

SOURCE Level of Care and Placement Web Entry and System Notification

Purpose

Providers submit *Level of Care and Placement* requests under the Service Options Using Resources in Community Environments (SOURCE) program via the Georgia Web portal. In addition to completing the *Level of Care and Placement* online form, SOURCE providers are required to submit additional supporting documentation. This additional documentation may be attached to the *Level of Care and Placement* request when the request is submitted; or attached to an existing *Level of Care and Placement* request if the request is pending or initially tech denied.

Web 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 .
2. Log in using your assigned user name and password to open the *Secure Home* page.
3. On the *Secure Home* page, select **Prior Authorization**; then **Submit/View**.
4. Select the **SOURCE** link.
5. 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



Figure 1

6. Click **Submit** to open the *Level of Care and Placement* request form.
7. 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.

8. Enter the physician's first name and last name in the 'Physician Name' box (required).
9. 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.
10. Enter the physician's phone number in the 'Phone' box (required). The system auto formats the phone number.
11. 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.
12. Although not required, physician address information and license number can be provided.

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

Figure 2

Contact Information:

13. The system pulls in most of the contact information. However, any contact information that is missing should be entered manually. Also, if the contact information inserted by the system is not correct, edit the information. It is important that the email address be correct for ‘no-reply’ email notifications.

Contact Information			
* Contact Name:	<input type="text" value="Jane Doe"/>	Contact Email:	<input type="text" value="jdoe@hotmail.com"/>
Contact Phone:	<input type="text" value="555-555-5555"/>	Ext.:	<input type="text"/>
		* Contact Fax:	<input type="text" value="555-555-5554"/>

Figure 3

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, release of information, and place of service. All information is required.

- 14. 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.
- 15. Enter the DON-R screening score in the ‘DON-R Telephone Screening Score’ box. The DON-R score is not required for Reassessments.
- 16. 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.
- 17. Indicate whether or not the member is approved for *Money Follows the Person* by selecting *Yes* or *No*.

18. Select the applicable release of information type from the 'Release of Info Code' drop list. If not known, select *Plan Sponsor*.
19. From the 'Place of Service' drop list, select the location where services, related to this request, are provided. The choices are *Home* or *Other*.

Request Information			
* Recommendation Type :	<input checked="" type="radio"/> Initial <input type="radio"/> Reassessment	* DON-R Telephone Screening Score :	14
* Initial Admit Date :	02/22/2012	* Approved for Money Follows the Person?	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Release of Info Code :	InformedConsent	* Place of Service :	Home

Figure 4

Diagnosis:

This table captures the ICD-9 diagnosis code (or codes) associated with the patient's condition. At least one diagnosis code is required.

20. Enter the ICD-9 code in the 'ICD-9' box. If the ICD-9 has a decimal point, include 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 ICD-9 code.
21. The system populates the diagnosis description when the diagnosis is added.
22. Enter the date that the diagnosis was determined in the 'ICD-9 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.
23. 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.
24. Click **Add** at the end of the diagnosis line. **You must click Add to add the diagnosis information to the request.**

* Diagnosis					
ICD-9 Code	ICD-9 Description	ICD 9 Date	Primary	Admission	
331.0	ALZHEIMER'S DISEASE	08/30/2011	Yes	No	EDIT DELETE
<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="checkbox"/>	ADD

Figure 5

25. 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.

26. 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.

27. Enter the member's primary admission diagnosis code in the 'ICD-9 Code' box. The system will insert the diagnosis description when the diagnosis is added. Select the 'Primary' indicator.

28. Click **Add**.

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

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

Figure 6

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 Medications (or Treatment Procedures) Attached” in the Treatment Plan text box.

Medications

- 29. Click the down arrow from the ‘Name’ drop list and select a medication category.
- 30. Enter the dosage of the medication in the ‘Dosage’ box.
- 31. Select the administration method from the ‘Route’ drop list, and the frequency of administration from the ‘Frequency’ drop list.
- 32. Click **Add**.
- 33. 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 7

Diagnostic and Treatment Procedures

- 34. From the ‘Type’ drop list, select a diagnostic/treatment procedure.
- 35. Enter the frequency for the treatment procedure in the ‘Frequency’ box.
- 36. Click **Add**.

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

Figure 8

37. 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.

38. Click the down arrow from the ‘Services’ drop list and select a service type.

39. In the ‘Amount’ box, enter the unit of service requested.

40. 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.

41. 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*.

42. Click **Add** to add the service information to the request.

The screenshot shows a form titled "Services" with a description: "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)." Below the description is a table with the following structure:

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

Figure 9

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

The screenshot shows the "Services" form with two entries. The table structure is as follows:

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

Figure 10

Treatment Plan:

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

- 44. 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 Treatment Plan Attached” in the text box.

