information and diagnosis information is complete, go to the bottom of the form and click **Review Request**.

19. The next page displays an Attestation *Statement* (bottom of page). Review the statement carefully.

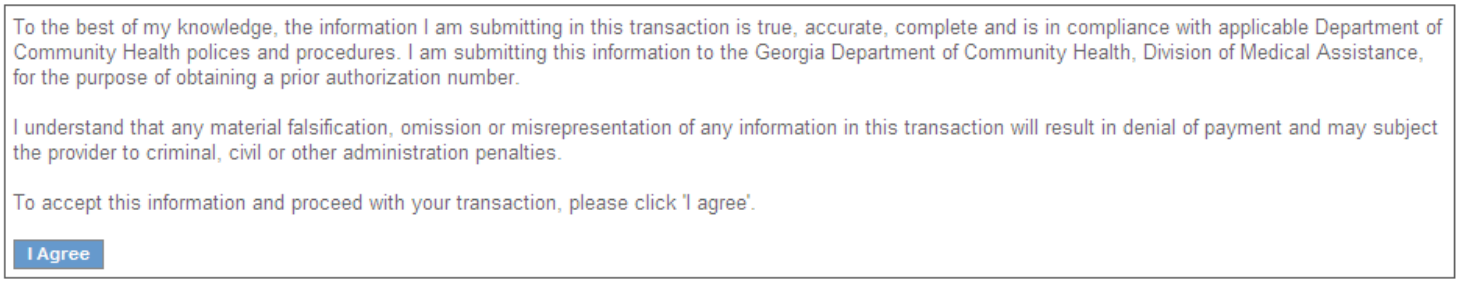


Figure 288

20. In order to proceed, **I Agree** must be clicked to confirm agreement with the statement.

21. When **I Agree** is clicked, the link to submit the request displays at the bottom of the page. Click **Submit Request**.

22. The next page displays the pending 12 digit authorization tracking number (top of the page). This number is also called the Request ID or PA ID. If the DMA6A is approved, this number is the DMA6A authorization number.

23. 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.

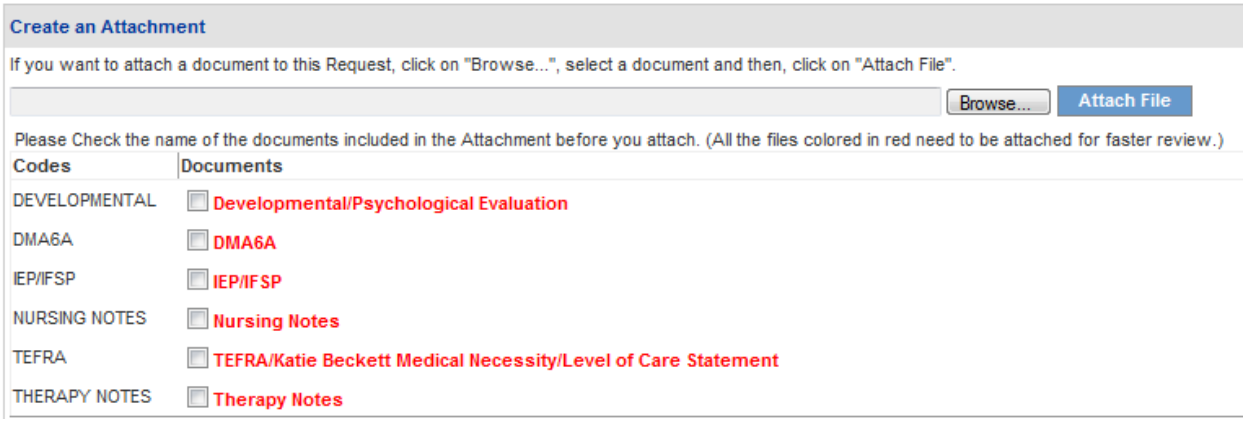


Figure 289

Attach Documents

Create an Attachment 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 file may be attached for all required documents (**this is the preferred method**); or a different file may be attached for each document.

1. For example, to attach one file for all documents, click in each checkbox.

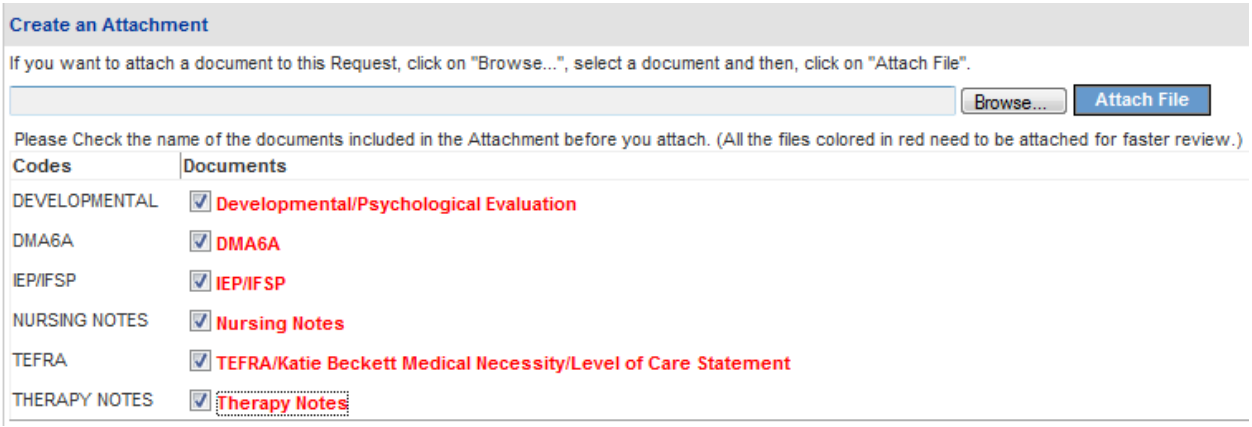


Figure 290

2. Then, click **Browse** to find the file saved to the file directory.

3. Select and open the file in the directory, and the name of the file displays in the box next to **Browse** as shown in the next figure.

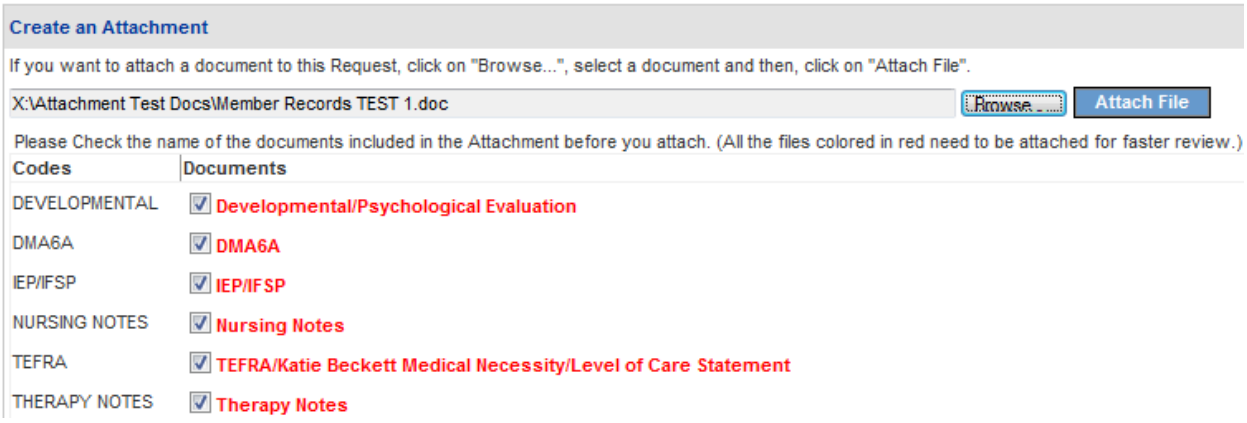


Figure 291

4. Next, click **Attach File**. The file attached is associated with each document type in the **Attached Files** table as shown below.

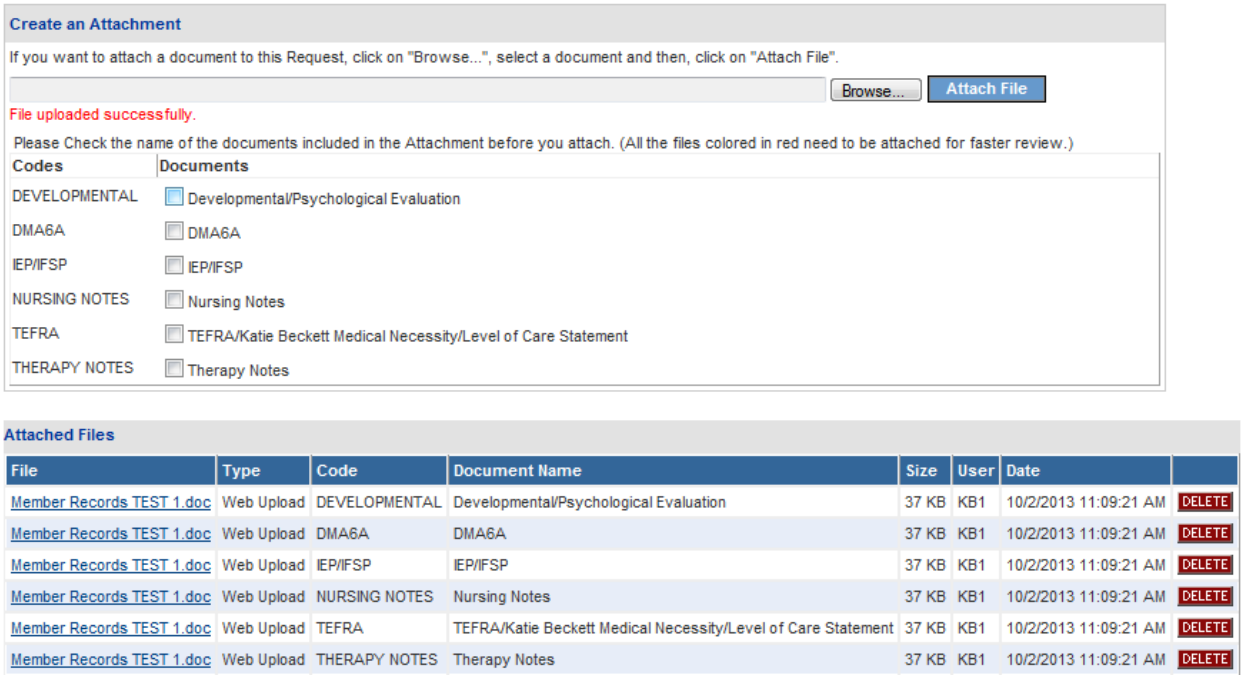


Figure 292

Note: For more detailed guidelines regarding the attachment process, please refer to the user guide – ***Attach Files to a PA Request*** – located on the *Provider Workspace* under Education and Training/User Manuals.

