

# GA Web Portal FFS Prior Authorization

Provider User Manual - Version 2.5



### Revision History

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## 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**

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## 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)	<b>Z</b>	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	<b>M</b>	Request for surgical procedures performed in a practitioner's office.
In-State Transplant Reviews (Precertification – In State Transplants)	<b>Z</b>	Request for transplant services provided in Georgia.
Out-of-State Reviews (Precertification – Out of State)	<b>Z</b>	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.)	<b>R</b>	Request for dental services for members under 21 years of age.
Adult Dental	<b>T</b>	Request for certain dental services for members 21 years and older.
Emergency Ambulance Ground Air	<b>E</b> <b>A</b>	Request for emergency ground ambulance services. Request for emergency air transport services.
Non-Emergency Travel	<b>N</b>	Request for non-emergency travel and transport.
Vision	<b>V</b>	Request for vision case services (glasses and contacts) for members under 21 years of age.
Oral/Maxillofacial Surgery	<b>OM</b>	Request for Oral-Maxillofacial procedures.
Durable Medical Equipment	<b>D</b>	Request for the purchase, lease, replacement, or repair of durable medical equipment.
Orthotics and Prosthetics	<b>DP</b>	Request for the purchase, replacement, or repair of O&P devices.

<b>Review Type</b>	<b>PA Type</b>	<b>Description</b>
Hearing Aide Services	<b>DH</b>	Request for hearing aids, accessories, and/or repairs.
Additional Physician Office Visits	<b>U</b>	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.)	<b>PY</b>	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.)	<b>PS</b>	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	<b>ZT</b>	Request for therapeutic services (PT, OT, and ST) provided in an outpatient hospital.
Radiology PA- Facility Setting	<b>Z</b>	Request for certain radiology procedures provided in an outpatient hospital.
Radiology PA-Physician Office	<b>M</b>	Request for certain radiology procedures provided in a physician's office.
Medications PA- Facility Setting	<b>ZD</b>	Request for certain high cost injectable drug codes provided in an outpatient hospital.
Medications PA-Physician Office	<b>M</b>	Request for certain high cost injectable drug codes provided in a physician's office.
PASRR Level I	<b>L1</b>	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	<b>M1</b>	Request for authorization of mechanical ventilation services provided in a nursing facility.
Swingbed	<b>SW</b>	Request for admission/continued stay to a Swingbed facility for adults (DMA6) or children (DMA6A).
Intermediate Care Facility- Mental Retardation	<b>MR</b>	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>B</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	<b>I6 I</b>	Requests for admission/continued placement in the Independent Care Waiver program; and requests for service authorization.
SOURCE Level of Care and Placement  Source Services PA	<b>S6  SC</b>	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 request: <b>These requests are not reviewed by GMCF staff</b> but are approved upon submission.
CCSP Level of Care and Placement	<b>C6</b>	Request for initial admission and continued placement (reassessment) in the Community Care Services Program.
NOW Level of Care and Placement	<b>N6</b>	Requests for initial admission and continued placement in the New Options Waiver Program.
COMP Level of Care and Placement	<b>CO6</b>	Requests for initial admission and continued placement in the Comprehensive Supports Waiver Program.
Georgia Pediatric Program (GAPP) DMA6A DMA80	<b>G6 GP</b>	Request for admission or continued enrollment in the Georgia Pediatric Program; and requests for service authorization.
TEFRA/Katie Beckett DMA6A	<b>DW</b>	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 in-state 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 in-state transplant requests.

<b>Hospital Admissions and Outpatient Procedures</b>	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
<b>Instate Transplants</b>	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](http://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.

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

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

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

Member Medicaid ID:

Facility Provider ID :

Medical Practitioner Reference ID :

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'.

The screenshot shows a form titled "Request Information" with the following fields: "Admit Date" with the value "04/05/2010", "Discharge Date" with an empty box and a checked "Still in Facility" checkbox, "Admission Type" with a dropdown menu showing "Emergency", and "Place of Service" with a dropdown menu showing "Inpatient Hospital".

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:

The screenshot shows a form with a dropdown menu labeled "Select the patient's current location:" and three radio buttons labeled "Yes", "No", and "Unknown" with the question "Did patient fail to improve enough to safely discharge after 24-36 hours of hospital level care?".

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'.

The screenshot shows a form with a dropdown menu labeled "Select the patient's current location:" with "General Acute Care Medical" selected, and three radio buttons labeled "Yes", "No", and "Unknown" with the question "Did patient fail to improve enough to safely discharge after 24-36 hours of hospital level care?".

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.

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

Figure 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).

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

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.

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

**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.

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

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

**Figure 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.

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

Figure 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.

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

Figure 12

**Retro-Eligibility:**

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

Does this member have retro eligibility for the submitted dates of service ? <input type="radio"/> Yes <input checked="" type="radio"/> 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.

**Additional Information**

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

**Inpatient Diabetic - Adult**

**Clinical History and Findings Questions:**

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

**Treatment Description Questions:**

1 Did patient receive Insulin IV?  Yes  No  Unknown

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

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

**Figure 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](http://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’.

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

* Admit Date :	<input type="text" value="04/27/2010"/>	Discharge Date :	<input type="text"/>	<input type="checkbox"/> Still in Facility
* Admission Type :	<input type="text" value="Elective"/>	* Place of Service :	<input type="text" value="Outpatient Hospital"/>	

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.

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

Figure 16

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

**Procedures Table:**

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

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

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

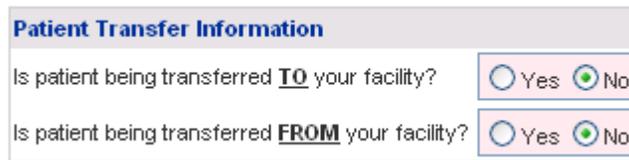
Figure 17

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.



**Patient Transfer Information**

Is patient being transferred **TO** your facility?  Yes  No

Is patient being transferred **FROM** your facility?  Yes  No

**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.

**Supporting Information**

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

**\* Clinical Data to Support Request :**

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

Enter clinical data

**\* Admitting Treatment Plan :**

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

Describe treatment plan

**Figure 19**

***Retro-Eligibility:***

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

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

**Figure 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.

**ColonScopyFOC**

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

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

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

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

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

**Figure 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](http://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:

<b>Out of State Services</b>	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](http://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.

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

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

Member Medicaid ID: 333000000200

Facility Provider ID :

Medical Practitioner Provider ID : 007100063B [Physician Demo](#)

Fictitious member/provider data

System inserts requesting physician ID and name. →

Figure 22 Physician Requestor

**Note:** When the Facility Provider ID box is left blank, the system auto-populates ‘REFGMCF00S’ 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.

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

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

Member Medicaid ID: 333000000200

Facility Provider ID : 007100064A [GMCF Hospital](#)

Medical Practitioner Provider ID : REF007100063

System inserts requesting facility ID and name. →

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.

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

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

**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.

The screenshot shows the same form as Figure 24, but with a black box labeled "Fictitious provider data" above it. The fields are populated with the following information:

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

**Figure 25**

**Rendering Facility Information:**

This section captures out of state facility information.

The screenshot shows a form titled "Rendering Facility Information" with the following fields: "Out-of-State Facility Name" (text box), "Address Line 1" (text box), "Address Line 2" (text box), "City" (text box), "State" (dropdown menu), "Zip" (text box), "Phone" (text box with hyphens), "Ext." (text box), and "Fax" (text box with hyphens).

**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.

The screenshot shows the same form as Figure 26, but with the following data entered: "Out-of-State Facility Name" is "Columbus Kids Hospital"; "Address Line 1" is "22 Address Lane"; "Address Line 2" is empty; "City" is "Columbus"; "State" is "OH"; "Zip" is "45200"; "Phone" is "514-888-8880"; "Ext." is empty; and "Fax" is "514-888-8889". A black box labeled "Fictitious provider data" is overlaid on the top right of the form.

**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.

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

Figure 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’.

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

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
<input type="text"/>	<input type="text"/>	01/01/2014	<input type="checkbox"/>	<input type="checkbox"/>		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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL

Figure 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.

The screenshot shows a form titled "Supporting Information". It has two main sections. The first section is titled "Clinical Data to Support Request" and includes the instruction "Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission". Below this instruction is a large text area containing the text "Attached to request". The second section is titled "Admitting Treatment Plan" and includes the instruction "Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments." Below this instruction is another large text area containing the text "Attached to request".

**Figure 32**

***Retro-Eligibility:***

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

The screenshot shows a question: "Does this member have retro eligibility for the submitted dates of service?". There are two radio buttons: "Yes" and "No". The "No" radio button is selected, indicated by a green dot in the center.

**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](http://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.

**Hospital OutPatient Therapy**

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

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

Member Medicaid ID:

Facility Provider ID :

**Submit**

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.

**Hospital OutPatient Therapy**

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

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

Member Medicaid ID:

Facility Provider ID :

**Submit**

Fictitious member/provider data

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. .

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

Figure 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.

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

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.

- 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'.
- Click **Add** to add the diagnosis code to the request.

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

Figure 38

- 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.

- Enter the procedure code for the service requested in the 'CPT Code' box; or search for and have system insert the procedure code.
- 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.
- Enter the number of visits requested for the procedure date span under 'Units'.
- 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.
- Click **Add** to add the procedure code to the request.

Procedures

Enter procedure code(s), From/To Date, and Number of Visits Per Week. If the service is to be provided only once, please select '1 Time Only' for the Number of Visits Per Week.

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

1 Time Only  
 1x Per Week  
 2x Per Week  
 3x Per Week  
 4x Per Week  
 5x Per Week

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".

97001	PT EVALUATION	01/03/2011	01/31/2011	1	1 Time Only					EDIT DELETE
<input type="text"/>	ADD CANCEL									

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.

The screenshot shows a form titled "Supporting Information". It contains two main sections, each with a heading and a text area. The first section is titled "\* Clinical Data to Support Request :" and includes the instruction "Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission". Below this is a text area with the prompt "Describe the patient's severity of illness/acute condition requiring therapeutic services." The second section is titled "\* Admitting Treatment Plan :" and includes the instruction "Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments." Below this is another text area with the prompt "Describe the therapeutic services to be provided." Both text areas are currently empty and have a light pink background.

**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 :

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

Is this a request for continued therapy services ?  Yes  No

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

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

If Yes, provide the diagnosis for the chronic illness.

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

If Yes, indicate which programs.

**Range of Motion Evaluation :**

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

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

**Strength Evaluation :**

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

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

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

If yes, date of certification:

Medical Practitioner Name :

Medical Practitioner contact number : aaa-xxx-xxxx

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

If Yes, date signed by Medical Practitioner :

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

If Yes, provide this statement.

enter statement regarding member's potential for rehab

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

---

**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:

<b>Radiology - Physician</b>	430 – Physician Services 431 – Physician’s Assistant Services 480 – Nurse Midwifery 550 – Podiatry 740 – Nurse Practitioner
<b>Radiology – Facility Setting</b>	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](http://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.

Fictitious member/provider data

System inserts requesting facility provider ID and name. →

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

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).

System inserts requesting physician provider ID and name. →

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

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.

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

Figure 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.

The screenshot shows a form titled "Request Information" with two fields. The "Date of Service" field contains "12/15/2011" and the "Admission Type" field is a dropdown menu with "Elective" selected.

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.

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

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.

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

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.

The screenshot shows a form titled "Supporting Information". It contains two main sections, each with a header and a text input area. The first section is labeled "Clinical Data to Support Request" and includes instructions to include vital signs, history, physical, lab reports, X-rays, and signs/symptoms. The second section is labeled "Admitting Treatment Plan" and includes instructions to describe services to be provided, such as IV fluids, medications, and wound care.

**Figure 49**

***Retro-Eligibility:***

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

The screenshot shows a question: "Does this member have retro eligibility for the submitted dates of service?". There are two radio button options: "Yes" and "No". The "No" option is selected, indicated by a filled green circle.

**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.

**MRI Brain**

1 Is this for evaluation of head trauma?  Yes  No

2 Is stroke/CVA suspected?  Yes  No

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

4 Is there a new onset seizure?  Yes  No

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

6 Is the patient taking Tysabri?  Yes  No

7 Are metastasis present or suspected?  Yes  No

8 Are there new or worsening CNS symptoms/findings? If so, indicate all that apply  Yes  No  Focal neurological finding by physical exam  Ataxia  
 Headache  Mental status changes  
 Meningismus  Other

Figure 51

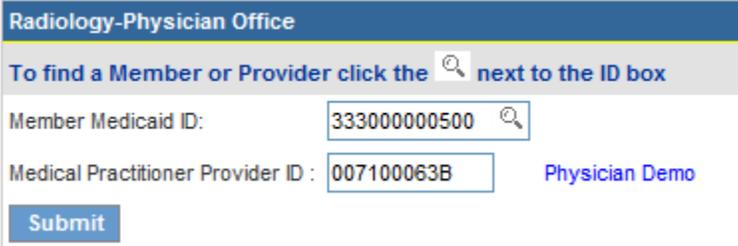
24. When all data is entered on the request form, click **Review Request** at the bottom of the page to display the *Attestation Statement*. If the *Attestation Statement* does not display when **Review Request** is selected; or a message displays that ‘information is missing or incorrect’, scroll up 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](http://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.



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

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
Medications Physician Office	Other drugs: 6 months or one year.

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](http://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.

Fictitious member/provider data

System inserts requesting hospital provider ID

**Medications PA Facility Setting**

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

Member Medicaid ID:

Facility Provider ID :  GMCF Hospital

Medical Practitioner Reference ID :

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.

**Contact Information**

\* Contact Name:

\* Contact Email:

Contact Phone:  Ext.

\* Contact Fax:

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.



The screenshot shows a form titled "Request Information" with three fields: "Admit Date" with the value "01/17/2012", "Admission Type" with a dropdown menu set to "Elective", and "Place of Service" with a radio button selected for "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’.



The screenshot shows a form titled "Patient Information" with two fields: "Patient Height (inches)" with the value "55" and "Patient Weight (pounds)" with the value "125".

**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.

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

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.

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

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.

**Supporting Information**

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

Enter clinical justification

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

Describe the treatment plan

**Figure 59**

***Retro-Eligibility:***

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

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

**Figure 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.

**Treanda**

**Additional information is required for Code J9033.**

Has the patient failed purine analog based therapy (fludarabine, pentostatin)?  Yes  No

If no, please comment:

\_\_\_\_\_

\_\_\_\_\_

Has the patient previously or is currently being treated with Rituxin?  Yes  No

If no, please comment:

\_\_\_\_\_

\_\_\_\_\_

Has the member's NHL progressed during or within six months of treatment with Rituxin (rituximab) or a regimen containing Rituxin, and Treanda is being used as monotherapy?  Yes  No

If no, please comment:

\_\_\_\_\_

\_\_\_\_\_

Has the member's NHL responded well to Rituxin (rituximab) in the past, and Treanda is being used in combination with Rituxin?  Yes  No

If no, please comment:

Explain No response.

\_\_\_\_\_

\_\_\_\_\_

Figure 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](http://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.

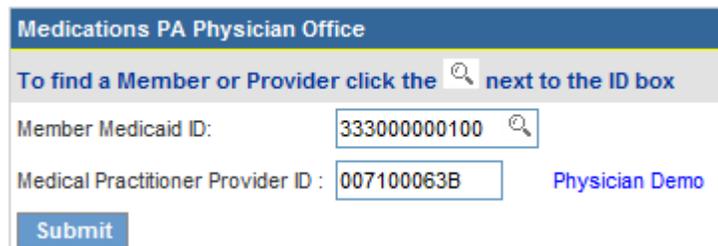


Figure 62

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.

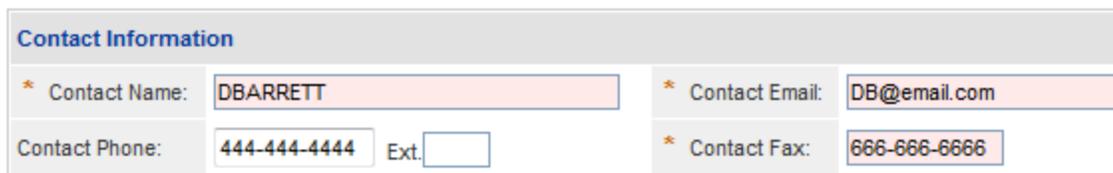


Figure 63

***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.



The screenshot shows a form titled "Request Information" with three input fields. The first field is "Date of Service" with the value "01/25/2012". The second field is "Admission Type" with a dropdown menu showing "Elective". The third field is "Place of Service" with a radio button selected for "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](http://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.

Practitioner's Office Surgical Procedures (Form Number: GMCF form PA81/100)

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

Member Medicaid ID:

Medical Practitioner Provider ID:  [Physician Demo](#)

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.

Contact Information

\* Contact Name:  \* Contact Email:

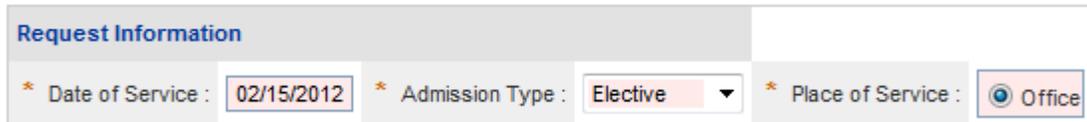
Contact Phone:  Ext.  \* Contact Fax:

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.



**Request Information**

\* Date of Service : 02/15/2012 \* Admission Type : Elective \* Place of Service : 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.



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

Figure 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.

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

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.

**Supporting Information**

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

Enter clinical justification

---

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

Describe the treatment plan

Figure 70

**Retro-Eligibility:**

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

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

Figure 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.

**Additional Information**

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

**Outpatient Bunionectomy**

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

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

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

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

**Figure 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](http://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.

Additional Physician Office Visit (Form Number: DMA-81)

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

Member Medicaid ID:  

Medical Practitioner Provider ID :  [Physician Demo](#)

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.

Contact Information

\* Contact Name:  \* Contact Email:

Contact Phone:  Ext.  \* Contact Fax:

Figure 74

**Request Information:**

This section captures Place of Service.