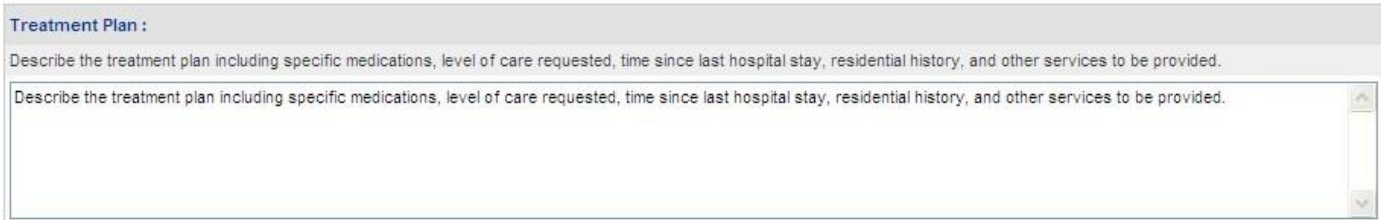


Figure 11

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.

- 45. Indicate whether or not the member is free of communicable diseases.
- 46. Indicate whether or not the member’s condition is manageable by SOURCE.
- 47. Indicate whether or not the member’s condition is manageable by Home Health Services.
- 48. Indicate whether or not the physician has certified that the member requires intermediate level of care provided by a nursing facility.
- 49. 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 12

Evaluation of Nursing Care Needed:

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

50. 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'.

51. Enter the number of hours that the member is usually out of bed per day in the 'Hours out of the bed Per Day' box (optional).

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

Figure 13

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.

- 52. **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.
- 53. **Activities of Daily Living:** For each ADL category, click the down arrow and select the level of assistance needed from the drop list.
- 54. **Level of Impairment:** For each category of impairment, click the down arrow and select the level impairment from the drop list.

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

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

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

Figure 14

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.

- 55. In the 'Justification and Services' textbox, explain why SOURCE services are necessary for the member's care.
- 56. 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.
- 57. Enter the date that the form was signed in the 'Date Signed' box.

Justification and Circumstances for Admission or Continued Placement :

Provide justification for the services ordered.

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

Name of RN Signing Form : Date Signed :

Figure 15

58. 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.
59. 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.
60. Review the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.
61. 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.
62. 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.)

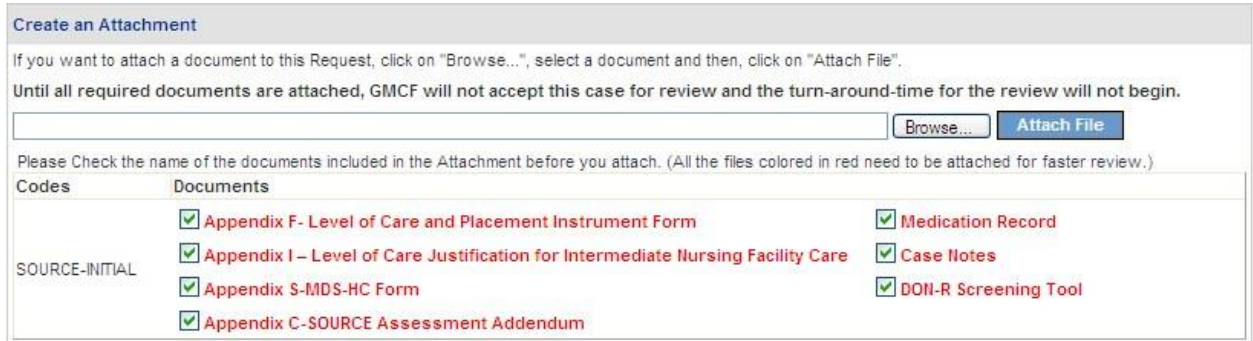
Codes	Documents	
SOURCE-INITIAL	<input type="checkbox"/> Appendix F - Level of Care and Placement Instrument Form	<input type="checkbox"/> Medication Record
	<input type="checkbox"/> Appendix I - Level of Care Justification for Intermediate Nursing Facility Care	<input type="checkbox"/> Case Notes
	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

Figure 16

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:

63. Click each document type checkbox.



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".

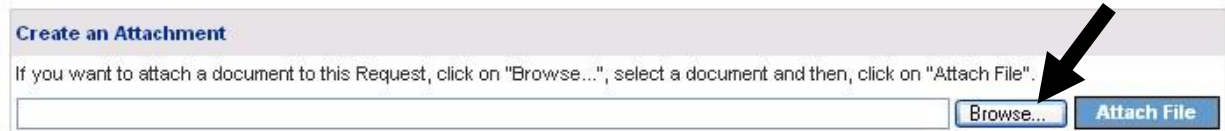
Until all required documents are attached, GMCF will not accept this case for review and the turn-around-time for the review will not begin.

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

Figure 17

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



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".

