

# GA Web Portal FFS Prior Authorization

Provider User Manual - Version 2.6

**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 PA system and is available for review by Alliant 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<br>Ground<br>Air                                  | <b>E</b><br><b>A</b> | Request for emergency ground ambulance services.<br>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)<br>DMA6<br>DMA80    | <b>I6<br/>I</b>       | Requests for admission/continued placement in the Independent Care Waiver program; and request for service authorization. The ICWP provides home and community based services to adult individuals with physical disabilities or traumatic brain injuries.   |
| SOURCE   | <b>S6<br/><br/>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.<br><br>SOURCE Services request: <b>These requests are not reviewed by Alliant 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.   |
| Georgia Pediatric Program (GAPP)<br>DMA6A<br>DMA80 | <b>G6<br/>GP</b>      | Request for admission or continued enrollment in the Georgia Pediatric Program; and request 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<br>070 – Outpatient Hospital Services<br>670 – Ambulatory Surgical Center<br>430 – Physician Services<br>431 – Physician’s Assistant Services,<br>450 – Health Check Dental Program<br>460 – Adult Dental Program<br>480 – Nurse Midwifery<br>490 – Oral Maxillofacial Surgery<br>550 – Podiatry<br>740 – Nurse Practitioner |
| <b>Instate Transplants</b>                           | 010– Inpatient Hospital Services<br>070 – Outpatient Hospital Services<br>670 – Ambulatory Surgical Center<br>430 – Physician Services<br>480 – Nurse Midwifery<br>490 – Oral Maxillofacial Surgery<br>550 – Podiatry<br>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"/> | <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 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/Specialty Unit not available at original facility. (Explain in Clinical) |
|   | <input checked="" type="checkbox"/> c. Back transfer to lower level of care facility. (select all that apply)      |
|   | <input type="checkbox"/> 1. Higher level of care is no longer warranted.   |
|   | <input checked="" type="checkbox"/> 2. Level of care continues to meet inpatient confinement.                      |
|   | <input type="checkbox"/> 3. Transfer back does not compromise patient care.  |
|   | <input type="checkbox"/> 4. Transfer back is not to alleviate bed overcrowding at sending facility.                |
|   | <input type="checkbox"/> d. Patient/family/physician convenience. (Explain in Clinical)                            |
|   | <input type="checkbox"/> e. No beds available at original facility. (Explain in Clinical)                          |

Figure 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. |
| * 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 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 ?  Yes  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 and values:

|                    |            |                      |                      |  |
|--------------------|------------|----------------------|----------------------|--|
| * Admit Date :     | 04/27/2010 | Discharge Date :     | <input type="text"/> | <input type="checkbox"/> Still in Facility |
| * Admission Type : | Elective   | * Place of Service : | 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<br>070 – Outpatient Hospital Services<br>670 – Ambulatory Surgical Center (ASC)<br>430 – Physician Services<br>480 – Nurse Midwifery<br>490 – Oral Maxillofacial Surgery<br>550 – Podiatry<br>740 – Nurse Practitioner<br>440 – Community Mental Health Services<br>570 – Psychological Services |
|------------------------------|---|

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.



- 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.

- 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

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



**Rendering Physician Information:**

This section captures out of state physician information.

| Rendering Physician Information |  |                        |   |
|---------------------------------|--|------------------------|---|
| Out-of-State Provider Name :    | <input type="text"/>                               | Taxonomy (Specialty) : | <input type="text" value="v"/>                            |
| Address Line 1 :                | <input type="text"/>                               | Address Line 2 :       | <input type="text"/>                                      |
| City :                          | <input type="text"/>                               | State :                | <input type="text" value="v"/> 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.

| Rendering Physician Information |  |                        |  |
|---------------------------------|--|------------------------|--|
| Out-of-State Provider Name :    | John Green                             | Taxonomy (Specialty) : | Pediatric Pulmonology <input type="text" value="v"/> |
| Address Line 1 :                | 12 Address Lane                        | Address Line 2 :       | <input type="text"/>                                 |
| City :                          | Columbus                               | State :                | OH <input type="text" value="v"/> 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 and "Ext." label), 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 a black box labeled "Fictitious provider data" overlaid on the top right. The form fields are populated with the following data: "Out-of-State Facility Name" (Columbus Kids Hospital), "Address Line 1" (22 Address Lane), "Address Line 2" (empty), "City" (Columbus), "State" (OH), "Zip" (45200), "Phone" (514-888-8880), "Ext." (empty), and "Fax" (514-888-8889).

**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.

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

|                 |              |                  |              |
|-----------------|--------------|------------------|--------------|
| * Contact Name: | DBARRETT     | * Contact Email: | DB@email.com |
| Contact Phone:  | 444-444-4444 | Ext.:            |              |
|                 |              | * 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'.

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

|                |            |                    |        |                      |   |
|----------------|------------|--------------------|--------|----------------------|---|
| * 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 contains two main sections:

- Clinical Data to Support Request :** This section 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 pink rectangular area with the text "Attached to request" at the top left.
- Admitting Treatment Plan :** This section 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 pink rectangular area with the text "Attached to request" at the top left.

**Figure 32**

**Retro-Eligibility:**

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

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

**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. .



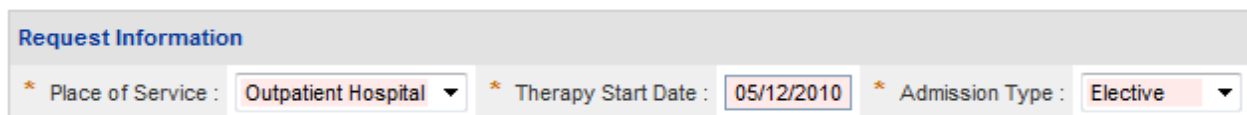
A screenshot of a web form titled "Contact Information". The form contains four fields: "Contact Name" with the value "DBARRETT", "Contact Email" with "DB@email.com", "Contact Phone" with "444-444-4444" and an empty "Ext." field, and "Contact Fax" with "666-666-6666". Each field is preceded by an asterisk,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

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.



A screenshot of a web form titled "Request Information". The form contains three fields: "Place of Service" with a dropdown menu showing "Outpatient Hospital", "Therapy Start Date" with a date input field containing "05/12/2010", and "Admission Type" with a dropdown menu showing "Elective". Each field is preceded by an asterisk, indicating it is a required field.

Figure 37

**Diagnosis Table:**

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

12. Enter a diagnosis code in the 'Diag Code' box; or search for and have system insert the diagnosis code. If the diagnosis code includes a decimal point, enter the code with the decimal point.
13. Enter the date that this diagnosis was established in the 'Date' box.



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

| * 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

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

**Procedures Table:**

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

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

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"/> | <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  |

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.

**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  
Describe the patient's severity of illness/acute condition requiring therapeutic services.

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

**Figure 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.**

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<br>431 – Physician’s Assistant Services<br>480 – Nurse Midwifery<br>550 – Podiatry<br>740 – Nurse Practitioner   |
| <b>Radiology – Facility Setting</b> | 070 – Outpatient Hospital Services<br>670 – Ambulatory Surgical Center<br>430 – Physician Services<br>480 – Nurse Midwifery<br>490 – Oral Maxillofacial Surgery<br>550 – Podiatry<br>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:  

Facility Provider ID :  [GMCF Hospital](#)



Medical Practitioner Reference ID :  


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:  

Facility Reference ID :  

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

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". 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 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 *Medical Review Portal 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 input fields. The "Date of Service" field contains "12/15/2011". 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"/> |         |       | 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"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <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.

**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

Describe the patient's condition requiring the radiology service

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

Describe the procedure to be provided.

Figure 49

***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 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.

Radiology-Physician Office

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

Member Medicaid ID:  

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

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.

- The provider ID for the hospital is system populated in the 'Facility Provider ID' box.
- 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

- 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.

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

Contact Information

\* Contact Name:

\* Contact Email:

Contact Phone:  Ext.

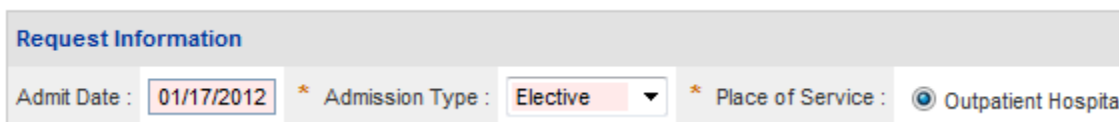
\* Contact Fax:

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 input fields. The first field is "Admit Date" with the value "01/17/2012". 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 "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 input fields. The first field is "Patient Height (inches)" with the value "55 in.". The second field is "Patient Weight (pounds)" with the value "125 lb.".

**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 | EDIT DELETE |
| <input type="text"/> | <input type="text"/>     | <input type="text" value="02/21/2010"/> |         |       | ADD         |

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                   | EDIT DELETE |
| <input type="text"/>                   | <input type="text"/>   | <input type="text"/> | <input type="text"/> | <input type="text"/> | ADD CANCEL  |

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.

The screenshot shows a web form titled "Medications PA Physician Office". Below the title is a search instruction: "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 "333000000100" and a magnifying glass icon to its right; and "Medical Practitioner Provider ID:" with the value "007100063B" and a "Physician Demo" link to its right. A blue "Submit" button is located at the bottom left of the form.

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.

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

Figure 63

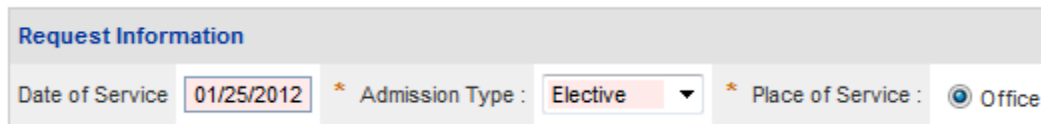
#### **Request Information:**

## Alliant Health Solutions

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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 fields: "Date of Service" containing "01/25/2012", "Admission Type" with a dropdown menu set to "Elective", and "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.

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

- \* Date of Service : 02/15/2012
- \* Admission Type : Elective (dropdown menu)
- \* Place of Service : Office (radio button selected)

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"/>  | <input type="text"/> | <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                    |                      |                      |                      |                      | <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="button" value="ADD"/> <input type="button" value="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?   | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| 2 Is skin irritation or callus and a hallux valgus deformity present?  | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| 3 Is Hallux Valgus Angle between 15 & 35 degrees?  | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| 4 Has patient failed 12 or more weeks of conservative treatment with well fit, low heeled shoes, NSAIDS, bunion pads or orthotics? | <input type="radio"/> Yes <input checked="" type="radio"/> 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"/> | <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 |

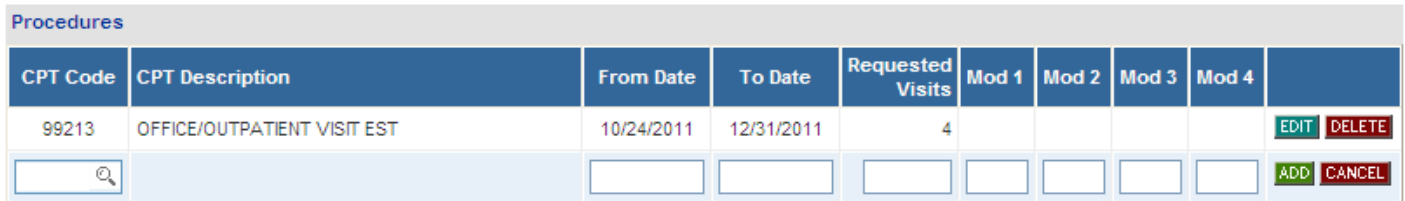
Figure 77

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.



The screenshot shows a table titled "Procedures" with the following columns: CPT Code, CPT Description, From Date, To Date, Requested Visits, Mod 1, Mod 2, Mod 3, Mod 4, and a set of action buttons. The first row contains the data: CPT Code 99213, CPT Description OFFICE/OUTPATIENT VISIT EST, From Date 10/24/2011, To Date 12/31/2011, Requested Visits 4, and empty Mod 1-4 boxes. Action buttons EDIT and DELETE are visible to the right of this row. A second row shows empty input fields for all columns, with ADD and CANCEL buttons to the right.

| 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.



The screenshot shows a form titled "Physician's Examination Report and Recommendation :". It contains two date input fields: "Date Patient First Seen for Diagnosis : 06/01/2011" and "Date of Most Recent Visit : 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.

**Patient's Present Medical Status :**

Include pertinent clinical information to support the need for additional physician office visits.

Describe the patient's current medical condition for which the office visits are necessary.

---

**Treatment or Services Rendered :**

Describe the specific services to be provided to the patient during the requested additional office visits.

Describe the services to be provided.

---

**Plan of Care :**

Summarize the patient's plan of treatment.

Summarize the plan of care.

---

**Justification and Circumstances for Requested Additional Services :**

Provide the clinical rationale for these additional office visits.

Enter clinical rationale.

---

Figure 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.

- The medical practitioner’s provider ID is system populated in the ‘Medical Practitioner Provider ID’ box.
- Enter the member’s Medicaid ID.

Additional Psychiatric Services (Form Number:GMCF PSY/PA)

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

Member Medicaid ID:

Medical Practitioner Provider ID :  BARRETT, DARLENE

Fictitious member and provider data

Figure 80

- 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.

- 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 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.

- Click *Office* or *Other* to enter the ‘Place of Service’.
- 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 :  11 - Office  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.)  Yes  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 | EDIT DELETE |
| <input type="text"/> | <input type="text"/>    | <input type="text"/> | <input type="checkbox"/> |       | ADD         |

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.

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

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

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)     |

**Medications**

List the member's medications and frequency

**Justification and Circumstances for Requested Additional Services (Include meds)**

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.



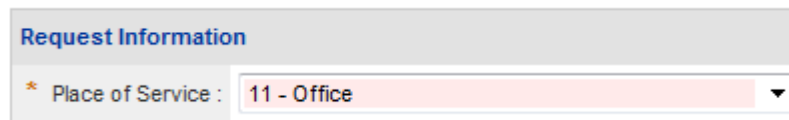
The screenshot shows a form titled "Contact Information" with four input fields. The "Contact Name" field contains "DBARRETT". The "Contact Email" field contains "DB@email.com". The "Contact Phone" field contains "444-444-4444" and an empty "Ext." field. The "Contact Fax" field contains "666-666-6666".

Figure 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". The dropdown menu is open, showing "11 - Office" as the selected option.