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

Request Information

\* Place of Service :  11 - Office  99 - Other

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.

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

Figure 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.

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

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.

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

**Figure 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.

Physician's Examination Report and Recommendation :	
Date Patient First Seen for Diagnosis :	<input type="text" value="06/01/2011"/>
Date of Most Recent Visit :	<input type="text" value="09/05/2011"/>

**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.

<b>Patient's Present Medical Status :</b>
Include pertinent clinical information to support the need for additional physician office visits.
<input type="text"/>
<b>Treatment or Services Rendered :</b>
Describe the specific services to be provided to the patient during the requested additional office visits.
<input type="text"/>
<b>Plan of Care :</b>
Summarize the patient's plan of treatment.
<input type="text"/>
<b>Justification and Circumstances for Requested Additional Services :</b>
Provide the clinical rationale for these additional office visits.
<input type="text"/>

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](http://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.

The screenshot shows a web form titled "Additional Psychiatric Services (Form Number:GMCF PSY/PA)". Below the title is a grey bar with the text "To find a member or provider ID click the [magnifying glass icon] next to the ID box". There are two input fields: "Member Medicaid ID:" with the value "333000000400" and a magnifying glass icon to its right; and "Medical Practitioner Provider ID:" with the value "007100074A" and the name "BARRETT, DARLENE" to its right. A blue "Submit" button is at the bottom left. A black box with white text "Fictitious member and provider data" is overlaid on the right side of the form.

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.

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

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.**

Request Information	
* Place of Service : <input checked="" type="radio"/> 11 - Office <input type="radio"/> 99 - Other	* Is this a request for additional visits beyond the 24 visits permitted per calendar year without a PA? (If YES, continue with submission; If NO, PA is not required.) <input checked="" type="radio"/> Yes <input type="radio"/> No

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.

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

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.

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

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:**

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

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.

**Progress to Date Including Compliance with Recommended Treatment**  
Provide brief psychological history and patient's compliance with treatment regimen.

Provide brief psychological history and patient's compliance with treatment regimen.

**Current Clinical and Anticipated Goals for Additional Hours**  
Describe the expected outcome resulting from additional hours of treatment.

Describe the expected outcome resulting from additional hours of treatment.

**Current Clinical Information to Support Request (Complete Checklist and Explanation)**  
Current Global Assessment of Functioning (GAF Scale 0-100):

Which of the following conditions does the Patient display? (Check all that apply)

<input type="checkbox"/> Currently Suicidal	<input checked="" type="checkbox"/> Suicidal by History	<input type="checkbox"/> Homicidal	<input type="checkbox"/> History of Significant Psychological Trauma
<input type="checkbox"/> Specialized School Placement	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Sexually Aggressive	<input type="checkbox"/> Foster Home
<input type="checkbox"/> Psychotic	<input type="checkbox"/> Physically Aggressive	<input type="checkbox"/> Multiple Foster Homes	<input type="checkbox"/> Serious Runaway Behavior
<input type="checkbox"/> Legal Issues	<input checked="" type="checkbox"/> Severe Somatization	<input checked="" type="checkbox"/> Physically Self-Destructive	<input type="checkbox"/> Other (Please specify in comment below)

List the member's medications and frequency

Provide the justification for the requested additional services - why the services are medically necessary.

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](http://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.

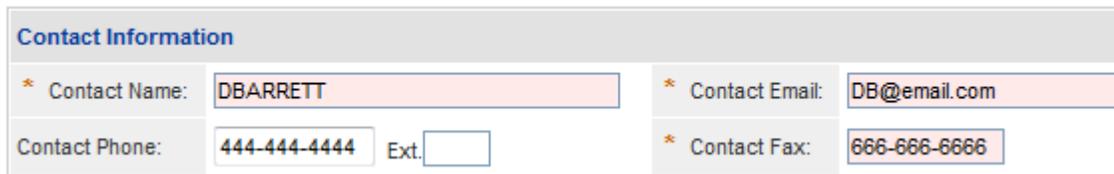
Figure 87

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.



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

Figure 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.



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

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.

Procedures											
CPT Code	CPT Description	From Date	To Date	Quantity	Amount	Tooth	Surface	Tooth Quad	Oral Cavity Code	Code List Qualifier	
D9920		05/17/2010	05/26/2010	1	100.00						ADD CANCEL

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’.

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

**Identify all missing teeth :**

Permanent Teeth

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

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

Primary Teeth

A  B  C  D  E  F  G  H  I  J

T  S  R  Q  P  O  N  M  L  K

Figure 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.

**Remarks / Summary of Radiology Findings :**

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

Interpretation of Xrays and justification for services requested.

Figure 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.

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

**Child Dental D9920 Behavior Management**  
**Please select from the following clinical situations, which describes the information entered in the Remarks box.**

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

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

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

**Figure 94**

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

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

**Child Dental D9920 Behavior Management**  
**Please select from the following clinical situations, which describes the information entered in the Remarks box.**

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

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

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

**Figure 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](http://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.

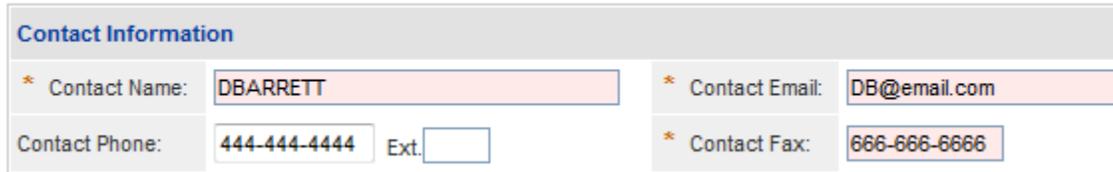
Figure 96

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.



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

Figure 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.



The screenshot shows a form titled "Request Information" with three input fields. The "Admission Date" field contains "03/31/2012". The "Discharge Date" field contains "03/31/2012". The "Place of Service" field is a dropdown menu with "11 - Office" selected.

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.

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

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.

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

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.



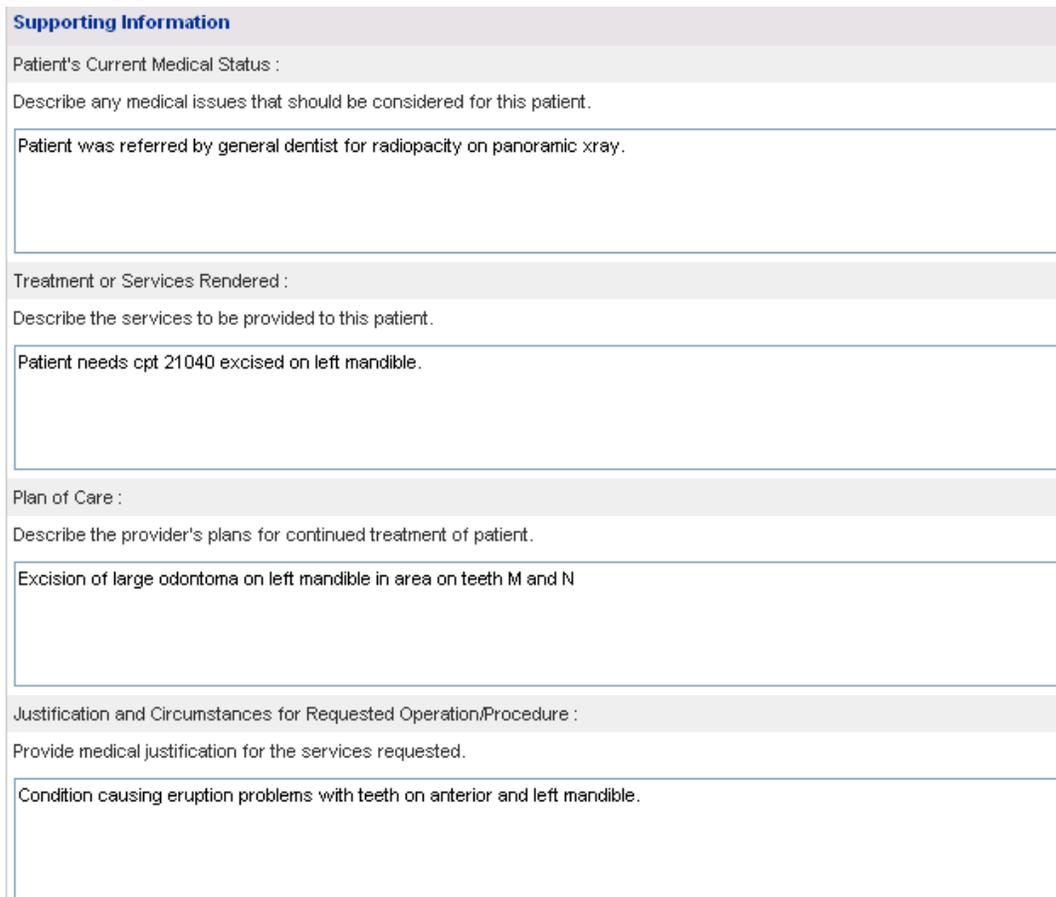
A screenshot of a web form showing a date input field. The label is "Date of Most Recent Visit :" and the value entered is "05/10/2010".

**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.



A screenshot of a web form titled "Supporting Information". It contains four textboxes for patient information:

- Patient's Current Medical Status :**  
Describe any medical issues that should be considered for this patient.  
Patient was referred by general dentist for radiopacity on panoramic xray.
- Treatment or Services Rendered :**  
Describe the services to be provided to this patient.  
Patient needs cpt 21040 excised on left mandible.
- Plan of Care :**  
Describe the provider's plans for continued treatment of patient.  
Excision of large odontoma on left mandible in area on teeth M and N
- Justification and Circumstances for Requested Operation/Procedure :**  
Provide medical justification for the services requested.  
Condition causing eruption problems with teeth on anterior and left mandible.

**Figure 102**

***Retro-Eligibility:***

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



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

**Figure 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](http://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.

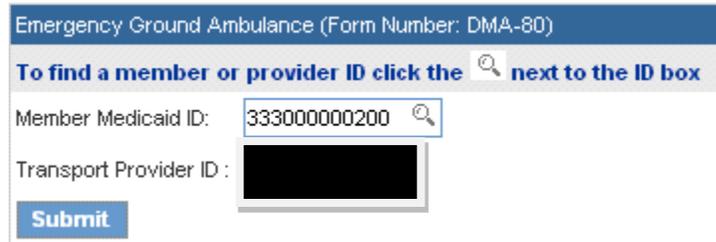


Figure 104

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.

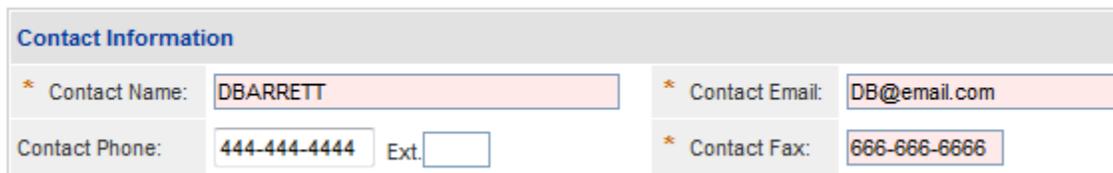


Figure 105

**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.

Origin Address				Destination Address			
* Name :	Residence	* Address :	1127 Test St	* Name :	Good Hospital	* Address :	12 Testing Ave
* City :	Atlanta	* State :	GA	* City :	Atlanta	* State :	GA
		* Zip :	30030			* Zip :	30030

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.

* Mode of Transportation :	Licensed Ambulance	* Emergency Transportation :	<input checked="" type="radio"/> Yes <input type="radio"/> No	* Total Miles :	200
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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.

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

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.”

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

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.

**Ambulance Certification**

Ambulance Transport Code :

Ambulance Transport Reason Code :

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.

**Please Select Medical Services Rendered (Check all that apply.)**

IV/PICC Line    Medications IV/IM    Cardiac Monitor    Oxygen    Ventilator    Trach Tube    Peg Tube    Foley Catheter

Other (Please specify in the box below. For example, wound care)

STRETCHER AND DRAWSHEET ENROUTE.

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.

**Description of Services Requested**

Describe the services that were provided during transportation.

Describe services provided during the transport

**Justification and Circumstances for Requested Services**

Provide rationale for services requested including staffing required during transportation.

Provider rationale for service provided including staffing

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](http://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.

#### New Request for Prior Authorization

Figure 114

5. Enter the member's Medicaid ID.

Durable Medical Equipment (Form Number: DMA-610)

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

Member Medicaid ID:  

Service Provider 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.

Contact Information

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

Figure 116

**Request Information:**

This section captures the Place of Service.

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

Request Information

\* Place of Service :  Home  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.

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

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.

Procedures												
CPT Code	CPT Description	From Date	To Date	Months or Units of Service Requested	Requested Price/Unit	Mod 1	Mod 2	Equipment Make	Equipment Model	Manufacturer ID	Serial No	
E0431	PORTABLE GASEOUS O2	05/10/2010	03/09/2011	10	300.00	RR						<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="ADD"/> <input type="button" value="CANCEL"/>				

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'.

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

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

Figure 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’.

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

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.

**Justification and Circumstances for Requested Services :**

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

Provide medical justification for the requested services.

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.

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

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.

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

Is Member on continuous Oxygen Therapy ?  Yes  No

**Prescription Information :**

Date oxygen prescribed :   Initial  Renewal Date last seen by physician :  Method of delivery :

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

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

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

If Other is selected, please describe :

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

**Laboratory Results :**

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

Oxygen saturation performed?  Yes  No Date of test :  Oxygen Saturation Test Result :  %

Was the test performed on room air?  Yes  No

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

Explain why test not performed on room air.

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

Figure 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.

**Create an Attachment**

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

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

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

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.

**Create an Attachment**

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

File uploaded successfully.

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

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

**Attached Files**

File	Type	Code	Document Name	User	Date	
<a href="#">CMN and Testing Results.pdf</a>	4	E0431	Copy of Testing Results		5/18/2010 2:38:52 PM	✗
<a href="#">CMN and Testing Results.pdf</a>	4	E0431	Certificate of Medical Necessity (CMN)		5/18/2010 2:38:52 PM	✗

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](http://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.

Orthotics and Prosthetics (Form Number: DMA-610)

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

Member Medicaid ID:

Service Provider 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.

Contact Information

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

Figure 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*.

Request Information

\* Place of Service :  Home  Other

Figure 130

**Request Information**

\* Place of Service :  Outpatient Hospital  Office  Other

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.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
728.71	PLANTAR FIBROMATOSIS	02/14/2010	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text" value="02/14/2010"/>	<input type="checkbox"/>		ADD

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

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

Figure 134 Hearing Aide Services

***Retro-Eligibility:***

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

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

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

***Repairs and Replacements:***

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

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

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’.

Therapist Information			Patient Information	
* Therapist / Other Service Provider Name :	* Georgia License / Certification Number :	* Certification Type :	Patient Height (inches) :	Patient Weight (pounds) :
JANE THERAPIST	CO111111111	CO	60 in.	110 lb.

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.

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

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.

**Justification and Circumstances for Requested Services :**

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

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

Figure 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.

Was a signed physician's prescription or Certificate of Medical Speciality on file within 90 days of request ?  Yes  No

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.

**Additional Information**

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

**Foot and Ankle Orthotics**

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

**Does member have a history of:**

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

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

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

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

Figure 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.

**Additional Information**

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

**Foot and Ankle Orthotics**

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

**Does member have a history of:**

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

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

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

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

Figure 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](http://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.

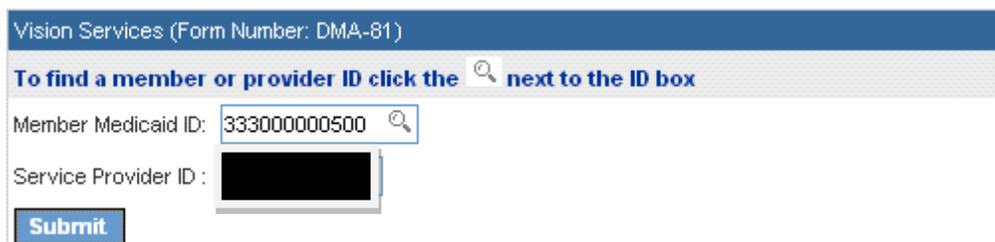


Figure 142

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.



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

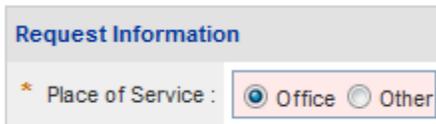
* Contact Name:	DBARRETT	* Contact Email:	DB@email.com
Contact Phone:	444-444-4444	Ext.	
		* Contact Fax:	666-666-6666

Figure 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.



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

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

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.

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

Figure 145

- 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.

- Enter the procedure code for the vision service in the ‘CPT Code’ box.
- Enter the date that the service started or is to start in the ‘From Date’ box. Enter manually or use the calendar popup.
- In the ‘To Date’ box, enter the same date as entered in the ‘From Date’ box. The system will calculate the applicable authorization span.
- Enter the total units requested for the service in the ‘Units’ box. Enter whole numbers only.
- Enter the unit price for the service requested in the ‘Requested Price/Unit’ box.
- 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.

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

Figure 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’.



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



**Physician's Examination Report and Recommendation :**  
Date Patient First Seen for Diagnosis : 05/20/2010      Date of Most Recent Visit : 05/20/2010

**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.

**Patient's Present Medical Status :**  
Include the patient's visual acuity and other medical factors related to the patient's vision.  
Visual acuity without glasses is 20/25 and is improved to 20/20 with correction.

**Treatment or Services Rendered (Include the provider's prescription information) :**  
Describe the vision care services to be provided, i.e., glasses/contacts, special needs.  
Recommend glasses to be worn full time. Rx OD:+0.50-0.25x042 OS:+0.75 sph.

**Plan of Care :**  
Summarize the patient's plan of treatment by the physician.  
Glasses to be worn full time, return in one year for annual exam.

**Justification and Circumstances for Vision Series :**  
Provide the clinical rationale for these vision series.  
glasses required to see 20/20

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.

Is there a signed prescription on file?  Yes  No Date : 05/18/2010

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](http://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.