2.20.3 Update Member ID

New Katie Beckett participants may be added to the Katie Beckett PA tracking system before they have been assigned Member Medicaid IDs. When the new participant is added, the PA system assigns a temporary 'system' ID, which looks similar to 00222GMC. When the member becomes a Medicaid member and is assigned a Medicaid Member ID, the Medicaid ID needs to be added to the participant's chart and existing DMA6As **before** continued placement requests 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.

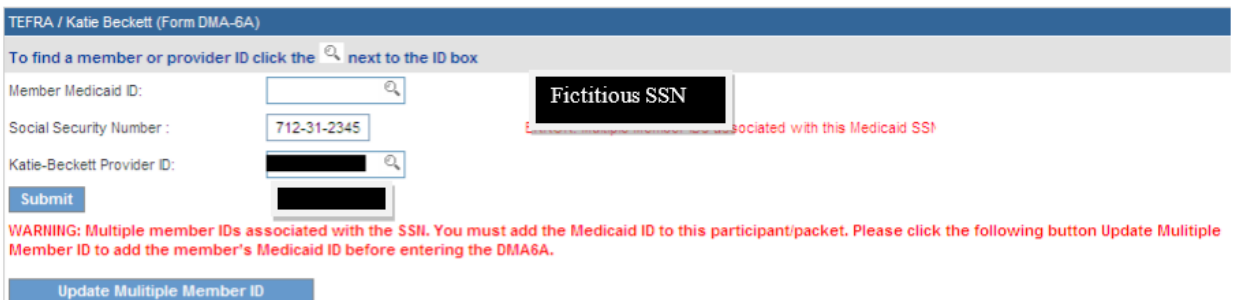


Figure 293

NOTE: At this time, the RSM Medicaid Unit may only update member IDs for cases that are associated with their provider ID. Refer member updates for other DMA6As to GMCF review staff.

1. To add the member's Medicaid ID, click **Update Multiple Member ID**.

Figure 294

2. When the update link is selected, the update page opens with the member's SSN auto-populated.

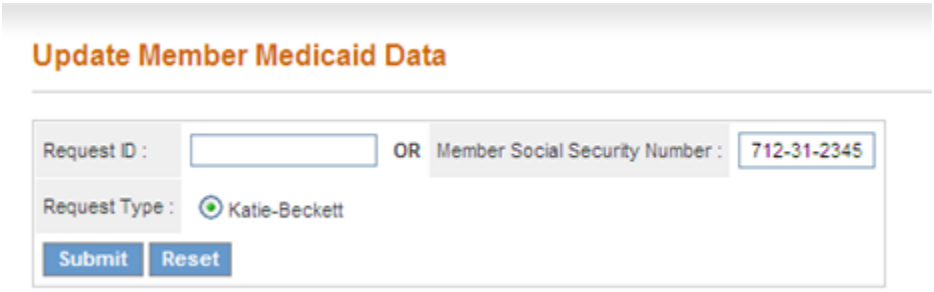


Figure 295

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.

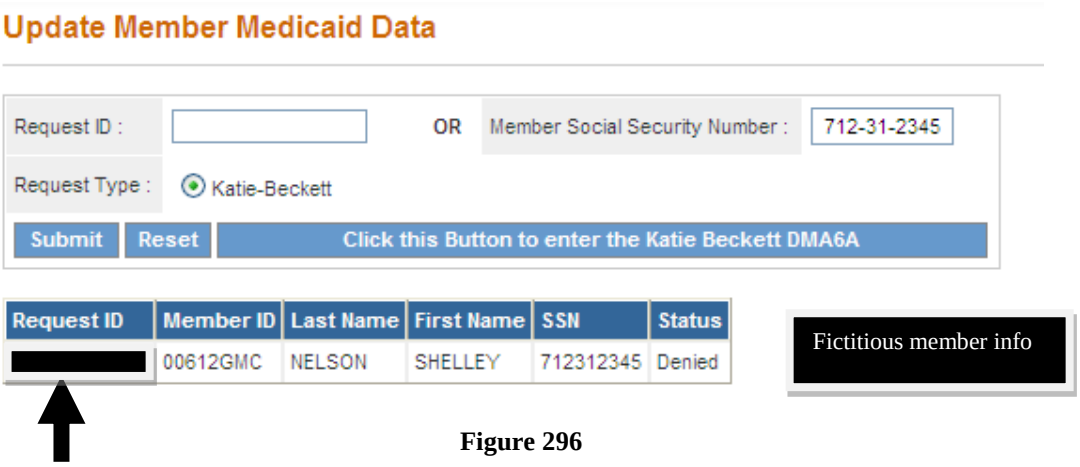


Figure 296

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.

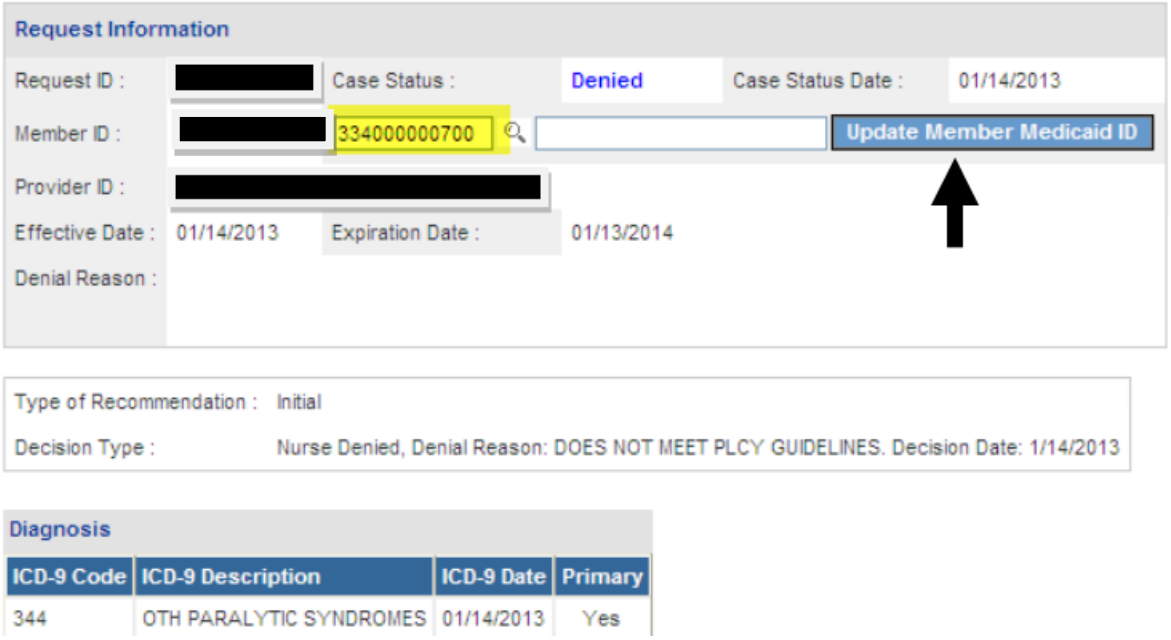


Figure 297

7. Then, click **Update Member Medicaid ID**; and the request is updated with the member ID as shown in the next figure.

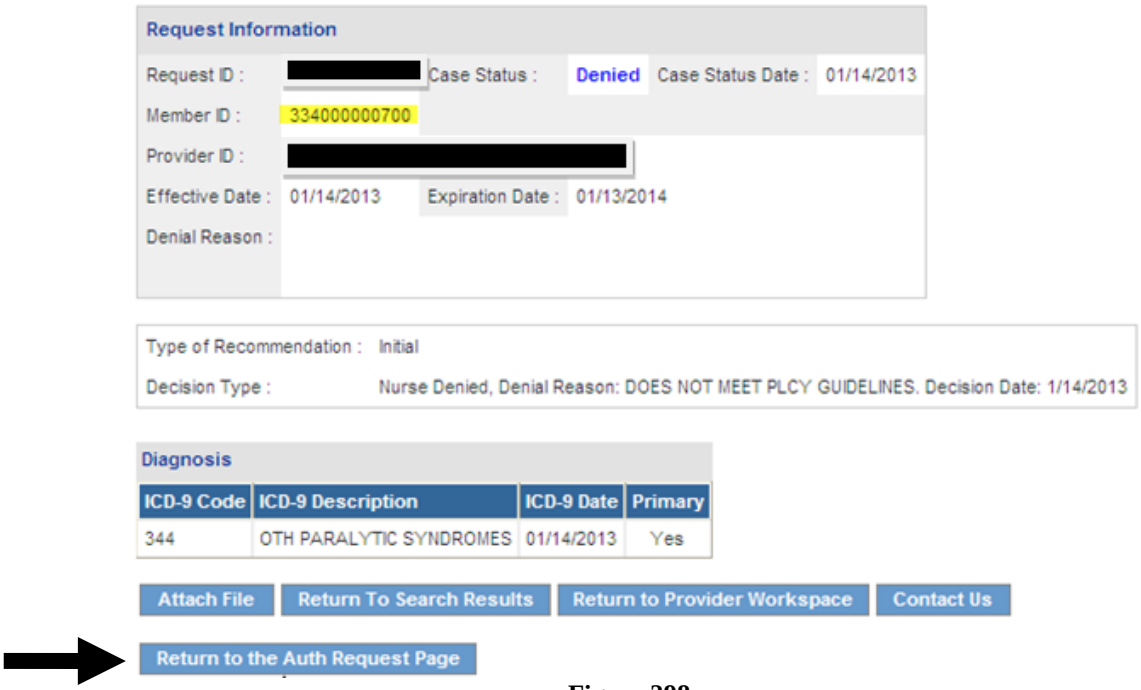


Figure 298

8. To return to the *New Request for Prior Authorization* page and enter the DMA6A, click **Return to the Auth Request Page**, as shown in the previous figure.

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.

