

PASRR
User Manual



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NOTE: Valid member, provider and PA IDs are redacted in this manual. Member/provider information displayed is fictitious.

1.0 PASRR Level I Overview

The *PASRR USER Guide* describes the functionality available to Medicaid providers to electronically process PASRR Assessment Screenings. The functionality available includes:

- Submit a Pre-Admission Screening Resident Review (PASRR) Level I.
- View existing Level I requests, and edit Level I requests that have not been reviewed.
- Modify Member Medicaid IDs for a Level I assessment.
- Link for Skilled Nursing Facilities to view and edit assessments of residents in their facilities.

2.0 Submit a PASRR Level I Request

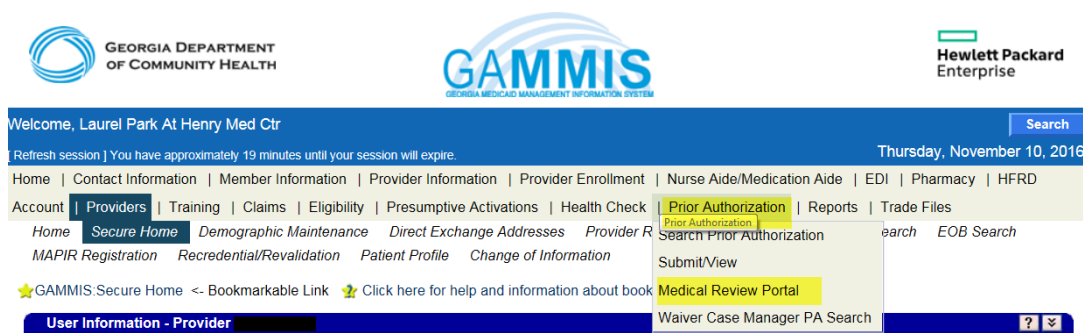
2.1 Description

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 portal secure home page via the **Medical Review Portal**. 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- **Withdrawn:** If the system returns a decision of 'Withdrawn', it means that a response on the form reflects that the applicant's physician anticipates the nursing facility stay will be less than 30 days.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.

2.2 Web Entry Instructions

1. Go to the Georgia Web Portal at www.mmis.georgia.gov.
2. On the portal home page, click on [Prior Authorization](#) → [Medical Review Portal](#)



3. Scroll down to the [PASRR Level I Information](#) section and select [Enter a New PASRR Request](#).

PASRR Level I Information

[Enter a New PASRR Request](#) - Use this link to enter a new request for PASRR Level I screening.

[PASRR Level I Search, Edit, and Member Medicaid ID Updates](#) - Use this link to Search, Edit, and modifying Member Medicaid IDs for PASRR Level I.

[Enter Change Request for a PASRR Level I](#) - Use this link to request a change to your existing PASRR Level I requests when you are [More...](#)

[Nursing Facility Level I Lookup](#) - Use this link to find Level I authorizations for Medicaid Members in your facility. [More...](#)

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

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

5. Click **Submit** to open the Level I screening form. At the top of the form, the following warning displays:

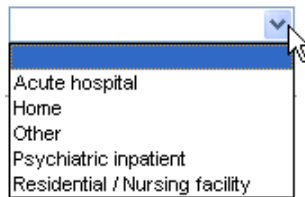
“DO NOT PROCEED IF PHYSICIAN HAS NOT CERTIFIED A DMA-6 FOR A LEVEL OF CARE”

The intent of this warning is to remind the 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).

6. If the applicant's Medicaid ID was entered or the SSN entered corresponds to an individual with a Medicaid ID, the system will populate the Medicaid ID, social security number, Member name, date of birth and gender in the applicable boxes.
7. If the applicant is not a Medicaid recipient, the member information **except for Member ID** must be entered. Enter the applicant's 'Last Name', 'First Name', 'Middle Initial' (if applicable), 'Date of Birth' (manually or using the calendar popup), and select a 'Gender' from the drop list. The system inserts the SSN entered on the Level I entry page.
8. Enter the applicant's current location by selecting the location from the 'Current Location' drop list.