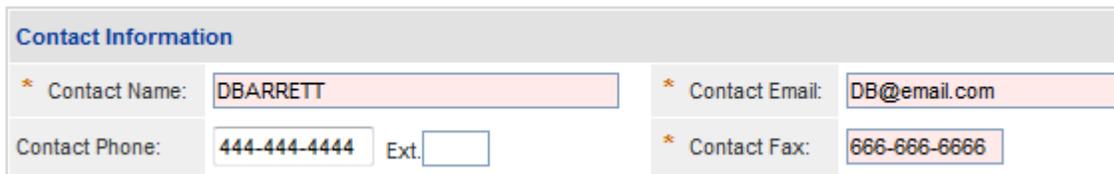
Figure 151

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.



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

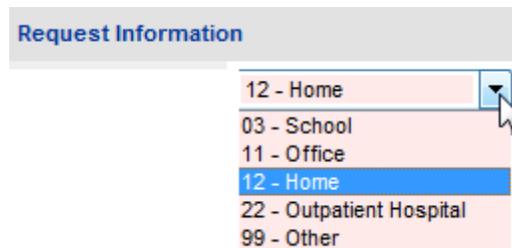
* Contact Name:	DBARRETT	* Contact Email:	DB@email.com
Contact Phone:	444-444-4444	Ext.:	
		* Contact Fax:	666-666-6666

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.



The screenshot shows a dropdown menu titled "Request Information" with the following options: 12 - Home, 03 - School, 11 - Office, 12 - Home (highlighted), 22 - Outpatient Hospital, and 99 - 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.

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

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.**

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

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’.

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

\* Date admitted to program : 09/24/2007

**Description of Services Requested :**

Physical Therapy     Occupational Therapy     Speech/Language Therapy

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.

**Justification and Circumstances for Required Services :**

Medical necessity and expected outcomes.

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

Primary Care Physician Name: Doctor Doctor

Figure 157

**Outcomes:**

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

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

**Outcomes**

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

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

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

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

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

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

Figure 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.

Is this PA request a continuation from a previous PA?	<input type="radio"/> Yes <input checked="" type="radio"/> No	If Yes, Previous PA#:	-- Please select --
Is there a current Individualized Education Plan (IEP)?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If Yes, IEP Date:	05/17/2010
		If No, please explain why:	<input type="text"/>
Is there a current Individualized Family Service Plan (IFSP) on file ?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Date Signed :	<input type="text"/>
Is there a current Attestation form attached (child does not have an IEP or IFSP)?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If Yes, date Attestation form was signed :	05/17/2010
Is there a current Letter of Medical Necessity, Written Service Plan or Plan of Care?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If Yes, LMN/WSP/POC date:	05/17/2010
Are current standardized testing results attached?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If Yes, standardized testing date:	05/17/2010
Are there current progress notes attached?	<input type="radio"/> Yes <input checked="" type="radio"/> No	If Yes, most current progress note date:	<input type="text"/>
If No, is this a new patient?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If No, please explain why there are no progress notes :	<input type="text"/>
Is there a valid parental consent on file and the parent has not withdrawn consent ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed :	05/04/2010
Name of Service Coordinator :	<input type="text"/>	Title :	Coordinator

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**.

**Create an Attachment**

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

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

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

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](http://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.

Independent Care Waiver Program/Traumatic Brain Injury (ICWP/TBI) (Form Number: DMA-6)

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

Member Medicaid ID:

Service Provider ID :

Physician Reference ID :

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.

**Contact Information**

\* Contact Name:  \* Contact Email:

Contact Phone:  Ext.  \* Contact Fax:

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*.

Request Information	
* Recommendation Type :	<input type="radio"/> Continued Placement <input checked="" type="radio"/> Initial Placement
Initial Admission Date :	Initial Request ID :
* Place of Service :	12 - Home

Figure 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.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
344.9	PARALYSIS NOS	01/01/2010	Yes	No	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	01/01/2010	<input type="checkbox"/>	<input type="checkbox"/>		ADD

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.**

Medications				
Name	Dosage	Route	Frequency	
Anticonvulsive	10mg	Rectal	PRN: As Necessary	EDIT DELETE
Anticonvulsive	312.5mg	Oral	Regular	EDIT DELETE
Narcotic	2.5mg	Oral	PRN: As Necessary	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

Figure 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.

Type	Frequency	
Patient/Family Education	monthly	EDIT DELETE
Clean Dressing	bid	EDIT DELETE
<input type="text"/>	<input type="text"/>	ADD

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.

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

Describe the treatment plan.

Figure 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.

<input checked="" type="radio"/> Yes <input type="radio"/> No	Is the patient free of communicable diseases?
<input checked="" type="radio"/> Yes <input type="radio"/> No	Can this patient's condition be managed by :
<input checked="" type="radio"/> Yes <input type="radio"/> No	- Community Care ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	- Home Health Services ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	Has the physician certified that this patient requires the level of care provided by a nursing facility or an intermediate care facility for the mentally retarded ?

Date Signed by Physician :	<input type="text" value="04/26/2010"/>
----------------------------	---

**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.

Evaluation of Nursing Care Needed : <i>(check all that apply)</i>					
Diet :	Bladder :	Bowel :	Decubiti :	Restorative Potential :	Overall Condition :
<input checked="" type="checkbox"/> Regular	<input type="radio"/> Continent	<input checked="" type="radio"/> Continent	<input type="checkbox"/> Yes	<input type="radio"/> Good	<input type="radio"/> Improving
<input type="checkbox"/> Diabetic	<input checked="" type="radio"/> Occasionally Incontinent	<input type="radio"/> Occasionally Incontinent	<input checked="" type="checkbox"/> No	<input checked="" type="radio"/> Fair	<input checked="" type="radio"/> Stable
<input type="checkbox"/> Formula	<input type="radio"/> Incontinent	<input type="radio"/> Incontinent	<input type="checkbox"/> Infected	<input type="radio"/> Poor	<input type="radio"/> Fluctuating
<input type="checkbox"/> Low Sodium	<input type="radio"/> Other	<input type="radio"/> Colostomy	<input type="checkbox"/> On Admission	<input type="radio"/> Questionable	<input type="radio"/> Deteriorating
<input type="checkbox"/> Tube Feeding			<input type="checkbox"/> Surgery Date	<input type="radio"/> None	<input type="radio"/> Critical
<input type="checkbox"/> Other					<input type="radio"/> Terminal
Mental & Behavioral Status : <i>(check all that apply)</i>			Nursing Care and Treatment : <i>(Check all that apply)</i>		
<input type="checkbox"/> Agitated	<input type="checkbox"/> Noisy	<input checked="" type="checkbox"/> Dependent	<input type="checkbox"/> Catheter Care	<input type="checkbox"/> Bedfast	
<input type="checkbox"/> Confused	<input type="checkbox"/> Nonresponsive	<input type="checkbox"/> Independent	<input type="checkbox"/> Intake	<input type="checkbox"/> Colostomy Care	
<input type="checkbox"/> Cooperative	<input type="checkbox"/> Vacillating	<input type="checkbox"/> Anxious	<input type="checkbox"/> Output	<input type="checkbox"/> Sterile Dressings	
<input type="checkbox"/> Depressed	<input type="checkbox"/> Violent	<input type="checkbox"/> Well Adjusted	<input type="checkbox"/> IV	<input type="checkbox"/> Suctioning	
<input type="checkbox"/> Forgetful	<input type="checkbox"/> Wanders	<input type="checkbox"/> Disoriented	<input checked="" type="checkbox"/> N/A		
<input type="checkbox"/> Alert	<input checked="" type="checkbox"/> Withdrawn	<input type="checkbox"/> Inappropriate Reaction			
Hours out of the Bed Per Day :			<input type="text" value="12"/> Hrs.		

Figure 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.

- For each therapy that the member is receiving or needs, enter the number of hours **received** per week in the first column; and the number of hours of therapy that is **needed** in the second column.

Indicate Frequency Per Week (in Hours)		
	Received	Needed
Physical Therapy	<input type="text" value="4"/>	<input type="text" value="6"/>
Occupational Therapy	<input type="text" value="0"/>	<input type="text" value="4"/>
Remotive Therapy	<input type="text"/>	<input type="text"/>
Reality Orientation	<input type="text"/>	<input type="text"/>
Speech Therapy	<input type="text"/>	<input type="text"/>
Bowel and Bladder Retrain	<input type="text"/>	<input type="text"/>
Activities Program	<input type="text"/>	<input type="text"/>

Figure 171

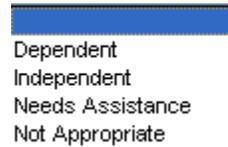
***Level of Impairment and Activities of Daily Living:***

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.

Activities of Daily Living		Level of Impairment	
Eating	Independent	Sight	Moderate
Wheelchair	Dependent	Hearing	Moderate
Transferring	Needs Assistance	Speech	None
Bathing	Dependent	Limited Motion	Severe
Ambulating	Not Appropriate	Paralysis	Severe
Dressing	Independent		

**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.

**Justification and Circumstances for Admission or Continued Placement :**  
*Provide a brief summary of the pertinent information that justifies medical necessity.*

Summary of pertinent information that supports medical necessity.

Name of MD / RN Signing Form :  Date Signed :

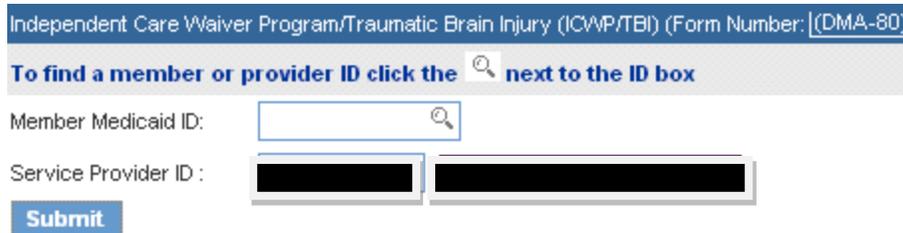
Figure 175

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:

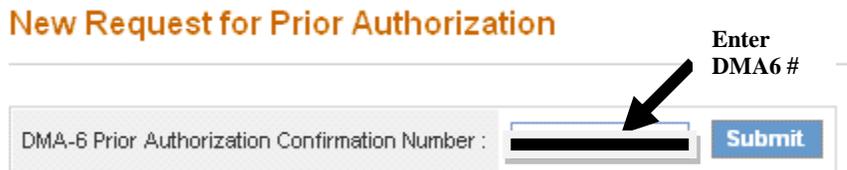
1. Go to the **Georgia Web Portal** at [www.mmis.georgia.gov](http://www.mmis.georgia.gov) and log in using your assigned user name and password.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Independent Care Waiver Program (Form number DMA-80)** to open the *New Request for Prior Authorization* page.
4. The requesting ICWP provider ID is system populated in the ‘Service Provider ID’ box



The screenshot shows a web form titled "Independent Care Waiver Program/Traumatic Brain Injury (ICWP/TBI) (Form Number: [(DMA-80)]". Below the title is a grey instruction bar: "To find a member or provider ID click the [magnifying glass icon] next to the ID box". There are two input fields: "Member Medicaid ID:" with a magnifying glass icon, and "Service Provider ID:" with two adjacent input boxes. A blue "Submit" button is located below the first input field.

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.



The screenshot shows the "New Request for Prior Authorization" form. The title "New Request for Prior Authorization" is in orange. Below it is a grey instruction bar: "Enter DMA6 #". There is an input field for "DMA-6 Prior Authorization Confirmation Number:" with a magnifying glass icon. A black arrow points to the input field. A blue "Submit" button is located to the right of the input field.

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.

- 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.

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

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

Figure 178

**Request Information:**

This section captures the following request information: location where services are provided and consumer directed status.

- The system defaults the ‘Place of Service’ to *Home*.
- 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.

- 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.
- 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.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
344.9	PARALYSIS NOS	01/01/2010	Yes	No	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text" value="01/01/2010"/>	<input type="checkbox"/>	<input type="checkbox"/>		ADD

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.

Procedures													
Service Code	Service Description	From Date	To Date	Units	Requested Units/Day	Requested Units/Month	Requested Amount	Cost Sharing Amount	Mod 1	Mod 2	Mod 3	Mod 4	
T1016	CASE MANAGEMENT	05/03/2010	05/02/2011	480	0	40	3,000.00	200.00	U1				EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD CANCEL						

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.

Program Information :					
Program Admit Date :	<input type="text" value="05/01/2010"/>	Program Discharge Date :	<input type="text"/>	<input checked="" type="radio"/> Initial Admission <input type="radio"/> Renewal	Date Last Certified : <input type="text"/>

Figure 182



- **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*.

Is there a signed Letter of Medical Necessity at the agency ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed :	<input type="text" value="04/30/2010"/>
Is there a signed Letter of Understanding on file ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed :	<input type="text" value="04/30/2010"/>
Is there a signed Client Rights and Responsibilities on file ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed :	<input type="text" value="04/30/2010"/>
Is there a signed Freedom of Choice form on file ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Date Signed :	<input type="text" value="04/30/2010"/>
Is the patient receiving any other waiver services ?	<input type="radio"/> Yes <input checked="" type="radio"/> No		

**Figure 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**.

## 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](http://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.

## New Request for Prior Authorization

Source

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

Member Medicaid ID: 333000000300 

Source Provider ID:   Provider ID displays here

Submit

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.

Physician Information			
* Physician Name :	<input type="text" value="John Physician"/>	<input checked="" type="checkbox"/> Primary Physician <input type="checkbox"/> SOURCE Site Medical Director	Physician ID :
Address Line 1 :	<input type="text"/>	Address Line 2 :	<input type="text"/>
City :	<input type="text"/>	State : <input type="button" value="v"/>	Zip : <input type="text"/> County : <input type="button" value="v"/>
* Phone :	<input type="text" value="404-444-4444"/>	Ext. <input type="text"/>	Fax : <input type="text" value="- -"/>
* Date LOC signed by Physician:	<input type="text" value="06/07/2012"/>	Physician License Number :	<input type="text"/>

Figure 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.

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

Figure 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*.

Request Information			
* Recommendation Type :	<input checked="" type="radio"/> Initial <input type="radio"/> Reassessment	DON-R Telephone Screening Score :	<input type="text" value="25"/>
* Initial Admit Date :	<input type="text" value="01/01/2014"/>	* Approved for Money Follows the Person?	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Place of Service :	<input type="text" value="12 - Home"/>		

Figure 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.**

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
344.1	PARAPLEGIA NOS	01/01/2012	Yes	No	ICD-9	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text"/>	<input type="text"/>	<input type="text" value="01/01/2012"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="button" value="ADD"/>

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**.

The screenshot shows a web form with two main sections. The top section is titled "Acute Care Hospital Dates" and contains two date input fields: "From Date" with the value "02/01/2012" and "To Date" with the value "02/05/2012". The bottom section is titled "Diagnosis on Admission to Hospital" and contains a table with the following data:

Diag Code	Diagnosis Description	Primary	
362.07	DIABETIC MACULAR EDEMA	Yes	<input type="button" value="EDIT"/> <input type="button" value="DELETE"/>
<input type="text"/>	<input type="text"/>		<input type="button" value="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.

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

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**.

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

**Services**  
Describe the services and for each service indicate the amount, frequency and duration (example: RN Service, 1 session or 1 visit, 2X/week, (for) 6 weeks).

Services	Amount	Frequency	Duration	
T1030-Skilled Nursing Services RN	1 visit	2X week	6 weeks	ADD

Figure 193

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

**Services**  
Describe the services and for each service indicate the amount, frequency and duration (example: RN Service, 1 session or 1 visit, 2X/week, (for) 6 weeks).

Services	Amount	Frequency	Duration	
T1031-Skilled Nursing Services LPN	1 visit	2X week	6 weeks	EDIT DELETE
S5170-Home Delivered Meals	2 meals	7 days/week	6 months	EDIT DELETE
				ADD

Figure 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.

**Treatment Plan:**  
Describe the treatment plan including specific medications, level of care requested, time since last hospital stay, residential history, and other services to be provided.

Describe the treatment plan including specific medications, level of care requested, time since last hospital stay, residential history, and other services to be provided.

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.

<input checked="" type="radio"/> Yes <input type="radio"/> No	Is the patient free of communicable diseases?
	Can this patient's condition be managed by :
<input checked="" type="radio"/> Yes <input type="radio"/> No	- Source ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	- Home Health Services ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	Has the physician certified that this patient requires the intermediate level of care provided by a nursing facility?
<input checked="" type="radio"/> Yes <input type="radio"/> No	Has the physician certified that the attached plan of care addresses the client's needs for Community Care?

**Figure 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).

Evaluation of Nursing Care Needed : (check all that apply)					
Diet :	Bladder :	Bowel :	Decubiti :	Restorative Potential :	Overall Condition :
<input checked="" type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Formula <input type="checkbox"/> Low Sodium <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Other	<input type="radio"/> Continent <input type="radio"/> Occasionally Incontinent <input checked="" type="radio"/> Incontinent <input type="radio"/> Other	<input type="radio"/> Continent <input type="radio"/> Occasionally Incontinent <input type="radio"/> Incontinent <input checked="" type="radio"/> Colostomy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Infected <input type="checkbox"/> On Admission <input type="checkbox"/> Surgery Date	<input type="radio"/> Good <input checked="" type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Questionable <input type="radio"/> None	<input type="radio"/> Improving <input type="radio"/> Stable <input checked="" type="radio"/> Fluctuating <input type="radio"/> Deteriorating <input type="radio"/> Critical <input type="radio"/> Terminal
Mental & Behavioral Status : (check all that apply)			Nursing Care and Treatment : (Check all that apply)		
<input type="checkbox"/> Agitated <input checked="" type="checkbox"/> Confused <input type="checkbox"/> Cooperative <input type="checkbox"/> Depressed <input type="checkbox"/> Forgetful <input type="checkbox"/> Alert	<input type="checkbox"/> Noisy <input type="checkbox"/> Nonresponsive <input type="checkbox"/> Vacillating <input type="checkbox"/> Violent <input checked="" type="checkbox"/> Wanders <input type="checkbox"/> Withdrawn	<input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Anxious <input type="checkbox"/> Well Adjusted <input checked="" type="checkbox"/> Disoriented <input type="checkbox"/> Inappropriate Reaction	<input type="checkbox"/> Catheter Care <input type="checkbox"/> Intake <input type="checkbox"/> Output <input type="checkbox"/> IV <input checked="" type="checkbox"/> N/A	<input type="checkbox"/> Bedfast <input checked="" type="checkbox"/> Colostomy Care <input checked="" type="checkbox"/> Sterile Dressings <input type="checkbox"/> Suctioning	
Hours out of the Bed Per Day :			<input type="text" value="10"/> Hrs.		