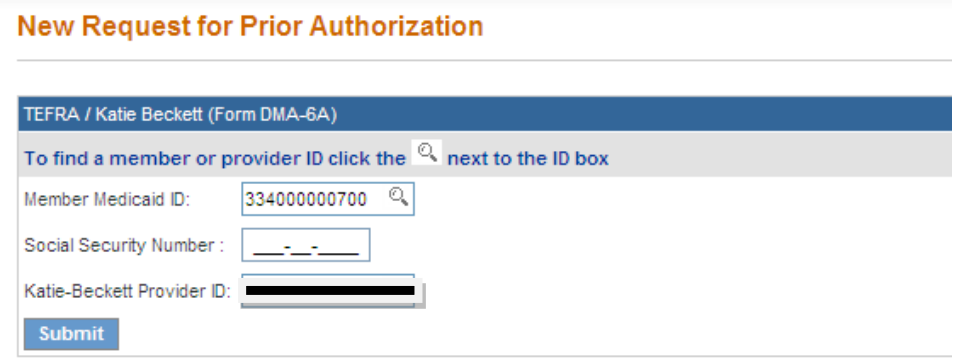


Figure 299

11. Click **Submit** to enter the DMA6A.

2.22 Swingbed Requests

Program	Authorization Period
Swingbed	14 days – initial 30 days – continued
Swingbed (DMA-6A)	

Table 26

2.22.1 Description

Requests for Swingbed (SW) admission and continued stay may be submitted via the web portal using the *Swingbed Form DMA-6* for individuals 21 years and older; and *Swingbed Form DMA6A* 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

2.22.2 Web Entry Instructions

Follow these instructions to enter a Swingbed request:

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. 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.

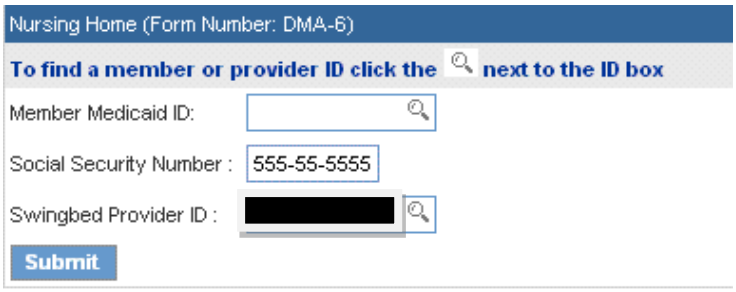


Figure 300

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

7. The requesting Swingbed provider information is system populated; and, if the patient is a Medicaid recipient, the patient's Medicaid ID, Last Name, First Name, Date of Birth, Gender and Social Security number (SSN) display at the top of the form.

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 a type from the drop list.

Figure 301

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.

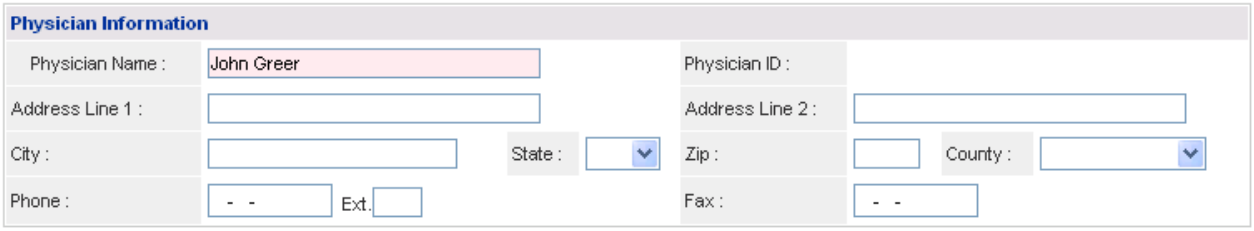


Figure 302

Contact Information:

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

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

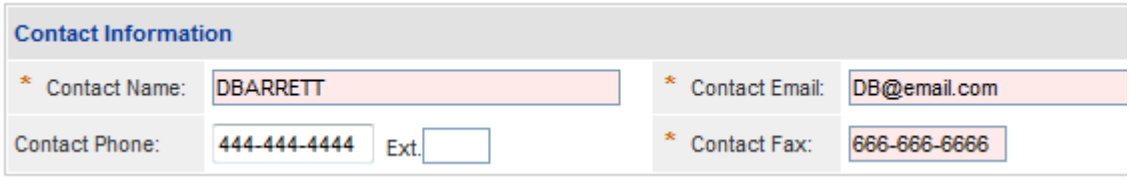


Figure 303

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. **DMA-6A Form 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.

13. **If continued placement selected**, the system pulls in the 'Initial Admission Date'. 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*.

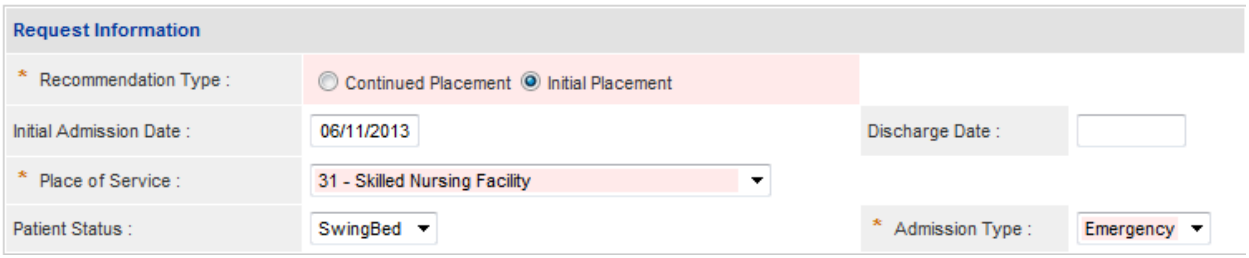


Figure 304 Request Information/SW Initial Placement

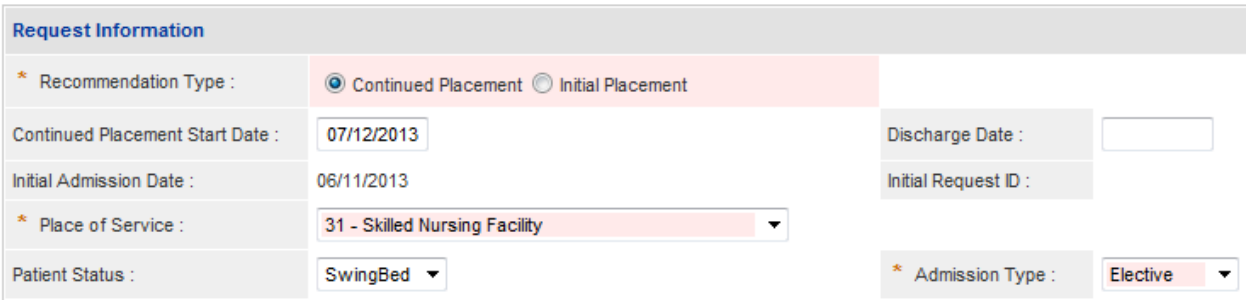


Figure 305 Request Information/SW Continued Placement

DMA-6A Form Note: In place of the *Request Information* 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:

- Respond *Yes* or *No* to indicate whether or not the child's caretaker believes that the child would require institutionalization if services were not provided.
- Respond *Yes* or *No* to indicate whether or not the child attends school.
- Enter the date of Medicaid application. If not known, enter the PA request date.
- Respond *Yes* or *No* to indicate whether or not the parent/legal representative has authorized release of health information.
- Enter the date that parent/legal representative signed the DMA-6A.

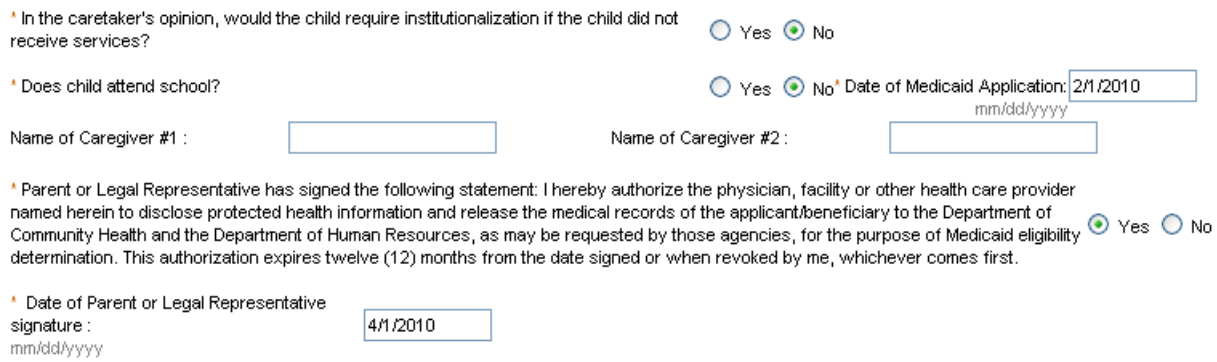


Figure 306

Diagnosis Table:

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

17. 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.

18. Enter the date that this diagnosis was established in the 'Date' box, or if not known, enter the Swingbed admission date. Enter the date manually or select from the calendar popup.

19. 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.

20. Click **Add** at the end of the diagnosis line to add the diagnosis information to the request.

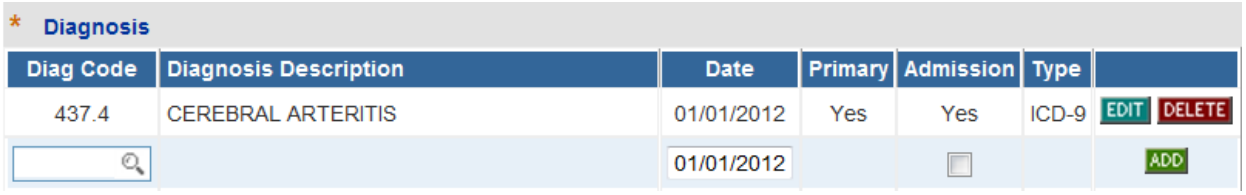


Figure 307

21. 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'.

Figure 308

22. Click 'Yes' if the patient has 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.

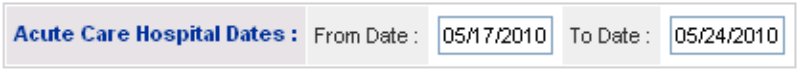


Figure 309

Diagnosis on Admission to Hospital:

This section is optional

Figure 310

Medications and Diagnostic/Treatment Procedures Tables:

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

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.

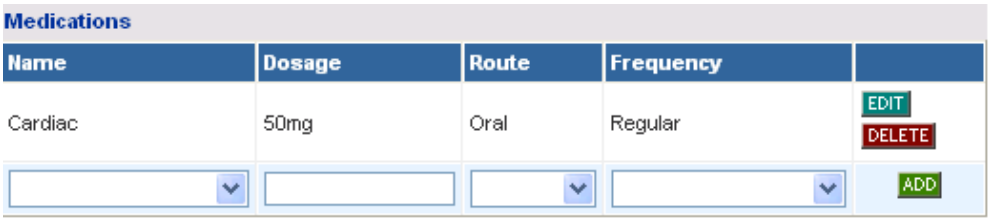


Figure 311

29. Follow the same process to add other medication information. **Remember to click Add after each entry.**

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.

Figure 312

33. Repeat the process to add other diagnostic/treatment procedures. **Remember to 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.