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 |       |         |            |                  |                     | <input type="button" value="ADD"/> <input type="button" value="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 the following fields and values:

|                 |              |                  |              |
|-----------------|--------------|------------------|--------------|
| * Contact Name: | DBARRETT     | * Contact Email: | DB@email.com |
| Contact Phone:  | 444-444-4444 | Ext.:            |              |
|                 |              | * Contact Fax:   | 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 the following fields and values:

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

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"/>  | 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.

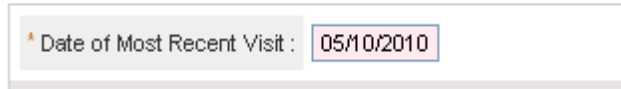
| Procedures           |                        |                      |                      |                      |                      |                      |                      |                      |             |
|----------------------|------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|-------------|
| 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"/> | 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.



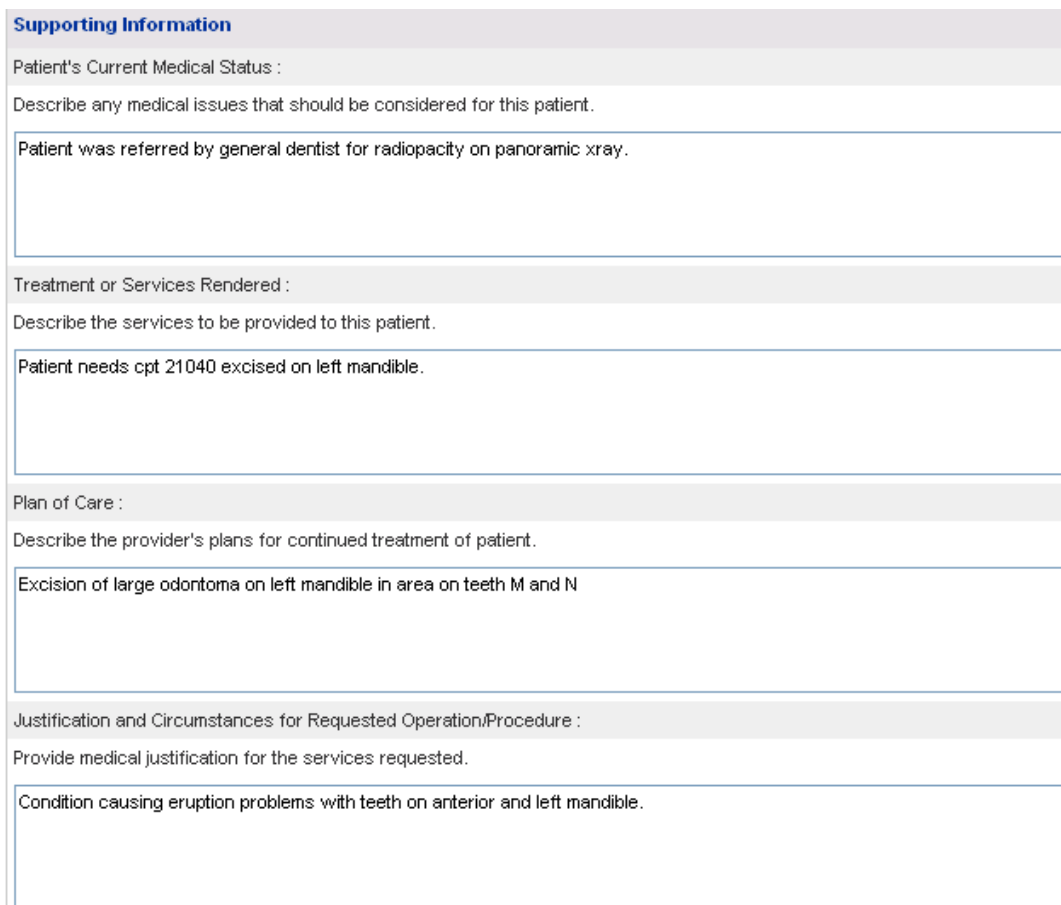
A screenshot of a date input field. The label is "Date of Most Recent Visit :" and the value entered is "05/10/2010".

**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 form titled "Supporting Information". It contains four sections, each with a label, a description, and a text input field:

- Supporting Information** (Section Header)
- 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’.



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                    |

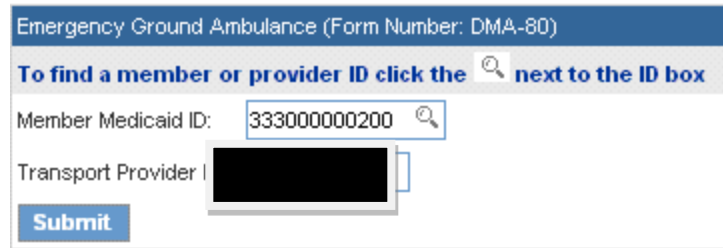
Table 15

### 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.





Emergency Ground Ambulance (Form Number: DMA-80)

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

Member Medicaid ID:

Transport Provider 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.



Contact Information

\* Contact Name:

\* Contact Email:

Contact Phone:  Ext.

\* Contact Fax:

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.



Request Information

\* Place of Service :

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 |
| * City :       | Atlanta   | * State :   | GA                  | * City :  | Atlanta       |
|                |           | * Zip :     | 30030               | * State : | GA            |
|                |           |             |                     | * 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 |
|----------------------------|--------------------|------------------------------|---|-----------------|-----|

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"/> | <input type="checkbox"/> |       | 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               |                      |                      |                      |                      | 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 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.

The screenshot shows a form titled "Ambulance Certification". It contains two dropdown menus. The first is labeled "Ambulance Transport Code" and has "Initial Trip" selected. The second is labeled "Ambulance Transport Reason Code" and has "Patient was transported for a higher level of care or availability of specialized equipment or specialist" selected. The dropdown for the first menu lists "Initial Trip", "Return Trip", "Round Trip", and "Transfer Trip". The dropdown for the second menu lists "Patient was transported for a higher level of care or availability of specialized equipment or specialist", "Patient was transported to nursing home or residence", "Patient was transferred to rehabilitation facility", and "Patient was transported to nearest facility for care of symptoms, complaints or both".

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.

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

Figure 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

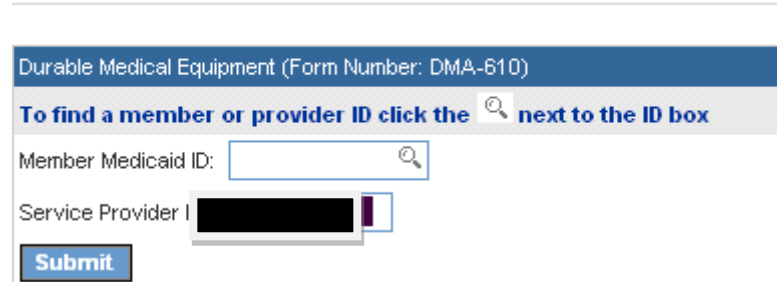


Figure 114

5. Enter the member's Medicaid ID.

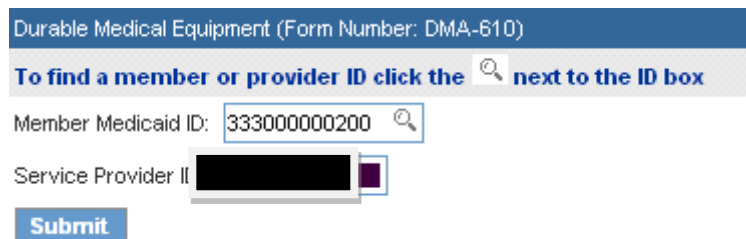


Figure 115

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:     | DBARRETT     | * Contact Email: | DB@email.com |
| Contact Phone:      | 444-444-4444 | Ext.:            |              |
|                     |              | * Contact Fax:   | 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 : | <input checked="" type="radio"/> Home <input type="radio"/> 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"/>  | 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"/><br><input type="button" value="DELETE"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>                 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="button" value="ADD"/><br><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"/> in. |
|   |                      | Patient Weight (pounds) :                | <input type="text" value="22"/> 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 Date of Order.
- 33. 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="10/10/2016"/>                       |
| Date of Order :  | <input type="text" value="10/10/2016"/>                       |
| Ordering Practitioner Last Name :  | <input type="text" value="██████████"/>                       |
| Ordering Practitioner First Name :   | <input type="text" value="██████████"/>                       |

**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.

34. 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 :

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

**Figure 125**

35. 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.

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

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

- 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"/> <b>Certificate of Medical Necessity (CMI)</b> <input type="checkbox"/> <b>Copy of Testing Results</b> |

Figure 126

- 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

|                |                      |
|----------------|----------------------|
| <b>Program</b> | <b>Authorization</b> |
|----------------|----------------------|

|                           | 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.

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.



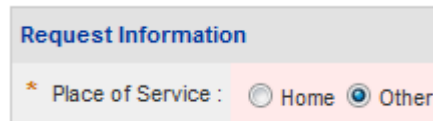
The screenshot shows a form titled "Contact Information" with four fields: "Contact Name" (DBARRETT), "Contact Email" (DB@email.com), "Contact Phone" (444-444-4444) with an "Ext." field, and "Contact Fax" (666-666-6666). Each field has a red border indicating it is required.

Figure 129

**Request Information:**

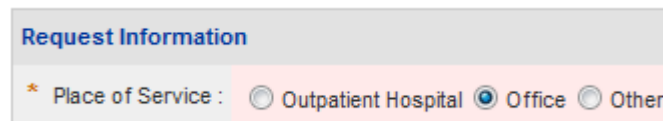
This section captures the Place of Service.

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*.



The screenshot shows a form titled "Request Information" with a "Place of Service" field. The field has two radio button options: "Home" and "Other". The "Other" option is selected.

Figure 130



The screenshot shows a form titled "Request Information" with a "Place of Service" field. The field has three radio button options: "Outpatient Hospital", "Office", and "Other". The "Office" option is selected.

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"/>  | 02/14/2010 |         |       | 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<br>DELETE |
| L3020                | FOOT LONGITUDMETATARSAL SUP | 05/19/2010           |                      | 2                                    | 10.00                |                      |                      |                      |                      |                      |                      |                      | EDIT<br>DELETE |
| <input type="text"/> | <input type="text"/>        | <input type="text"/> | <input type="text"/> | <input type="text"/>                 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | ADD<br>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"/> | <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"/>                       | 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.

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

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.



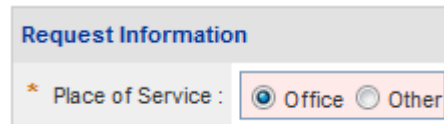
The screenshot shows a form titled "Contact Information" with four input fields. The "Contact Name" field contains "DBARRETT", "Contact Email" contains "DB@email.com", "Contact Phone" contains "444-444-4444" and "Ext." is empty, and "Contact Fax" contains "666-666-6666".

Figure 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 a "Place of Service" field. It contains two radio buttons: "Office" (which is selected) and "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

- 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.



## Alliant Health Solutions

**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 the following fields:

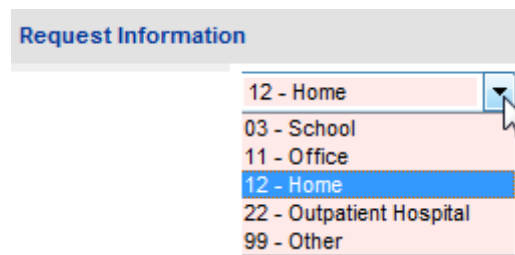
|                 |              |                  |              |
|-----------------|--------------|------------------|--------------|
| * Contact Name: | DBARRETT     | * Contact Email: | DB@email.com |
| Contact Phone:  | 444-444-4444 | Ext.:            |              |
|                 |              | * 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 form titled "Request Information" with a dropdown menu for "Place of Service". The dropdown menu is open, showing the following options:

- 12 - Home
- 03 - School
- 11 - Office
- 12 - Home
- 22 - Outpatient Hospital
- 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 | EDIT DELETE |
| <input type="text"/> | <input type="text"/>    | 01/01/2011 |         |       | ADD         |

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                   |                      |                      | <input type="button" value="EDIT"/> <input type="button" value="DELETE"/> |
| 97530                | THERAPEUTIC ACTIVITIES | 07/01/2011           | 07/31/2011           | 10                   | HA                   | GO                   |                      |                      | <input type="button" value="EDIT"/> <input type="button" value="DELETE"/> |
| 97530                | THERAPEUTIC ACTIVITIES | 08/01/2011           | 08/31/2011           | 8                    | HA                   | GO                   |                      |                      | <input type="button" value="EDIT"/> <input type="button" value="DELETE"/> |
| <input type="text"/> | <input type="text"/>   | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="button" value="ADD"/> <input type="button" value="CANCEL"/>  |

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

\* Date admitted to program :

**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:

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.

The screenshot shows a web form with two columns of questions and input fields. The left column contains questions with radio buttons for 'Yes' and 'No'. The right column contains questions with date boxes, text boxes, and a dropdown menu. The form is partially filled out with the date 05/17/2010 and the title Coordinator.

|   |   |   |                      |
|---|---|---|----------------------|
| 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/AVSP/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: 333000000100

Service Provider ID :

Physician Reference ID : REF000000001

**Submit**

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: DBARRETT

\* Contact Email: DB@email.com

Contact Phone: 444-444-4444 Ext.

\* Contact Fax: 666-666-6666

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*.

The screenshot shows a form titled "Request Information". It contains several fields:
 

- "Recommendation Type": Two radio buttons, "Continued Placement" (unselected) and "Initial Placement" (selected).
- "Initial Admission Date": An empty text field.
- "Initial Request ID": An empty text field.
- "Place of Service": A dropdown menu with "12 - Home" selected.

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"/>  | <input type="text"/> | <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 :

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 : (check all that apply) |   |  |  |                                       |   |
|--|---|--|--|---------------------------------------|---|
| 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 : (check all that apply) |   |   | Nursing Care and Treatment : (Check all that apply) |  |
|---|---|---|---|--|
| <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 :  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.

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

| 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**

- Mild
- Moderate
- None
- Severe

**Figure 173 ADLs Choices/I6**

- Dependent
- Independent
- Needs Assistance
- Not Appropriate

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**.