9. If 'Other' is selected as the current location, provide an explanation for this choice in the text box provided.
10. Under '**Check all that applies to the applicant/resident**', check each box related to the applicant's situation. If 'Other' is selected, enter an explanation in the text box provided.
11. If 'Out of State resident' is selected, enter the OOS contact person's 'Last Name', 'First Name' and 'Phone Number' in the 'Resident's OOS PASRR Contact Information' section.

Member Information					
Member ID	Last Name: Member	First Name: Test	Middle Initial: Y		
Social security Number: 777-66-6666	Date of Birth: 09/16/1930	Gender: Male			
Current location of applicant: 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.					
dfgasdfgasdfgasdfgasdfgasdf					
*Resident's OOS PASRR Contact Information: (if Out of State resident is selected)					
OOS Contact Last Name: OOS	OOS Contact First Name: Contact	Contact Phone #: 444-444-4444			

Level I Screening Questions:

12. 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:

- Alzheimer's Disease
 Vascular Changes
 HIV
 Head Trauma
 Huntington's Disease
 Creutzfeldt-Jakob (ABE)
- Parkinson's Disease
 Pick's Disease
 Other
 Dementia Diagnosis Code :

If 'Other' is selected, please explain.

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

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

If Yes, specify the physical illness :

- Coma, Functioning at a brain stem level
 Congestive Heart Failure
 Chronic Obstructive Pulmonary Disease
 Ventilator dependence
 Delirium
- Parkinson's Disease
 Huntington's Disease
 Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
 Other

If 'Other' is selected, please explain.

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

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

Mental Illness/Mental Retardation/Developmental Disability Questions:

13. Respond **Yes** or **No** to the following questions. If a response is ‘Yes’, additional information may be required.

Question 2: Does the individual have a primary (Axis I) diagnosis of mental illness based on DSM-IV criteria?

If ‘Yes’ to question #2, click a checkbox to indicate the applicable psychiatric illness. If ‘Other Psychotic Disorder’ or ‘Anxiety Disorder’ is checked, explain in the textboxes provided. The comments box is optional but can be used to note additional information regarding the patient’s psychiatric disorder.

Question 2a: Does the treatment history indicate the individual has experienced **at least ONE of the following?** (Respond Yes or No to (1) and (2) below).

(1) In-patient psychiatric treatment more than once in the past 2 years.

(2) Within the last 2 years experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Question 2b: **Within the past 3 to 6 months** the disorder results in functional limitations of major life activities that would normally be appropriate for the individual’s developmental stage. The individual typically has **AT LEAST ONE of the following** characteristics on a continuing or intermittent basis:

(Respond Yes or No to (1), (2) and (3) below).

(1) **Interpersonal functioning.** The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation.

(2) **Concentration, persistence, and pace.** The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks

(3) Adaptation to change. This individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

Question 3: The individual has an Axis II diagnosis of mental retardation based on DSM IV criteria (diagnosed prior to age 18) or developmental disability (manifested before the person reaches age 22). The following **disabilities** MAY indicate a **RELATED CONDITION:** Autism, Blind/Severe Visual Impairment, Cerebral Palsy, Cystic Fibrosis, Deaf/Severe Hearing Impairment, Head Injury, Epilepsy/Seizure Disorder, Multiple Sclerosis, Spina Bifida, Muscular Dystrophy, Orthopedic Impairment, Speech Impairment, Spinal Cord Injury, Deafness/Blindness.

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

If Yes, specify the physical illness :

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

Comments :

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

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

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

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

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

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

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

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

Nursing Facility Information:


This section captures nursing facility information. It must be completed if yes is the response to the first question in this section regarding admission to the nursing facility.

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

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

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

17. To enter the name of the nursing facility and nursing facility provider ID, follow this procedure:

- a. Click the spy glass  next to the ‘Nursing Facility Provider ID’ box to display the *Nursing Facility Search* page.

Nursing Facility Provider ID : 

- 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.