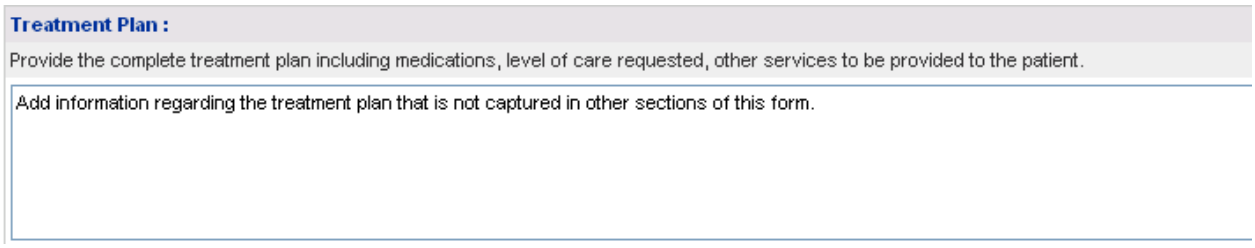


Figure 313

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.

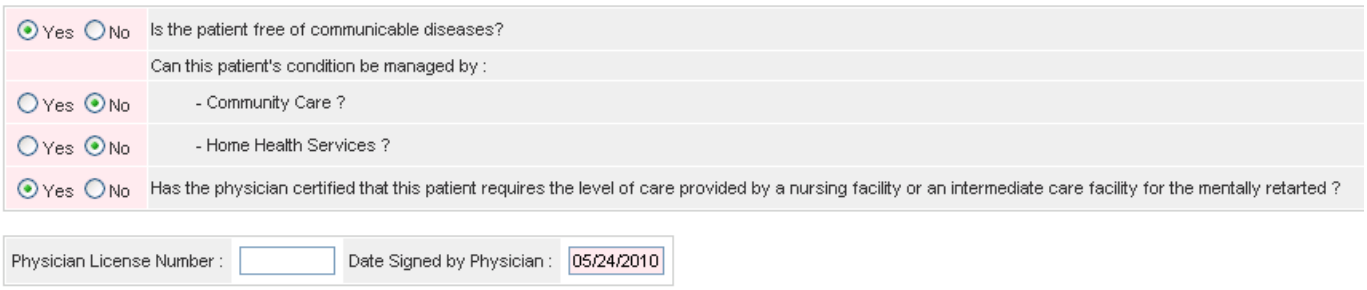


Figure 314

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:

- 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.
- Enter the recommended level of care by selecting *Nursing Facility* from the 'Level of Care Recommended' drop list.
- Enter the type of recommendation (initial or continued placement) by selecting the type from the drop list.
- Indicate where the patient was transferred from by clicking the *Hospital* button
- Indicate the length of time that care is needed by selecting the *Temporary* button; and then enter '1' as the estimated temporary length of time.
- Respond to each of the certification questions by clicking *Yes* or *No*.
- Enter the name of the physician that signed the DMA-6A in the 'Physician Name' box.
- Enter the date that the physician signed the DMA-6A in the 'Date Signed by Physician' box.
- Enter the physician's license number in the 'Physician License Number' box.
- Enter the physician's phone number in the 'Physician Phone' box.

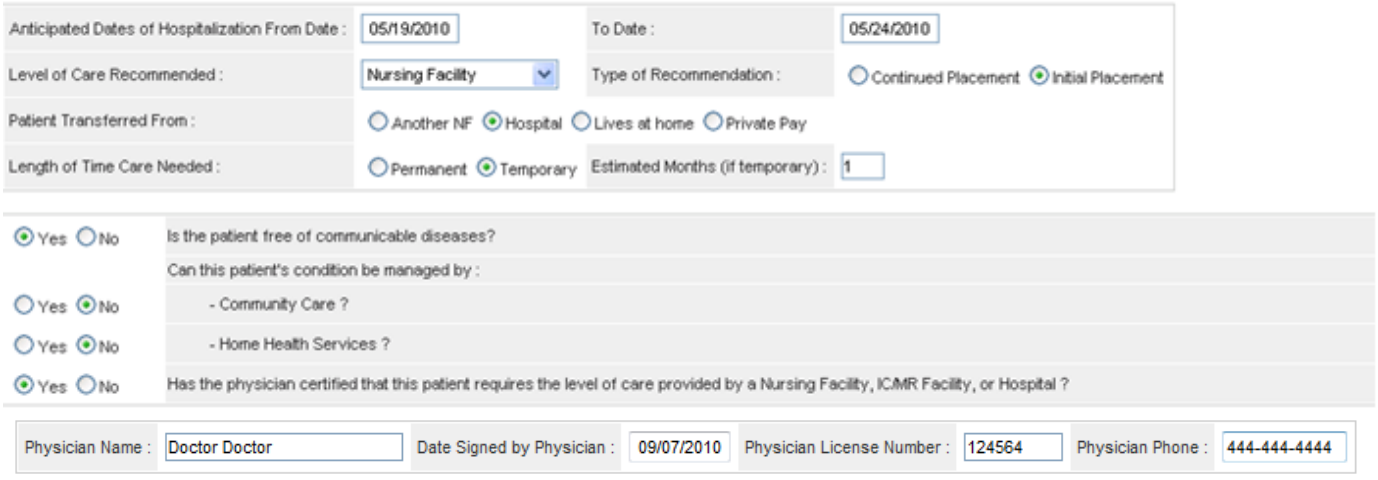


Figure 315

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.

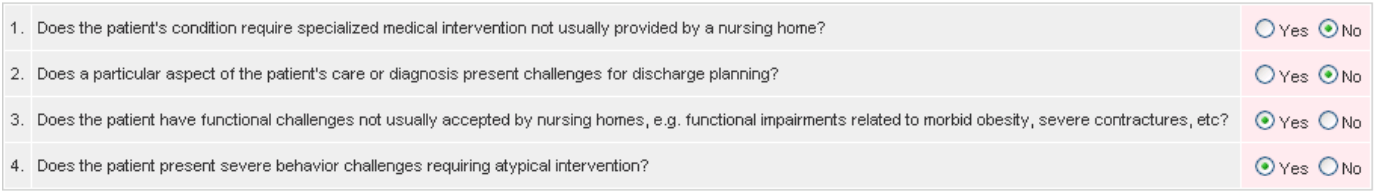


Figure 316

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. **DMA-6A Form Note:** The *Evaluation of Care Needed/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.

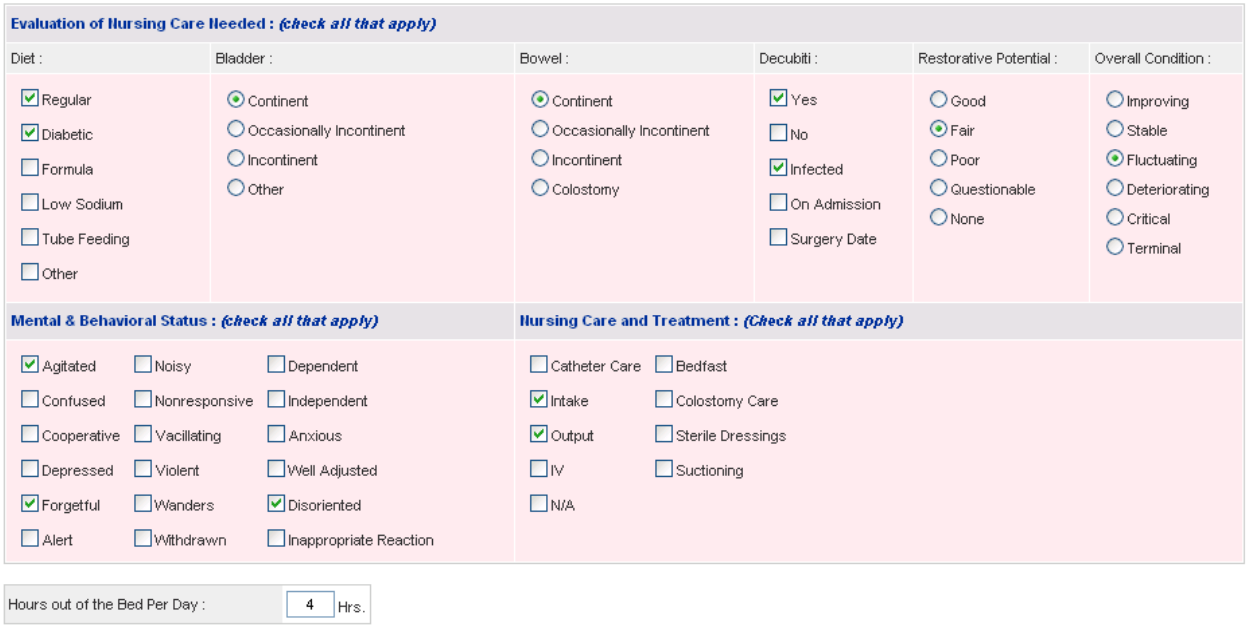


Figure 317

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.

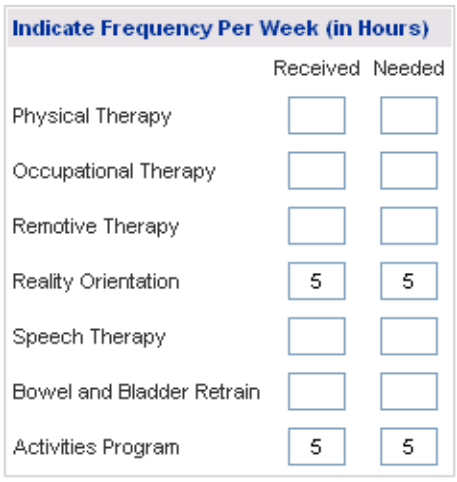


Figure 318

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. **DMA-6A Form 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.

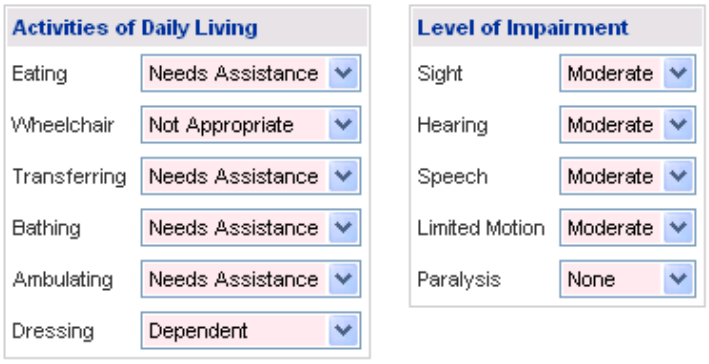


Figure 319

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.