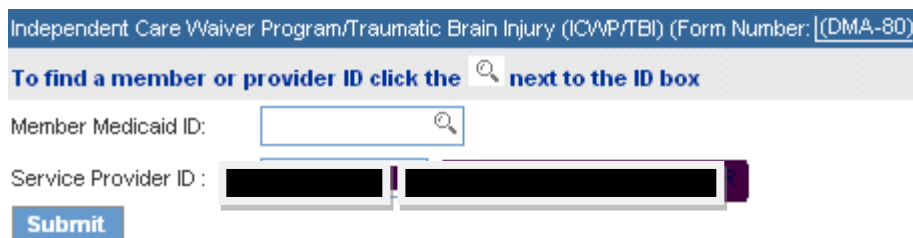


43. When the request is successfully submitted, the system displays the pending PA tracking number.

**ICWP DMA-80**

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

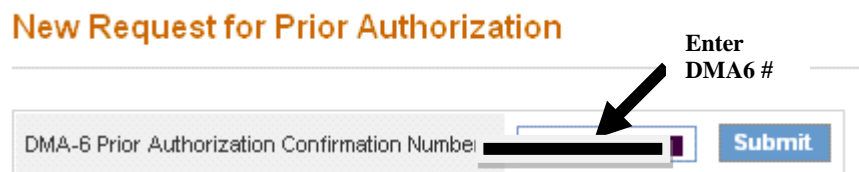
1. Go to the **Georgia Web Portal** at [www.mmis.georgia.gov](http://www.mmis.georgia.gov) and log in using your assigned user name and password.
2. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
3. Select **Independent Care Waiver Program (Form number DMA-80)** to open 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 box: "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:" which is pre-filled with a blacked-out ID. A blue "Submit" button is located below the fields.

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 with the "DMA-6 Prior Authorization Confirmation Number" field highlighted. An arrow points to the input box with the text "Enter DMA6 #". A blue "Submit" button is to the right of the 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.
9. At the top of the DMA-80 request form, the Member and requesting ICWP Provider information are system populated based on the Member and Provider ID entered on the *New Request for Prior Authorization* page.

**Contact Information:**

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

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



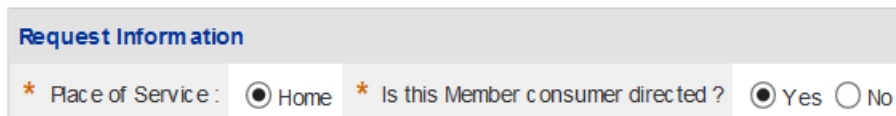
The screenshot shows a form titled "Contact Information" with four fields: "Contact Name" (DBARRETT), "Contact Email" (DB@email.com), "Contact Phone" (444-444-4444) with an "Ext." field, and "Contact Fax" (666-666-6666). Each field has a red highlight indicating it is required.

Figure 178

**Request Information:**

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

11. The system defaults the ‘Place of Service’ to *Home*.
12. Indicate if the member is a consumer directed participant by clicking the *Yes* button (the system defaults this question to No).



The screenshot shows a form titled "Request Information" with two radio button options: "Place of Service" (selected as Home) and "Is this Member consumer directed?" (selected as Yes).

Figure 179

**Diagnosis Table:**

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

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

| * 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"/> |       | 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"/> | <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.
- 30. 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.
- 31. **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 : 
  Program Discharge Date : 
  Initial Admission  Renewal 
 Date Last Certified :

Figure 182

**Supporting Information:**

This section may be used to capture a description of the services ordered for the member; and the medical justification for providing the services. **This section is optional.**

The screenshot shows a form titled "Supporting Information" with two distinct text entry sections. The first section is labeled "Description of Services Requested : (Describe all physician ordered treatments)" and contains a single line of placeholder text: "Physician ordered treatments. Physician ordered treatments. Physician ordered treatments. Physician ordered treatments. vPhysician ordered treatments. Physician ordered treatments. Physician ordered treatments. Physician ordered treatments. Physician ordered treatments. Physician ordered treatments. Physician ordered treatments. Physician ordered treatments. Physician ordered treatments. Physician ordered treatments. Physician ordered treatments. Physician ordered treatments." The second section is labeled "Justification and Circumstances for Requested Services : (Provide a brief summary of the pertinent information that justifies medical necessity.)" and contains a single line of placeholder text: "Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity. Summary of information justifying medical necessity." Both text areas are enclosed in rectangular boxes with scrollable bars on the right side.

**Figure 183**

**Social History:**

The section may be used to capture information regarding the Member’s social history. This section is **Optional.**

- **Presenting Problems:** Member’s presenting problems and the reason(s) for this evaluation.
- **Family Information:** Member’s family and living situation including information related to significant others and guardian.
- **Birth and Early Development:** Member’s birth and early developmental issues.
- **Medical Information:** Clinical information related to the Member’s present medical status.
- **Training and Education:** Education or training this Member has or is receiving.
- **Current Functioning:** Member’s present level of functioning including capabilities and disabilities.
- **Summary of Social History:** Summary of the Member’s social history.

32. When all the required 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. Also, from this page, the user may attach required documents under **Create an Attachment**. The attachment panel provides a checkbox for each required document. Click a box or boxes before attaching a file. One PDF file with all required documents is recommended.

## 2.17 Service Options Using Resources in Community Environments (SOURCE)

| Program - SOURCE            | Authorization Period                            |
|-----------------------------|---|
| Level of Care and Placement | Initials/Reassessments:<br>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 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:

Source Provider ID:  **Provider ID displays here**

Figure 184

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 :   Primary Physician  SOURCE Site Medical Director Physician ID :

Address Line 1 :  Address Line 2 :

City :  State :  Zip :  County :

\* Phone :  Ext.  Fax :

\* Date LOC signed by Physician:  Physician License Number :

Figure 185

**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.



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 186

**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*.



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

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

Figure 187

**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.**

| Diag Code            | Diagnosis Description | Date       | Primary                  | Admission                | Type  |
|----------------------|-----------------------|------------|--------------------------|--------------------------|-------|
| 344.1                | PARAPLEGIA NOS        | 01/01/2012 | Yes                      | No                       | ICD-9 |
| <input type="text"/> | <input type="text"/>  | 01/01/2012 | <input type="checkbox"/> | <input type="checkbox"/> |       |

**Figure 188**

23. Repeat the same process to add other diagnosis codes, if necessary. Remember to click Add after each addition

**Acute Care Hospital Dates and Diagnosis on Admission to Hospital:**

This information is not required but may be entered if applicable to the request.

24. If the member was admitted to an acute hospital setting in the past six (6) months, enter the admission date in the ‘From Date’ box and enter the discharge date in the ‘To Date’ box.
25. Enter the member’s primary admission diagnosis code in the ‘Diag Code’ box. The system will insert the diagnosis description when the diagnosis is added. Select the ‘Primary’ indicator.
26. Click **Add**.

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

| Diagnosis on Admission to Hospital |                        |         |             |
|------------------------------------|------------------------|---------|-------------|
| Diag Code                          | Diagnosis Description  | Primary |             |
| 362.07                             | DIABETIC MACULAR EDEMA | Yes     | EDIT DELETE |
| <input type="text"/>               | <input type="text"/>   |         | ADD         |

Figure 189

**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              | EDIT DELETE |
| Sed/hypnotic         | 50mg                 | Oral                 | Regular              | EDIT DELETE |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | ADD         |

Figure 190

**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**.

| Type                  | Frequency            |             |
|-----------------------|----------------------|-------------|
| Medication Regulation | Daily                | EDIT DELETE |
| <input type="text"/>  | <input type="text"/> | ADD         |

Figure 191

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

Figure 192

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              | <input type="button" value="EDIT"/> <input type="button" value="DELETE"/> |
| S5170-Home Delivered Meals   | 2 meals              | 7 days/week          | 6 months             | <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 193 S

**Treatment Plan:**

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

- 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 194

**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.

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

|   |   |
|---|---|
| <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 195

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

**Figure 196**

**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.

The screenshot shows three distinct form sections. The first section, 'Indicate Frequency Per Week (in Hours)', is a table with two columns: 'Received' and 'Needed'. It lists services such as Physical Therapy, Occupational Therapy, Restorative Therapy, Reality Orientation, Speech Therapy, Bowel and Bladder Retrain, and Activities Program. Reality Orientation has '0' in the 'Received' column and '15' in the 'Needed' column. Bowel and Bladder Retrain has '2' and '4' respectively. The second section, 'Activities of Daily Living', lists tasks like Eating, Wheelchair, Transferring, Bathing, Ambulating, and Dressing, each with a dropdown menu. The third section, 'Level of Impairment', lists categories like Sight, Hearing, Speech, Limited Motion, and Paralysis, each with a dropdown menu.

|                           | 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       | 0                    | 15                   |
| Speech Therapy            | <input type="text"/> | <input type="text"/> |
| Bowel and Bladder Retrain | 2                    | 4                    |
| Activities Program        | <input type="text"/> | <input type="text"/> |

| Activities of Daily Living | Level            |
|----------------------------|------------------|
| Eating                     | Independent      |
| Wheelchair                 | Needs Assistance |
| Transferring               | Dependent        |
| Bathing                    | Needs Assistance |
| Ambulating                 | Not Appropriate  |
| Dressing                   | Needs Assistance |

| Level of Impairment | Level    |
|---------------------|----------|
| Sight               | Mild     |
| Hearing             | Moderate |
| Speech              | Severe   |
| Limited Motion      | Severe   |
| Paralysis           | None     |

Figure 197

**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.

The screenshot shows a form section titled 'Justification and Circumstances for Admission or Continued Placement :'. Below the title is a prompt: 'Provide justification for the services ordered.' There is a large text area with a pink background and a scroll bar, containing the instruction: '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.' Below the text area are two input fields: 'Name of RN Signing Form : Jane Doe' and 'Date Signed : 06/15/2012'.

Figure 198

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

Figure 199

- 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 Medical Review Portal/Education and Training/User Manuals.

**To attach one file for all document types:**

- 62. Click each document type checkbox.

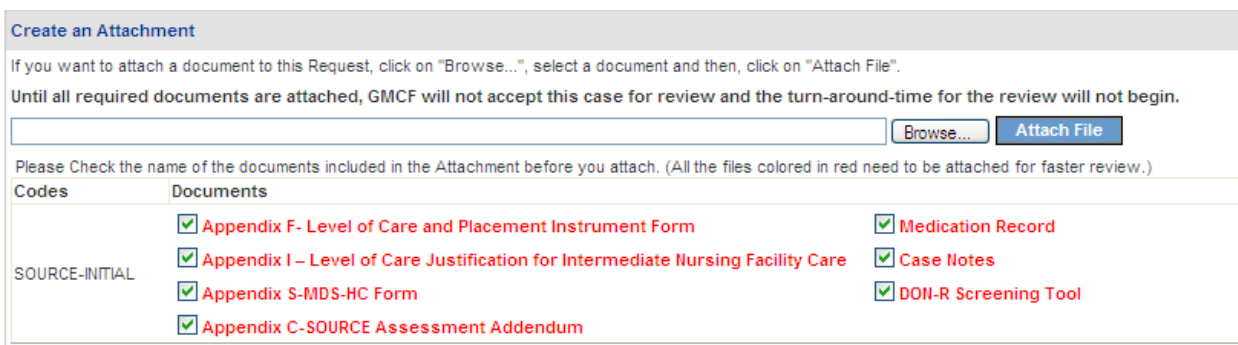


Figure 200

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

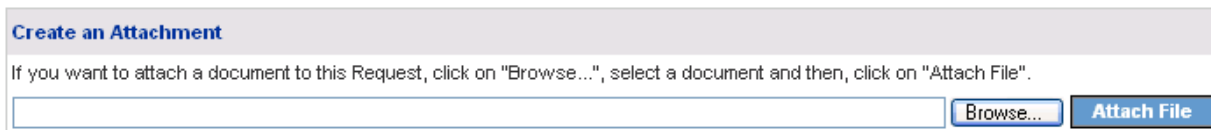


Figure 201

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**.

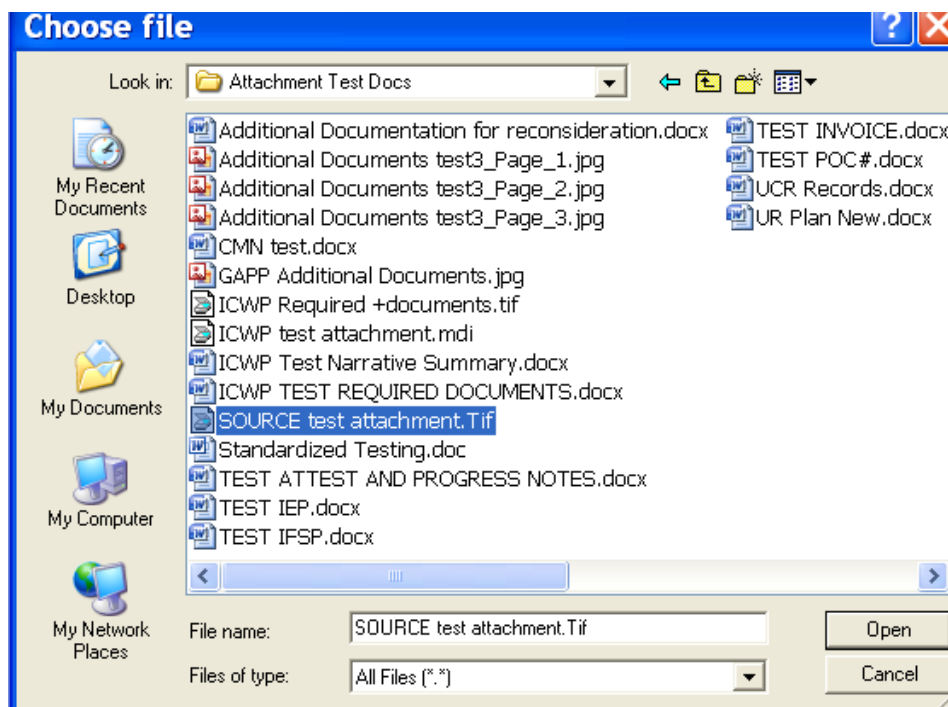


Figure 202

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

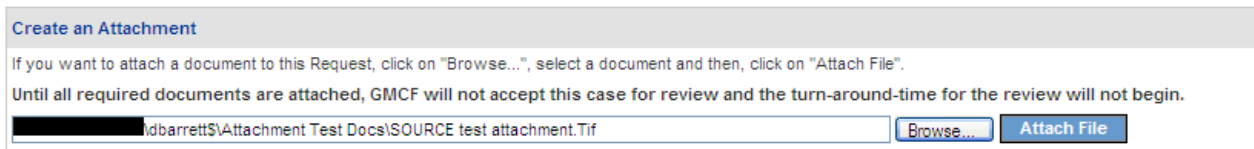


Figure 203

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.