Provider Name: Provider ID:

Referral Provider ID	Provider Name

1 2 3 4 5 6 7 8 9 10 ...

Provider list intentionally obscured

- 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 :

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	Date Signed :	<input type="text" value="04/05/2010"/>
Zip :	<input type="text" value="30003"/>	County :	<input type="text" value="DeKalb"/>		

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

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"/>

35. After all Level I questions are answered and all data entered, click **Review Request** at the bottom of the form. The page may temporarily 'gray' out as the system validates data.
36. If all required data is entered correctly, an attestation statement displays at the bottom of the *Review Request* page. Click **I Agree**.

37. When 'I agree' is selected, the *Review Request* page is refreshed and two new links display at the bottom: **Edit Request** and **Submit Request**.
38. Select **Submit Request**. The Level I is submitted; and the tracking number and Level I decision (pending, approved, or withdrawn) display at the top of the page as shown in the figure below.

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

Thank you for submitting your Medicaid Prior Authorization request online. You may check the case status of your request online after 24 hours of 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 :	10040706783	Status :	Pending
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3.0 View and Edit PASRR Level I

3.1 Searching and Editing Instructions - Provider

Providers may view and edit the requests **associated with their provider ID** when the requests are entered via the secure portal (after logging in). To edit a Level I request, the request must be pending and not referred for Level II assessment. As part of the edit functionality, providers are also able to add a Member Medicaid ID to a Level I request in the event the applicant did not have a Medicaid ID when the Level I was entered.

3.1.1 Searching and Viewing Level I Assessment - Provider

1. Open the *Medical Review Portal* and select **PASRR Level I Search, Edit** to open the **PASRR Request Search** page.

PASRR Request Search

Request ID :	<input type="text"/>	GHP Decision :	<input type="text" value="v"/>	Case Status :	<input type="text" value="v"/>
Member Social Security Number :	<input type="text" value="____-__-____"/>	Member First Name :	<input type="text"/>	Member Last Name :	<input type="text"/>
Member Medicaid ID :	<input type="text"/>	Physician Name :	<input type="text"/>	OBRA Number :	<input type="text"/>
From Date :	<input type="text"/>	To Date :	<input type="text"/>	Entered Via :	<input type="radio"/> Web <input type="radio"/> Non-Web
<input type="button" value="Search"/> <input type="button" value="Reset"/>					

2. To find a specific Level I request, enter the Level I tracking/authorization number in the ‘Request ID’ box and then click **Search**. This is the **preferred way to search** for a Level I request.
3. If the request ID is not available, search by using the member’s Social Security Number (SSN) or the member’s Medicaid ID. **Note:** The search will only pull up results for the past 90 days.
4. Search results may be limited by combining a SSN or Medicaid ID with other search parameters, such as:
 - **GHP Decision:** Level I decision - Approved, Referred for OBRA Review, or Withdrawn.
 - **Case Status:** The overall authorization status, which could be Approved, Denied, or Pending. Requests that are ‘Referred for OBRA Review’ are pending.
 - **Physician Name:** The name of the physician on the level I request
 - **From Date and To Date:** These dates refer to the date that the Level I was entered into the PA system. Enter a ‘From Date’ and a ‘To Date’ to find Level I requests submitted during a specific period of time.
5. Once a search is conducted, the results of the search display below the search panel. If the search was conducted using the Request ID, only one result will display. If more than one search criterion is used, the search returns Level I requests that match any of the search criteria.
6. To open a Level I request for viewing, click the **Request ID**.

PASRR Request Search

The screenshot shows a search form with the following fields: Request ID (11513019999), Member Social Security Number (--- --), Member Medicaid ID, From Date, To Date, GHP Decision (dropdown), Case Status (dropdown), Member First Name, Member Last Name, Physician Name, OBRA Number, and Entered Via (radio buttons for Web and Non-Web). Below the form is a table with one row of results. A red arrow points to the 'Request ID' column header in the table.