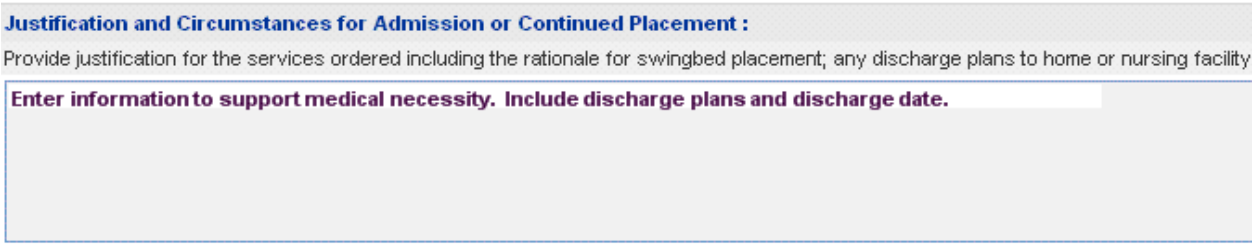


Figure 320

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.

Figure 321

46. 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.

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

48. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.

2.23 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)	

Table 27

2.23.1 Description

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 *ICFMR DMA-6* for individuals 21 years and older; and *ICFMR DMA6A* 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:

- 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.

2.22.2 Web Entry Instructions

Follow these instructions to enter an ICFMR request:

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. 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.

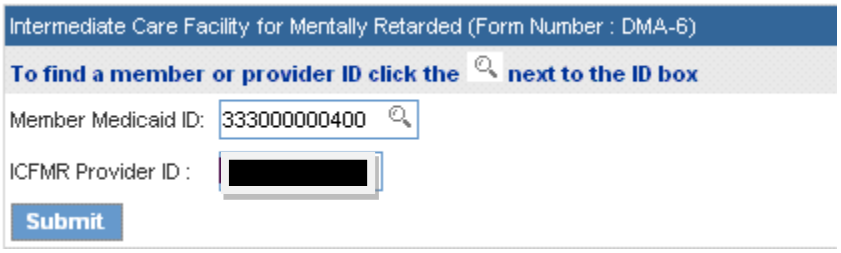


Figure 322

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.

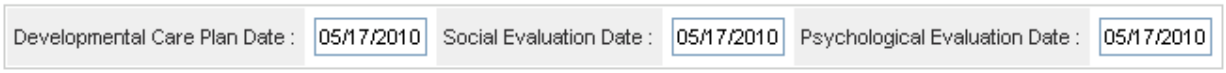


Figure 323

2.24 Nursing Facility Mechanical Ventilation Services

Program	Authorization Period
Nursing Facility Mechanical Ventilation Services	Initial – 90 days Continued – 90 days

Table 28

2.24.1 Description

Requests for authorization of mechanical ventilation services provided in a nursing facility are submitted via the web portal utilizing the *Nursing Facility Mechanical Ventilation Services* 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.

2.24.1 Web Entry Instructions

Follow these instructions to enter a Mechanical Ventilation Services request:

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. 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**.

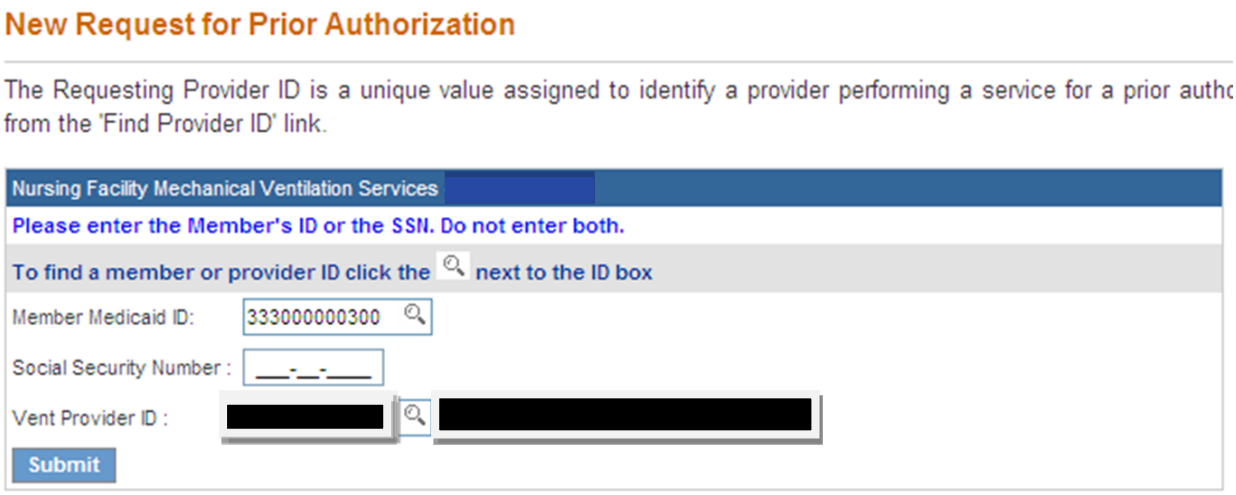


Figure 324

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).

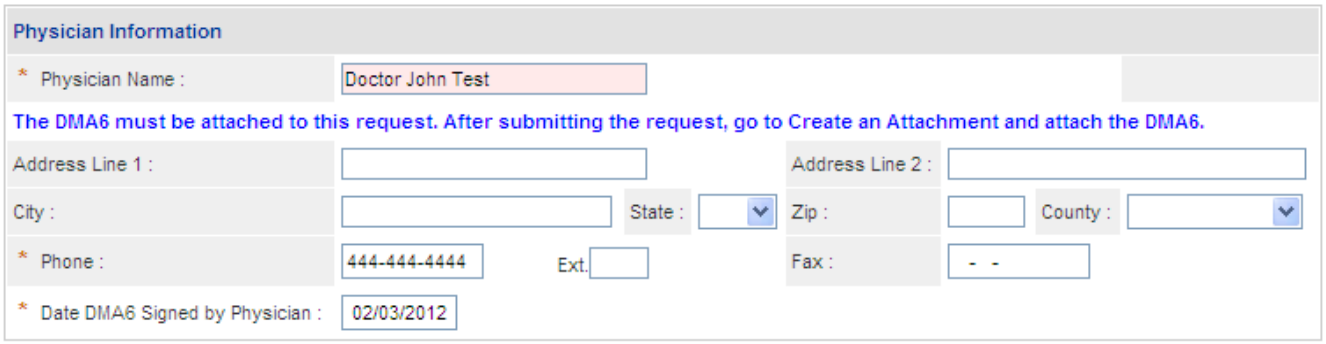


Figure 325

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.

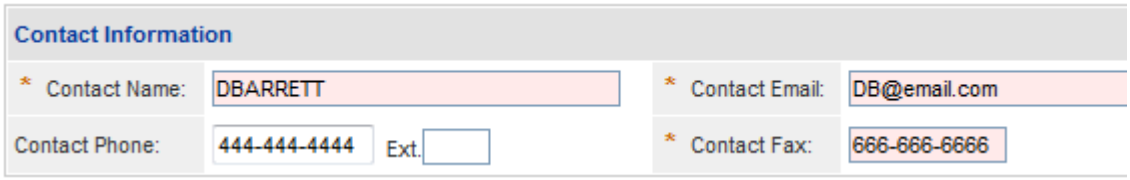


Figure 326

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.

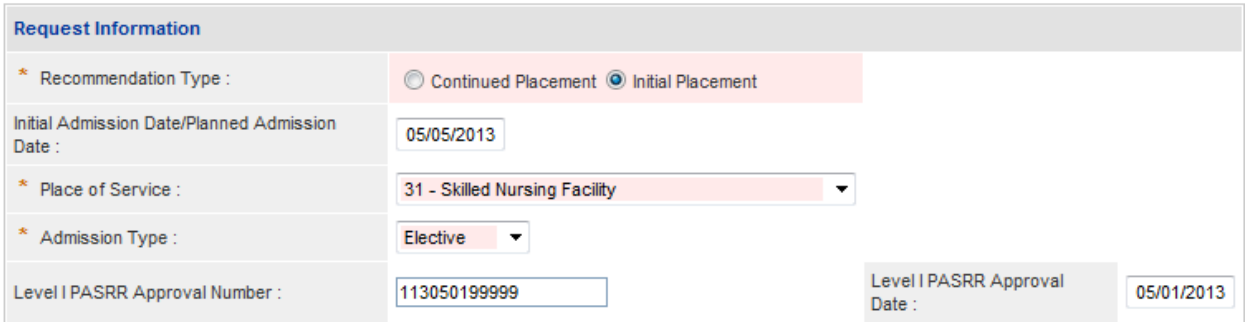


Figure 327

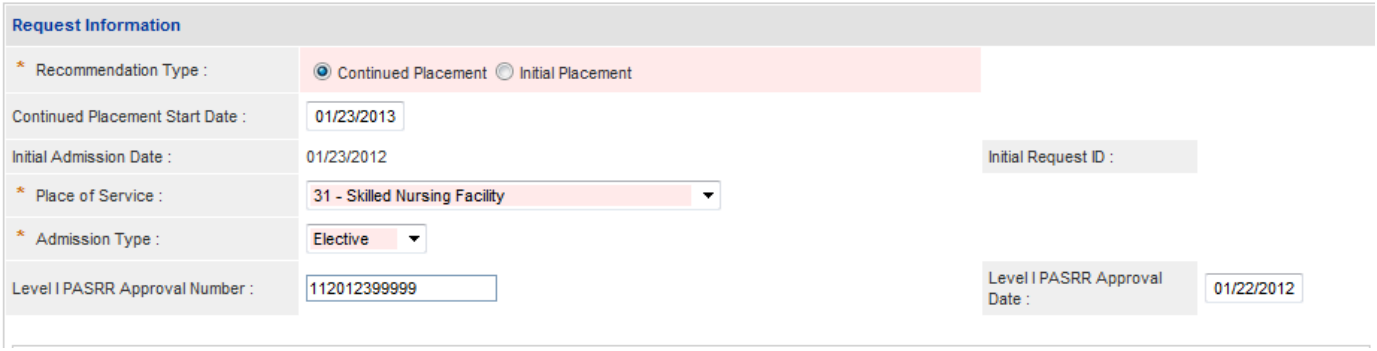


Figure 328

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

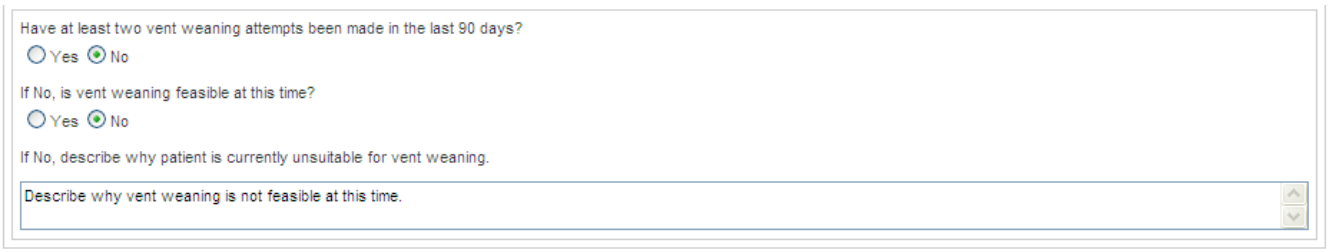


Figure 329

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.**

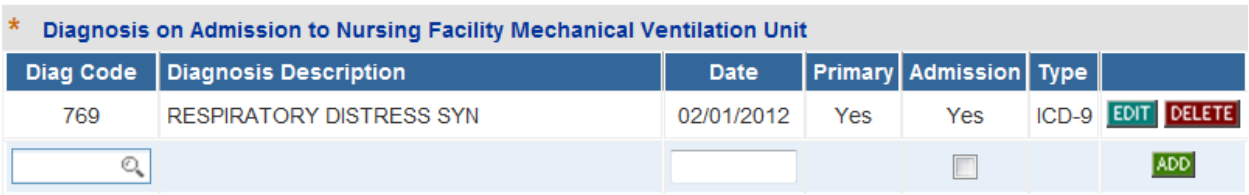


Figure 330

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.