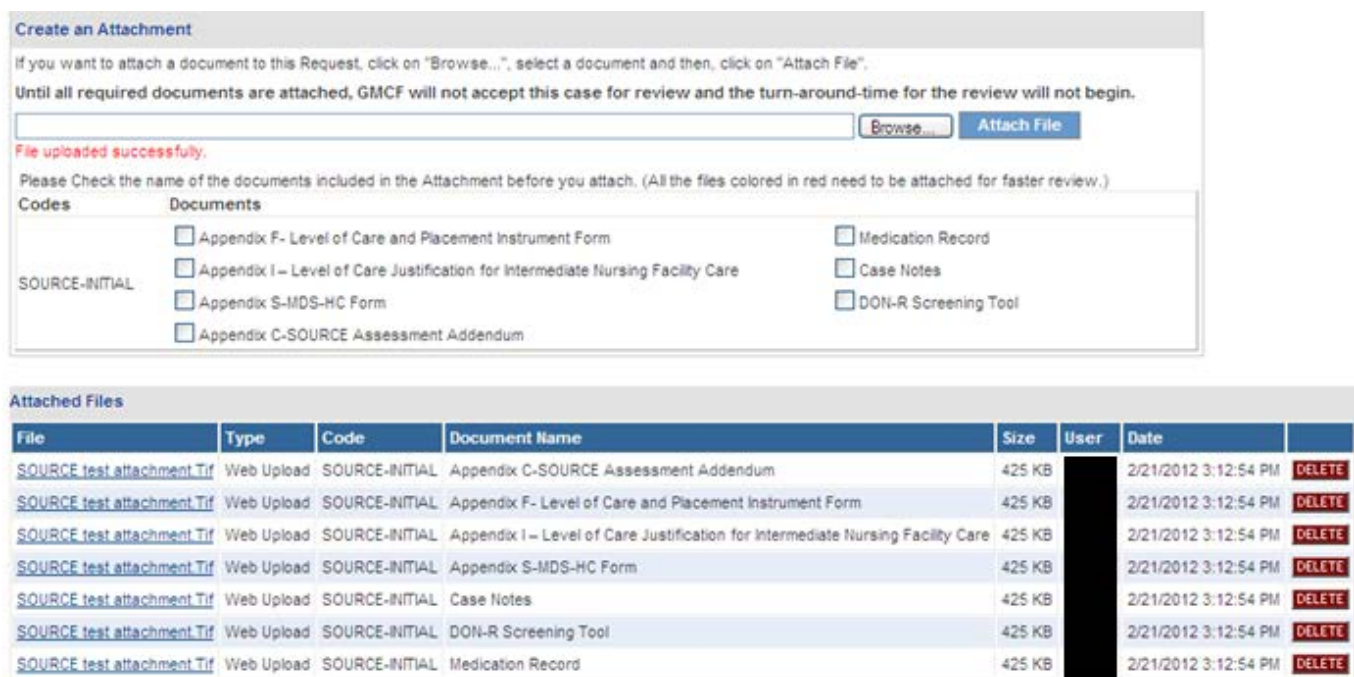


Figure 204 A

**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 *Medical Review Portal* 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 *Medical Review Portal*. 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 **Medical Review Portal**.
2. At the top of the workspace, a ‘PA Notifications’ drop list shows the last ten PAs with notifications related to the provider’s ID.

#### Provider Workspace

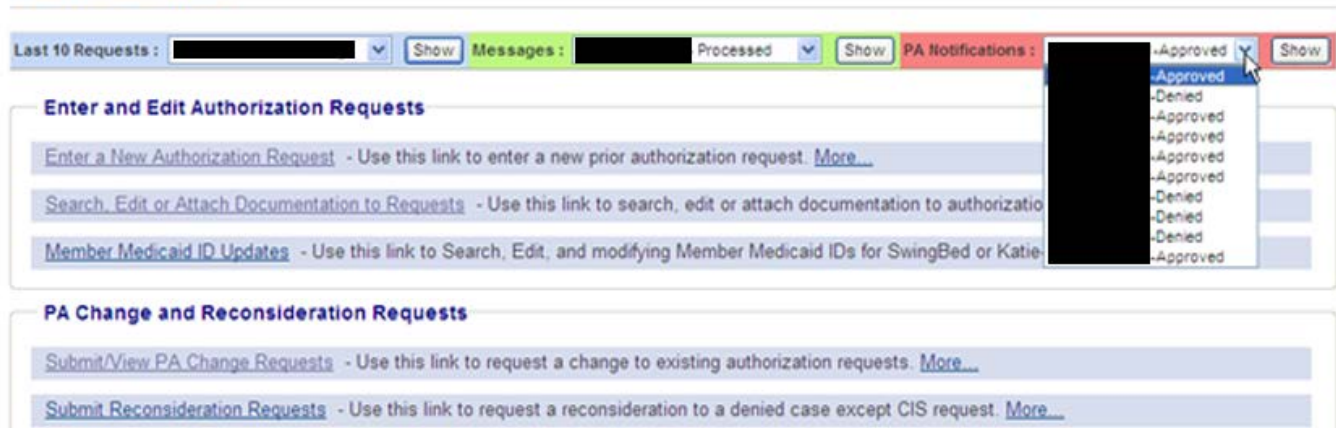


Figure 205

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**.

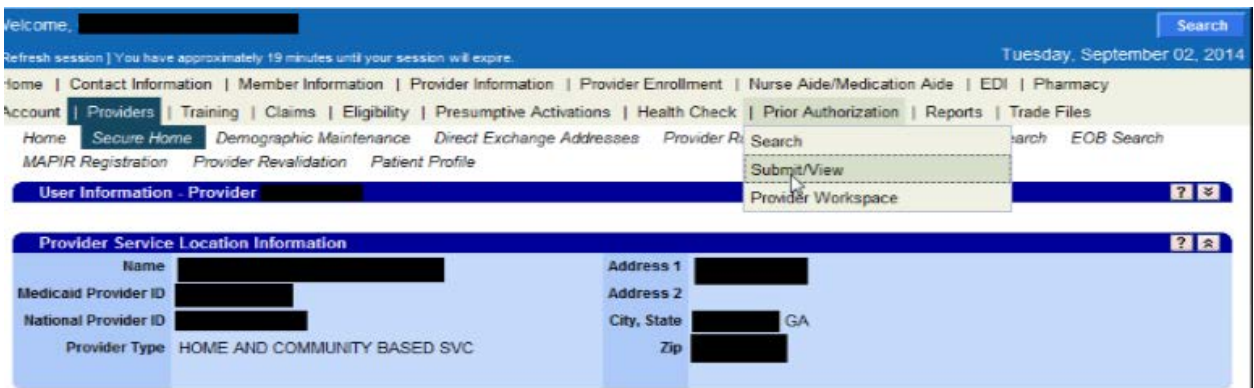


Figure 206

3. **OR** – Select **Medical Review Portal**; and on the workspace page, click **Enter a New Authorization Request**.
4. On the next window, click the **Source Services** option.

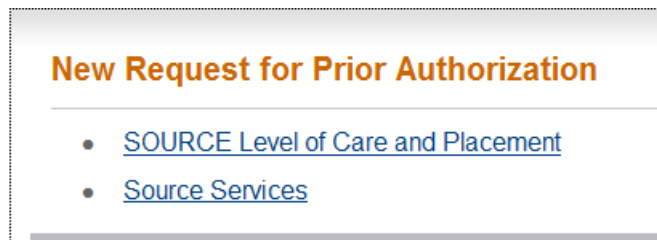


Figure 207

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**.

The screenshot shows a web form titled "New Request for Prior Authorization". Below the title is a blue header bar with the word "Source". Underneath, there is a grey instruction bar: "To find a Member or Provider click the [magnifying glass icon] next to the ID box". Below this are two input fields: "Member Medicaid ID:" with the value "333000000500" and a magnifying glass icon, and "Source Provider ID:" with the value "000000999J". At the bottom left of the form is a blue "Submit" button.

Figure 208

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.

The screenshot shows a web form titled "New Request for Prior Authorization". Below the title is a grey input field with the label "Source LOC Prior Authorization Confirmation Number :". The field contains the value "114082599999". To the right of the input field is a blue "Submit" button.

Figure 209

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.

The screenshot shows a web form titled "Contact Information". It contains four input fields arranged in a 2x2 grid. The top-left field is labeled "\* Contact Name:" and contains the value "GMCf99". The top-right field is labeled "\* Contact Email:" and contains the value "srinithya.ranganathan@gmcf.org". The bottom-left field is labeled "Contact Phone:" and contains the value "229-888-7777" followed by "Ext." and an empty input box. The bottom-right field is labeled "\* Contact Fax:" and contains the value "229-555-2222".

Figure 210



**Request Information:**

- 10. The ‘Place of Service’ defaults to *Home*.
- 11. Click ‘Yes’ if the member is consumer directed; otherwise leave as ‘No’.

The screenshot shows a form titled "Request Information". It contains two fields:
 

- "\* Place of Service :  Home" (radio buttons for Home, Office, etc.)
- "\* Is this Member consumer directed ?  Yes  No" (radio buttons for Yes, No)

Figure 211

**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               | QUADRIPLEGIA, UNSPECIFD | 01/01/2010           | Yes                  | ICD-9                | EDIT DELETE |
| <input type="text"/> | <input type="text"/>    | <input type="text"/> | <input type="text"/> | <input type="text"/> | ADD         |

Figure 212

**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.

**Alliant Health Solutions**

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    |       |       |  |
| T1021        | HH AIDE OR CN AIDE PER VISIT | 09/01/2014 | 08/04/2015 | 5,700 | 480               | 3,000.00 | 0.00                |                       | TF    |       |       |  |
| S5170        | HOMEDELIVERED PREPARED MEAL  | 09/15/2014 | 03/15/2015 | 672   | 56                | 2,210.00 | 0.00                |                       |       |       |       |  |
|              |                              |            |            |       |                   |          |                     | <input type="text"/>  |       |       |       |  |

**Figure 213**

**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 : 09/01/2014 Program Discharge Date :   Initial Admission  Renewal Date Last Certified :

Figure 214

### 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.



Is there a signed Level of Care and Placement tool (Appendix F) ?  Yes  No Date Signed : 08/01/2014

Figure 215

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 *Medical Review Portal*. Open the *Medical Review Portal* 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"/> | Provider ID :              | <input type="text" value="REDACTED"/>  |
| Request From Date :                   | <input type="text"/>                      | Request To Date :                    | <input type="text"/> |                            |  |
| Member Medicaid ID :                  | <input type="text"/>                      | Member First Name :                  | <input type="text"/> | Member Last Name :         | <input type="text"/>   |
| Effective Date :                      | <input type="text"/>                      | Expiration Date :                    | <input type="text"/> | Include PA Notifications : | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ALL |
| <input type="button" value="Search"/> |   | <input type="button" value="Reset"/> |                      |                            |  |

Figure 216

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

Prior Authorization - Source Review Request

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

| Request Information      |              |                     |            |
|--------------------------|--------------|---------------------|------------|
| Request ID :             | ██████████   | Case Status :       | Approved   |
| Member ID :              | 333000000400 | Case Status Date :  | 09/03/2014 |
| Social Security Number : | 132549678    |                     |            |
| Provider ID :            | ██████████   | CMO PA Request ID : |            |
| Admission Date :         |              | Discharge Date :    |            |
| 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                |

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

[Return to the Auth Request Page](#)

Figure 217

- 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.

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

Figure 218

- The following data may be modified:
  - Procedure start and end dates
  - Units
  - Units per Month
  - Amount
  - Cost Sharing
- After modifying data, click **Save** at the end of the procedure line.

- When a procedure line for a ‘new’ provider needs to be added, enter the service information on the open (blank) procedure line. Click **Add** after all the required information is entered. In the figure below, the first highlighted service line is the original service line for T1021 which was ‘cut back’ and end dated to 12/1/14. A new service line for the new provider (second highlighted line) was added for the same procedure, different provider, and a start date of 12/2/14 – a day after the end of the other service line.

| Service Code | Service Description          | From Date  | To Date    | Units | Req Units / Month | Amount   | Cost Sharing Amount | Rendering Provider ID | Mod 1 | Mod 2 | Mod 3 |               |
|--------------|------------------------------|------------|------------|-------|-------------------|----------|---------------------|-----------------------|-------|-------|-------|---------------|
| T1021        | HH AIDE OR CN AIDE PER VISIT | 09/01/2014 | 12/01/2014 | 400   | 100               | 1,400.00 | 0.00                |                       | 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          |
|              |                              |            |            |       |                   |          |                     |                       |       |       |       | ADD<br>CANCEL |

Figure 219

- To submit the changes made to the PA, go to the bottom of the page and click **Review Request**.
- Then click **I Agree** to the *Attestation Statement* again, and then **Submit Request**. **The PA is modified but the authorization ID remains the same.**

## 2.18 Community Care Services Program (CCSP) Level of Care

| Program - CCSP              | Authorization Period                        |
|-----------------------------|---|
| Level of Care and Placement | Initial and Reassessment:<br>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.**

CCSP Level of Care and Placement

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

Member Medicaid ID:

AIMs Number :

Social Security Number :

CCSP Provider ID :

Figure 220

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, 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 the following 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 221**

**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. <input type="text"/> | Fax : <input type="text" value="- -"/> |

| Care Coordinator/Assessment Nurse Contact Information |                      |                           |                             |
|---|----------------------|---------------------------|-----------------------------|
| * Contact Name:                                       | JEAN THE COORDINATOR | * Contact Email:          | JCOORD@GMAIL.COM            |
| Contact Phone:  | 404-999-2222         | Ext. <input type="text"/> | * Contact Fax: 404-999-3333 |

Figure 222

**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 :        | <input type="text" value="36"/>                               |
| * Assessment Date       | <input type="text" value="08/01/2014"/>                                     | * Approved for Money Follows the Person? | <input type="radio"/> Yes <input checked="" type="radio"/> No |

Figure 223

**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 224

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 225

**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 |

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

| Diagnostic and Treatment Procedures |                      |     |
|-------------------------------------|----------------------|-----|
| Type                                | Frequency            |     |
| <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 226

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 Medical Review Portal/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 Alliant 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 227

**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 *Medical Review Portal*.
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 *Medical Review Portal* for decision details.

**View Decision Details:**

1. To view decision details, open the *Medical Review Portal* 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 *Medical Review Portal* 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**.