Request ID	Last Name	First Name	Birth Date	SSN	GHP Decision	OBRA Number	Status
11513019999	c	c	04/25/2010	121121212	Withdrawn		Denied

Displaying Page 1 of 1 Displaying 1 cases from 1 to 1 of Total 1 cases

3.1.2 Editing Level I Request - Provider

1. If the Level I request selected from search results is still pending/not referred, the level I form opens in a format that may be edited.
2. Change or modify information on the Level I form as needed.
3. If the member was given a 'system assigned' ID (such as 00111GMC as shown in the next figure) when the Level I was requested, but the member now has a valid Medicaid ID, it is possible to add the member's Medicaid ID by utilizing the **Update Member Medicaid ID** button.

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

Request ID :	115130299999	Status :	Approved
Member Information			
Member ID :	00111GMC	Update Member Medicaid ID	Last Name:

4. Replace the system assigned ID with the member's valid Medicaid ID number.

Request ID :	115130299999	Status :	Approved
Member Information			
Member ID :	333000000300	Update Member Medicaid ID	Last Name:

5. Click **Update Member Medicaid ID**.
6. Click **Submit Request** to save the changes made to the Level I request. The Level I authorization number remains the same.

3.2 Searching and Editing Instructions – Skilled Nursing Facility

Nursing facility providers with a category of service (COS) of 110/Skilled Care Nursing Facility or COS 160/Intermediate Care Nursing Facility may use the link *Nursing Facility Level I Lookup* function to view and edit PASRR Level I assessments for Medicaid Members in their facility.

3.2.1 Searching and Viewing Level I Assessment - SNF

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

- On the portal home page, click on **Prior Authorization** → **Medical Review Portal**
- Scroll down to the **PASRR Level I Information** section and select *Nursing Facility Level I Lookup*.

PASRR Level I Information

- [Enter a New PASRR Request](#) - Use this link to enter a new request for PASRR Level I screening.
- [PASRR Level I Search, Edit, and Member Medicaid ID Updates](#) - Use this link to Search, Edit, and modifying Member Medicaid IDs for PASRR Level I.
- [Enter Change Request for a PASRR Level I](#) - Use this link to request a change to your existing PASRR Level I requests when you are [More...](#)
- [Nursing Facility Level I Lookup](#) - Use this link to find Level I authorizations for Medicaid Members in your facility. [More...](#)

- On the PASRR (Level I) Look Up page, the following member data is required:
 - Medicaid ID or the last four digits of Social Security Number (Do not enter both)
 - Date of Birth

PASRR (Level I) Look Up

Member Medicaid ID : OR Last 4 digits of Member Social Security Number :

AND

Member Date of Birth :

[Search](#) [Reset](#)

- Click **Search** to display the Level I Request ID, Status, and Effective_Date.
- To open a Level I request, click the **Request ID**.

PASRR (Level I) Look Up

Member Medicaid ID : OR Last 4 digits of Member Social Security Number :

AND

Member Date of Birth :

[Search](#) [Reset](#)

Request ID	Status	Effective_Date
<input type="text"/>	Approved	1/6/2011 9:50:33 AM

3.2.2 Editing a Level I Assessment – SNF

1. If the Level I request selected has a GMCF Member ID, 00111GMC, the level I form opens in a format that may be edited.

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

Request ID : 11611100001 Status : Approved

This SSN belongs to another member ID. Please check.

Please provide the required information for this PA request on this page. When you have completed entering the data for this PA request, select the Review Request link to view the information entered.
In accordance with Section 1919(b)(3)(f) of the Social Security Act, a nursing facility cannot admit any new resident without this preadmission identification screen. This screen is part of the Preadmission Screening/Resident Review (PASRR), and determines whether each applicant to a nursing facility has indicators for a related condition of mental illness, mental retardation, or developmental disability.