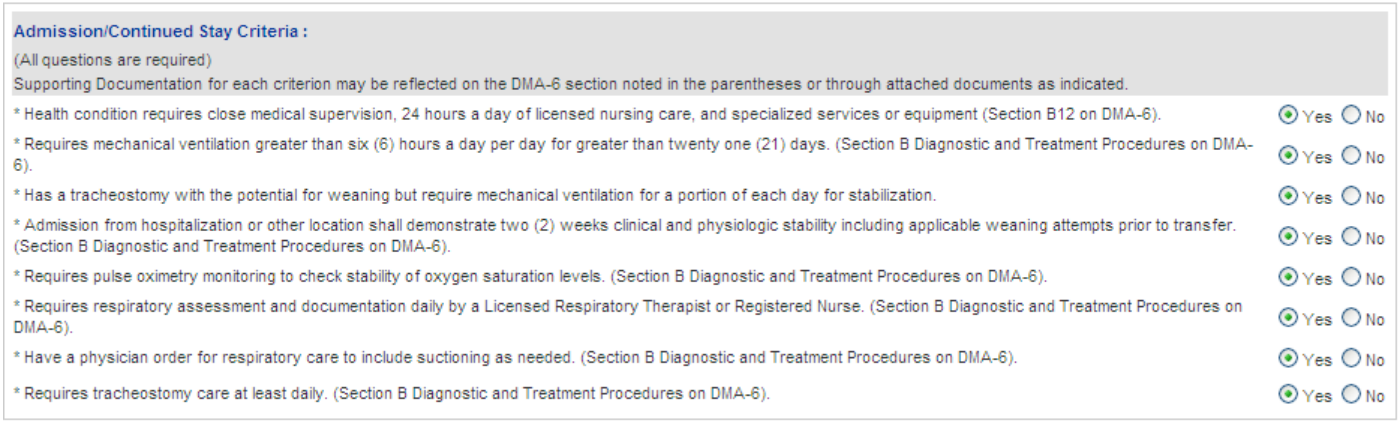


Figure 331

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.

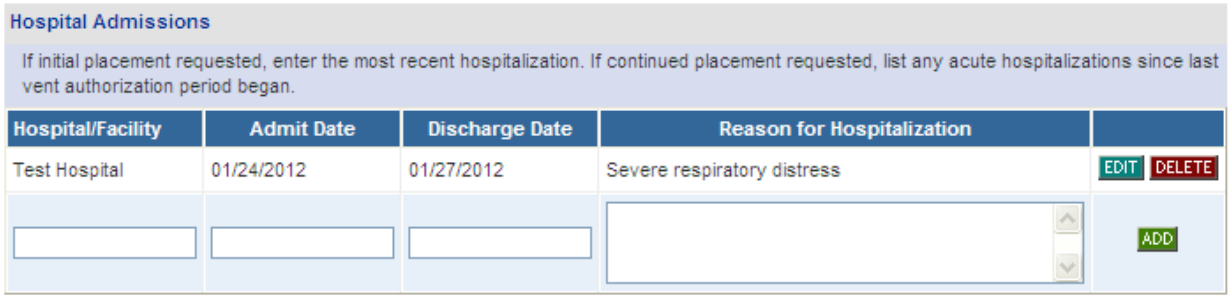


Figure 332

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'.

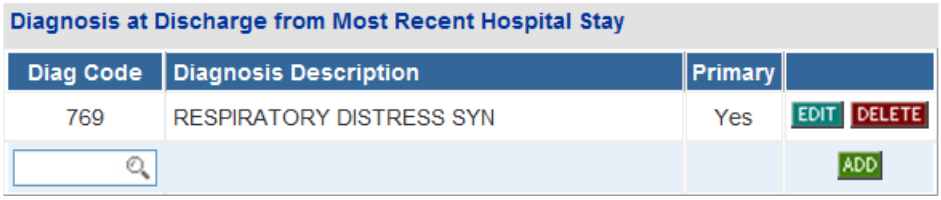


Figure 333

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.

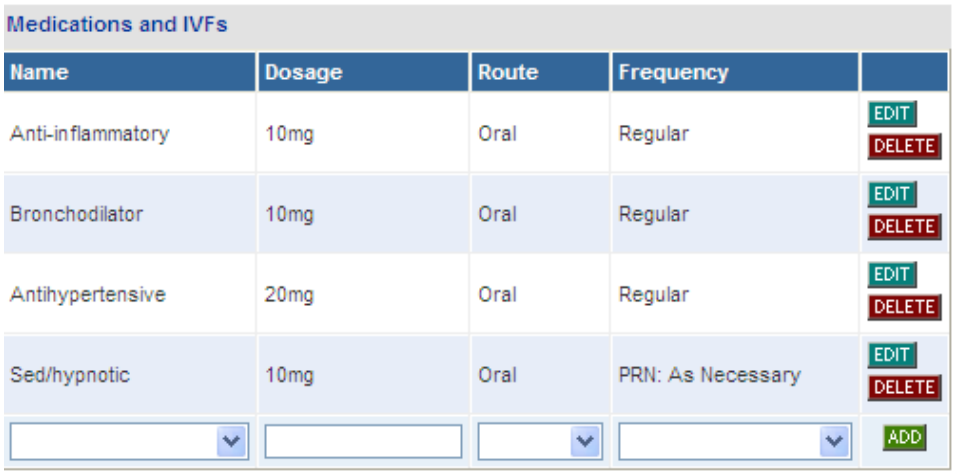


Figure 334

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.

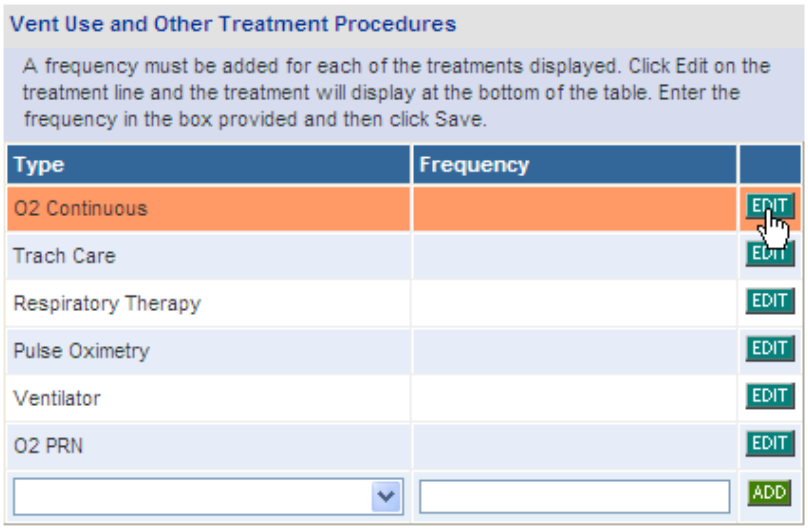


Figure 335

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**.

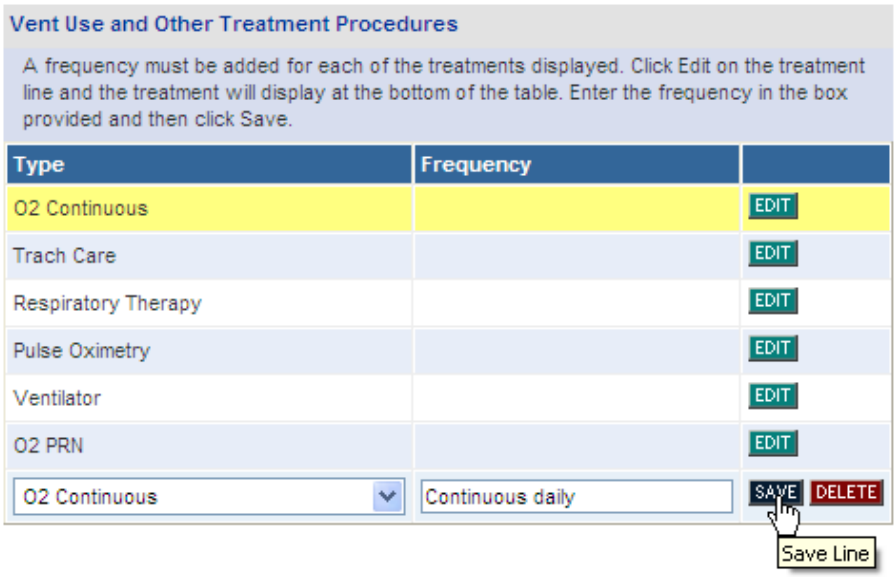


Figure 336

47. The treatment and frequency are saved and added to the request.

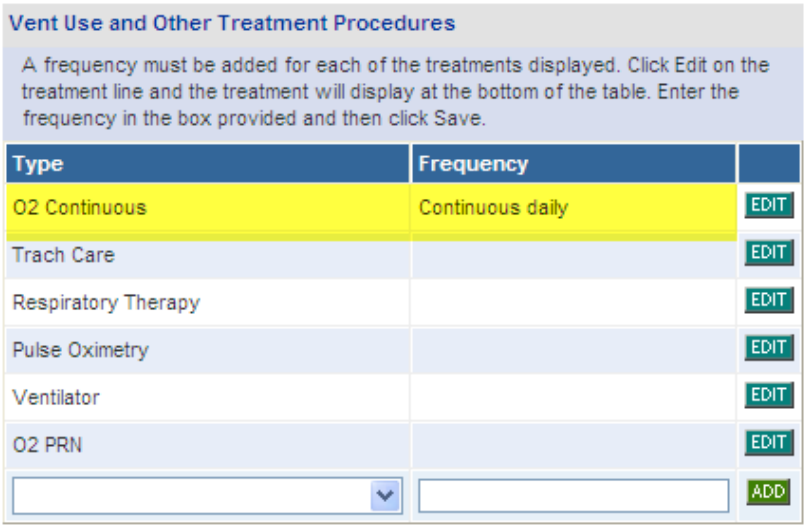


Figure 337

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 02 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**.