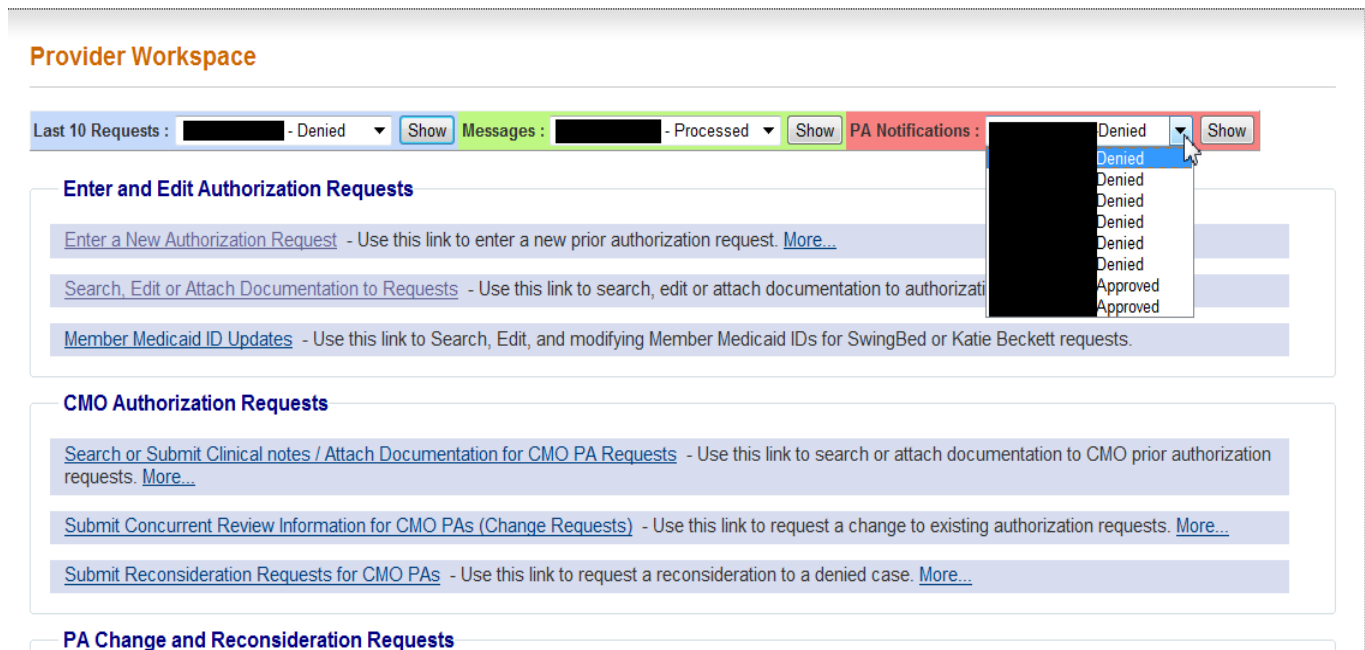


Figure 228

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<br>8:33:30 AM | Technical Denial Notification | We are unable to make a decision regarding level of care since the Case Notes from AIMS were never submitted; and the other documents submitted were incomplete. You may request a hearing if you disagree with this decision. |

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

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

Figure 229

## 2.19 NOW and COMP Level of Care and Placement

| Program - CCSP              | Authorization Period                        |
|-----------------------------|---|
| Level of Care and Placement | Initial and Reassessment:<br>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.

Figure 230

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

***Member Information and DBHDD Regional Office Information:***

7. When the request form opens, the requesting regional office ‘provider’ information is pre-populated.
8. Member information is also populated according to these guidelines:
  - If a Medicaid ID was entered **or** if the SSN entered matches a Medicaid participant, the system populates the member information including the member’s address.
  - If a SSN is entered but there is no match to a Medicaid member in the database, the member information must be entered manually, including the applicant’s address information, similar to what is shown in the next figure.

Figure 231

***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. <input type="text"/> | * Contact Fax:   | 555-666-7777                   |

Figure 232

**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 233

**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 <input type="text"/> |                       | 07/01/2002 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |      | <input type="button" value="ADD"/> |

Figure 234

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 | <b>EDIT</b> <b>DELETE</b> |
| <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |       | <b>ADD</b>                |

Figure 235

**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 Medical Review Portal/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 Alliant reviewer.

**Create an Attachment**

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

Browse... **Attach File**

File uploaded successfully.

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

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

**Attached Files**

| File                                  | Type              | Code         | Document Name  | Size  | User     | Date                 |               |
|---------------------------------------|-------------------|--------------|--|-------|----------|----------------------|---------------|
| <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 236

**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 *Medical Review Portal*.
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 *Medical Review Portal* for decision details.

**View Decision Details:**

18. To view decision details, open the *Medical Review Portal* 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 *Medical Review Portal* 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**.

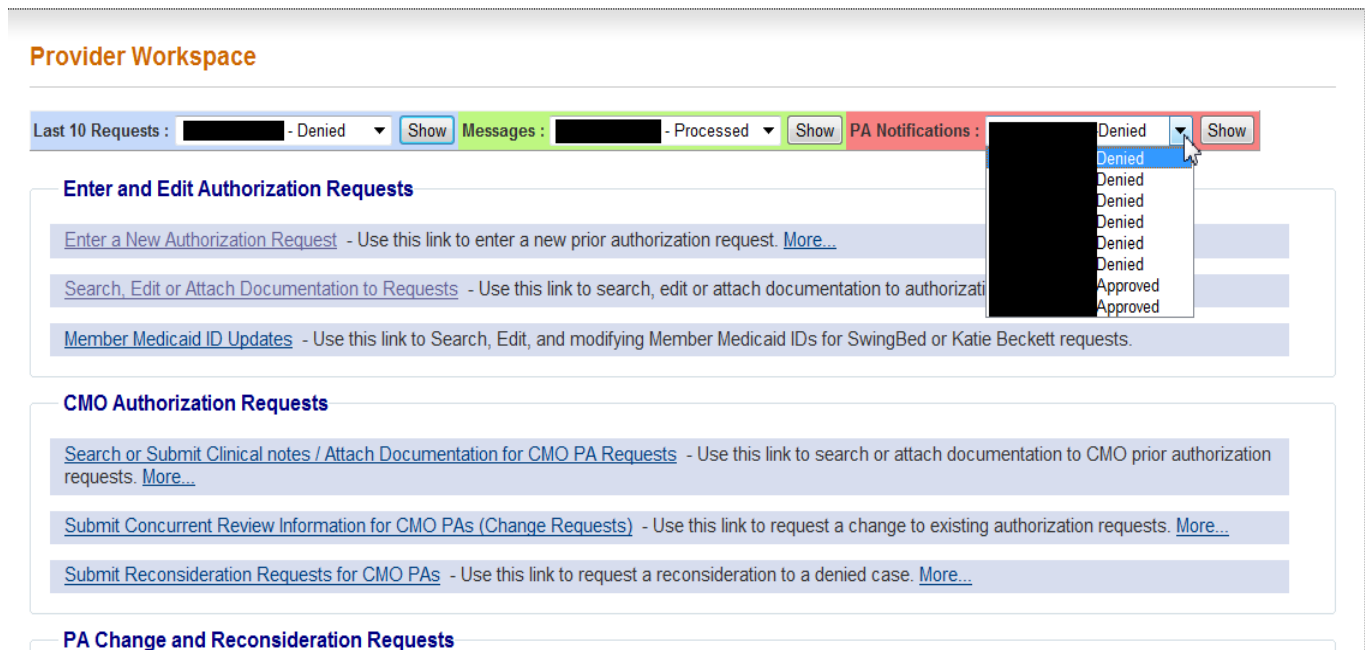


Figure 237

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.

**Alliant Health Solutions**

- **Denial Notifications:** This section shows the specific decision date, the letter type that was sent, and the reviewer’s denial rationale noted on the letter.
- **Letter Information:** If a decision notification (letter) has been sent to the Member, the letter is attached in this section. Click the file name to view.
- **Request Information:** This section shows the specific type of decision and decision date.

**Notification(s) for this PA**

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

**Denial Notification(s)**

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

**Letter Information**

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

**Request information**

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

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

**Diagnosis**

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

**Attached Files**

| File               | Type       | Document Name                                | User       | Date                  |
|--------------------|------------|--|------------|-----------------------|
| ChapterHeader.docx | Web Upload | Health Risk Screening Tool (HRST) *Optional* | [REDACTED] | 5/26/2015 11:54:57 AM |

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

**Figure 238**

## 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 239

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 240

**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 241

**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 | <input type="button" value="EDIT"/> <input type="button" value="DELETE"/> |
| <input type="text"/> | <input type="text"/>    | <input type="text" value="12/29/2010"/> | <input type="checkbox"/> | <input type="checkbox"/> |       | <input type="button" value="ADD"/>  |

Figure 242

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="text"/>  | <input type="checkbox"/> | <input type="button" value="ADD"/> |

Figure 243

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              | <input type="button" value="EDIT"/><br><input type="button" value="DELETE"/> |
| Steroids             | 10mg                 | Oral                 | Regular              | <input type="button" value="EDIT"/><br><input type="button" value="DELETE"/> |
| Anticonvulsive       | 5mg                  | Rectal               | Regular              | <input type="button" value="EDIT"/><br><input type="button" value="DELETE"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="button" value="ADD"/>   |

Figure 244

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                | <b>EDIT</b> <b>DELETE</b> |
| <input type="text"/>                | <input type="text"/> | <b>ADD</b>                |

Figure 245

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 246

***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.

## Alliant Health Solutions

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

Figure 247

### 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"/> |
|------------------|--|----------------------------|---|-------------------|---|

Figure 248

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

Figure 249

**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.



A screenshot of a web form. It has two input fields. The first is labeled 'Name of MD / RN Signing Form' and contains the text 'Jean RN'. The second is labeled 'Date Signed' and contains the date '05/10/2010'.

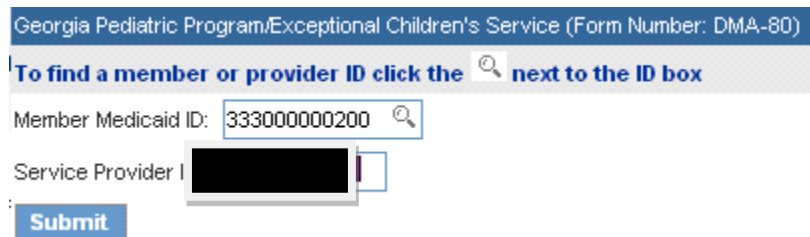
**Figure 250**

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.



A screenshot of a web form titled 'Georgia Pediatric Program/Exceptional Children's Service (Form Number: DMA-80)'. Below the title is a grey instruction box: '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 '333000000200' and a magnifying glass icon, and 'Service Provider ID' which is currently blank. A blue 'Submit' button is located at the bottom left of the form.

**Figure 251**

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 252

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

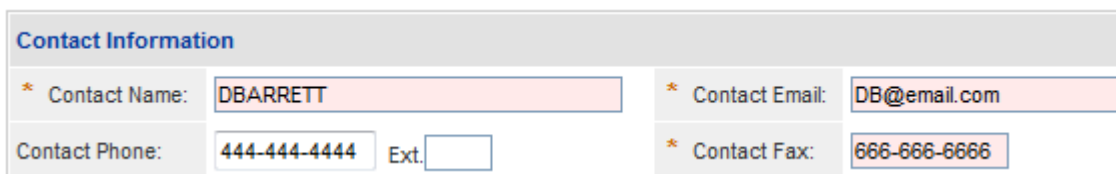
***Member/Provider Information:***

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

***Contact Information:***

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

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



**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 253

***Request Information:***

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

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

**Request Information**

\* Place of Service :  12 - Home  99 - Other GAPP Member ID : 149507

Figure 254

**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"/>    | 12/29/2010 | <input type="checkbox"/> | <input type="checkbox"/> |       | ADD         |

Figure 255

**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.
37. Enter the units of service to be provided each week in the ‘Requested Units/Week’ box.
38. Enter the units of service to be provided each day in the ‘Requested Units/Day’ box.
39. Enter the number of units of service to be provided each month in the ‘Requested Units/Month’ box.

40. 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.
41. 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                |               |
| SS124                | NURSING CARE, IN THE HOME; B | 05/01/2010           | 05/31/2010           | 40                   | 8                    | 200                   |                      |                      |                      |                      | EDIT          |
| SS124                | NURSING CARE, IN THE HOME; B | 06/01/2010           | 06/30/2010           | 40                   | 8                    | 200                   |                      |                      |                      |                      | EDIT          |
| SS124                | NURSING CARE, IN THE HOME; B | 07/01/2010           | 07/31/2010           | 40                   | 8                    | 200                   |                      |                      |                      |                      | 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"/> | ADD<br>CANCEL |

Figure 256

**Program Information:**

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

42. **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 257 GP-80 Initial

43. **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 258 GP-80 Renewal

44. **Initial or Renewal Comments:** An optional textbox is available to enter information related to the admission type.



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**.
48. On the next page, the pending PA ID displays.
49. Also, from this page, the user may attach required documents under **Create an Attachment**. The attachment panel provides a checkbox for each required document. Click a box or boxes before attaching a file. One PDF file with all required documents is recommended.

**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  |
|----------------|--|
| RENEWAL        | <input type="checkbox"/> Letter of Medical Necessity <input type="checkbox"/> Insurance Information <input type="checkbox"/> Letter of Understanding |
|                | <input type="checkbox"/> Nursing Care Plan <input type="checkbox"/> 60 Day Summary <input type="checkbox"/> Freedom of Choice                        |
|                | <input type="checkbox"/> Physician Plan of Treatment <input type="checkbox"/> Nurses Notes <input type="checkbox"/> Caregiver Skills Checklist       |
|                | <input type="checkbox"/> IFSP or IEP <input type="checkbox"/> Signed LON <input type="checkbox"/> Seizure Logs                                       |

Figure 259

## 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.

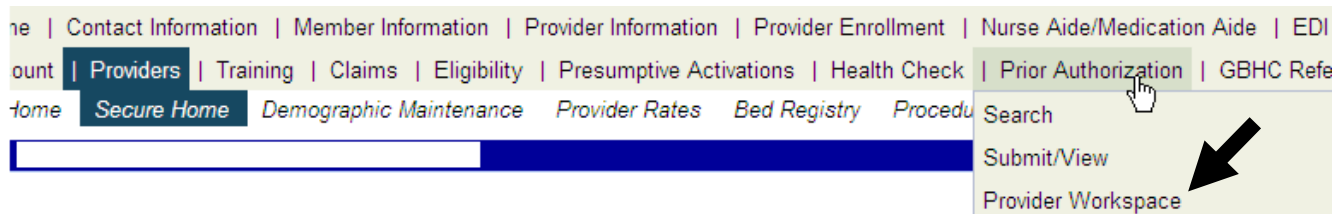


Figure 260

3. Then, select *Medical Review Portal* 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 261

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

Figure 262

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 Alliant using ‘Contact Us’.