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

Member Information				
Member ID : 111111GMC	Last Name: test	First Name : test	Middle Initial :	<input type="checkbox"/>
Update Member Medicaid ID				
Social security Number : 111-11-1111	Date of Birth : 10/21/1947	Gender :	Male <input type="checkbox"/>	
Current location of applicant :	Acute hospital	Requesting Provider:		

2. The following member data is editable by a nursing facility:
 - First Name
 - Last Name
 - DOB
 - GMC Member ID
3. To modify the first name, last name or DOB, type the correct data in the text entry field.
4. To modify the Member ID, enter the members Medicaid ID in the member ID field and select the **Update Member Medicaid ID** button
5. Scroll to the bottom of the page and select the **Review** button to review the request. If all changes are correct, select the **Submit** button to complete the task. If more changes are needed, select the **Edit** button, and restart the process.

4.0 Change Request

If changes to the Level I are needed that cannot be made via the edit functionality provided, submitting providers and Skilled Nursing Facilities may submit a Change Request via the Medical Review Portal.

- Scroll to the **PASRR Level I Information** section on the Portal and select **Enter Change Request for PASRR Level I** to display the **PASRR Request Search** page

PASRR Level I Information

- [Enter a New PASRR Request](#) - Use this link to enter a new request for PASRR Level I screening.
- [PASRR Level I Search, Edit, and Member Medicaid ID Updates](#) - Use this link to Search, Edit, and modifying Me Level I.
- [Enter Change Request for a PASRR Level I](#) - Use this link to request a change to your existing PASRR Level I re

- Click the Level I request ID to display the **Change Request Information** page

PASRR Request Search

Request ID	Last Name	First Name	Birth Date	SSN	GHP Decision	OBRA Number	Status
115130199999	c	c	04/25/2010	121121212	Withdrawn		Denied

Displaying Page 1 of 1 Displaying 1 cases from 1 to 1 of Total 1 cases

- Enter the requested information on the **Change Request Information** page and select **Submit**.

Change Request Information

Request ID : 116082500001 CMO Request ID :

Date Requested	Contact Name	Contact Phone	Change Required	Change Rationale	CR Status	Date Processed	Processed By
11/22/2016	testttttttUpdate testtttttt	777777777	testtttttttt	testtttttttttttttttttt	Not Processed		

Please review the change request information. Once you finish making appropriate changes to PA, update the Change Request by checking change request processed indicator. P complete the following S\$change requestSS form. Please make your information as complete as possible, as this will be used for determining whether your S\$change requestSS is approved or denied. You may be contacted by a review staff member if there are any questions concerning your S\$change requestSS. You may attach documents to this request. A you click Submit, a confirmation page will display. Use 'Create An Attachment' on that page to attach documents."

You will receive an email once this Change Request/Reconsideration Request is processed. Please check All contact information (name, pho and email address) and make sure that the information is correct. If not correct, edit the information.

Contact Name : testttttttttUpdate testtttttt Phone: 777-777-7777 Ext: Fax: - - Email : vickie.chandler@gmcf.org

Describe what you want to change.
Enter what you would like changed

Provide your rationale for changing the Prior Authorization Request.
Enter the rationale to support your changes

Please select Change Request Rationale List:

Change Member Change Provider Add or Change Diagnosis Codes Add or Change Procedure Codes Recertification Reque
 Withdraw Entire Request Change Admit Date or Date of Service Change Place of Service Increase in Requested Units Other

Submit Close Window

- The Change Request Information page will display informing the provider that their *“Change Request has been successfully entered into the system”* and allow providers to [Browse and Attach](#) supporting documentation

Change Request Information

Request ID : 116082500001 Contact Name : testttttttttUpdate testtttttttt Phone : 777-777-7777 Ext : Fax : -- CMO Request ID : Email : vi

Describe what you want changed.
Enter what you would like changed

Provide your rationale for changing the Prior Authorization Request.
Enter the rationale to support your changes

Your Change Request has been successfully entered into the system. Should a review staff member have any questions, you will be contacted.

To attach documents, use Create an Attachment below. You may attach files that are no more than approximately 20 pages.

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".

- Providers will receive a no-reply email when a change request is submitted to notify the provider that the message was received. When the nurse reviewer processes the change request, another no-reply email will be sent notifying the provider that the request has been processed.
- Follow the process in section 5.2 *Correspondence Search Instructions* to view the changes request decision.