Figure 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.

Indicate Frequency Per Week (in Hours)		
	Received	Needed
Physical Therapy	<input type="text"/>	<input type="text"/>
Occupational Therapy	<input type="text"/>	<input type="text"/>
Restorative Therapy	<input type="text"/>	<input type="text"/>
Reality Orientation	<input type="text" value="0"/>	<input type="text" value="15"/>
Speech Therapy	<input type="text"/>	<input type="text"/>
Bowel and Bladder Retrain	<input type="text" value="2"/>	<input type="text" value="4"/>
Activities Program	<input type="text"/>	<input type="text"/>

Activities of Daily Living	
Eating	<input type="text" value="Independent"/>
Wheelchair	<input type="text" value="Needs Assistance"/>
Transferring	<input type="text" value="Dependent"/>
Bathing	<input type="text" value="Needs Assistance"/>
Ambulating	<input type="text" value="Not Appropriate"/>
Dressing	<input type="text" value="Needs Assistance"/>

Level of Impairment	
Sight	<input type="text" value="Mild"/>
Hearing	<input type="text" value="Moderate"/>
Speech	<input type="text" value="Severe"/>
Limited Motion	<input type="text" value="Severe"/>
Paralysis	<input type="text" value="None"/>

Figure 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.

Justification and Circumstances for Admission or Continued Placement :	
<i>Provide justification for the services ordered.</i>	
Describe the treatment plan including specific medications, level of care requested, time since last hospital stay, residential history, and other services to be provided. Describe the treatment plan including specific medications, level of care requested, time since last hospital stay, residential history, and other services to be provided. Describe the treatment plan including specific medications, level of care requested, time since last hospital stay, residential history, and other services to be provided.	
Name of RN Signing Form :	<input type="text" value="Jane Doe"/>
Date Signed :	<input type="text" value="06/15/2012"/>

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).

**Create an Attachment**

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

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

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

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

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.

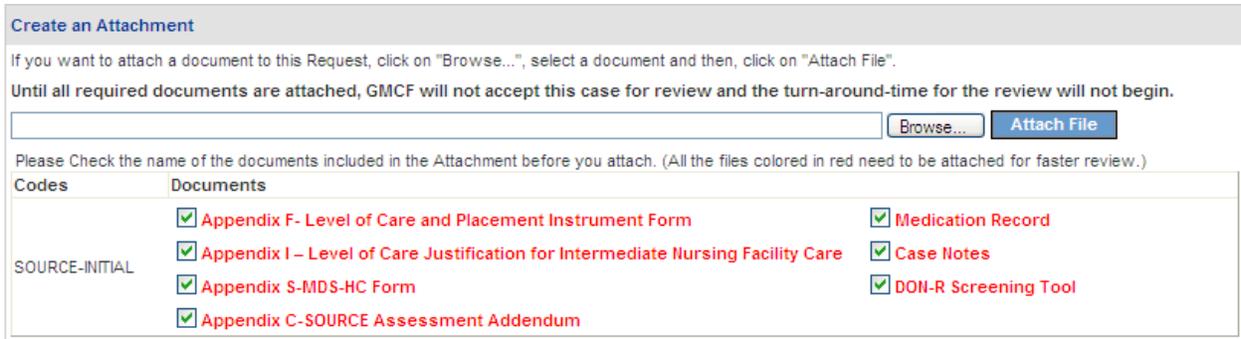


Figure 201

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

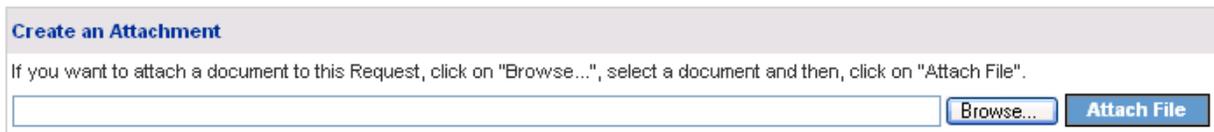


Figure 202

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**.

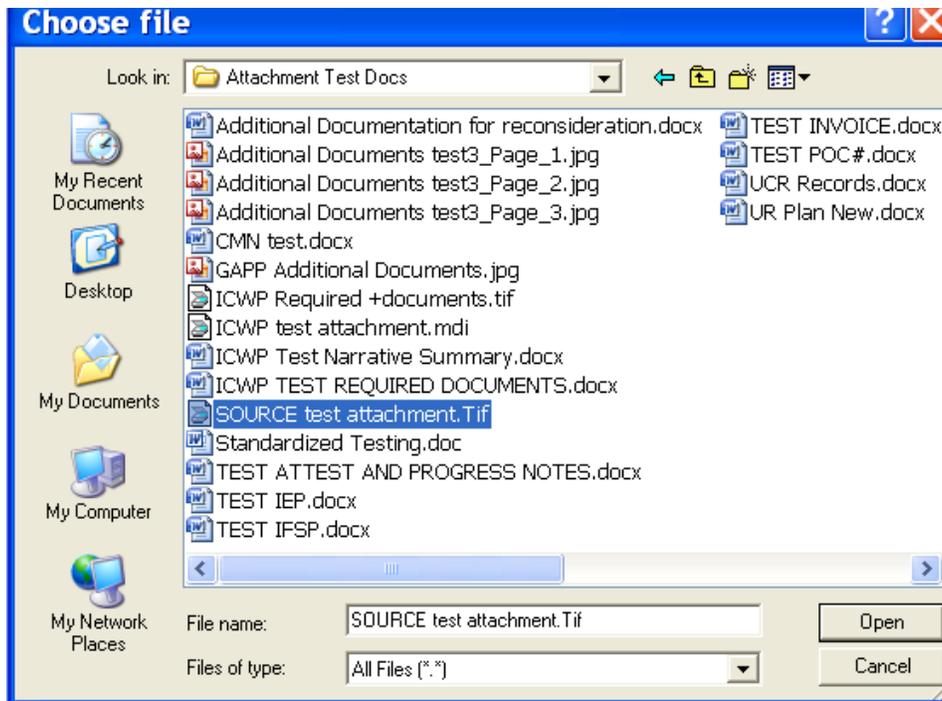


Figure 203

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

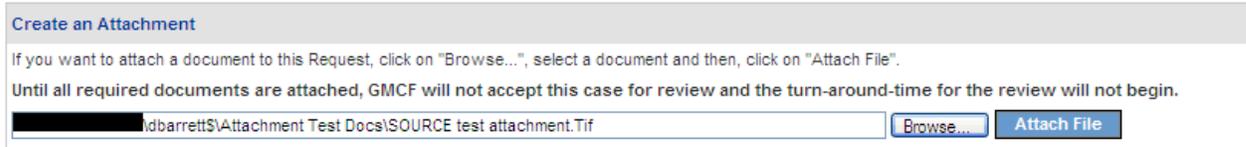


Figure 204

66. Click the **Attach File** button. If the file is uploaded, the ‘File uploaded successfully’ message displays, and **the 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

**To attach more than one file related to different document types:**

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.

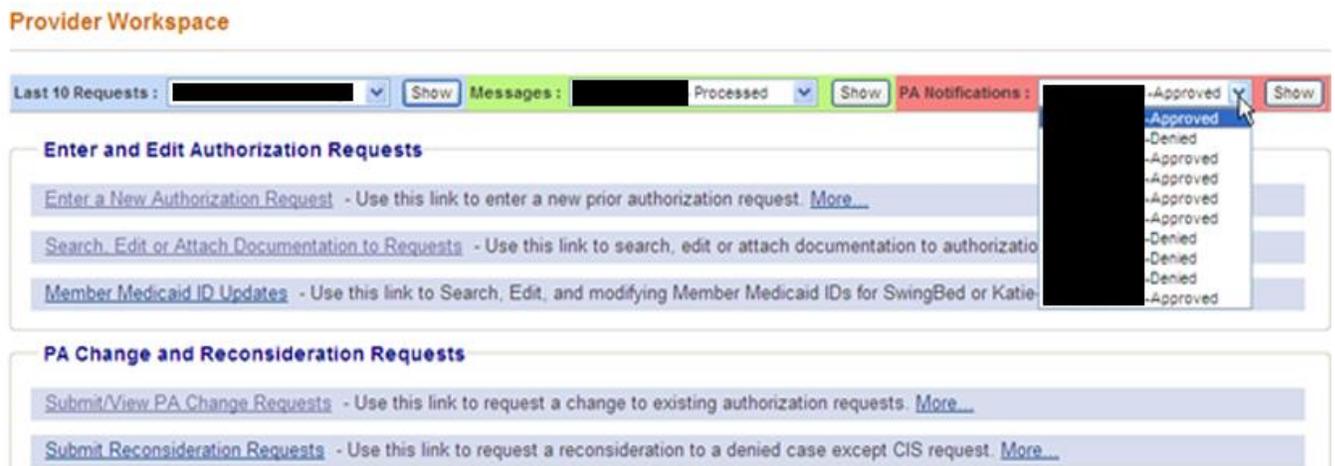


Figure 206

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](http://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**.

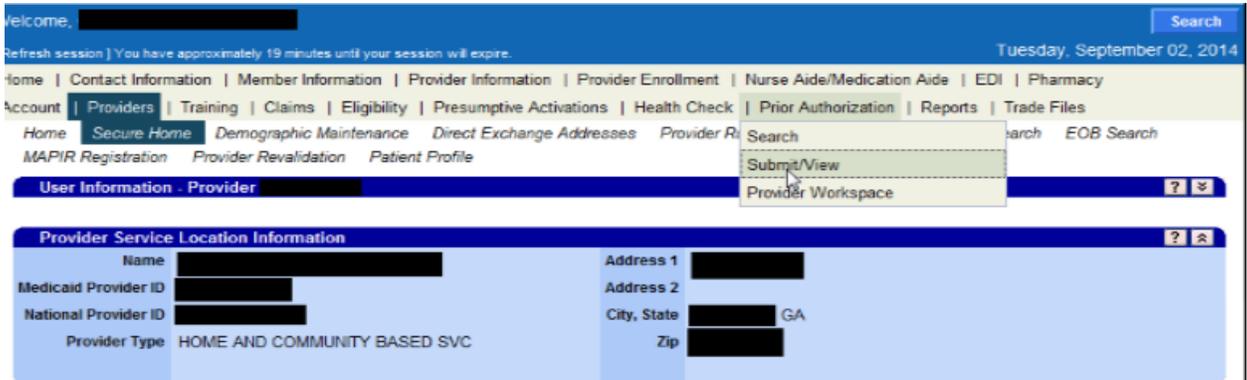


Figure 207

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.

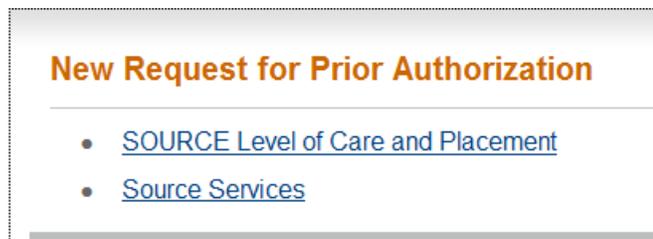


Figure 208

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**.

**New Request for Prior Authorization**

Source

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

Member Medicaid ID:

Source Provider ID

Figure 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.

**New Request for Prior Authorization**

Source LOC Prior Authorization Confirmation Number :

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.

Contact Information			
* Contact Name:	GMCF99	* Contact Email:	srinithya.ranganathan@gmcf.org
Contact Phone:	229-888-7777	Ext.	<input type="text"/>
		* Contact Fax:	229-555-2222

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'.

Request Information	
* Place of Service :	<input checked="" type="radio"/> Home
* Is this Member consumer directed ?	<input type="radio"/> Yes <input checked="" type="radio"/> 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.

* Diagnosis					
Diag Code	Diagnosis Description	Date	Primary	Type	
344.00	QUADRIPLÉGIA, UNSPECIFD	01/01/2010	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>			ADD

Figure 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		SE			EDIT DELETE
T1021	HH AIDE OR CN AIDE PER VISIT	09/01/2014	08/04/2015	5,700	480	3,000.00	0.00		TF			EDIT DELETE
S5170	HOMEDELIVERED PREPARED MEAL	09/15/2014	03/15/2015	672	56	2,210.00	0.00					EDIT DELETE
												ADD CANCEL

Figure 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.

Program Information :

\* Program Admit Date :  Program Discharge Date :

Initial Admission  Renewal Date Last Certified :

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.



The image shows a screenshot of a web form. On the left, there is a text input field containing the question "Is there a signed Level of Care and Placement tool (Appendix F) ?". To the right of this field are two radio buttons labeled "Yes" and "No". The "Yes" radio button is selected. Further to the right is a "Date Signed :" label followed by a date input field containing the date "08/01/2014".

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**.

### Prior Authorization Request Search

Request ID :	<input type="text" value="114090299999"/>	PA Status:	<input type="text" value=""/>	Provider ID :	<input type="text" value=""/>
Request From Date :	<input type="text" value=""/>	Request To Date :	<input type="text" value=""/>		
Member Medicaid ID :	<input type="text" value=""/>	Member First Name :	<input type="text" value=""/>	Member Last Name :	<input type="text" value=""/>
Effective Date :	<input type="text" value=""/>	Expiration Date :	<input type="text" value=""/>	Include PA Notifications :	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ALL
<input type="button" value="Search"/> <input type="button" value="Reset"/>					

Figure 217

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

### Prior Authorization - Source Review Request

Warning: You cannot submit a change request for this PA Type.

Request Information			
Request ID :	<input type="text" value=""/>	Case Status :	Approved
Member ID :	333000000400	Case Status Date :	09/03/2014
Social Security Number :	132549678		
Provider ID :	<input type="text" value=""/>	CMO PA Request ID :	<input type="text" value=""/>
Admission Date :	<input type="text" value=""/>	Discharge Date :	<input type="text" value=""/>
Effective Date :	09/01/2014	Expiration Date :	09/01/2015

Diagnosis				
Diag Code	Diagnosis Description	Date	Primary	Type
344.00	QUADRIPLEGIA, UNSPECIFD	09/03/2014	Yes	ICD-9

Procedures									
CPT Code	CPT Description	Effective Date	Expiration Date	Units	Approved Units	Approved Amount	Decision	Reason	Family of Code(s)
S5170	HOMEDELIVERED PREPARED MEAL	09/01/2014	09/01/2015	672	672	2210.00	Approved		No
T1021	HH AIDE OR CN AIDE PER VISIT	09/01/2014	09/01/2015	850	850	2800.00	Approved		No
T2022	CASE MANAGEMENT, PER MONTH	09/01/2014	09/01/2015	12	12	1800.00	Approved		No

Figure 218

- To edit the PA, click **Edit Request** at the bottom of the page.
- On the next page, go to the **Procedures** table and click **Edit** at the end of the procedure line that needs to be modified.

Service Code	Service Description	From Date	To Date	Units	Req Units / Month	Amount	Cost Sharing Amount	Rendering Provider ID	Mod 1	Mod 2	Mod 3	
S5170	HOMEDELIVERED PREPARED MEAL	09/01/2014	09/01/2015	672	56	2,210.00	0.00					EDIT
T1021	HH AIDE OR CN AIDE PER VISIT	09/01/2014	09/01/2015	850	200	2,800.00	0.00		TF			EDIT
T2022	CASE MANAGEMENT, PER MONTH	09/01/2014	09/01/2015	12	1	1,800.00	0.00		SE			EDIT

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.

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		TF			EDIT
S5170	HOMEDELIVERED PREPARED MEAL	09/01/2014	09/01/2015	672	56	2,210.00	0.00					EDIT
T2022	CASE MANAGEMENT, PER MONTH	09/01/2014	09/01/2015	12	1	1,800.00	0.00		SE			EDIT
T1021	HH AIDE OR CN AIDE PER VISIT	12/02/2014	09/01/2015	180	60	1,000.00	0.00		TF			EDIT

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](http://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.

The screenshot shows a web form with two main sections. The first section, titled "Member Information", contains several input fields: "Member ID" (empty), "First Name" (VICKY), "MI" (M), "Last Name" (TEST MEMBER), "Suffix" (empty), "Date of Birth" (05/20/1970), "Social Security Number" (765-43-2111), "Gender" (Female), and "AIMS Number" (AIMS23456). The second section, titled "Participant Address", contains: "Address Line 1" (22 SHADOW LANE), "Address Line 2" (empty), "City" (CITY), "State" (GA), and "Zip" (33333).

**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.

Physician Information			
* Physician Name :	DOCTOR DOCTOR		
* Phone :	404-999-1111	Ext.:	
		Fax :	- -

Care Coordinator/Assessment Nurse Contact Information			
* Contact Name:	JEAN THE COORDINATOR	* Contact Email:	JCOORD@GMAIL.COM
Contact Phone:	404-999-2222	Ext.:	
		* Contact Fax:	404-999-3333

Figure 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.

Request Information			
* Recommendation Type :	<input checked="" type="radio"/> Initial <input type="radio"/> Reassessment	DON-R Telephone Screening Score :	36
* Assessment Date	08/01/2014	* Approved for Money Follows the Person?	<input type="radio"/> Yes <input checked="" type="radio"/> No

Figure 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](#).

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
344.1		01/01/2014	<input checked="" type="checkbox"/>	<input type="checkbox"/>		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.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
344.1	PARAPLEGIA NOS	08/01/2014	Yes	No	ICD-9	EDIT DELETE
				<input type="checkbox"/>		ADD

Figure 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.