### Add a New Participant/Package

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



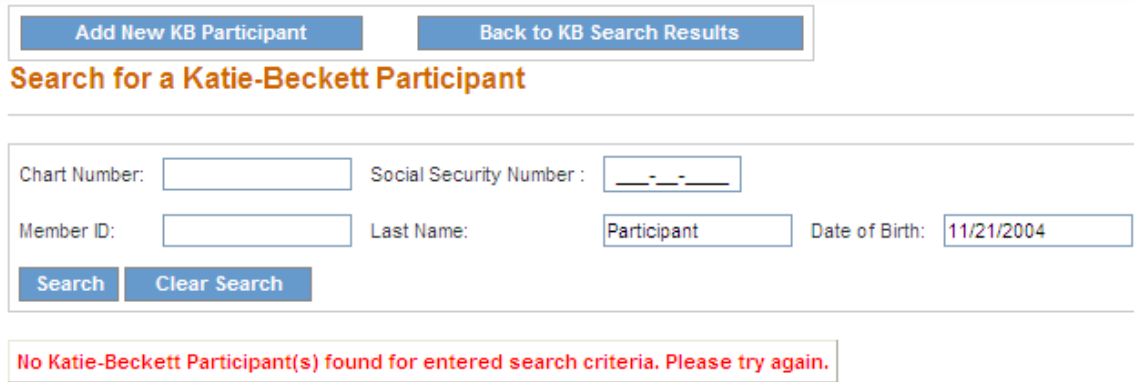


Figure 263

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

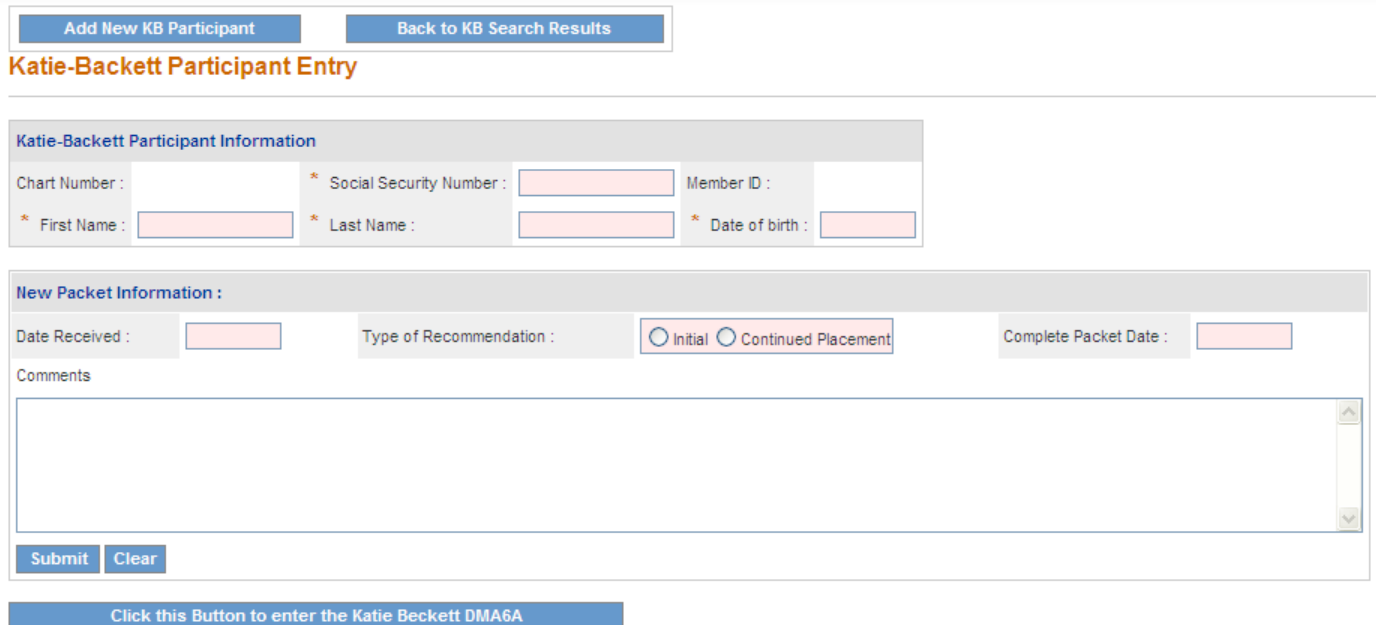


Figure 264

- Enter the participant’s Social Security Number in the box provided.
- 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.
- 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.
- In the *New Packet Information* section, enter the date that the packet information was received. Enter the date manually or use the calendar.
- Select the ‘Type of Recommendation’ by clicking the *Initial* button since this is a packet for a new participant.

- 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.
- Additional information regarding the participant or packet may be entered in the **‘Comments’** box but this is optional.

Add New KB ParticipantBack to KB Search Results

### Katie-Beckett Participant Entry

---

**Katie-Beckett Participant Information**

|                |                                    |                            |  |                   |   |
|----------------|------------------------------------|----------------------------|--|-------------------|---|
| Chart Number : |                                    | * Social Security Number : | <input type="text" value="434344445"/>   | Member ID :       |   |
| * First Name : | <input type="text" value="Katie"/> | * Last Name :              | <input type="text" value="Participant"/> | * Date of birth : | <input type="text" value="11/21/2004"/> |

**New Packet Information :**

|                 |   |                          |  |                        |                      |
|-----------------|---|--------------------------|--|------------------------|----------------------|
| Date Received : | <input type="text" value="01/07/2013"/> | Type of Recommendation : | <input checked="" type="radio"/> Initial <input type="radio"/> Continued Placement | Complete Packet Date : | <input type="text"/> |
|-----------------|---|--------------------------|--|------------------------|----------------------|

Comments

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

SubmitClear

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

Figure 265

- Click **Submit** to save the participant/packet information.
- Once the packet information is submitted successfully, the **Previous Comments** table opens below the **‘Comments’** box. This table displays all the packet information entered in the system for the participant. Once the DMA6A is submitted, the system inserts the DMA6A tracking/authorization number in this table under **‘PA Number’** to associate each packet with the corresponding DMA6A.

Comments

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

Submit Clear

Previous Comments

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

Click this Button to enter the Katie Beckett DMA6A

Figure 266

### 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                  |
|---------------|--------------|------------------|-------------------|------------------------|----------------------|
| <u>774048</u> | 333000000700 | WILLIAMS         | JAMES             | 818181818              | 2/3/2004 12:00:00 AM |

Figure 267

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 268**

- To add the continued placement packet information, enter the date that the packet was received in the 'Date Received' box.
- 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.
- 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 269**

## Enter the DMA6A

Enter the DMA6A after packet information has been added for a new participant; or after packet information has been added for an existing participant. **The packet information must be added before the DMA6A may be entered** to ensure that each packet is associated with a different DMA6A.

1. After submitting the packet information, select - [Click this Button to enter the Katie Beckett DMA6A](#) – below the ‘Previous Comments’ table.

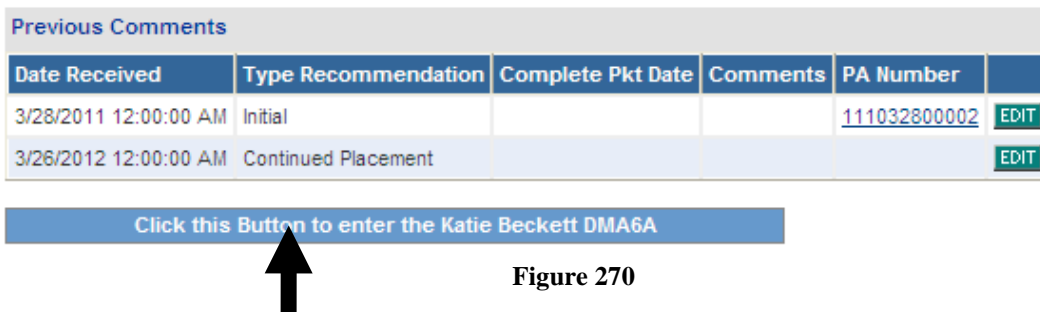


Figure 270

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

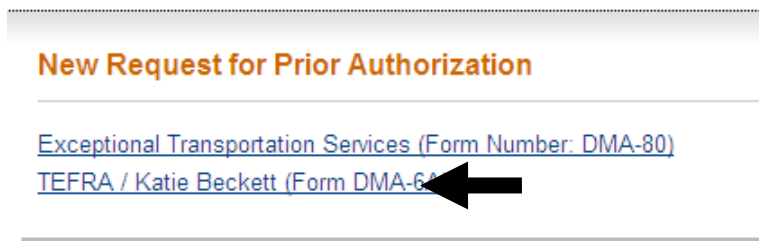


Figure 271

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

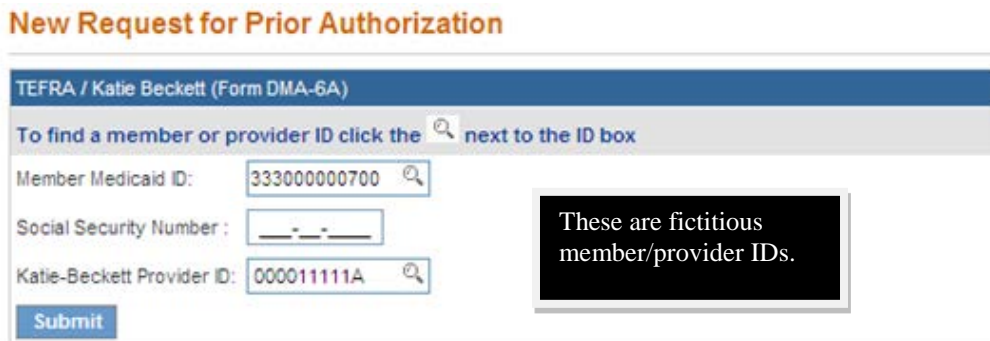


Figure 272

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 |  |

Figure 273

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.

The screenshot shows two sections of a form. The top section, titled "Member Information", contains fields for Member ID (03396GMC), First Name (Mary), MI (empty), Last Name (Smith), Suffix (empty), Date of Birth (07/14/2009), Social Security Number (111-11-1111), and Gender (Female). The bottom section, titled "Participant Address", contains fields for Address Line 1 (Required), Address Line 2, City (Required), State (GA), and Zip (Required).

Figure 274

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.**

The screenshot shows the "Contact Information" section of a form. It includes fields for Contact Name (Mary Smith), Contact Email (RSM@email.org), Contact Phone (404-999-8765), Ext. (empty), and Contact Fax (404-888-7654).

Figure 275

- 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"/> |      | <input type="button" value="ADD"/> |

Figure 276

- 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 | <input type="button" value="EDIT"/> <input type="button" value="DELETE"/> |
| <input type="text"/> |                       | <input type="text" value="09/15/2014"/> | <input type="checkbox"/> | <input type="checkbox"/> |       | <input type="button" value="ADD"/>  |

Figure 277

- Other diagnosis codes may be entered, following the same procedure just described.
- After the contact information and diagnosis information is complete, go to the bottom of the form and click **Review Request**.
- 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 policies and procedures. I am submitting this information to the Georgia Department of Community Health, Division of Medical Assistance, for the purpose of obtaining a prior authorization number.

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

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

I Agree

Figure 278

- 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.)

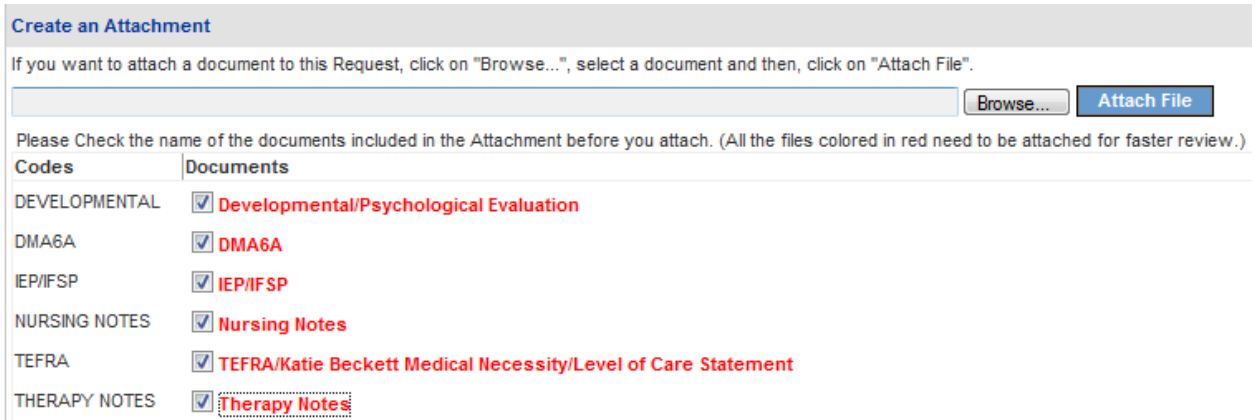
| Codes         | Documents  |
|---------------|--|
| DEVELOPMENTAL | <input type="checkbox"/> Developmental/Psychological Evaluation                        |
| DMA6A         | <input type="checkbox"/> DMA6A   |
| IEP/IFSP      | <input type="checkbox"/> IEP/IFSP  |
| NURSING NOTES | <input type="checkbox"/>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

