# APPENDIX Q

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
DEPARTMENT OF AGING
**OFFICE OF LONG-TERM LIVING**

PROVIDER SUPPORT
BUREAU

P.O. BOX 8025
HARRISBURG, PENNSYLVANIA 17105-8025

TELEPHONE (717) 772-2570
FAX (717) 772-0965

Dear Administrator:

This is to inform you that the Office of Long-Term Living (OLTL) will be initiating our bi-annual peer counselor assessment review in the near future as part of the Peer Counselor for Evaluation of Durable Medical Equipment (PCEDME) project. As in past years, the agency contracted by OLTL will provide a letter to your facility listing the names of targeted residents that meet the qualifications for the project. The Department compiled the list of the targeted residents from your May 1, 2013, Minimum Data Set (MDS) picture date. The list will target Medical Assistance (MA) residents who have a diagnosis of quadriplegia, paraplegia, cerebral palsy, multiple sclerosis, amyotrophic lateral sclerosis (ALS), or spina bifida. Please share a copy of this letter with your Social Services Department.

A peer counselor from the PCEDME project will directly contact the Director of Social Services to schedule an appointment to interview each resident on the list. The main purpose of the interviews is to determine if the targeted residents require additional or different Durable Medical Equipment (DME) to attain or maintain their highest practicable physical, mental, and psychosocial well-being. With the resident's permission, the resident will be asked questions regarding the DME currently provided to them. The peer counselor will determine the potential for additional or different DME to better meet the resident's individual needs.

The peer counselor may discuss the resident's services with you or your staff and may request additional information. After the information is gathered from the interviews and discussions, the peer counselor will complete a non-clinical assessment and share the recommendation of the assessment with targeted residents, your Social Services staff and OLTL.

You may decide to agree or disagree with the peer counselor's recommendation and the non-clinical assessment. Please see the enclosure and follow the appropriate steps based on your decision. Thank you in advance for cooperating with the peer counselor and ensuring that MA residents obtain the best quality of life.

Should you have any questions regarding this initiative or if you want to verify the peer counselor's authority to act on the OLTL's behalf, please contact Special Projects Unit (SPU) at 1-877-299-2918.

Sincerely,

Sallee Rowe
Director

**Enclosure**

Enclosure:

Upon receipt of the peer counselor's recommendation form, you must determine what action you need to take. The peer counselor will follow up by contacting you within seven (7) working days to ascertain your plan of action.

1. If you agree with the peer counselor's recommendation and the non-clinical assessment:
   - You must immediately arrange for the clinical assessment. A physical/occupational therapist or other qualified medical professional must perform the clinical assessment.
     - If a motorized wheelchair is needed, evaluations must be conducted at a facility that is certified by:
       - The Joint Committee on Accreditation of Healthcare Organizations (JCAHO). The website for JCAHO is: www.jcaho.org.
       - The Commission on Accreditation of Rehabilitation Facilities (CARF). The website for CARF is: www.carf.org.
     - If you must arrange for a clinical assessment at a certified evaluation facility on an outpatient basis, the MA program will reimburse the clinical assessment as an outpatient visit. However, you must submit the results of the clinical assessment to:

       Office of Long-Term Living
       Bureau of Provider Support
       PCEDME Project
       P.O. Box 8025
       Harrisburg, PA 17105-8025.

     - If the clinical assessment indicates the DME is medically necessary, your facility must provide the equipment to the resident.
       - To qualify for additional MA reimbursement, you must request a grant from OLTL, at the address above.
       - You must submit the Forms MA-97 and MA-97 LTC with all required documents, along with a copy of the resident's clinical assessment to the address on the front of the MA-97.
       - MA reimbursement will be determined after review by the staff in the OLTL's Exceptional Payment Unit (EPU). The requested DME must be exceptional as defined in the notice published in the Pennsylvania Bulletin on July 07, 2012.
       - If you need to receive a complete DME packet, call the EPU hotline number at 1-877-299-2918.