**Acute Care Hospital Dates** ; From Date :  To Date :

**Diagnosis on Admission to Hospital**

Diag Code	Diagnosis Description	Primary	
<input type="text"/>		<input type="checkbox"/>	ADD

**Diagnostic and Treatment Procedures**

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

**Medications**

Name	Dosage	Route	Frequency	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

**Services**

Describe the services and for each service indicate the amount, frequency and duration (example: RN Service, 1 session or 1 visit, 2X/week, (for) 6 weeks).

Services	Amount	Frequency	Duration	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

**Treatment Plan :**

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

Figure 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.

**Create an Attachment**

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

File uploaded successfully.

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

Codes	Documents
CCSP-INITIAL	<input type="checkbox"/> Appendix E- Level of Care and Placement Instrument Form
	<input type="checkbox"/> Crosswalk from AIMS
	<input type="checkbox"/> Minimum Data Set (MDS) for Home Care (MDS-HC) from AIMS
	<input type="checkbox"/> Demographic information from AIMS
	<input type="checkbox"/> Medication Record
	<input type="checkbox"/> Case notes from AIMS
	<input type="checkbox"/> DON-R

**Attached Files**

File	Type	Code	Document Name	Size	User	Date	
<a href="#">CCSP Required Documentation.docx</a>	Web Upload	CCSP-INITIAL	Appendix E- Level of Care and Placement Instrument Form	22 KB		8/20/2014 8:33:15 AM	DELETE
<a href="#">CCSP Required Documentation.docx</a>	Web Upload	CCSP-INITIAL	Case notes from AIMS	22 KB		8/20/2014 8:33:15 AM	DELETE
<a href="#">CCSP Required Documentation.docx</a>	Web Upload	CCSP-INITIAL	Crosswalk from AIMS	22 KB		8/20/2014 8:33:15 AM	DELETE
<a href="#">CCSP Required Documentation.docx</a>	Web Upload	CCSP-INITIAL	DON-R	22 KB		8/20/2014 8:33:15 AM	DELETE
<a href="#">CCSP Required Documentation.docx</a>	Web Upload	CCSP-INITIAL	Demographic information from AIMS	22 KB		8/20/2014 8:33:15 AM	DELETE
<a href="#">CCSP Required Documentation.docx</a>	Web Upload	CCSP-INITIAL	Medication Record	22 KB		8/20/2014 8:33:15 AM	DELETE
<a href="#">CCSP Required Documentation.docx</a>	Web Upload	CCSP-INITIAL	Minimum Data Set (MDS) for Home Care (MDS-HC) from AIMS	22 KB		8/20/2014 8:33:15 AM	DELETE

Figure 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**.

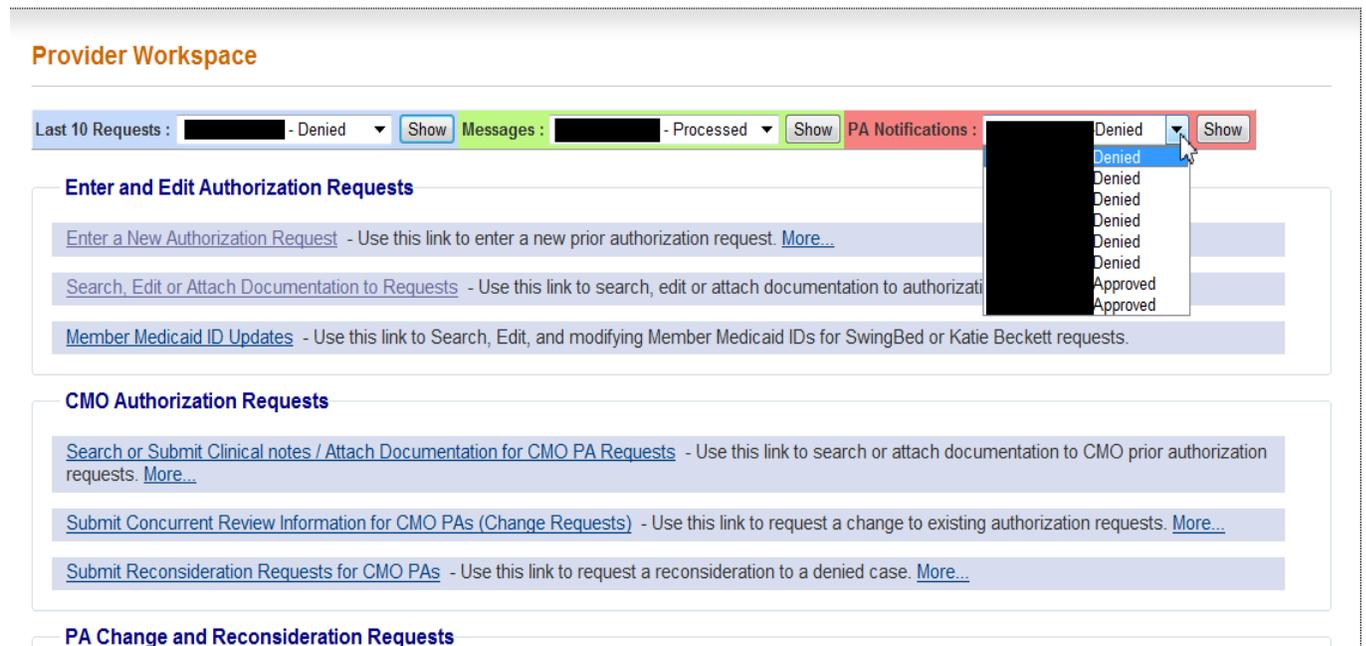


Figure 229

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.

**Prior Authorization - CCSP Level of Care and Placement Review Request**

Notification(s) for this PA		
Date	Status	Notification
07/29/2014		The CCSP PA # [REDACTED] submitted by you, has been Denied. The PA is missing some document(s) : Case notes from AIMS.

Denial Notification(s)		
Denial Decision Date	Letter Type	Reason for Denial
7/29/2014 8:33:30 AM	Technical Denial Notification	We are unable to make a decision regarding level of care since the Case Notes from AIMS were never submitted; and the other documents submitted were incomplete. You may request a hearing if you disagree with this decision.

Request Information			
Request ID :	[REDACTED]	Case Status :	Denied
Member ID :	[REDACTED]	Case Status Date :	07/29/2014
Social Security Number :	[REDACTED]		
Provider ID :	[REDACTED]	CMO PA Request ID :	
Effective Date :	07/29/2014	Expiration Date :	10/27/2014
Denial Reason :			

Type of Recommendation :	Reassessment
Decision Type :	Final Tech Denial. Decision Date: 7/29/2014

Figure 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](http://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.

COMP Level of Care and Placement

Please enter the Member's ID or the SSN. Do not enter both.

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

Member Medicaid ID:

Social Security Number :

COMP Provider ID :

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.

Member Information

Member ID :  First Name :  MI :  Last Name :  Suffix :

Date of Birth :  Social Security Number :  Gender :

Participant Address

Address Line 1 :  Address Line 2 :

City :  State :  Zip :

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.

DBHDD Regional Office Contact Information			
* Contact Name:	Ms Nice	* Contact Email:	srinithya.ranganathan@gmcf.org
Contact Phone:	444-555-6666	Ext.	
		* Contact Fax:	555-666-7777

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.

Request Information			
* Recommendation Type :	<input checked="" type="radio"/> Initial <input type="radio"/> Reassessment		
* Assessment Date	07/28/2015	* Approved for Money Follow s the Person?	<input checked="" type="radio"/> Yes <input type="radio"/> No

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](#).

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
758.0		07/01/2002	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<a href="#">ADD</a>

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.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
758.0	DOWN'S SYNDROME	07/01/2002	Yes	No	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>		ADD

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.

**Create an Attachment**

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

Brow se... **Attach File**

File uploaded successfully.

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

Codes	Documents
COMP-INITIAL	<input type="checkbox"/> DMA6/6A(Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded) <input type="checkbox"/> Nursing Assessment *Optional* <input type="checkbox"/> Psychological/Behavioral Assessment
	<input type="checkbox"/> Health Risk Screening Tool (HRST) *Optional* <input type="checkbox"/> Social Work Assessment *Optional* <input type="checkbox"/> Initial Behavioral Assessment *Optional*
	<input type="checkbox"/> Support Intensity Scale (SIS) *Optional*

Attached Files							
File	Type	Code	Document Name	Size	User	Date	
<a href="#">COMP Attachments.docx</a>	Attached By Nurse	COMP-INITIAL	Psychological/Behavioral Assessment	14 KB	DBARRETT	7/20/2015 9:48:42 AM	<b>DELETE</b>
<a href="#">COMP Attachments.docx</a>	Attached By Nurse	COMP-INITIAL	DMA6/6A(Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded)	14 KB	DBARRETT	7/20/2015 9:48:42 AM	<b>DELETE</b>

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**.

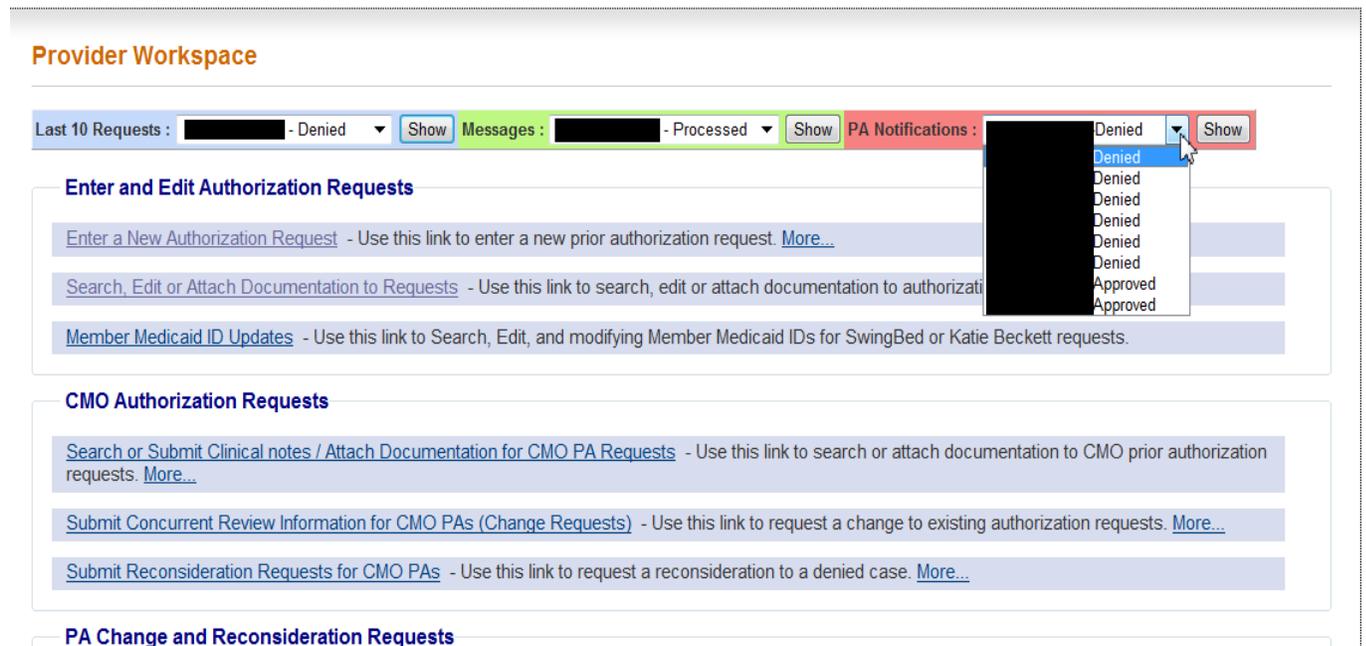


Figure 238

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.

**Notification(s) for this PA**

Date	Status	Notification
06/16/2015		The COMP PA # [REDACTED] submitted by you, has been Denied. The PA is missing some document(s) : DMA-7 (Level of Care Re-Evaluation Form for ICF/IID) , Psychological/Behavioral Assessment Update (Required Q3 years if 16 years or younger).

**Denial Notification(s)**

Denial Decision Date	Letter Type	Reason for Denial
6/16/2015 12:00:00 AM	Standard Approval/Denial Notification	

**Letter Information**

Letter Type	File	Reason	Letter Sent Date
Member	[REDACTED]_LTRTOMBR.pdf	Manual Update by Nurse	10/03/2014

**Request Information**

Request ID : [REDACTED] Case Status : **Denied** Case Status Date : 06/16/2015  
 Member ID : [REDACTED]  
 Social Security Number : [REDACTED]  
 Provider ID : [REDACTED] CMO PA Request ID : [REDACTED]  
 Effective Date : 05/26/2015 Expiration Date : 05/25/2016  
 Denial Reason : [REDACTED]

Type of Recommendation : Reassessment  
 Decision Type : Final Tech Denial. Decision Date: 6/16/2015

**Diagnosis**

Diag Code	Diagnosis Description	Date	Primary	Type
334.9	SPINOCEREBELLAR DIS NOS	01/01/2000	Yes	ICD-9

**Attached Files**

File	Type	Document Name	User	Date
<a href="#">Chapter Header.docx</a>	Web Upload	Health Risk Screening Tool (HRST) *Optional*	[REDACTED]	5/26/2015 11:54:57 AM

[Enter Change Request](#)
[Attach File](#)
[Return To Search Results](#)
[Return to Provider Workspace](#)
[Contact Us](#)

Figure 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](http://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.**

Independent Care Waiver Program/Traumatic Brain Injury (ICWP/TBI) (Form Number: DMA-6)

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

Member Medicaid ID: 333000000100

Service Provider ID:

Physician Reference ID: REF000000001

**Submit**

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.

**Contact Information**

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

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

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

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

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.

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

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



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

[ADD](#)

**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.**

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

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.

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

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.

**Treatment Plan :**

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

Describe the plan of treatment.

Figure 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 use 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.

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

Figure 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.

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

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

**Evaluation of Nursing Care Needed : (check all that apply)**

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

Figure 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.

Name of MD / RN Signing Form :	Jean RN	Date Signed :	05/10/2010
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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](http://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.

Georgia Pediatric Program/Exceptional Children's Service (Form Number: DMA-80)

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

Member Medicaid ID:  

Service Provider ID :

**Submit**

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.



DMA-6 Prior Authorization Confirmation Number :

Figure 253

- 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.

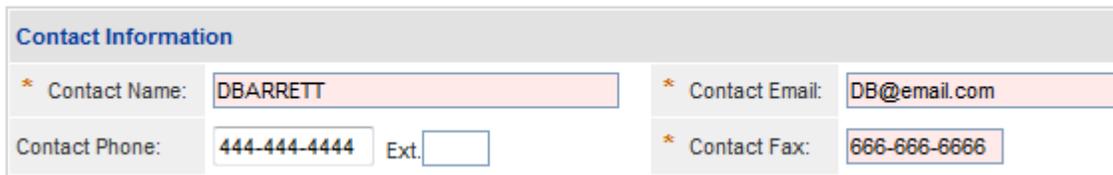
**Member/Provider Information:**

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.

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



**Contact Information**

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

Figure 254

**Request Information:**

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

- Enter the location of service by selecting *Home* or *Other* (daycare).
- 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.



**Request Information**

* Place of Service :	<input checked="" type="radio"/> 12 - Home <input type="radio"/> 99 - Other	GAPP Member ID :	<input type="text" value="149507"/>
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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.

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

Figure 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.

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

Figure 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’.

**Program Information :**

\* Program Admit Date :  Program Discharge Date :  Date Last Certified :

\* Admission Type :  Initial Admission  Renewal

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.

**Program Information :**

\* Program Admit Date :  Program Discharge Date :  Date Last Certified :

\* Admission Type :  Initial Admission  Renewal

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.

The screenshot shows a web form with two main sections. The first section is titled "Description of Services Requested:" and contains a text box with the placeholder text "Describe services ordered for this patient." and "Services requested". The second section is titled "Justification and Circumstances for Requested Services:" and contains a text box with the placeholder text "Provide justification for the above ordered services." and "Justification".

**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.

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

**Figure 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.**

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

Figure 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).

CareGivers			
Is the Primary Caregiver competent ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Is the Secondary Caregiver competent ?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Does Primary Caregiver work ?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Primary Caregiver's work schedule :	<input type="text" value=""/> Hrs
Does Secondary Caregiver work ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Secondary Caregiver's work schedule :	<input type="text" value="8"/> Hrs
		Hours of work on weekends :	<input type="text" value=""/> Hrs
		Hours of work on weekends :	<input type="text" value="0"/> Hrs

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’.

Skilled Nursing Needs					
* Location :	<input checked="" type="radio"/> In-Home <input type="radio"/> Day-Care	Current In-Home/Day-Care Hours :	<input type="text" value="8"/> Hrs	Requested In-Home/Day-Care Hours :	<input type="text" value="8"/> Hrs
	<input type="checkbox"/> Nursing Assistant	Current Nurse Assistant Hours :	<input type="text" value="5"/> Hrs	Requested Nurse Assistant Hours :	<input type="text" value="5"/> Hrs
* Transfer ?	<input type="radio"/> Yes <input checked="" type="radio"/> No	If Yes, Transfer Type :	<input type="radio"/> To In-Home (PDN) <input type="radio"/> To DayCare (MFDC)	Is it within the same agency?	<input type="radio"/> Yes <input checked="" type="radio"/> No

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 O<sub>2</sub>'.
59. **If receiving oxygen**, indicate the percentage of oxygen prescribed in the '%' box, **and** the hours prescribed per day in the 'Hours' box.
60. Indicate whether or not the child requires pulse oximetry by clicking *Yes* or *No* to the question: 'Pulse Oximetry'.
61. Indicate whether or not the child requires chest percussion treatment by clicking *Yes* or *No* to 'CPT'.
62. Indicate whether or not the child receives tracheostomy care by clicking *Yes* or *No* to 'Trach Care'.
63. If the child has a tracheostomy, indicate how often during the day the tracheostomy tube is suctioned in the 'Suctioning/Frequency' box.
64. Indicate whether or not the child is on ventilator treatment by clicking *Yes* or *No*.
65. Select the 'During the Day' checkbox if vent treatment is during the day, and enter the number of hours per day in the 'Hours' box.
66. If the child is on ventilator treatment during the night, select 'During the Night', and enter the number of hours per night in the 'Hours' box.
67. Indicate whether or not the child is receiving C-PAP or BI-PAP treatment by clicking *Yes* or *No*.
68. If *Yes* for C-PAP or BI-PAP, select 'During the Day' or 'During the Night' to indicate if treatment is during the day or night and enter the hours of treatment in the 'Hours' boxes provided. If treatment is provided during the day and night, select both boxes.