Figure 279

## 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.

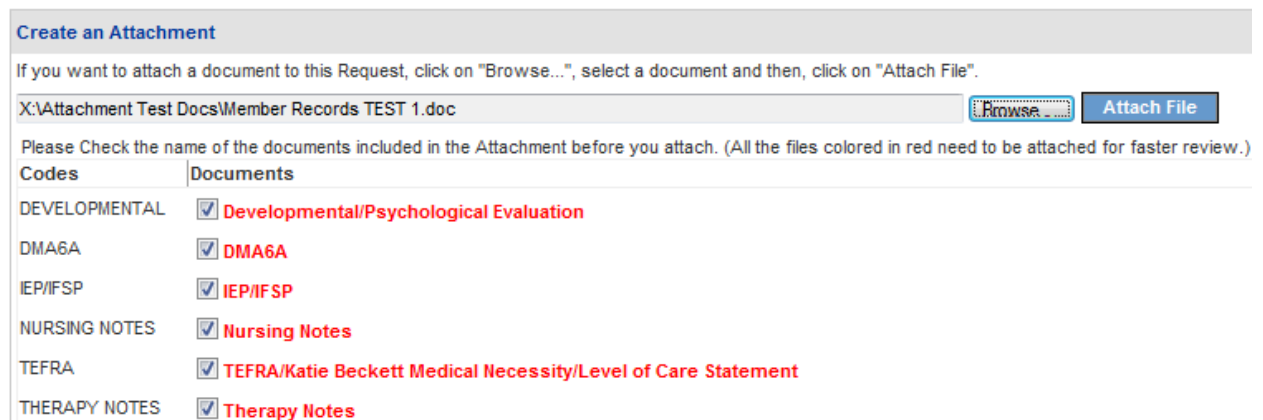


The screenshot shows the 'Create an Attachment' form. At the top, there is a header 'Create an Attachment' and a sub-header 'If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".' Below this is a text input field and two buttons: 'Browse...' and 'Attach File'. A note below the buttons says 'Please Check the name of the documents included in the Attachment before you attach. (All the files colored in red need to be attached for faster review.)' The main part of the form is a table with two columns: 'Codes' and 'Documents'. 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 280

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 after a file has been selected. The 'Browse...' button now contains the file path 'X:\Attachment Test Docs\Member Records TEST 1.doc'. The 'Attach File' button is still present. The table of document types and checkboxes is the same as in Figure 280:

| 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 281

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 282

**Note:** For more detailed guidelines regarding the attachment process, please refer to the user guide – *Attach Files to a PA Request* – located on the *Medical Review Portal* 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 :

Katie-Beckett Provider ID:

**Fictitious SSN**  
Error: Multiple member IDs associated with this Medicaid SSN

**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 283

**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 Alliant review staff.

1. To add the member’s Medicaid ID, click [Update Multiple Member ID](#).



Figure 284

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 : 712-31-2345

Request Type :  Katie-Beckett

Submit Reset

Figure 285

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 : 712-31-2345

Request Type :  Katie-Beckett

Submit Reset Click this Button to enter the Katie Beckett DMA6A

| Request ID | Member ID | Last Name | First Name | SSN       | Status |
|------------|-----------|-----------|------------|-----------|--------|
| [Redacted] | 00612GMC  | NELSON    | SHELLEY    | 712312345 | Denied |

Fictitious member info

A black arrow points to the 'Request ID' cell in the table.

Figure 286

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 : [REDACTED] Case Status : **Denied** Case Status Date : 01/14/2013

Member ID : 00612GMC **334000000700**  **Update Member Medicaid ID**

Provider ID : [REDACTED]

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

Denial Reason :

Type of Recommendation : Initial

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

**Diagnosis**

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

Figure 287

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

**Request Information**

Request ID : [REDACTED] Case Status : **Denied** Case Status Date : 01/14/2013

Member ID : **334000000700**

Provider ID : [REDACTED]

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

Denial Reason :

Type of Recommendation : Initial

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

**Diagnosis**

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

**Return to the Auth Request Page**

Figure 288


- 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.
- On the next screen, click the link to the Katie Beckett request form.




10. The *New Request for Prior Authorization* page opens with the member's Medicaid ID and the requesting provider ID inserted by the system.

**New Request for Prior Authorization**

TEFRA / Katie Beckett (Form DMA-6A)

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

Member Medicaid ID:  

Social Security Number :


Katie-Beckett Provider  

Figure 289

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.

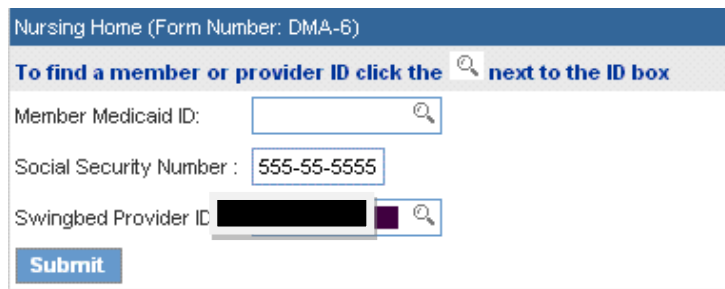


Figure 290

6. Click **Submit** to open the request form.
7. The requesting Swingbed provider information is system populated; and, if the patient is a Medicaid recipient, the patient’s Medicaid ID, Last Name, First Name, Date of Birth, Gender and Social Security number (SSN) display at the top of the form.
8. If the patient is not a Medicaid recipient, the SSN previously entered displays in the ‘Social Security Number’ box; and the following information must be entered:
  - **Name:** Enter the patient’s last name in the ‘Last Name’ box, and the patient’s first name in the ‘First Name’ box. A middle initial and suffix are optional.
  - **Date of Birth:** Enter manually or use the calendar popup
  - **Gender:** Enter the gender of the patient by selecting a type from the drop list.



Figure 291

**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 292

**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 293

**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 294 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 295 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.

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\* 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 296

### 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 297

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

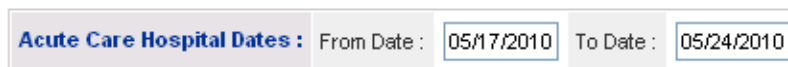
Figure 298

- 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.

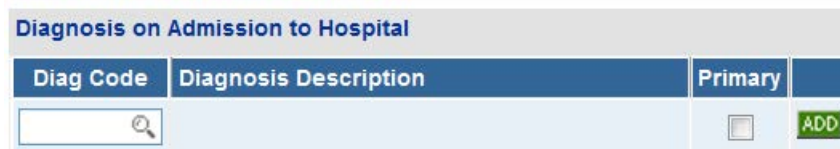


Acute Care Hospital Dates : From Date : 05/17/2010 To Date : 05/24/2010

Figure 299

**Diagnosis on Admission to Hospital:**

This section is optional



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

Figure 300

**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              | EDIT<br>DELETE |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | ADD            |

Figure 301

- 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                  | EDIT<br>DELETE |
| <input type="text"/>                | <input type="text"/> | ADD            |

Figure 302

- 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.

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

Figure 303

**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 304

**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:

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- 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"/> |
|------------------|--|----------------------------|---|----------------------------|-------------------------------------|-------------------|---|

Figure 305

**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 306

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

Figure 307

**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 308

**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 309

**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.**

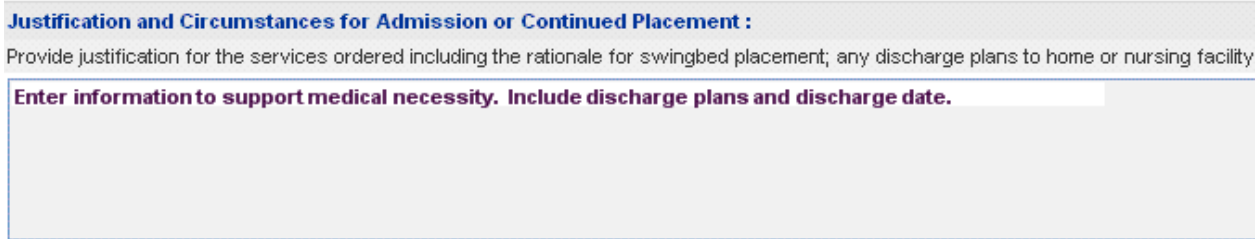


Figure 310

***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 311

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 312

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 313

## 2.24 Nursing Facility Mechanical Ventilation Services

| Program  | Authorization Period                     |
|--|--|
| Nursing Facility Mechanical Ventilation Services | Initial – 90 days<br>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 314

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 315

**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 316

**Request Information:**

This section captures recommendation type, admission date, place of service, admission type, and 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

20. , 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 web form titled "Request Information". The "Recommendation Type" is set to "Initial Placement" (radio button selected). The "Initial Admission Date/Planned Admission Date" is 05/05/2013. The "Place of Service" is "31 - Skilled Nursing Facility". The "Admission Type" is "Elective". The "Level I PASRR Approval Number" is 113050199999. The "Level I PASRR Approval Date" is 05/01/2013.

Figure 317

The screenshot shows a web form titled "Request Information". The "Recommendation Type" is set to "Continued Placement" (radio button selected). The "Continued Placement Start Date" is 01/23/2013. The "Initial Admission Date" is 01/23/2012. The "Place of Service" is "31 - Skilled Nursing Facility". The "Admission Type" is "Elective". The "Level I PASRR Approval Number" is 112012399999. The "Level I PASRR Approval Date" is 01/22/2012. There is also an "Initial Request ID" field which is currently empty.

Figure 318

**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.

- 21. Click *Yes* or *No* to indicate whether or not at least two vent weaning attempts have been made in the last 90 days.
- 22. If *No* selected, indicate whether or not weaning is feasible at this time by clicking *Yes* or *No*.
- 23. If *No* selected, describe in the box provided, the reason or reasons that vent weaning is not possible at this time

The screenshot shows a web form with two radio button questions and a text box. The first question is "Have at least two vent weaning attempts been made in the last 90 days?" with "No" selected. The second question is "If No, is vent weaning feasible at this time?" with "No" selected. Below the questions is a text box with the prompt "Describe why vent weaning is not feasible at this time." and a scroll bar.

Figure 319

***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.

- 24. 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.
- 25. The system populates the diagnosis description when the diagnosis is added.
- 26. 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.
- 27. 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.
- 28. 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 320

- 29. 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.**

30. 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 321**

***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.

31. Enter the name of the hospital or facility in the ‘Hospital/Facility’ box.

32. Enter the date admitted in the ‘Admit Date’ box.

33. Enter the date discharged in the ‘Discharge Date’ box.

34. Explain the reason for admission in the ‘Reason for Hospitalization’ box.

35. Click **ADD** to add the information to the request.

36. 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 322

37. 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).
38. Select the diagnosis as primary, if applicable.
39. 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 323

**Medications and IVFs:**

This section records the patient’s medications including intravenous fluids.

40. Select a drug category from the ‘Name’ drop list.
41. Enter the dosage for the medication in the ‘Dosage’ box.
42. Select the administration route from the ‘Route’ drop list.
43. Select the frequency of administration from the ‘Frequency’ drop list.
44. Click **ADD** to add the drug information to the request.
45. Repeat the same process to add other medications.

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

Figure 324

***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:

- 46. 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 325

- 47. 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 326

48. 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 327

- 49. 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.
- 50. 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 328

**Ventilator Settings:**

51. 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 329

**Treatment Plan:**

This text box captures a summary of the patient's treatment plan.

52. 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 330

**Justification and Circumstances for Admission or Continued Placement**

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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.

53. Enter the justification and circumstances for the admission or continued placement in the box provided.
54. 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 331

55. 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.
56. Click **I Agree** in response to the *Attestation Statement*.
57. 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 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.

### 2.25.1 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 on *Medical Review Portal* → *Prior authorization* accessed from the secure home page after logging into the portal.
3. Scroll down to the **PASRR Level I Information** section and select *Enter a New PASRR Request* link.

#### **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 not able to edit the request directly. There may be restrictions on when change requests can be made submitted. Also, use this link to find change requests previously submitted and view the status of the change requests.

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)

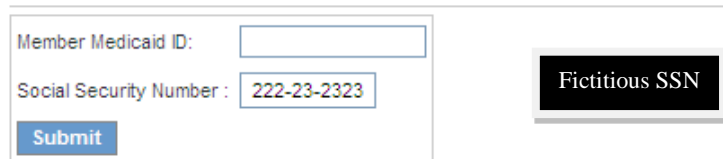


Figure 332

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.

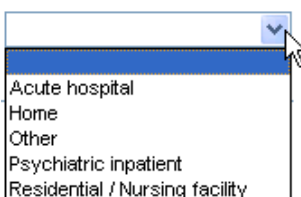


Figure 333

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:  First Name :  Middle Initial :

Social security Number :  Date of Birth :  Gender :

Current location of applicant :

If 'Other' is selected, please explain.

Check all that apply to the applicant/resident

New admission     
  Readmission to NF from psychiatric hospital     
  Readmission to NF from acute hospital     
  Respite care, less than 30 days  
 Transfer from residential to NF     
  Transfer between NF's     
  Emergency, requiring Protective Services     
  Out of State resident(OOS)  
 Other

If 'Other' is selected, please explain.

dfgadfgasdgasdgfasdgfasdgsdg

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

OOS Contact Last Name :  OOS Contact First Name :  Contact Phone # :

Figure 334

**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:

|   |   |                                |  |   |  |
|---|---|--------------------------------|--|---|--|
| <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 335

**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.

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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 336



***Nursing Facility Information:***

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

- 14. Respond *Yes* or *No* to indicate whether or not the patient has been admitted to the nursing facility.
- 15. If **No** is the response, go to the **Physician Information** section.
- 16. If **Yes** is the response, enter the date of admission to the nursing facility in the ‘Date of Admission to Nursing Facility’ box.
- 17. To enter the name of the nursing facility and nursing facility provider ID, follow this procedure:
  - a. Click the spy glass  next to the ‘Nursing Facility Provider ID’ box to display the *Nursing Facility Search* page.



**Figure 337**

- 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 338**

- c. Select the applicable Referral Provider ID from the lists, or use the search function to find the specific nursing facility

## Alliant Health Solutions

- 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 : 04/05/2010 Name of Nursing Facility : [REDACTED] Nursing Facility Provider ID : [REDACTED]

Figure 339

### ***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 : Doctor Doctor Office or Hospital : Office Phone : 444-444-4444

Address 1 : 1 Address Address 2 : City : City State : Georgia

Zip : 30003 County : DeKalb Physician Signed?  Yes  No Date Signed : 04/05/2010

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

Figure 340

### ***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"/> | Contact Facility Type : | <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="- -"/>      | E-mail :                | <input type="text"/>                  |
| Address :                | <input type="text" value="Hospital St"/> | City :      | <input type="text" value="city"/>         | State :                    | <input type="text" value="Georgia"/>  | Zip Code :              | <input type="text" value="30030"/>    |

Figure 341

- 35. After all Level I questions are answered and all data entered, click **Review Request** at the bottom of the form. The page may temporarily 'gray' out as the system validates data.
- 36. If all required data is entered correctly, an attestation statement displays at the bottom of the *Review Request* page. Click **I Agree**.
- 37. When 'I agree' is selected, the *Review Request* page is refreshed and two new links display at the bottom: **Edit Request** and **Submit Request**.
- 38. Select **Submit Request**. The Level I is submitted; and the tracking number and Level I decision (pending, approved, or withdrawn) display at the top of the page as shown in the figure below.