2. If you do not agree with the peer counselor's recommendation and the non-clinical assessment :
   - You must submit a written statement from the resident's attending physician and medical documentation justifying your decision to the SPU.
   - These documents must be received by the SPU within fifteen (15) working days from the date of the peer counselor's visit.
   - The SPU will review all documents and determine if the resident is receiving appropriate care and services in accordance with applicable requirements, including requirements of the Nursing Home Reform Law, and the Americans with Disabilities Act.
   - Additionally, the OLTL will also determine if further verification by the SPU staff and/or the Department of Health is necessary.

**Procedure for the Peer Counselor Recommendation Form**
**(Initial and Follow-up)**

Process:

1. Peer Counselor Recommendation Form must be completed electronically, written legibly or typed.
2. All components at top of form must be completed.
3. Form must not be altered.
4. Peer Counselor Recommendation form must be used for all initial interviews.
5. Peer Counselor Recommendation Follow-Up form must be used for all follow-up visits.
6. Peer Counselor Recommendation Follow-up form must be submitted for a telephone follow-up and identified as such.
7. Forms must be reviewed, signed and forwarded to OLTL by the project coordinator.
8. If the program is sub-contracted, the prime contractor must forward the forms to OLTL.
9. Send forms to:

DPW/OLTL/PCEDME
P.O. Box 8025
Harrisburg, Pennsylvania 17105

Or

Fax to OLTL/PCEDME at
(717) 346-1483

9/25/07

# INITIAL RECOMMENDATION FORM FOR PEER COUNSELORS

Date _____ Resident _____
Facility _____ Resident SSN _____
Address _____ Telephone Number _____
_____ County _____
_____

Peer Counselor _____
Contractor _____ Telephone Number _____

- ☐ Contact person _____ Telephone number _____
- ☐ Nursing Facility refuses peer counselor's visit
- ☐ Resident refuses peer counselor non-clinical assessment
- ☐ Resident's needs appear to be met—recommend no further action
- ☐ Current DME appears to not meet resident's needs
- ☐ Peer counselor/resident requests clinical assessment
- ☐ Resident refuses to have a clinical assessment
- ☐ MA 97/MA97 LTC forms and instructions given to Nursing Facility;
  Date/Administrator's name ___/___/___ _____
- ☐ Physician wrote order for clinical assessment
- ☐ Attending physician refuses to order clinical assessment
  Contact person _____ Telephone number _____
- ☐ Clinical assessment completed ___/___/___
  - ☐ No need for DME
  - ☐ DME needed
- ☐ MA97/MA97LTC submitted to OLTL ___/____/_____
- ☐ Nursing facility refuses to submit MA97/MA97 LTC forms
  Contact person _____ Telephone number _____
- ☐ Nursing facility uncooperative
- ☐ OLTL brochure given
- ☐ Initial form given to Nursing Facility ___/___/___

Comments _____
_____
_____

Return to: DPW, OLTL, PCEDME, P.O. Box 8025, Harrisburg, Pennsylvania 17105
1-877-299-2918 Fax: 717-346-1483

1/18/13

# FOLLOW-UP RECOMMENDATION FORM FOR PEER COUNSELORS

**Follow-up Date** _____ Resident _____
Facility _____ Resident SSN _____
Address _____ Telephone Number _____
_____ County _____
_____

Peer Counselor _____
Contractor _____ Telephone Number _____

- ❑ Telephone Follow Up
- ❑ Contact person _____ Telephone number _____
- ❑ Nursing Facility refuses peer counselor's visit
- ❑ Resident refuses peer counselor non-clinical assessment
- ❑ Resident's needs appear to be met—recommend no further action
- ❑ Peer counselor recommends clinical assessment
- ❑ Resident refuses to have a clinical assessment
- ❑ MA 97/MA97 LTC forms and instructions given to Nursing Facility;
  Date/Administrator's name _____/_____
- ❑ Physician writes order for clinical assessment
- ❑ Attending physician refuses to order clinical assessment
  Contact person _____ Telephone number _____
- ❑ Clinical assessment completed ___/___/___
  - ❑ No need for DME
  - ❑ DME needed
- ❑ MA97/MA97LTC submitted to OLTL ___/____/_____
- ❑ DME received (type) _____ Date _____
- ❑ Equipment is satisfactory – no further follow up
- ❑ Equipment is unsatisfactory – contact person at facility _____
- ❑ Nursing facility refuses to submit MA97/MA97 LTC forms
  Contact person _____ Telephone number _____
- ❑ Nursing facility uncooperative
- ❑ OLTL brochure given
- ❑ Follow-up form given to Nursing Facility ___/___/___