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

Figure 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*.

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

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

Figure 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.

School Services			
Is child in school ?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Number of hours per day in school :	<input type="text"/> Hrs
IFSP Current ?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Number of days per week in school :	<input type="text"/> Hrs
Level of Care in School :	<input type="radio"/> Skilled Nursing <input type="radio"/> Unskilled Nursing (Aide) <input checked="" type="radio"/> N/A	IEP Current ?	<input type="radio"/> Yes <input checked="" type="radio"/> No
		Number of hours per day :	<input type="text"/> Hrs

Figure 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.

Home Health Agency Nursing Assessment
Skilled Nursing Care needs :
<input type="text"/>
Justification for requested skilled-nursing care hours :
<input type="text"/>
Recommendations :
<input type="text"/>

Figure 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.

**Create an Attachment**

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

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

Type of Review	Documents
INITIAL	<input type="checkbox"/> Letter of Medical Necessity
	<input type="checkbox"/> Care Plan
	<input type="checkbox"/> Medical Plan of Treatment (MD-POT)
	<input type="checkbox"/> GAPP Assessment Form (Appendix K)
	<input type="checkbox"/> IFSP or IEP
	<input type="checkbox"/> Insurance Information
	<input type="checkbox"/> Signed LON

Figure 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.

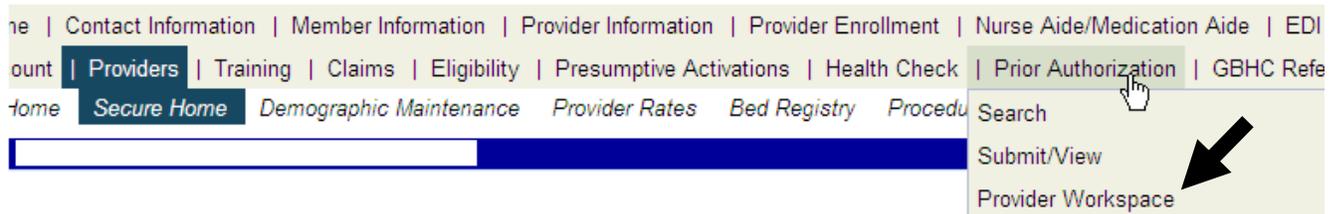


Figure 270

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.

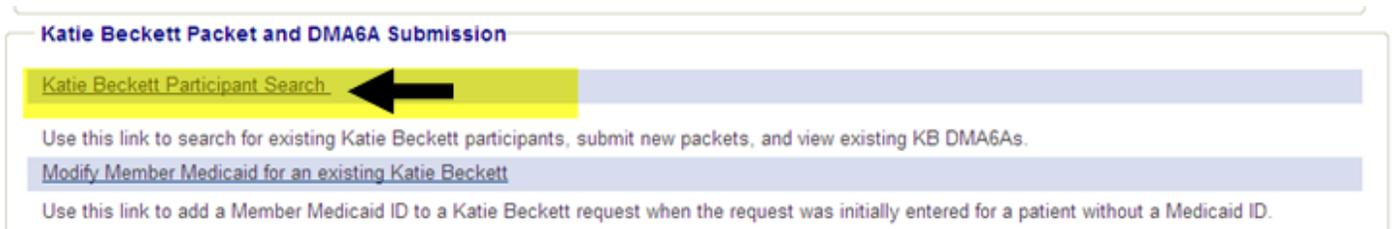
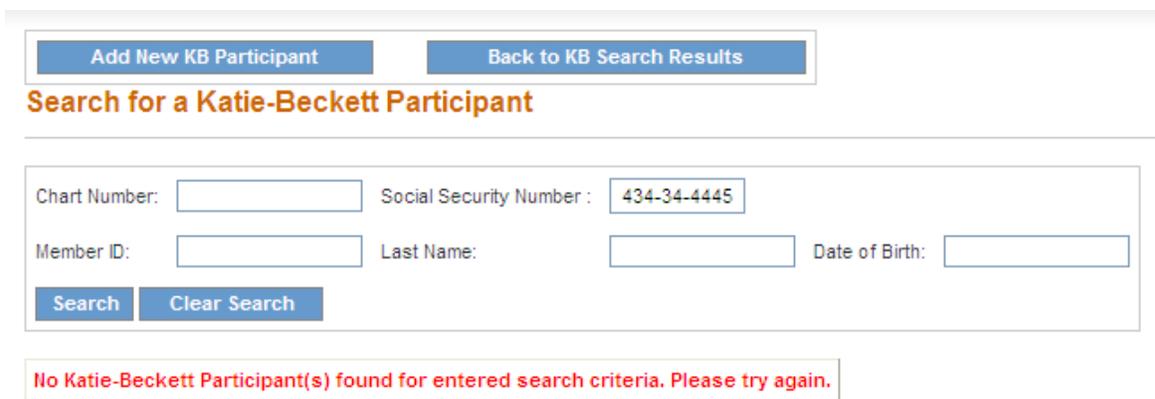


Figure 271

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**.



The screenshot shows a web interface for adding or searching for participants. At the top, there are two buttons: "Add New KB Participant" and "Back to KB Search Results". Below these is a heading "Search for a Katie-Beckett Participant". The search form contains several input fields: "Chart Number:", "Social Security Number:" (with the value "434-34-4445" entered), "Member ID:", "Last Name:", and "Date of Birth:". There are two buttons at the bottom of the form: "Search" and "Clear Search". Below the form, a red message box states: "No Katie-Beckett Participant(s) found for entered search criteria. Please try again."

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**.

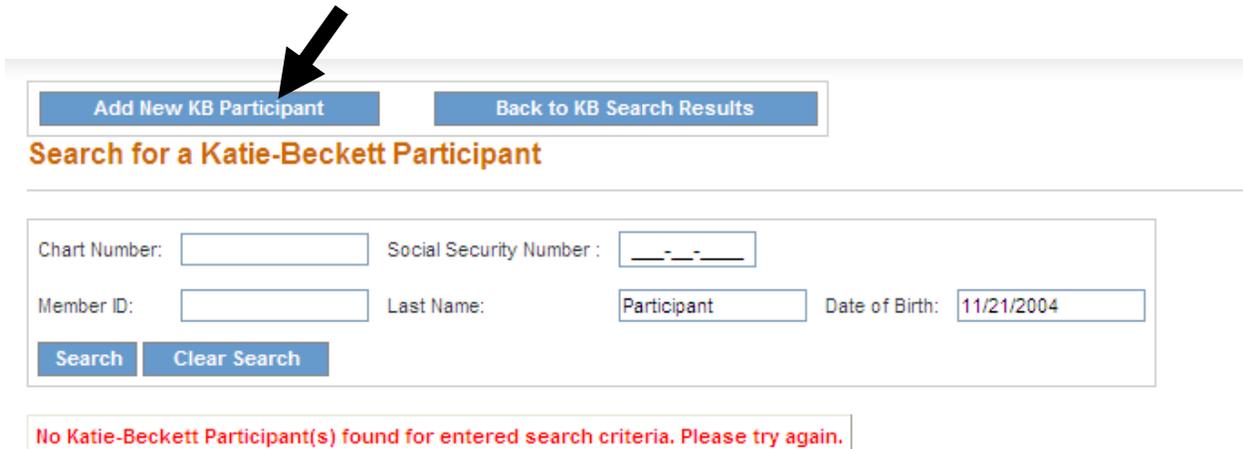
25. Next, try searching for the participant by 'Last Name' and 'Date of Birth'. Enter the participant's last name; and enter the date of birth using the calendar popup or enter manually as mm/dd/yyyy.

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](#).



[Add New KB Participant](#) [Back to KB Search Results](#)

### Search for a Katie-Beckett Participant

Chart Number:  Social Security Number :

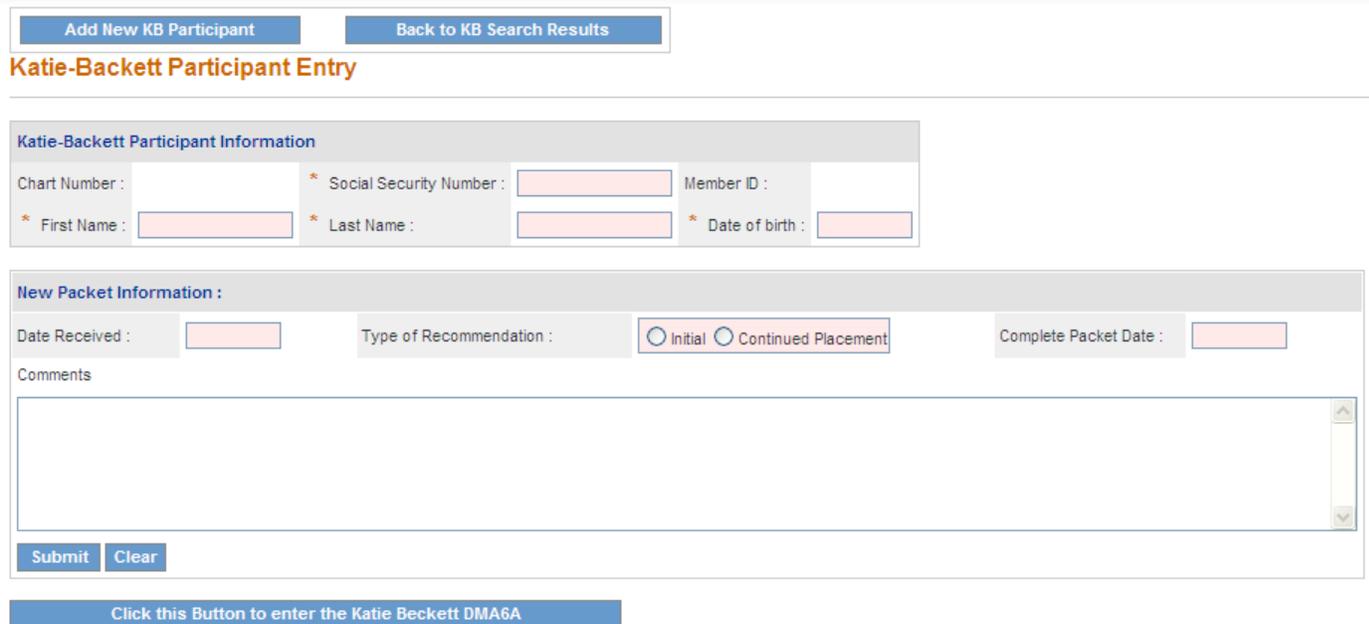
Member ID:  Last Name:  Date of Birth:

[Search](#) [Clear Search](#)

No Katie-Beckett Participant(s) found for entered search criteria. Please try again.

Figure 273

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



[Add New KB Participant](#) [Back to KB Search Results](#)

### Katie-Beckett Participant Entry

**Katie-Beckett Participant Information**

Chart Number :  \* Social Security Number :  Member ID :

\* First Name :  \* Last Name :  \* Date of birth :

**New Packet Information :**

Date Received :  Type of Recommendation :  Initial  Continued Placement Complete Packet Date :

Comments

[Submit](#) [Clear](#)

[Click this Button to enter the Katie Beckett DMA6A](#)

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.

**Add New KB Participant**      **Back to KB Search Results**

**Katie-Beckett Participant Entry**

---

**Katie-Beckett Participant Information**

Chart Number :      \* Social Security Number : 434344445      Member ID :  
\* First Name : Katie      \* Last Name : Participant      \* Date of birth : 11/21/2004

**New Packet Information :**

Date Received : 01/07/2013      Type of Recommendation :  Initial  Continued Placement      Complete Packet Date :  
Comments  
This box is optional but may be used to provide additional information regarding the participant and/or packet.

**Submit**      **Clear**

**Click this Button to enter the Katie Beckett DMA6A**

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.

Comments

This box is optional but may be used to provide additional information regarding the participant and/or packet.

Submit Clear

Previous Comments

Date Received	Type Recommendation	Complete Pkt Date	Comments	PA Number	
1/7/2013 12:00:00 AM	Initial		This box is optional but may be used to provide additional information regarding the participant and/or packet.		<a href="#">EDIT</a>

Click this Button to enter the Katie Beckett 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.

### Search for a Katie-Beckett Participant

Chart Number:  Social Security Number :

Member ID:  Last Name:  Date of Birth:

Search Clear Search

Fictitious member info

Chart Number	Member ID	Member Last Name	Member First Name	Social Security number	DOB
<a href="#">774048</a>	333000000700	WILLIAMS	JAMES	818181818	2/3/2004 12:00:00 AM

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.

Add New KB Participant
Back to KB Search Results

### Katie-Beckett Participant Entry

**Katie-Beckett Participant Information**

Chart Number : 774048      \* Social Security Number : 818181818      Member ID : 333000000700

\* First Name : JAMES      \* Last Name : WILLIAMS      \* Date of birth : 02/03/2004

**New Packet Information :**

Date Received :       Type of Recommendation :  Initial  Continued Placement      Complete Packet Date :

Comments

**Previous Comments**

Date Received	Type Recommendation	Complete Pkt Date	Comments	PA Number	
3/28/2011 12:00:00 AM	Initial			111032800002	<input type="button" value="EDIT"/>

Click this Button to enter the Katie Beckett DMA6A

Figure 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.

Previous Comments					
Date Received	Type Recommendation	Complete Pkt Date	Comments	PA Number	
3/28/2011 12:00:00 AM	Initial			111032800002	<input type="button" value="EDIT"/>
3/26/2012 12:00:00 AM	Continued Placement				<input type="button" value="EDIT"/>

Figure 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.

Previous Comments					
Date Received	Type Recommendation	Complete Pkt Date	Comments	PA Number	
3/28/2011 12:00:00 AM	Initial			<a href="#">111032800002</a>	<a href="#">EDIT</a>
3/26/2012 12:00:00 AM	Continued Placement				<a href="#">EDIT</a>

[Click this Button to enter the Katie Beckett DMA6A](#)



Figure 280

2. On the next screen, click [TEFRA/Katie Beckett \(Form DMA-6A\)](#).

**New Request for Prior Authorization**

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[Exceptional Transportation Services \(Form Number: DMA-80\)](#)

[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.

### New Request for Prior Authorization

**TEFRA / Katie Beckett (Form DMA-6A)**

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

Member Medicaid ID:  

Social Security Number:

Katie-Beckett Provider ID:  

[Submit](#)

These are fictitious member/provider IDs.

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.

### New Request for Prior Authorization

TEFRA / Katie Beckett (Form DMA-6A)

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

Member Medicaid ID:

Social Security Number :

Katie-Beckett Provider ID:

select the Katie-Beckett packet for which you want to create a PA. If you don't see the packet you want, you a packet.

Available Katie-Beckett Packets			
Date Received	Type Recommendation	Comments	
3/26/2012 12:00:00 AM	Continued Placement		<b>Select</b>

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.

Member Information									
Member ID :	03396GMC	First Name :	<input type="text" value="Mary"/>	MI :	<input type="text"/>	Last Name :	<input type="text" value="Smith"/>	Suffix :	<input type="text"/>
Date of Birth :	<input type="text" value="07/14/2009"/>	Social Security Number :	<input type="text" value="111-11-1111"/>	Gender :	<input type="text" value="Female"/>				

Participant Address							
Address Line 1 :	<input type="text"/>	Required	Address Line 2 :	<input type="text"/>			
City :	<input type="text"/>	Required	State :	<input type="text" value="GA"/>	Zip :	<input type="text"/>	Required

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.**

Contact Information			
* Contact Name:	Mary Smith	Contact Email:	RSM@email.org
Contact Phone:	404-999-8765	Ext.:	
		* Contact Fax:	404-888-7654

Figure 285

- 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.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
<input type="text"/>		<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>		<a href="#">ADD</a>

Figure 286

- 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.
- Enter the date that the diagnosis was determined in the ‘Date’ box. If not known, enter the date that the physician signed the DMA6A.
- Click the ‘Primary’ checkbox to indicate that the diagnosis is the primary diagnosis.
- Click **ADD** to add the diagnosis code to the request. When add is clicked, another blank diagnosis line is added; and **EDIT** and **DELETE** links appear. At this point, the code may be edited/deleted if entered incorrectly. However, **once the DMA6A is submitted, the diagnosis code cannot be removed or edited.**

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

Figure 287

- 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.

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

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

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

Figure 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.

**Create an Attachment**

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

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

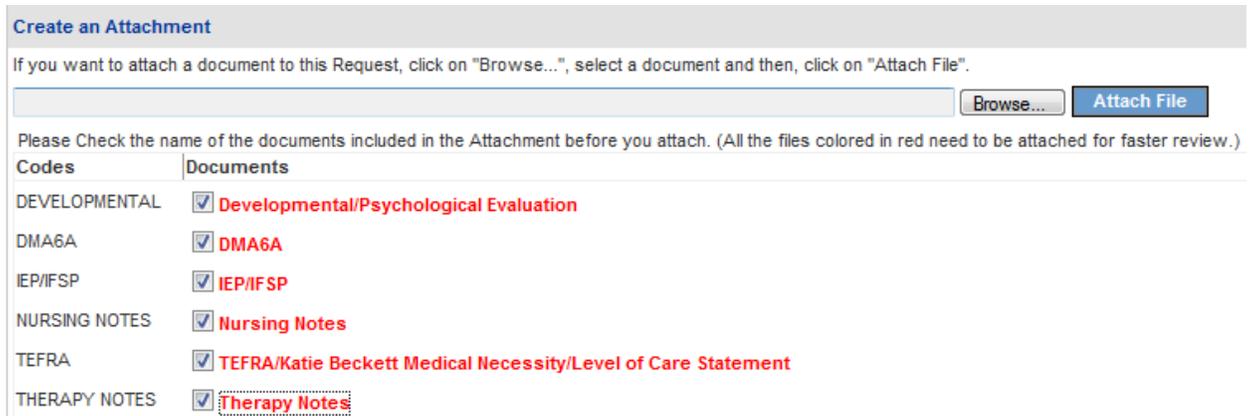
Codes	Documents
DEVELOPMENTAL	<input type="checkbox"/> Developmental/Psychological Evaluation
DMA6A	<input type="checkbox"/> DMA6A
IEP/IFSP	<input type="checkbox"/> IEP/IFSP
NURSING NOTES	<input type="checkbox"/> Nursing Notes
TEFRA	<input type="checkbox"/> TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
THERAPY NOTES	<input type="checkbox"/> Therapy Notes

Figure 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.