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

Thank you for submitting your Medicaid Prior Authorization request online. You may check the case status of your request online after 24 hours of submission. If you have any questions regarding the 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 : | 110040706780 | Status : | Pending |
|--------------|--------------|----------|---------|

Figure 342

### 3.0 Newborn Notifications

The Newborn Delivery Notification is submitted via the *centralized* portal using an entry process similar to submitting a FFS Hospital Admissions request. The notification forms can only be submitted for female members who are between 9 and 55 years of age.

#### Newborn Delivery Notification

The Newborn Delivery Notification is completed for all OB deliveries that are submitted for claims payments to Medicaid FFS. The notification form is entered under the Mom’s Medicaid ID and captures newborn information for single or multiple births. The form should not be used to request a future C-section surgery date. The Newborn Delivery Notification information is used by Medicaid FFS to generate the maternal delivery authorization.

### 3.1 Initiate a Notification Form

Follow these instructions to initiate a Newborn Delivery notification via the GA web portal.

1. Go to the GA Web Portal at [www.mmis.georgia.gov](http://www.mmis.georgia.gov).
2. Login with assigned user ID and password.
3. On the portal secure home page, click the **Prior Authorization** tab.
4. Click **Submit/View** (or select **Medical Review Portal** to open the workspace and then click **Enter a New Authorization Request**).



5. A request menu displays with the notification forms and request types applicable to the **requesting provider's category of service.**

### New Request for Prior Authorization

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- [Georgia Pregnancy Notification Form](#)
  - [Hospital OutPatient Therapy](#)
  - [Medications PA Facility Setting](#)
  - [Newborn Delivery Notification Form](#)
  - [Hospital Admissions and Outpatient Procedures \(Form Number: GMCF form PA81/100\)](#)
  - [In-State Transplants \(Form Number: PA-81\)](#)
  - [Out-of-State Services \(Form Number: GMCF FAX OOS\)](#)
  - [Radiology-Facility Setting](#)
  - [Swingbed \(Form Number: DMA-6\)](#)
  - [Pediatric Admission to Swingbed \(Form DMA-6A\)](#)
- 

6. Select the *Newborn Delivery Notification Form*. These forms are available to physicians/medical practitioners and hospital/facilities.
7. On the next page that displays, select FFS by clicking the FFS button.
8. Enter the mother's Medicaid ID in the 'Member Medicaid ID' box. The member must be female and between 9 and 55 years of age. If the member ID entered is not for a female or falls outside the acceptable age range, a message displays informing the user of the discrepancy. The member ID must be changed in order to initiate the request.
9. The requesting provider ID is populated by the system based on the portal login. Enter the Reference ID for the **other provider** in the box provided. The reference number always starts with REF.
10. A medical practitioner (such as a physician) **AND** a facility provider **must be entered** to initiate a Pregnancy or Newborn Delivery Notification request. For example, in the figure below, the provider requesting the notification was the physician. **Consequently, the reference number for a facility must be entered.** This is the facility where it is anticipated that the delivery will occur.

## New Request for Prior Authorization

Newborn Delivery Notification Form

Use this notification to report delivery outcome only. Do not use to request a future c-section surgery date.

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

Select FFS or a 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 :

11. Click **Submit** to open the notification form.

## 3.2 Enter Newborn Delivery Notification Data

### Member/Provider Information

When the notification form opens, the member and provider information is system populated at the top of the page based on the member ID and provider IDs entered.

### Contact Information

The system also populates the requesting provider’s contact information in the **Contact Information** section. The ‘Contact Name’, ‘Contact Phone’, and ‘Contact Fax’ are required. If this information is missing, enter the information in the boxes provided. All contact information may be edited if incorrect.

Contact Information

|   |  |
|---|--|
| * Contact Name: <input style="width: 90%;" type="text" value="DBARRETT"/>   | Contact Email: <input style="width: 90%;" type="text" value="db@gmail.com"/> |
| Contact Phone: <input style="width: 40%;" type="text" value="444-444-4444"/> Ext. <input style="width: 30%;" type="text" value=""/> | * Contact Fax: <input style="width: 90%;" type="text" value="444-444-9999"/> |

### Request Information

This section captures information specific to the admission for delivery.

1. In the ‘Maternal Admit Date’ box, enter the mother’s admit date. **Admit dates in the future are not allowed** since the submission of the Newborn Delivery notification indicates that a delivery is occurring or has occurred.

- If the mother was already discharged, enter the 'Discharge Date'; **or** if the mother is still in the facility, check 'Still in Facility'.
- Select the applicable 'Admission Type' from the drop list. The admission type should pertain to the delivery admission.

\* Admission Type :

- Emergency
- Urgent
- Elective

\* Diagnosis

- Select the applicable 'Place of Service' from the drop list. The place of service should relate to the facility where the delivery occurred.

\* Place of Service :

- 21 - Inpatient Hospital
- 22 - Outpatient Hospital
- 24 - Ambulatory Surgical Center
- 25 - Birthing Center

**Request Information**

\* Maternal Admit Date : 10/13/2015      Discharge Date :        Still in Facility

\* Admission Type : Elective      \* Place of Service : 25 - Birthing Center

### Diagnosis

This section captures the mother's primary delivery diagnosis. On the first diagnosis line, the system defaults to these values:

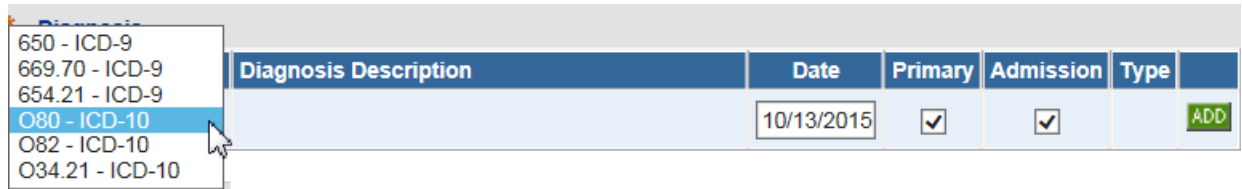
- The first diagnosis code in the diagnosis drop list
- Date = the date when form submitted
- Primary Diagnosis indicator is checked
- Admission Diagnosis indicator is checked

| * Diagnosis |   |            |                                     |                                     |      |     |
|-------------|---|------------|-------------------------------------|-------------------------------------|------|-----|
| Diag Code   | Diagnosis Description                     | Date       | Primary                             | Admission                           | Type |     |
| O80         | ENCOUNTER FOR FULL-TERM UNCOMPLICATED DEL | 12/21/2015 | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |      | ADD |

- If O80 is not the correct primary diagnosis, select a different diagnosis from the drop list. One of the diagnoses from the drop list must be selected as the primary diagnosis. **Select the diagnosis type (ICD9 or ICD10) that was valid on the 'Maternal Admit Date'.**



The choices are:



6. The diagnosis date is defaulted to the form request date. This date should be modified so that it corresponds to the diagnosis type selected (ICD9 or ICD10). For example, if an ICD9 is selected; then the diagnosis date should be before 10/1/15. If an ICD10 is selected, then the diagnosis date should be 10/1/15 or greater.
7. Click **Add** to add the diagnosis code information to the notification.
8. When **Add** is clicked, a blank diagnosis code line displays and the **Edit** button becomes available on the diagnosis line just entered.
9. If needed, enter another diagnosis code and diagnosis date.
10. Click **Add** to add the diagnosis code to the notification form.

### Mother/Baby Details

The next two sections capture details regarding the mother, delivery, and newborn. Highlighted fields are required; although other data should be entered if available or applicable.

#### **Member (Mother) Details:**

11. Enter the estimated date of delivery in the 'EDC Date' box. This is required. EDC information should be based on ultrasound dating or a combination of LMP and ultrasound dating. LMP dates are **NOT** allowed in this field. The gestational age should be between 23 and 45 weeks.
12. Indicate the delivery method by clicking the appropriate button. The default value is *Vaginal*. Click *C-Section* if that is the correct delivery method.
13. **Gravida:** Select the number of times that the mother has been pregnant from the 'Gravida' drop list (required). The available values are 0-9.

14. **Para:** Select the number of births including stillbirths from the 'Para' drop list (required). The available values are 0-9. **Note:** Gravida should be equal to or greater than Para.
15. **Abortus:** Select the number of pregnancies lost from the 'Abortus' drop list (required). The available values are 0-9.

| Member Details |   |                 |  |           |                                |        |                                |           |                                |
|----------------|---|-----------------|--|-----------|--------------------------------|--------|--------------------------------|-----------|--------------------------------|
| EDC Date :     | <input type="text" value="04/30/2013"/> | Delivery Type : | <input checked="" type="radio"/> Vaginal <input type="radio"/> C-Section | Gravida : | <input type="text" value="3"/> | Para : | <input type="text" value="2"/> | Abortus : | <input type="text" value="1"/> |

**Baby Information:**

| Baby #: New           |                                   |                       |  |                          |   |
|-----------------------|-----------------------------------|-----------------------|--|--------------------------|---|
| Baby's First Name :   | <input type="text"/>              | Middle Initial :      | <input type="text"/>   | Baby's Last Name :       | <input type="text"/>                            |
| Date of Birth :       | <input type="text"/>              | Gender :              | <input checked="" type="radio"/> Male <input type="radio"/> Female | Baby's Weight at Birth : | <input type="text"/> (grams)                    |
| Disposition of Baby : | <input type="text" value="Well"/> | Pediatrician Name :   | <input type="text"/>   |                          |   |
| APGAR Score (1 Min) : | <input type="text" value="0"/>    | APGAR Score (5 Min) : | <input type="text" value="0"/>                                     | Baby's Medicaid ID :     | <input type="text"/>                            |
|                       |                                   |                       |  |                          | <input type="button" value="Add Another Baby"/> |

16. Enter the baby's first name and the last name (required). Middle initial is optional.
17. Enter the baby's date of birth (required).
18. Gender defaults to Male. Select Female if that is the appropriate gender.
19. Enter the baby's birth weight in grams (required). Gram weights outside of 300 - 10,000 grams are not acceptable.
20. Select the disposition of the baby from the drop list. 'Well' is the default value. Other values include: *Stillborn, NICU, SCH, Adopted, and Detained*.
21. From the 'APGAR Score' drop lists, select the 1 minute Apgar score, and the 5 minute Apgar score. Both drop lists contain values from 0-10.
22. Enter the pediatrician's name. This is optional.
23. Finally, enter the baby's Medicaid ID **if this is known**. Otherwise, leave blank.

| Baby #: New           |   |                          |  |
|-----------------------|---|--------------------------|--|
| Baby's First Name :   | <input type="text" value="BABY BOY"/>   | Middle Initial :         | <input type="text" value="W"/>                                     |
| Date of Birth :       | <input type="text" value="05/03/2013"/> | Gender :                 | <input checked="" type="radio"/> Male <input type="radio"/> Female |
| Disposition of Baby : | <input type="text" value="Well"/>       | Pediatrician Name :      | <input type="text" value="Doctor John"/>                           |
| APGAR Score (1 Min) : | <input type="text" value="4"/>          | APGAR Score (5 Min) :    | <input type="text" value="5"/>                                     |
|                       |   | Baby's Last Name :       | <input type="text" value="SMITH"/>                                 |
|                       |   | Baby's Weight at Birth : | <input type="text" value="3400"/> (grams)                          |
|                       |   | Baby's Medicaid ID :     | <input type="text" value="333000000800"/>                          |

[Add Another Baby](#)

24. If there was more than one birth, click [Add Another Baby](#) to open another new baby section. (If clicked in error, the additional section can be removed by clicking [Remove](#)).

| Baby #: New           |   |                          |  |
|-----------------------|---|--------------------------|--|
| Baby's First Name :   | <input type="text" value="BABY BOY"/>   | Middle Initial :         | <input type="text" value="W"/>                                     |
| Date of Birth :       | <input type="text" value="05/03/2013"/> | Gender :                 | <input checked="" type="radio"/> Male <input type="radio"/> Female |
| Disposition of Baby : | <input type="text" value="Well"/>       | Pediatrician Name :      | <input type="text" value="Doctor John"/>                           |
| APGAR Score (1 Min) : | <input type="text" value="4"/>          | APGAR Score (5 Min) :    | <input type="text" value="5"/>                                     |
|                       |   | Baby's Last Name :       | <input type="text" value="SMITH"/>                                 |
|                       |   | Baby's Weight at Birth : | <input type="text" value="3400"/> (grams)                          |
|                       |   | Baby's Medicaid ID :     | <input type="text" value="333000000800"/>                          |

| Baby #: New           |   |                          |  |
|-----------------------|---|--------------------------|--|
| Baby's First Name :   | <input type="text"/>                    | Middle Initial :         | <input type="text"/>   |
| Date of Birth :       | <input type="text" value="05/03/2013"/> | Gender :                 | <input checked="" type="radio"/> Male <input type="radio"/> Female |
| Disposition of Baby : | <input type="text" value="Well"/>       | Pediatrician Name :      | <input type="text"/>   |
| APGAR Score (1 Min) : | <input type="text" value="0"/>          | APGAR Score (5 Min) :    | <input type="text" value="0"/>                                     |
|                       |   | Baby's Last Name :       | <input type="text"/>   |
|                       |   | Baby's Weight at Birth : | <input type="text"/> (grams)                                       |
|                       |   | Baby's Medicaid ID :     | <input type="text"/>   |

[Remove](#)

[Add Another Baby](#)

25. Enter the required information for the second birth.

26. When all data has been entered on the notification form, click [Review Request](#) at the bottom of the page to display the *Attestation Statement*. If a message displays that 'information is missing or incorrect', scroll up the page to find what is missing or incorrect. 'Required' displays next to a data box when information is missing. Enter or correct the data, and then click [Review Request](#) again.

27. Review the *Attestation Statement* and, if in agreement, click [I Agree](#). You must click agree to submit the notification form

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

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

I understand that this FFS pre-certification request does not guarantee payment, approval of service or member benefit eligibility for the service.

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

28. Review the information entered on the notification form. To change information entered, click [Edit Request](#). **Once a notification form is submitted, it is not possible to return to the form and make changes.**
29. Click [Submit Request](#). When the notification form is successfully submitted, the system displays a 12 digit Alliant tracking number that starts with a '1'. This number can be used to search for the PA via the *Medical Review Portal*.
30. To enter a new request or notification form under the same Portal ID/provider, click [Enter a New PA Request](#). The request type menu page re-displays.