Comments _____

_____

_____

Date File Started

Last Name

First Name

NewResident

Recipient #

Facility

Provider #

County Code

ResTransfered

Contractor

NF Refused PC Visit

Resident refused PC interview

Needs Met

No Prior Assessment

Assessment Refused

NF Uncooperative

Dr Refused CA

Assessment Completed

DME Recommended

NF Refused to Submit Forms

DME received

Training for DME from NF

Satisfied with DM

DPW Follow Up

DPW Follow Up - 2:

DPW Follow Up - 3:

DPW Follow Up - 4:

DPW Follow Up - 5:

DPW Follow Up - 6:

DPW Follow Up - 7:

DPW Follow Up - 8:

DPW Follow Up - 9:

DPW Follow Up - 10

DPW Follow Up - 11:

DPW Follow Up - 12:

File Closed

Date of Death

Dual Program

Equipment Type:

Amount of Grant: $0.00

Comment

Information

**PCEDME PROCEDURE: PCEDME Monthly Reports**
(see attached)

Contractor must submit PCEDME Monthly Reports every month to DPW/OLTL.

Process:

1. PCEDME Monthly Report must be legibly written or typed.
2. Report must not be altered.
3. Report must be received by OLTL by the 15th day of the following month.
4. The PCEDME contractor must sign and send report.
5. If the program is sub-contracted, the prime contractor is responsible to forward the report to OLTL.
6. Send reports to:

Office of Long Term Living
Bureau of Quality & Provider Management
Division of Provider & Operations Management
Quality Assessment and Certification Section
PCEDME Program
555 Walnut Street, 6th Fl
Harrisburg, PA 17101-1919

Or

Fax to OLTL at (717) 772-0965.

Or

Reports may be emailed to:
(Name and email address)

3/28/13

# MONTHLY REPORT MONITORING

Purpose:

To ensure the contractor is completing and submitting the monthly report in the proper format. The monthly report is attached to the billing statement from the Contractor.

PCEDME Process:

1. Receive monthly report from contractors by the 15th of the following month.
2. Review monthly report for accuracy and proper completion.
3. If information is inaccurate, a phone call is placed or an email is sent to the contractor requesting additional information.

3/28/13

PCEDME Monthly Report

Due Date: 15th Day of following month

| Contractor | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S |
| DATE | # NF's WHO REFUSED P.C. INTERVIEW | # NF RESIDENTS WHO HAD INITIAL INTERVIEWS | # NF RESIDENTS WHO REFUSED INITIAL INTERVIEW | # NF RESIDENTS NOT IN NEED OF CLINICAL ASSESSMENT (CA) | # NF RESIDENTS RECOMMENDED FOR CA | ATTENDING PHYSICIANS WHO REFUSED TO ORDER CAs | # NF RESIDENTS WHO HAD CAs | # NF RESIDENTS WHO DIDN'T HAVE CAs | # NF RESIDENTS WHO DECLINED CAs | # FOLLOW-UPS PERFORMED | # NFs FILING RELATED PAPERWORK | # NFs REFUSING TO SUBMIT MA 97 PAPERWORK | DME ORDERED - WAITING FOR RECEIPT | # NF RESIDENTS THAT RECEIVED DME AND TRAINING FROM NF | # NF RESIDENTS SATISFIED WITH DME PROVIDED | # NF RESIDENTS NOT SATISFIED W/DME & NEED NEW CA | # TARGETED RESIDENTS NOT REACHED - TRANSFERRED OUT OF REGION | # NF TARGETED RESIDENTS DECEASED |
| | | | | | | | | | | | | | | | | | | |

4/14/09

Resident/contractor

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
DEPARTMENT OF AGING
**OFFICE OF LONG -TERM LIVING**
P.O. BOX 8025
HARRISBURG, PENNSYLVANIA 17105-8025

TELEPHONE (717) 772-2571
FAX (717) 772-0965

PROVIDER SERVICES
PROGRAM EXCEPTION

(Date)

Contractor

Re: Resident
NF name

Dear _____:

This letter is a follow-up to your PCEDME Recommendation form for the above named resident that was completed on (Date). As a result of your referral, the Department was able to address the recommendations of the peer counselor.