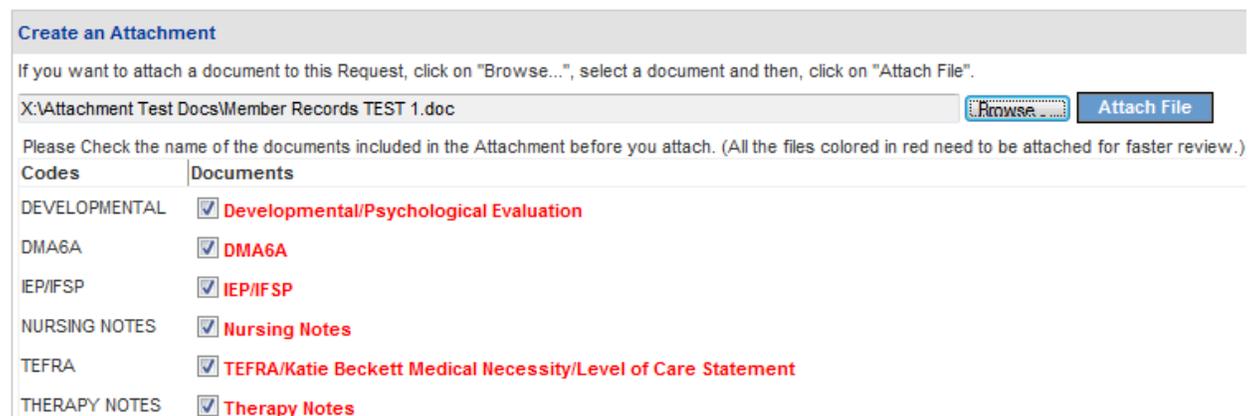


The screenshot shows the 'Create an Attachment' form. At the top, there is a title bar 'Create an Attachment' and a sub-header 'If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".' Below this is a text input field and two buttons: 'Browse...' and 'Attach File'. A note below the buttons reads: 'Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)' The main content is a table with two columns: 'Codes' and 'Documents'. The table lists several document types, each with a checked checkbox and a red label:

Codes	Documents
DEVELOPMENTAL	<input checked="" type="checkbox"/> Developmental/Psychological Evaluation
DMA6A	<input checked="" type="checkbox"/> DMA6A
IEP/IFSP	<input checked="" type="checkbox"/> IEP/IFSP
NURSING NOTES	<input checked="" type="checkbox"/> Nursing Notes
TEFRA	<input checked="" type="checkbox"/> TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
THERAPY NOTES	<input checked="" type="checkbox"/> Therapy Notes

Figure 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.



The screenshot shows the 'Create an Attachment' form with the file path 'X:\Attachment Test Docs\Member Records TEST 1.doc' entered in the text input field next to the 'Browse...' button. The rest of the form, including the document type checkboxes, is identical to Figure 290.

Figure 291

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

**Create an Attachment**

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

File uploaded successfully.

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

Codes	Documents
DEVELOPMENTAL	<input checked="" type="checkbox"/> Developmental/Psychological Evaluation
DMA6A	<input type="checkbox"/> DMA6A
IEP/IFSP	<input type="checkbox"/> IEP/IFSP
NURSING NOTES	<input type="checkbox"/> Nursing Notes
TEFRA	<input type="checkbox"/> TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
THERAPY NOTES	<input type="checkbox"/> Therapy Notes

**Attached Files**

File	Type	Code	Document Name	Size	User	Date	
<a href="#">Member Records TEST 1.doc</a>	Web Upload	DEVELOPMENTAL	Developmental/Psychological Evaluation	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>
<a href="#">Member Records TEST 1.doc</a>	Web Upload	DMA6A	DMA6A	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>
<a href="#">Member Records TEST 1.doc</a>	Web Upload	IEP/IFSP	IEP/IFSP	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>
<a href="#">Member Records TEST 1.doc</a>	Web Upload	NURSING NOTES	Nursing Notes	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>
<a href="#">Member Records TEST 1.doc</a>	Web Upload	TEFRA	TEFRA/Katie Beckett Medical Necessity/Level of Care Statement	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>
<a href="#">Member Records TEST 1.doc</a>	Web Upload	THERAPY NOTES	Therapy Notes	37 KB	KB1	10/2/2013 11:09:21 AM	<input type="button" value="DELETE"/>

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.

TEFRA / Katie Beckett (Form DMA-6A)

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

Member Medicaid ID:

Social Security Number:  Fictitious SSN associated with this Medicaid SSN

Katie-Beckett Provider ID:

**WARNING:** Multiple member IDs associated with the SSN. You must add the Medicaid ID to this participant/packet. Please click the following button Update Multiple Member ID to add the member’s Medicaid ID before entering the DMA6A.

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**.

**WARNING: Multiple member IDs associated with the SSN. You must add the Medicaid ID to this participant/packet. Please click the following button Update Multiple Member ID to add the member’s Medicaid ID before entering the DMA6A.**



Figure 294

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

**Update Member Medicaid Data**

Request ID :  OR Member Social Security Number :

Request Type :  Katie-Beckett

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.

**Update Member Medicaid Data**

Request ID :  OR Member Social Security Number :

Request Type :  Katie-Beckett

Request ID	Member ID	Last Name	First Name	SSN	Status
<input type="text"/>	00612GMC	NELSON	SHELLEY	712312345	Denied

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.

**Request Information**

Request ID : [blacked out] Case Status : Denied Case Status Date : 01/14/2013

Member ID : [blacked out] 334000000700 [input field] **Update Member Medicaid ID**

Provider ID : [blacked out]

Effective Date : 01/14/2013 Expiration Date : 01/13/2014

Denial Reason :

Type of Recommendation : Initial

Decision Type : Nurse Denied, Denial Reason: DOES NOT MEET PLCY GUIDELINES. Decision Date: 1/14/2013

**Diagnosis**

ICD-9 Code	ICD-9 Description	ICD-9 Date	Primary
344	OTH PARALYTIC SYNDROMES	01/14/2013	Yes

Figure 297

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

**Request Information**

Request ID : [blacked out] Case Status : Denied Case Status Date : 01/14/2013

Member ID : 334000000700

Provider ID : [blacked out]

Effective Date : 01/14/2013 Expiration Date : 01/13/2014

Denial Reason :

Type of Recommendation : Initial

Decision Type : Nurse Denied, Denial Reason: DOES NOT MEET PLCY GUIDELINES. Decision Date: 1/14/2013

**Diagnosis**

ICD-9 Code	ICD-9 Description	ICD-9 Date	Primary
344	OTH PARALYTIC SYNDROMES	01/14/2013	Yes

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

[Return to the Auth Request Page](#)

Figure 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.

The screenshot shows a web form titled "New Request for Prior Authorization" for "TEFRA / Katie Beckett (Form DMA-6A)". Below the title is a blue header bar with the text "TEFRA / Katie Beckett (Form DMA-6A)". Underneath is a grey instruction bar: "To find a member or provider ID click the [magnifying glass icon] next to the ID box". The form contains three input fields: "Member Medicaid ID" with the value "334000000700" and a magnifying glass icon; "Social Security Number" with a masked input field showing "\_\_\_-\_\_-\_\_\_\_"; and "Katie-Beckett Provider ID" with a masked input field showing "\_\_\_\_-\_\_\_\_-\_\_\_\_". A blue "Submit" button is located at the bottom left of the form.

Figure 299

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

## 2.22 Swingbed Requests

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

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](http://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.

Nursing Home (Form Number: DMA-6)

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

Member Medicaid ID:

Social Security Number:

Swingbed Provider ID:

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.

Member Information

Member ID :	First Name :	<input type="text" value="Test"/>	MI :	<input type="text"/>	Last Name :	<input type="text" value="Member"/>	Suffix :	<input type="text"/>
Date of Birth :	<input type="text" value="02/25/1940"/>	Social Security Number :	<input type="text" value="222-33-3444"/>	Gender :	<input type="text" value="Female"/>			

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.

Physician Information			
Physician Name :	<input type="text" value="John Greer"/>	Physician ID :	<input type="text"/>
Address Line 1 :	<input type="text"/>	Address Line 2 :	<input type="text"/>
City :	<input type="text"/>	State :	<input type="text" value="v"/>
Phone :	<input type="text" value="- -"/> Ext. <input type="text"/>	Zip :	<input type="text"/>
		County :	<input type="text" value="v"/>
		Fax :	<input type="text" value="- -"/>

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.

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

Figure 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*.

Request Information			
* Recommendation Type :	<input type="radio"/> Continued Placement <input checked="" type="radio"/> Initial Placement		
Initial Admission Date :	06/11/2013	Discharge Date :	<input type="text"/>
* Place of Service :	31 - Skilled Nursing Facility ▼		
Patient Status :	SwingBed ▼	* Admission Type :	Emergency ▼

Figure 304 Request Information/SW Initial Placement

Request Information			
* Recommendation Type :	<input checked="" type="radio"/> Continued Placement <input type="radio"/> Initial Placement		
Continued Placement Start Date :	07/12/2013	Discharge Date :	<input type="text"/>
Initial Admission Date :	06/11/2013	Initial Request ID :	<input type="text"/>
* Place of Service :	31 - Skilled Nursing Facility ▼		
Patient Status :	SwingBed ▼	* Admission Type :	Elective ▼

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.

\* In the caretaker's opinion, would the child require institutionalization if the child did not receive services?  Yes  No

\* Does child attend school?  Yes  No \* Date of Medicaid Application:   
mm/dd/yyyy

Name of Caregiver #1 :  Name of Caregiver #2 :

\* Parent or Legal Representative has signed the following statement: I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Department of Community Health and the Department of Human Resources, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.  Yes  No

\* Date of Parent or Legal Representative signature :   
mm/dd/yyyy

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.

* Diagnosis						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
437.4	CEREBRAL ARTERITIS	01/01/2012	Yes	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text" value="01/01/2012"/>	<input type="checkbox"/>	<input type="checkbox"/>		ADD

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’.



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



**Acute Care Hospital Dates :** From Date : 05/17/2010 To Date : 05/24/2010

**Figure 309**

***Diagnosis on Admission to Hospital:***

This section is optional



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

**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.

Medications				
Name	Dosage	Route	Frequency	
Cardiac	50mg	Oral	Regular	<a href="#">EDIT</a> <a href="#">DELETE</a>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<a href="#">ADD</a>

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.

Diagnostic and Treatment Procedures		
Type	Frequency	
S&A Accucheck	bid	<a href="#">EDIT</a> <a href="#">DELETE</a>
<input type="text"/>	<input type="text"/>	<a href="#">ADD</a>

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.

<b>Treatment Plan :</b>
Provide the complete treatment plan including medications, level of care requested, other services to be provided to the patient.
Add information regarding the treatment plan that is not captured in other sections of this form.

Figure 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.

<input checked="" type="radio"/> Yes <input type="radio"/> No	Is the patient free of communicable diseases?
Can this patient's condition be managed by :	
<input type="radio"/> Yes <input checked="" type="radio"/> No	- Community Care ?
<input type="radio"/> Yes <input checked="" type="radio"/> No	- Home Health Services ?
<input checked="" type="radio"/> Yes <input type="radio"/> No	Has the physician certified that this patient requires the level of care provided by a nursing facility or an intermediate care facility for the mentally retarded ?

Physician License Number :  Date Signed by Physician :

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.

Anticipated Dates of Hospitalization From Date :	<input type="text" value="05/19/2010"/>	To Date :	<input type="text" value="05/24/2010"/>
Level of Care Recommended :	<input type="text" value="Nursing Facility"/>	Type of Recommendation :	<input type="radio"/> Continued Placement <input checked="" type="radio"/> Initial Placement
Patient Transferred From :	<input type="radio"/> Another NF <input checked="" type="radio"/> Hospital <input type="radio"/> Lives at home <input type="radio"/> Private Pay		
Length of Time Care Needed :	<input type="radio"/> Permanent <input checked="" type="radio"/> Temporary	Estimated Months (if temporary) :	<input type="text" value="1"/>

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

Physician Name :	<input type="text" value="Doctor Doctor"/>	Date Signed by Physician :	<input type="text" value="09/07/2010"/>	Physician License Number :	<input type="text" value="124564"/>	Physician Phone :	<input type="text" value="444-444-4444"/>
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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.

1.	Does the patient's condition require specialized medical intervention not usually provided by a nursing home?	<input type="radio"/> Yes <input checked="" type="radio"/> No
2.	Does a particular aspect of the patient's care or diagnosis present challenges for discharge planning?	<input type="radio"/> Yes <input checked="" type="radio"/> No
3.	Does the patient have functional challenges not usually accepted by nursing homes, e.g. functional impairments related to morbid obesity, severe contractures, etc?	<input checked="" type="radio"/> Yes <input type="radio"/> No
4.	Does the patient present severe behavior challenges requiring atypical intervention?	<input checked="" type="radio"/> Yes <input type="radio"/> No

Figure 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.

Evaluation of Nursing Care Needed : (check all that apply)					
Diet :	Bladder :	Bowel :	Decubiti :	Restorative Potential :	Overall Condition :
<input checked="" type="checkbox"/> Regular	<input checked="" type="radio"/> Continent	<input checked="" type="radio"/> Continent	<input checked="" type="checkbox"/> Yes	<input type="radio"/> Good	<input type="radio"/> Improving
<input checked="" type="checkbox"/> Diabetic	<input type="radio"/> Occasionally Incontinent	<input type="radio"/> Occasionally Incontinent	<input type="checkbox"/> No	<input checked="" type="radio"/> Fair	<input type="radio"/> Stable
<input type="checkbox"/> Formula	<input type="radio"/> Incontinent	<input type="radio"/> Incontinent	<input checked="" type="checkbox"/> Infected	<input type="radio"/> Poor	<input checked="" type="radio"/> Fluctuating
<input type="checkbox"/> Low Sodium	<input type="radio"/> Other	<input type="radio"/> Colostomy	<input type="checkbox"/> On Admission	<input type="radio"/> Questionable	<input type="radio"/> Deteriorating
<input type="checkbox"/> Tube Feeding			<input type="checkbox"/> Surgery Date	<input type="radio"/> None	<input type="radio"/> Critical
<input type="checkbox"/> Other					<input type="radio"/> Terminal
Mental & Behavioral Status : (check all that apply)			Nursing Care and Treatment : (Check all that apply)		
<input checked="" type="checkbox"/> Agitated	<input type="checkbox"/> Noisy	<input type="checkbox"/> Dependent	<input type="checkbox"/> Catheter Care	<input type="checkbox"/> Bedfast	
<input type="checkbox"/> Confused	<input type="checkbox"/> Nonresponsive	<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Intake	<input type="checkbox"/> Colostomy Care	
<input type="checkbox"/> Cooperative	<input type="checkbox"/> Vacillating	<input type="checkbox"/> Anxious	<input checked="" type="checkbox"/> Output	<input type="checkbox"/> Sterile Dressings	
<input type="checkbox"/> Depressed	<input type="checkbox"/> Violent	<input type="checkbox"/> Well Adjusted	<input type="checkbox"/> IV	<input type="checkbox"/> Suctioning	
<input checked="" type="checkbox"/> Forgetful	<input type="checkbox"/> Wanders	<input checked="" type="checkbox"/> Disoriented	<input type="checkbox"/> N/A		
<input type="checkbox"/> Alert	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Inappropriate Reaction			
Hours out of the Bed Per Day : <input type="text" value="4"/> Hrs.					

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.

Indicate Frequency Per Week (in Hours)		
	Received	Needed
Physical Therapy	<input type="text"/>	<input type="text"/>
Occupational Therapy	<input type="text"/>	<input type="text"/>
Remotive Therapy	<input type="text"/>	<input type="text"/>
Reality Orientation	<input type="text" value="5"/>	<input type="text" value="5"/>
Speech Therapy	<input type="text"/>	<input type="text"/>
Bowel and Bladder Retrain	<input type="text"/>	<input type="text"/>
Activities Program	<input type="text" value="5"/>	<input type="text" value="5"/>

Figure 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.

Activities of Daily Living		Level of Impairment	
Eating	<input type="text" value="Needs Assistance"/>	Sight	<input type="text" value="Moderate"/>
Wheelchair	<input type="text" value="Not Appropriate"/>	Hearing	<input type="text" value="Moderate"/>
Transferring	<input type="text" value="Needs Assistance"/>	Speech	<input type="text" value="Moderate"/>
Bathing	<input type="text" value="Needs Assistance"/>	Limited Motion	<input type="text" value="Moderate"/>
Ambulating	<input type="text" value="Needs Assistance"/>	Paralysis	<input type="text" value="None"/>
Dressing	<input type="text" value="Dependent"/>		

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.

**Justification and Circumstances for Admission or Continued Placement :**  
Provide justification for the services ordered including the rationale for swingbed placement; any discharge plans to home or nursing facility

**Enter information to support medical necessity. Include discharge plans and discharge date.**

**Figure 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.

Name of MD / RN Signing Form :  Date Signed :

**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:

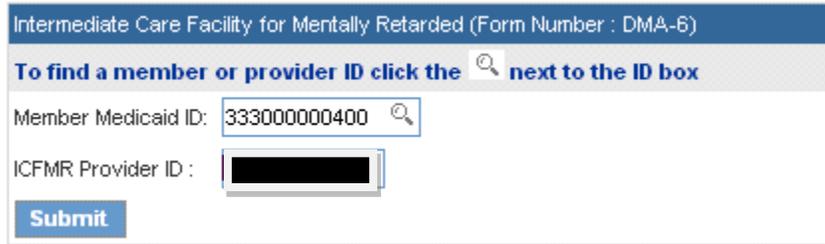
- Place of Service: For ICFMR, this value defaults to Intermediate Care Facility Mentally Retarded instead of Skilled Nursing Facility.
- Evaluation Dates: In place of the Patient Condition questions found on the SW form, the ICFMR form captures the completion dates of the Developmental Care Plan, Social 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](http://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.