Figure 18

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

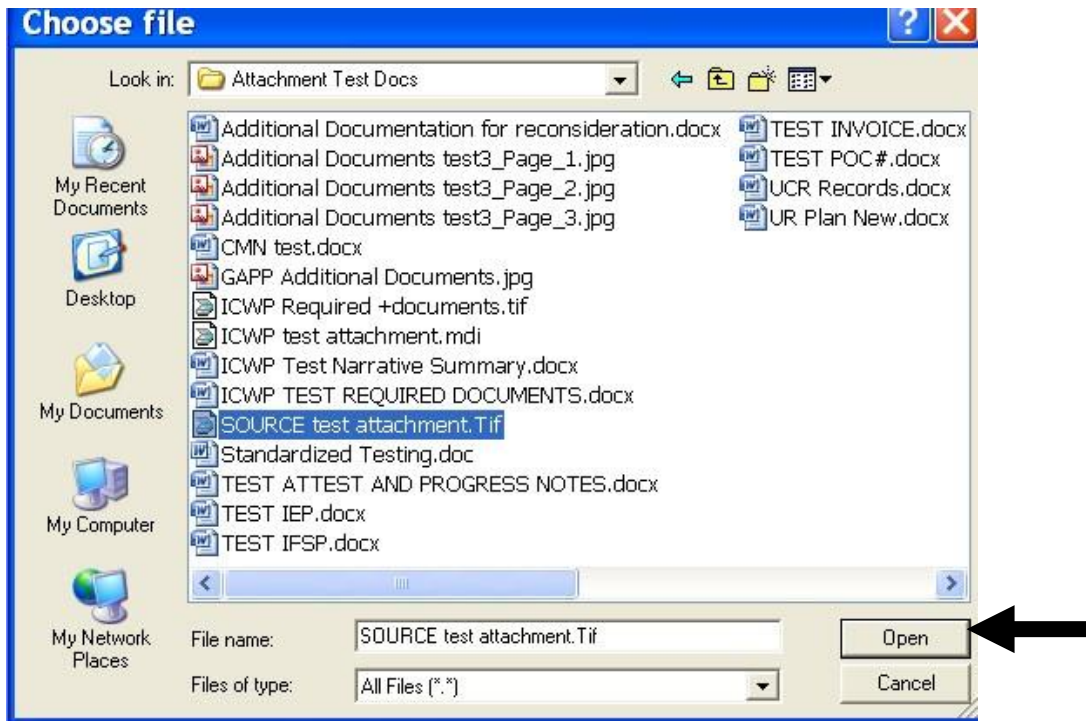


Figure 19

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

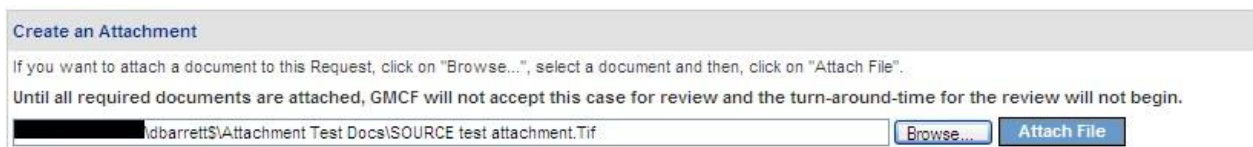


Figure 20

67. 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.

Create an Attachment

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

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

File uploaded successfully.

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

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

Attached Files

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

Figure 21

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

68. 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.
69. Select another checkbox or other checkboxes. Click **Browse** and find the next file to be attached. Click **Attach File**.
70. Repeat this process until all checkboxes have been selected.

System Notifications

When a case 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 **PA Notifications** on the *Medical Review Portal* for details. When the LOC was denied for missing information, the notification also specifies what documents are missing. Here is a sample of the no-reply email for a denial.

.....

No Reply Email (The PA ID is masked).

*** DO NOT RESPOND TO THIS E-MAIL ***

Dear Provider,

The Source Level of Care and Placement (PA#:*****0001) PA submitted by you, has been Denied. The PA is missing some document(s): DON-R Screening Tool. You can visit Medical Review Portal section of Georgia MMIS portal: <https://www.mmis.georgia.gov> to check the PA status details.

Regards,
Nurse Reviewer Team

*** Please note: This e-mail was sent from a notification-only address that cannot accept incoming e-mail. Please do not reply to this message. ***

Figure 22

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.



Figure 23

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. 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 as shown in the following figure.

Prior Authorization - Review Request

This PA cannot be edited. Either the PA is currently under process or the decision is taken or this PA type cannot be edited once it is submitted.

Notification(s) for this PA

Date	Status	Notification
12/27/2011		The Source PA # [redacted] submitted by you, has been Denied. The PA is missing some document(s) : Appendix F- Level of Care and Placement Instrument Form , Appendix I- Level of Care justification for Intermediate Nursing Facility Care , Appendix S-MDS-HC Form , Appendix C-SOURCE Assessment Addendum , Medication Record , Case Notes .

Request Information

Request ID : [redacted] Case Status : **Denied** Case Status Date : 12/27/2011

Member ID : [redacted]

Provider ID : [redacted]

Admission Date : 12/27/2011 Discharge Date : [redacted]

Effective Date : 12/27/2011 Expiration Date : 03/26/2012

Denial Reason :

Diagnosis

ICD-9 Code	ICD-9 Description	ICD-9 Date	Primary
344	OTH PARALYTIC SYNDROMES	12/27/2011	Yes

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

Figure 24

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