- ☐ The nursing facility administrator submitted the MA-97 and MA-97LTC forms to the Program Exception Section.
- ☐ The nursing facility Medical Doctor provided written documentation from the resident's evaluation that DME is not recommended and resident's appropriate medical **needs are being met.**
- ☐ The nursing facility administrator provided information that equipment has been ordered for the resident.
- ☐ Other: **Case is being closed.**

Thank you for your recommendations. If you have any questions, please contact me at 1-877-299-2918.

Sincerely,

(Name)
Peer Counselor Evaluation for Durable Medical Equipment Monitor

cc: NF Administrator

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
DEPARTMENT OF AGING
**OFFICE OF LONG-TERM LIVING**

PROVIDER SERVICES
PROGRAM EXCEPTION

P.O. BOX 8025
HARRISBURG, PENNSYLVANIA 17105-8025

TELEPHONE (877) 299-2918
FAX (717) 346-1483

(Date)

Administrator and
Address

Re: Resident
Ma # xxxxxxxxxx

Dear Mr. (Name):

This letter is in reference to the PCEDME peer counselor's non-clinical assessment and the Durable Medical Equipment (DME) recommendation for the above named resident. The recommendation form was given to you and you were to take one of the following actions. A letter was sent to all Administrators explaining the Peer Counselors for Evaluation of Durable Medical Equipment (PCEDME) program.

If you agreed, you were to immediately arrange for a clinical assessment. A physical/occupational therapist or appropriate qualified medical professional should perform the clinical assessment. The clinical assessment for a motorized wheelchair must be completed at one of the Department's certified evaluation facilities (a list may be obtained from the peer counselor or call us). When completed, you must submit the results of clinical assessment to the Bureau of Provider Support, Program Exception Section.

If you did not agree, you were to submit a written statement from the resident's attending physician and medical documentation justifying your decision to the Bureau of Provider Support, Program Exception Section, within fifteen (15) business days from the date of the peer counselor's visit. To date, we have not received a statement and medical documentation from the attending physician.

Please review the options listed above and the resident's plan of care. Forward your plan of action in writing within seven (7) business days from the date of this letter to:

Office of Long Term Living
Bureau of Quality & Provider Management
Division of Provider & Operations Management
Quality Assessment and Certification Section
PCEDME Program
555 Walnut Street, 6th Fl
Harrisburg, PA 17101-1919

If you have any questions, please call 1-877-299-2918 or fax information to (Name) at 717-772-0965.

Sincerely,

(Name), HSPS

Resident/contractor

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
DEPARTMENT OF AGING
**OFFICE OF LONG-TERM LIVING**

PROVIDER SERVICES
PROGRAM EXCEPTION

P.O. BOX 8025
HARRISBURG, PENNSYLVANIA 17105-8025

TELEPHONE (877) 299-2918
FAX (717) 346-1483

(Date)

Administrator
NF and address

Re: Resident
Ma # xxxxxxxx

Dear Mr. )Name):

This is a follow up to my (Date) correspondence regarding your plan of action for the above named resident. The Department requested written documentation defining your plan of action. The written documentation was due to be submitted by (Date). It has not been received.

As a participant in Pennsylvania's Medical Assistance (MA) Program, your facility is required to provide such nursing facility services as are necessary to allow your MA residents to attain or maintain their highest practicable level of physical, mental, and psychosocial well-being. 42U.S.C. §§ 1396r(b)(2) and 1396r(b)(4)(A). This obligation includes providing such Durable Medical Equipment (DME) as is necessary in order to achieve this result. 55 Pa. Code § 1187.51(c)(5). This obligation exists regardless of whether the DME in question is "exceptional" or "specially adapted", or if your facility receives a grant approving additional reimbursement. Thus, if the DME is determined to be medically necessary, but not specially adapted or exceptional, then it is the nursing facility's responsibility to provide such DME to the resident.