Intermediate Care Facility for Mentally Retarded (Form Number : DMA-6)

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

Member Medicaid ID:  

ICFMR Provider ID :

**Submit**

Figure 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.



Developmental Care Plan Date :  Social Evaluation Date :  Psychological Evaluation Date :

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](http://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.**

## New Request for Prior Authorization

The Requesting Provider ID is a unique value assigned to identify a provider performing a service for a prior auth from the 'Find Provider ID' link.

Nursing Facility Mechanical Ventilation Services

Please enter the Member's ID or the SSN. Do not enter both.

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

Member Medicaid ID:

Social Security Number :

Vent Provider ID :

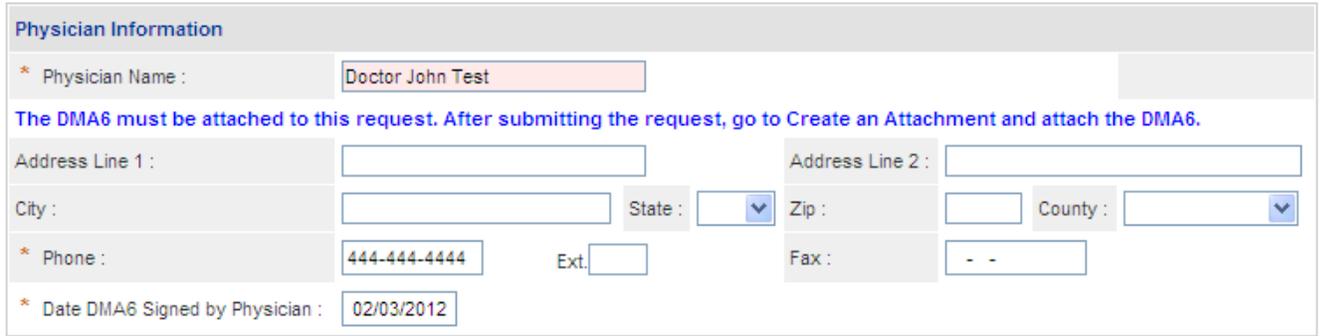
Figure 324

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).



**Physician Information**

\* Physician Name : Doctor John Test

The DMA6 must be attached to this request. After submitting the request, go to Create an Attachment and attach the DMA6.

Address Line 1 :  Address Line 2 :

City :  State :  Zip :  County :

\* Phone : 444-444-4444 Ext.  Fax : - -

\* Date DMA6 Signed by Physician : 02/03/2012

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.



**Contact Information**

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

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

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.

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

- Recommendation Type:** Radio buttons for 'Continued Placement' (unselected) and 'Initial Placement' (selected).
- Initial Admission Date/Planned Admission Date:** Text box containing '05/05/2013'.
- Place of Service:** Dropdown menu showing '31 - Skilled Nursing Facility'.
- Admission Type:** Dropdown menu showing 'Elective'.
- Level I PASRR Approval Number:** Text box containing '113050199999'.
- Level I PASRR Approval Date:** Text box containing '05/01/2013'.

Figure 327

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

- Recommendation Type:** Radio buttons for 'Continued Placement' (selected) and 'Initial Placement' (unselected).
- Continued Placement Start Date:** Text box containing '01/23/2013'.
- Initial Admission Date:** Text box containing '01/23/2012'.
- Initial Request ID:** Empty text box.
- Place of Service:** Dropdown menu showing '31 - Skilled Nursing Facility'.
- Admission Type:** Dropdown menu showing 'Elective'.
- Level I PASRR Approval Number:** Text box containing '112012399999'.
- Level I PASRR Approval Date:** Text box containing '01/22/2012'.

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

Have at least two vent weaning attempts been made in the last 90 days?  
 Yes  No

If No, is vent weaning feasible at this time?  
 Yes  No

If No, describe why patient is currently unsuitable for vent weaning.

Describe why vent weaning is not feasible at this time.

Figure 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.**

* Diagnosis on Admission to Nursing Facility Mechanical Ventilation Unit						
Diag Code	Diagnosis Description	Date	Primary	Admission	Type	
769	RESPIRATORY DISTRESS SYN	02/01/2012	Yes	Yes	ICD-9	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>		ADD

Figure 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.

Admission/Continued Stay Criteria :	
(All questions are required)	
Supporting Documentation for each criterion may be reflected on the DMA-6 section noted in the parentheses or through attached documents as indicated.	
* Health condition requires close medical supervision, 24 hours a day of licensed nursing care, and specialized services or equipment (Section B12 on DMA-6).	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Requires mechanical ventilation greater than six (6) hours a day per day for greater than twenty one (21) days. (Section B Diagnostic and Treatment Procedures on DMA-6).	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Has a tracheostomy with the potential for weaning but require mechanical ventilation for a portion of each day for stabilization.	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Admission from hospitalization or other location shall demonstrate two (2) weeks clinical and physiologic stability including applicable weaning attempts prior to transfer. (Section B Diagnostic and Treatment Procedures on DMA-6).	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Requires pulse oximetry monitoring to check stability of oxygen saturation levels. (Section B Diagnostic and Treatment Procedures on DMA-6).	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Requires respiratory assessment and documentation daily by a Licensed Respiratory Therapist or Registered Nurse. (Section B Diagnostic and Treatment Procedures on DMA-6).	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Have a physician order for respiratory care to include suctioning as needed. (Section B Diagnostic and Treatment Procedures on DMA-6).	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Requires tracheostomy care at least daily. (Section B Diagnostic and Treatment Procedures on DMA-6).	<input checked="" type="radio"/> Yes <input type="radio"/> No

**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.

Hospital Admissions				
If initial placement requested, enter the most recent hospitalization. If continued placement requested, list any acute hospitalizations since last vent authorization period began.				
Hospital/Facility	Admit Date	Discharge Date	Reason for Hospitalization	
Test Hospital	01/24/2012	01/27/2012	Severe respiratory distress	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

Figure 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’.

Diagnosis at Discharge from Most Recent Hospital Stay			
Diag Code	Diagnosis Description	Primary	
769	RESPIRATORY DISTRESS SYN	Yes	EDIT DELETE
<input type="text"/>	<input type="text"/>		ADD

Figure 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.

Medications and IVFs				
Name	Dosage	Route	Frequency	
Anti-inflammatory	10mg	Oral	Regular	EDIT DELETE
Bronchodilator	10mg	Oral	Regular	EDIT DELETE
Antihypertensive	20mg	Oral	Regular	EDIT DELETE
Sed/hypnotic	10mg	Oral	PRN: As Necessary	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ADD

Figure 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.

Vent Use and Other Treatment Procedures		
A frequency must be added for each of the treatments displayed. Click Edit on the treatment line and the treatment will display at the bottom of the table. Enter the frequency in the box provided and then click Save.		
Type	Frequency	
O2 Continuous		EDIT
Trach Care		EDIT
Respiratory Therapy		EDIT
Pulse Oximetry		EDIT
Ventilator		EDIT
O2 PRN		EDIT
<input type="text"/>	<input type="text"/>	ADD

Figure 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**.

**Vent Use and Other Treatment Procedures**

A frequency must be added for each of the treatments displayed. Click Edit on the treatment line and the treatment will display at the bottom of the table. Enter the frequency in the box provided and then click Save.

Type	Frequency	
O2 Continuous		EDIT
Trach Care		EDIT
Respiratory Therapy		EDIT
Pulse Oximetry		EDIT
Ventilator		EDIT
O2 PRN		EDIT
O2 Continuous	Continuous daily	SAVE DELETE

Save Line

Figure 336

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

**Vent Use and Other Treatment Procedures**

A frequency must be added for each of the treatments displayed. Click Edit on the treatment line and the treatment will display at the bottom of the table. Enter the frequency in the box provided and then click Save.

Type	Frequency	
O2 Continuous	Continuous daily	EDIT
Trach Care		EDIT
Respiratory Therapy		EDIT
Pulse Oximetry		EDIT
Ventilator		EDIT
O2 PRN		EDIT
		ADD

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 O2 PRN, click the down arrow to display the treatment procedures drop list. Select a treatment procedure; enter the frequency of the treatment; and then click **Add**.

**Vent Use and Other Treatment Procedures**

A frequency must be added for each of the treatments displayed. Click Edit on the treatment line and the treatment will display at the bottom of the table. Enter the frequency in the box provided and then click Save.

Type	Frequency	
O2 Continuous	Continuous daily	EDIT
Trach Care	Bid	EDIT
Respiratory Therapy	Once a day	EDIT
Pulse Oximetry	Twice a week	EDIT
Ventilator	10 hours a day	EDIT
O2 PRN	PRN	EDIT
Foley Catheter Care	Daily	EDIT DELETE
Intake & Output	Continuous	EDIT DELETE
<input type="text"/>	<input type="text"/>	ADD

Figure 338

**Ventilator Settings:**

50. For each ventilator setting, enter the numerical amount in the boxes provided. The box for FiO2 includes a decimal point; and the system inserts a '0' if only two digits are entered.

O2% :  Peep :  FiO2 :  Resp Rate Setting :

Figure 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.

**Treatment Plan :**

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

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

Figure 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.

Justification and Circumstances for Admission or Continued Placement :

Provide justification for the services ordered.

Provide justification for the services ordered.

Name of MD / RN Signing Form :  Date Signed :

**Figure 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:

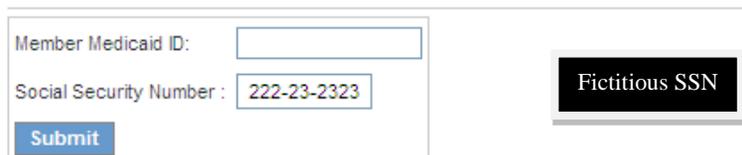
- **Approved:** A decision of 'Approved' indicates that all Level I criteria were met. No further action is needed and the applicant is approved for admission to a nursing facility. The Level I tracking number is now the Level I authorization number.
- **Pending:** A decision of 'Pending' indicates that 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](http://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.**

#### PreAdmission Screening/Resident Review(PASRR) Level I Assessment (Form : DMA-613)



The screenshot shows a web form for the PASRR Level I Assessment. It contains two input fields: 'Member Medicaid ID' and 'Social Security Number'. The 'Social Security Number' field contains the value '222-23-2323'. Below the input fields is a blue 'Submit' button. To the right of the form is a black box with the text 'Fictitious SSN' in white.

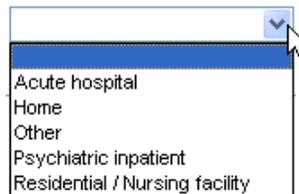
Figure 342

- 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).

- 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.
- 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.
- Enter the applicant’s current location by selecting the location from the ‘Current Location’ drop list.



**Figure 343**

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

**Member Information**

Member ID :	<input type="text"/>	Last Name:	<input type="text" value="Member"/>	First Name :	<input type="text" value="Test"/>	Middle Initial :	<input type="text" value="Y"/>
Social security Number :	<input type="text" value="777-66-6666"/>	Date of Birth :	<input type="text" value="09/16/1930"/>	Gender :	<input type="text" value="Male"/>		
Current location of applicant :	<input type="text" value="Home"/>						

If 'Other' is selected, please explain.

Check all that apply to the applicant/resident

<input type="checkbox"/> New admission	<input type="checkbox"/> Readmission to NF from psychiatric hospital	<input type="checkbox"/> Readmission to NF from acute hospital	<input type="checkbox"/> Respite care, less than 30 days
<input type="checkbox"/> Transfer from residential to NF	<input type="checkbox"/> Transfer between NF's	<input type="checkbox"/> Emergency, requiring Protective Services	<input checked="" type="checkbox"/> Out of State resident(OOS)
<input checked="" type="checkbox"/> Other			

If 'Other' is selected, please explain.

dfgadfsgasdgasdgfasdgfasdgasdg

\*Resident's OOS PASRR Contact Information: (if Out of State resident is selected)

OOS Contact Last Name :	<input type="text" value="OOS"/>	OOS Contact First Name :	<input type="text" value="Contact"/>	Contact Phone # :	<input type="text" value="444-444-4444"/>
-------------------------	----------------------------------	--------------------------	--------------------------------------	-------------------	---

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**?

1. Does the individual have a suspected mental illness, mental retardation, developmental disability or related condition?  Yes  No

a. Does the individual have a primary (Axis I) diagnosis of dementia based on DSM IV criteria?  Yes  No

If Yes, check the type of dementia, due to:

<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Vascular Changes	<input type="checkbox"/> HIV	<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Huntington's Disease	<input type="checkbox"/> Creutzfeldt-Jakob (ABE)
<input checked="" type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Pick's Disease	<input type="checkbox"/> Other	Dementia Diagnosis Code : <input type="text" value="332"/>		

If 'Other' is selected, please explain.

b. Is there current and accurate data found in the patient record to indicate that there is a **severe physical illness** that is so severe that the patient could not be expected to benefit from \*specialized services?  Yes  No

\* Specialized Services under Georgia's PASRR Program are services in combination with nursing facility services results in the implementation of an individualized plan of care that is developed and supervised by an interdisciplinary team, prescribes specific therapies and activities which necessitates supervision by trained mental health personnel and is directed toward stabilization and restoration. The services include crisis intervention, training/counseling, physician assessment & care, In-Service training services, Skills training with Rehab supports & therapy, day/community support for adults, and case management which involves assertive community treatment. For more information, see Nursing Facility Part II Medicaid Policy Manual, Appendix H.

If Yes, specify the physical illness :

<input type="checkbox"/> Coma, Functioning at a brain stem level	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Chronic Obstructive Pulmonary Disease	<input type="checkbox"/> Ventilator dependence	<input type="checkbox"/> Delirium
<input checked="" type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Huntington's Disease	<input type="checkbox"/> Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	<input type="checkbox"/> Other	

If 'Other' is selected, please explain.

c. Does the individual have a **terminal illness** as defined for hospice purpose under 42 CFR 483.130 which includes medical prognosis that his/her life expectancy is 6 months or less?  Yes  No

d. Does the individual applying for admission, **directly from hospital discharge, require NF services for the condition received while in the hospital** and whose attending physician has certified that the NF stay is likely to require **less than 30 days**?  Yes  No

Figure 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.

**2. Does the individual have a primary (Axis I) diagnosis of mental illness based on DSM IV criteria?**  Yes  No

If Yes, specify the physical illness :

<input type="checkbox"/> Schizophrenia, Paranoid Type	<input type="checkbox"/> Schizophrenia, Disorganized Type	<input type="checkbox"/> Schizophrenia, Catatonic Type	<input type="checkbox"/> Schizophrenia, Undifferentiated Type
<input type="checkbox"/> Schizophrenia, Residual Type	<input type="checkbox"/> Bipolar Disorder	<input checked="" type="checkbox"/> Depressive Disorder	<input type="checkbox"/> Somatoform Disorder
<input type="checkbox"/> Other Psychotic Disorder	<input type="text"/>	<input type="checkbox"/> Anxiety Disorder	<input type="text"/>

Comments :

**a. Does the treatment history indicate the individual has experienced at least ONE of the following?**

(1) In-patient psychiatric treatment more than once in the past 2 years.  Yes  No

(2) Within the last 2 years experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.  Yes  No

**b. Within the past 3 to 6 months** the disorder results in functional limitations of major life activities that would normally be appropriate for the individual's developmental stage. The individual typically has AT LEAST ONE of the following characteristics on a continuing or intermittent basis:

(1) **Interpersonal functioning.** The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation.  Yes  No

(2) **Concentration, persistence, and pace.** The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.  Yes  No

(3) **Adaptation to change.** This individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.  Yes  No

**3. The individual has an Axis II diagnosis of mental retardation based on DSM IV criteria (diagnosed prior to age 18) or developmental disability (manifested before the person reaches age 22).**  Yes  No

Figure 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.

**Nursing Facility Information**

Has the patient been admitted to the nursing facility?  Yes  No

Date of Admission to Nursing Facility :  Name of Nursing Facility :  Nursing Facility Provider ID :

**Figure 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.

Physician Information					
Physician's Name on DMA-6 :	<input type="text" value="Doctor Doctor"/>	Office or Hospital :	<input type="text" value="Office"/>	Phone :	<input type="text" value="444-444-4444"/>
Address 1 :	<input type="text" value="1 Address"/>	Address 2 :	<input type="text"/>	City :	<input type="text" value="City"/>
State :	<input type="text" value="Georgia"/>		Physician Signed?	<input checked="" type="radio"/> Yes <input type="radio"/> No	
Zip :	<input type="text" value="30003"/>	County :	<input type="text" value="DeKalb"/>	Date Signed :	<input type="text" value="04/05/2010"/>

DO NOT PROCEED IF PHYSICIAN HAS NOT CERTIFIED A DMA-6 FOR A LEVEL OF CARE

Figure 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.

Contact Information					
Contact First Name :	<input type="text" value="First Name"/>	Last Name :	<input type="text" value="Last Name"/>	Name of Contact Facility :	<input type="text" value="Hospital"/>
Date Level I Requested :	<input type="text" value="04/05/2010"/>	Phone :	<input type="text" value="555-555-5555"/>	Fax :	<input type="text" value="- -"/>
Address :	<input type="text" value="Hospital St"/>	City :	<input type="text" value="city"/>	State :	<input type="text" value="Georgia"/>
Contact Facility Type :	<input type="text" value="Hospital"/>		E-mail :	<input type="text"/>	
Zip Code :	<input type="text" value="30030"/>				

Figure 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.

### PreAdmission Screening/Resident Review(PASRR) Level I Assessment (Form : DMA-613) Request

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Thank you for submitting your Medicaid Prior Authorization request online. You may check the case status of your request online after 24 hours of prior authorization or prior authorization process, please click the "Contact Us" feature in the upper right-hand corner of this page, or call the toll-free number (800)766-4456.

Request ID :	10040706780	Status :	Pending
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Figure 352