Figure 338

Ventilator Settings:

50. For each ventilator setting, enter the numerical amount in the boxes provided. The box for Fi02 includes a decimal point; and the system inserts a '0' if only two digits are entered.

Figure 339

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.

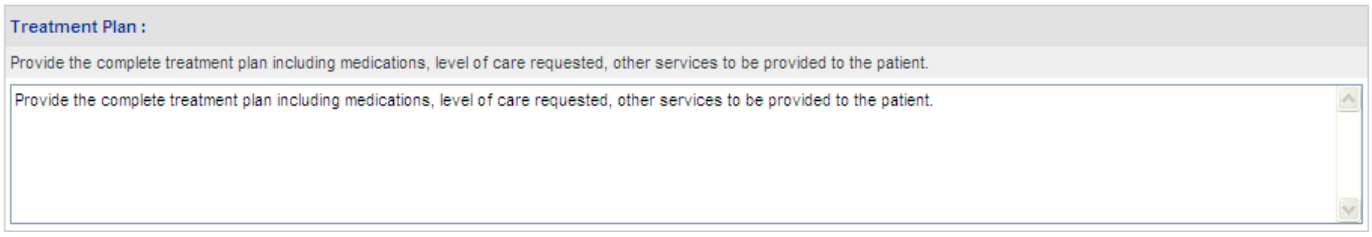


Figure 340

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.

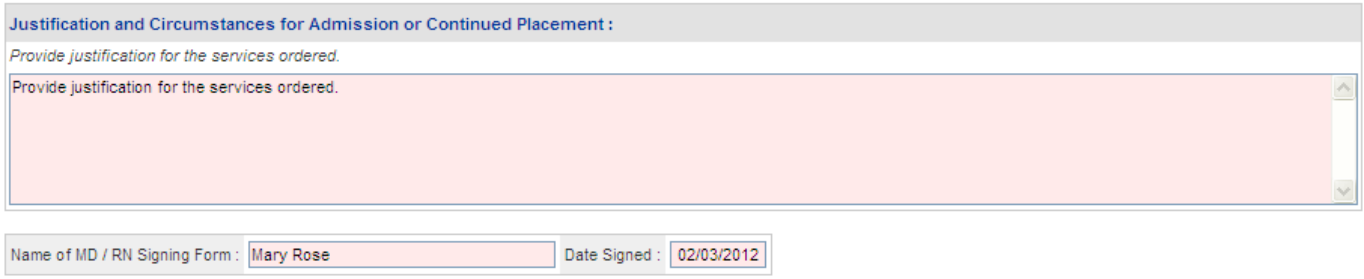


Figure 341

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.

2.25 PASRR Level I Requests

2.25.1 Description

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:

- **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.

2.25.1 Web Entry Instructions

Follow these instructions to enter a PASRR Level I:

1. Go to the Georgia Web Portal at www.mmis.georgia.gov.

2. On the portal home page, click the **Provider Information** link and select **PASRR Request**. The PASRR request link is also available on the *Provider Workspace* accessed from the secure home page after logging into the portal.

3. On the next window that displays, enter the applicant's Medicaid ID **OR** the applicant's Social Security Number. **Do not enter both numbers**.

Figure 342

4. 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 requesting provider that a physician should officially certify the DMA-6 before the Level I request is submitted.

Member Information:

This section captures member demographic information; member's current location and situation; and out of state contact information (if applicable).

5. 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.

6. 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.

7. Enter the applicant's current location by selecting the location from the 'Current Location' drop list.

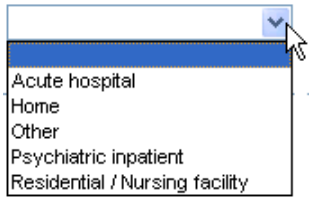


Figure 343

8. If 'Other' is selected as the current location, provide an explanation for this choice in the text box provided.

9. 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.

10. 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.

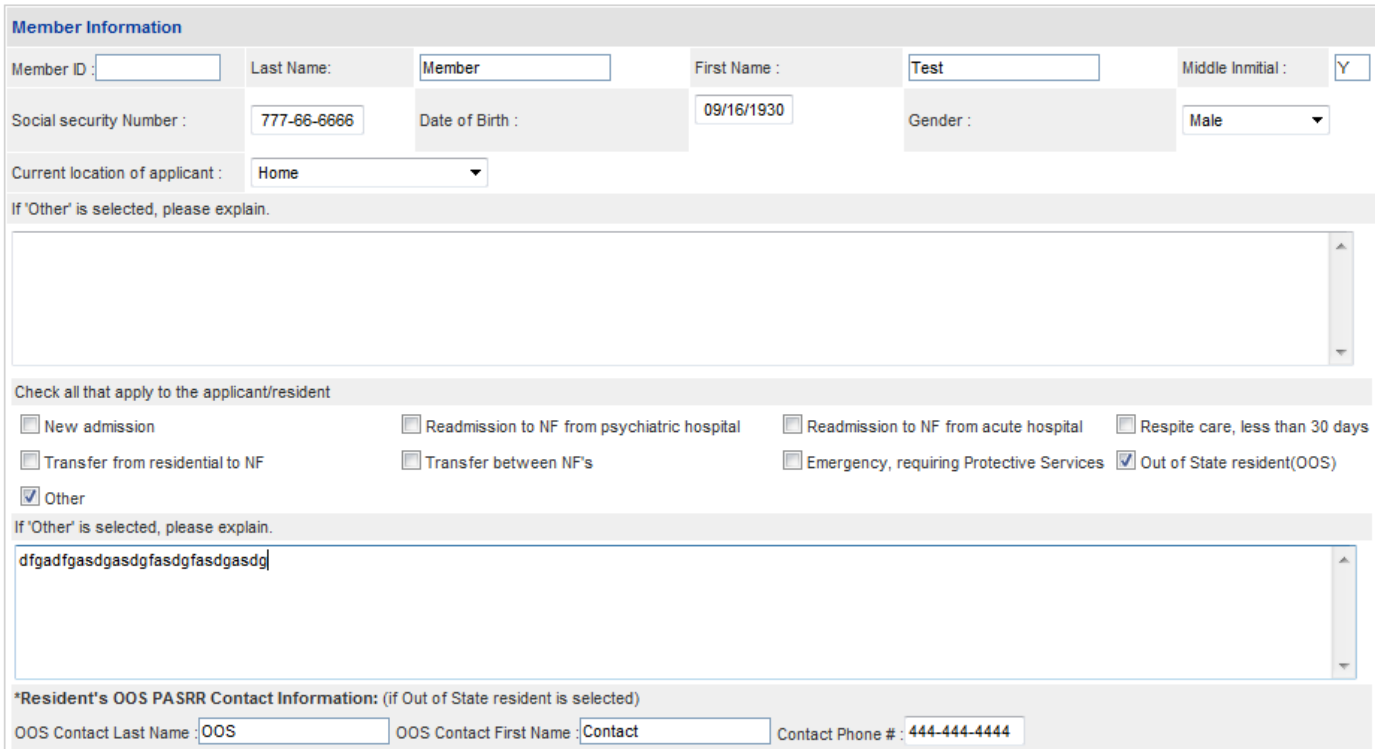


Figure 344

Level I Screening Questions:

11. Respond *Yes* or *No* to the screening questions. If a response is 'Yes'**,** additional information may be required.

    Question #1: Does the individual have a suspected mental illness, mental retardation, developmental disability or related condition?

    Question #1a: Does the individual have a primary (Axis I) diagnosis of dementia based on DSM-IV criteria?

        If 'Yes' to question 1a, click one of the checkboxes to specify the type of dementia. If 'Other' selected for the dementia type, explain in the text box provided.

        AND

        If 'Yes' to question 1a, enter the corresponding diagnosis code for the dementia condition in the 'Dementia Diagnosis Code' box.

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**?

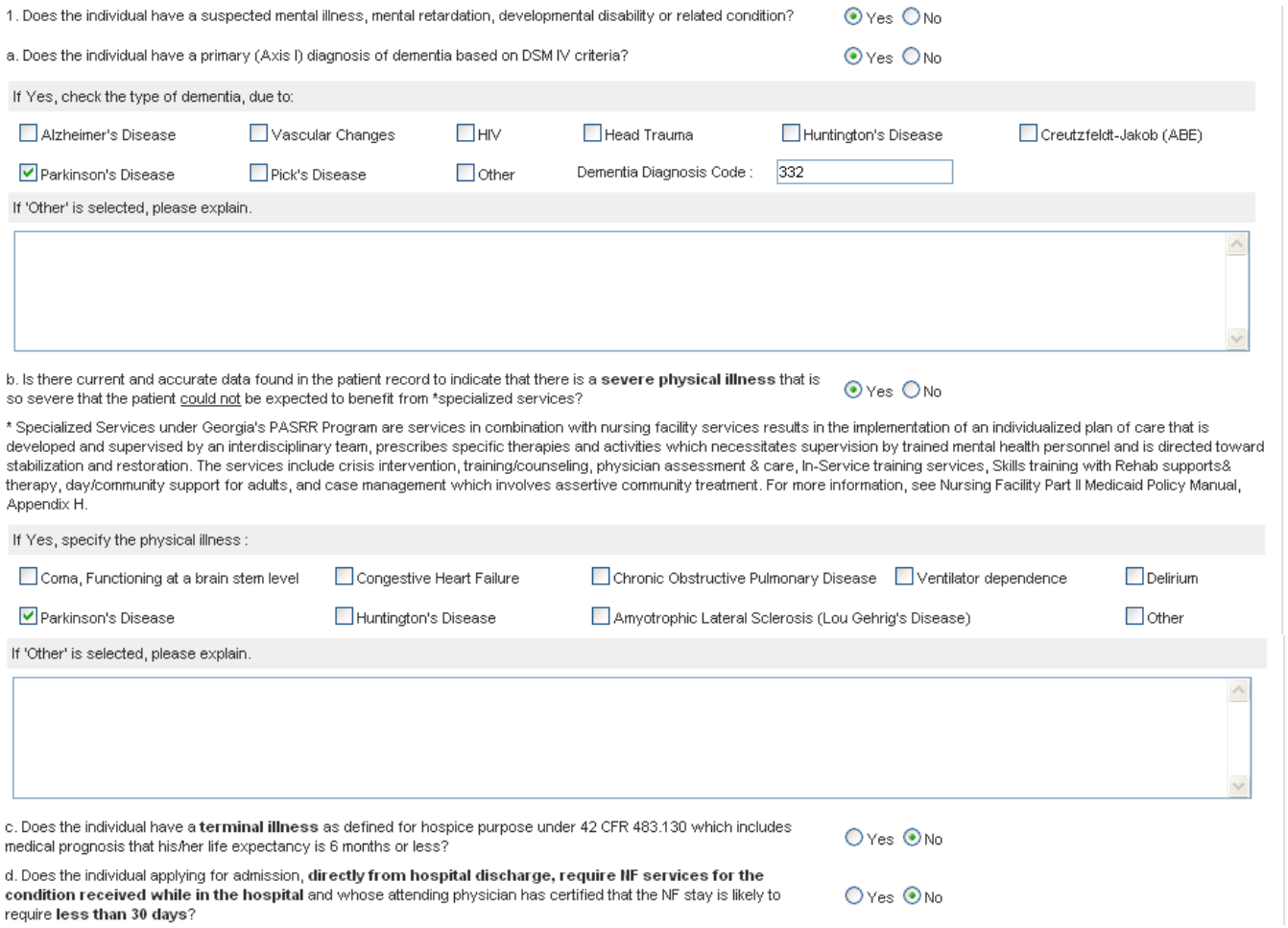


Figure 345

Mental Illness/Mental Retardation/Developmental Disability Questions:

12. 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.