5.0 Contacting Alliant GMCF

Providers can contact GMCF review nurses via the Contact Us section at the bottom of the **Medical Review Portal**. The Portal includes the following features:

- **Contact Us:** Submit questions and messages to Alliant/GMCF reviewers
- **Search My Correspondence:** View correspondence from an Alliant/GMCF reviewer

Help & Contact Us

[Education & Training Material and Links](#) - Use this link to access workshops, webinars, user manuals, and other resources.

[Contact Us or Search My Correspondence](#) - Use this link to contact review nurse staff behind the scenes of MMIS portal.

5.1 Contact Us Instructions

1. Click **Contact Us** link at the bottom of the Portal page to open the **Contact Us** form.

Contact Us

Contact Form

Correspondence ID :

Contact For :

Contact Name :

Contact Email Address :

Confirm Email Address :

Phone Number : Ext.

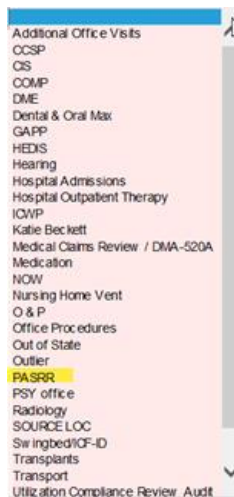
Message / Question :

GMCF Response :

Reference Attachments :

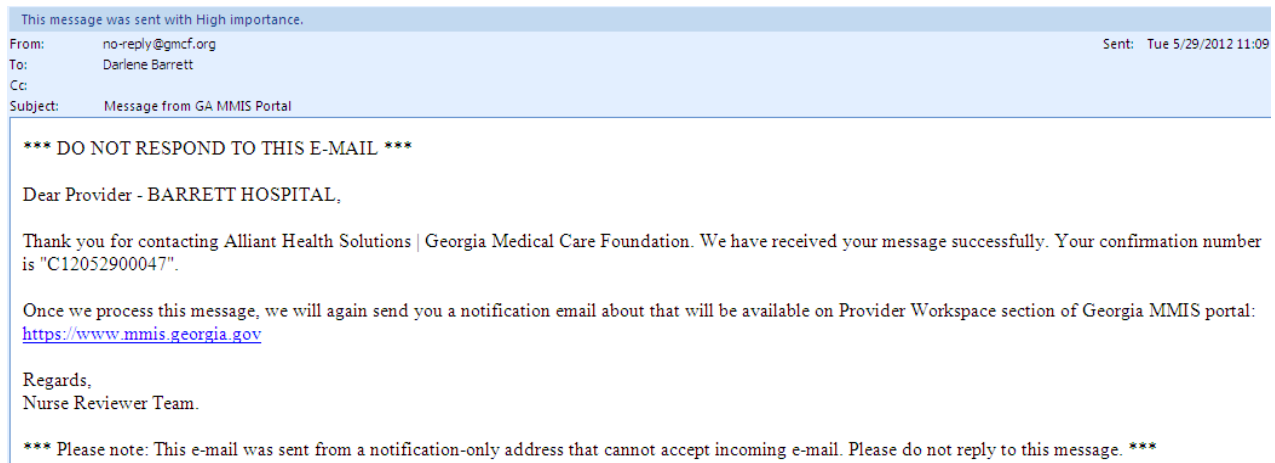
[Submit Information](#) [Reset Form](#) [< Back](#) [Return to Provider Workspace](#)

2. Select the PA type from the 'Contact For' drop list. **This is required.**



- Enter the Authorization Request ID
- Enter the name of the person submitting the correspondence in the 'Contact Name' box.