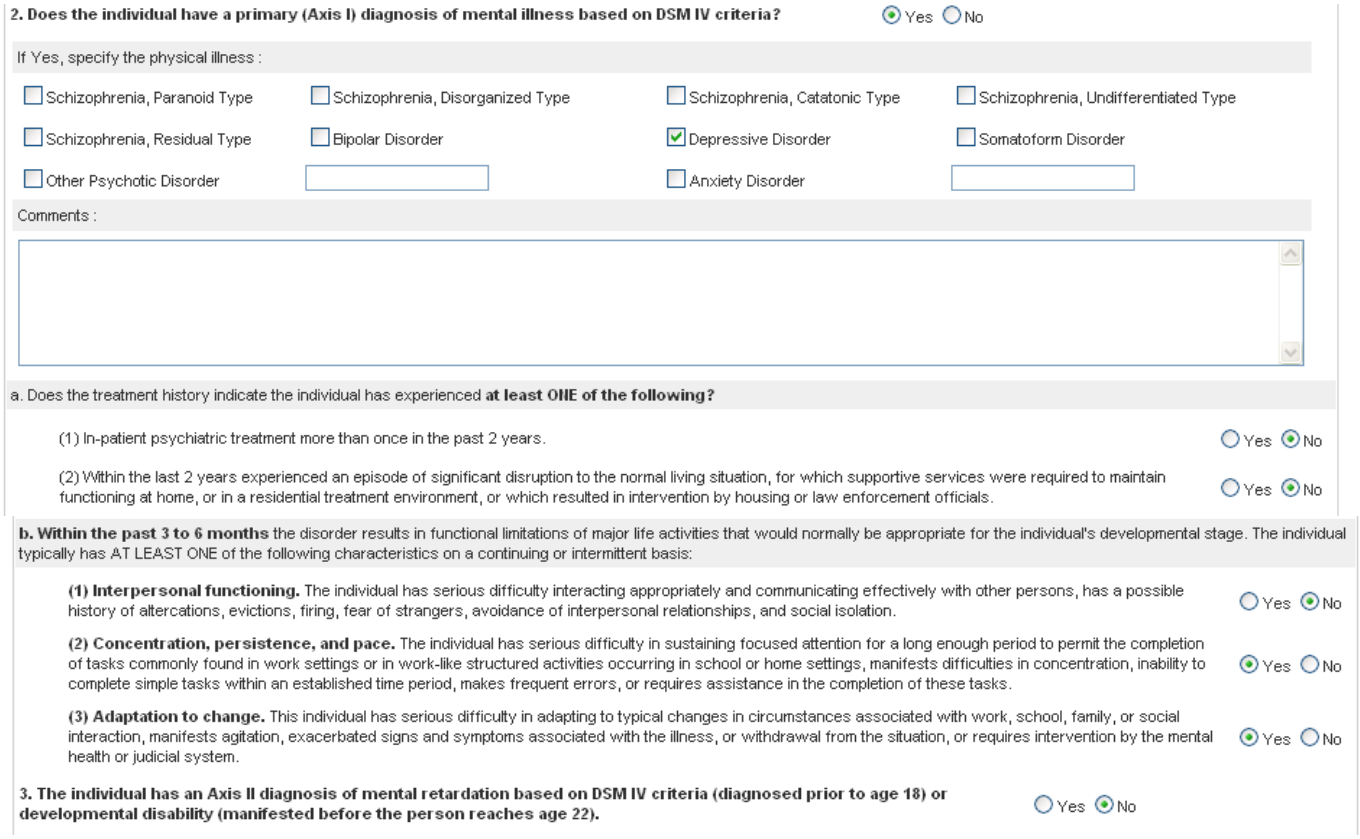


Figure 346

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.

13. Respond *Yes* or *No* to indicate whether or not the patient has been admitted to the nursing facility.

14. **If No is the response**, go to the **Physician Information** section.

15. **If Yes is the response**, enter the date of admission to the nursing facility in the 'Date of Admission to Nursing Facility' box.

16. 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 347

    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.

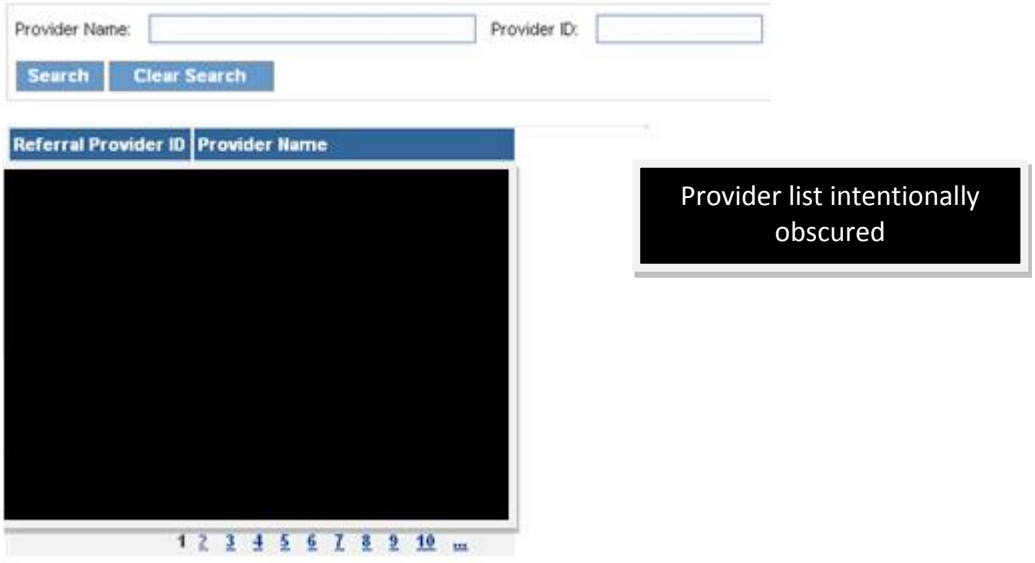


Figure 348

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.

Figure 349

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.

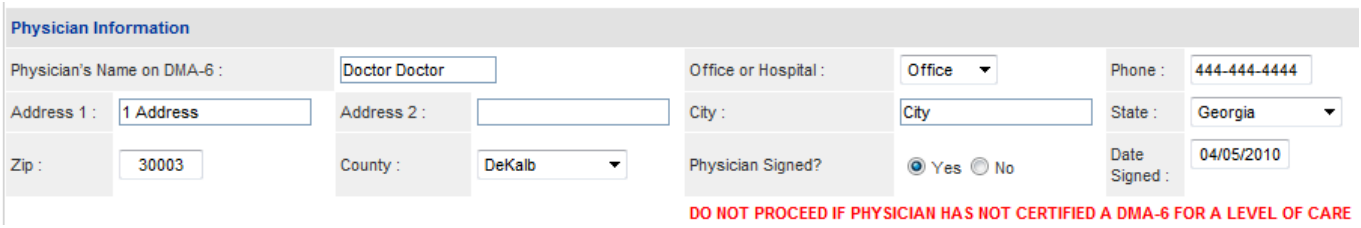


Figure 350

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.

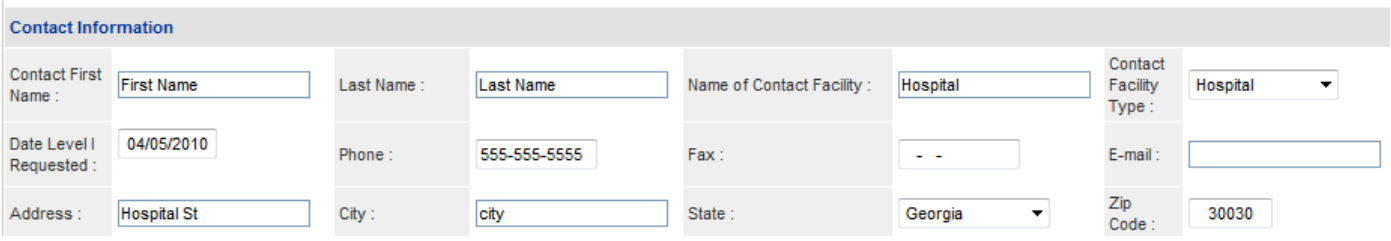


Figure 351

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.

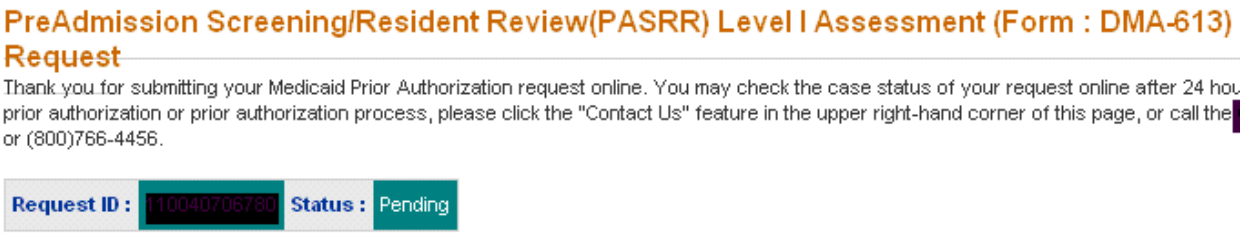


Figure 352