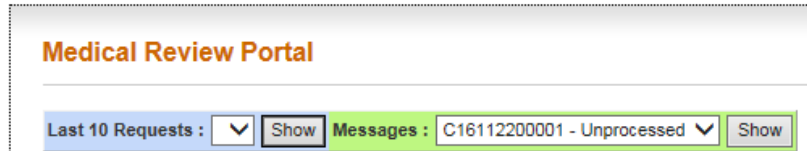
- Enter the contact person's email address in the 'Contact Email Address' box; and then enter the same email address again in 'Confirm Email Address' box to verify (required).
 - Enter the contact person's phone number in the 'Phone Number' box.
 - Enter the message or question in the 'Message/Question' box.
 - Click **Submit Information**.
 - If the contact submission is successful, a message displays in red below the contact form. The message includes the 'Correspondence ID' or confirmation number and indicates that an email has been sent to the contact person's email address. The 'Correspondence ID' may be used to search for the contact on the Provider Workspace.
- Record saved successfully. Notification Email has been sent on 7/13/2011 2:17:05 PM to email address provided above. Confirmation Number is : C11071300024.
- Once a correspondence is submitted, providers are allowed to attach documents to the correspondence via *Create an Attachment* functionality. **The correspondence must be submitted first before attachment functionality becomes available.**
 - Providers will receive a no-reply email when a correspondence is submitted to notify the provider that the message received. When the nurse reviewer processes the change request, another no-reply email will be sent notifying the provider that the request has been processed.



5.2 Correspondence Search Instructions

There are two ways to find and view existing correspondence from the **Medical Review Portal**.

- If the correspondence was submitted recently, check the ‘Provider Messages’ drop list at the top of the portal page. This list shows the last ten messages. Find the ‘Correspondence ID’ in the list; highlight the ID; and then click **Show** to open the contact form.



- Search for the specific correspondence by clicking **Search My Correspondence** at the bottom of the portal page to display the **Search Provider Inquiry / Correspondence** page.

Search Provider Inquiry / Correspondence

Provider ID : 007100074A Contact Name :

Contact For : Contact For ID :

Correspondence ID :

Entered Between : And

Phone Number :

Processed by GMCF : Yes No

Search **Clear Search** **Create New**

- Although a search is possible using any of the search values, the **best way to search is by the correspondence ID**, which is provided in the no-reply email notification.
 1. Enter the correspondence ID in the ‘Correspondence ID’ box. The provider ID is already populated by the system.
 2. Click **Search**, and the correspondence displays in the search results table.

Search Provider Inquiry / Correspondence

Provider ID :

Contact For : Contact Name :

Correspondence ID : C11071300024 Contact For ID :

Entered Between : And

Phone Number :

Processed by GMCF : Yes No

Search **Clear Search** **Create New**

Corr ID	ID	Contact Name	Contact Email	Phone	Date Entered	Processed	Processed Date
C11071300024	111050307826	<input type="text"/>	darlene.barrett@gmcf.org	444-444-4444	7/13/2011 2:17:05 PM	Yes	7/14/2011 3:47:57 PM

3. Click the ‘Correspondence ID’ (Corr ID) number underlined in blue font to open the contact form and view the response submitted by the Alliant/GMCF reviewer.

Contact Us

Contact Form

Correspondence ID : C11071300024

Contact For : Hospital Admissions, Office Procedures, PSY office

Prior Authorization Request ID : 111050307826

Contact Name : D. Brown

Contact Email Address : dariene.barrett@gmcf.org

Confirm Email Address : dariene.barrett@gmcf.org

Phone Number : 444-444-4444 Ext.

Message / Question :

This PA was denied for untimeliness but the member has retro eligibility for the PA date of service. What do I need to do to get this corrected?
- Submitted on : 7/13/2011 2:17:05 PM

GMCF Response :

Dear Provider

Member file does not show retro eligibility for PA dates of service. If you have documents to support retro eligibility, please submit a reconsideration of the denial and attach the documents.
- GMCF Nurse Reviewer (7/14/2011 3:47:57 PM)

Reference Attachments :

[Reset Form](#) [< Back](#) [Return to Provider Workspace](#)

4. If staff attaches documents to the response, the files will be listed next to ‘Reference Attachments’. Click the file name to open the attachment.
5. Click **Back** to return to correspondence search, or click **Provider Workspace** to return to the workspace page.