Since the Department has not received the written documentation that defines your plan of action provided to the above-named resident, this omission is a violation of the provider agreement the nursing facility has signed with the Department for providing required nursing facility services to the resident.

**If we do not receive the written documentation defining your plan of action for the resident within seven (7) business days from the date of this letter, the violation will be referred to the Department of Health for further investigation.**

Should you have any questions, please contact us at 1-877-299-2918.

Sincerely,

(Name)
Peer Counselor Evaluation for Durable Medical Equipment Monitor

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
DEPARTMENT OF AGING
**OFFICE OF LONG-TERM LIVING**
P.O. BOX 8025
HARRISBURG, PENNSYLVANIA 17105-8025

PROVIDER SERVICES
PROGRAM EXCEPTION

TELEPHONE (877) 299-2918
FAX (717) 346-1483

(Date)

Contractor

Re: Resident
MA # xxxxxxxxxx

Dear _____:

Enclosed is the Department's medical necessity letter for the above-named resident. By (date), the Peer Counselor should contact the nursing facility to verify the DME has been provided to the resident.

Should you have any questions, please contact me at 1-877-299-2918.

Sincerely,

(Name)
Peer Counselor Evaluation for Durable Medical Equipment Monitor

Enclosure

# COMMONWEALTH OF PENNSYLVANIA
# DEPARTMENT OF PUBLIC WELFARE
# MEDICAL ASSISTANCE PROGRAMS

## OUTPATIENT SERVICES AUTHORIZATION REQUEST
## MA 97

Detailed instructions for completing the MA 97 for either prior authorization - or - 1150 Waiver are on the reverse of this sheet for your convenience as they relate to each section of the form.

When the form is completed, remove this sheet at the perforation. Then, remove the first copy of the MA 97 and send it to the appropriate address as indicated below. For those services which require a prescription, attach a copy of the Rx to the MA 97. Retain the second copy for your record.

**FOR SHIFT NURSING OUTPATIENT SERVICES, SEND TO:**

**OUTPATIENT**
**PA / 1150 WAIVER SERVICES**
**PO BOX 8188**
**HARRISBURG, PA 17105-8188**

**FOR ALL OTHER OUTPATIENT SERVICES, SEND TO:**

**OUTPATIENT**
**PA / 1150 WAIVER SERVICES**
**PO BOX 8188**
**HARRISBURG, PA 17105-8188**

**PLEASE TURN TO INSTRUCTIONS ON REVERSE**

# GUIDELINES FOR COMPLETING THE OUTPATIENT SERVICE AUTHORIZATION REQUEST FORM (MA97)

Items 1 & 2 Prior Authorization/1150 Waiver (Program Exception) (MUST, IF APPLICABLE)

Place a check (✓) in the appropriate box for the type of request. Check only ***one*** box per MA 97. If both types of requests are required, ***separate MA 97s*** must be completed for each type of request.

**PATIENT INFORMATION**

Items 3 through 6 are to be completed using information obtained from the Eligibility Verification System (EVS).

Item 3 Recipient Number (MUST)

Enter the 10-digit recipient identification number.

Item 4 Patient's Name (Last, First, MI) (MUST)

Enter the recipient's last name, first name, and middle initial (if any).

Item 5 Birthdate (mmddccyy) (MUST)

Enter the recipient's birthdate in an 8-digit format.

Item 6 Sex (OPTIONAL)

Check the appropriate box, "M" (male) or "F" (female).

**PROVIDER/PRESCRIBER INFORMATION**

Items 7 through 11 are to be completed using the information found on the provider's PROMISe™ Provider Enrollment Notice Information.

Item 7 Provider Name (MUST)

Enter the provider's last name, first name, and middle initial (if any).

Item 8 Provider ID (MUST)

Enter the provider's 13-digit PROMISe™ Provider ID Number.

Item 9 Provider's Own Reference No. (OPTIONAL)

Enter your own reference number or recipient's name to comply with the provider's filing system.

Items 10 through 11 will only be completed if the payment for services will be sent to someone other than the provider of services. A group/payee must be enrolled with DPW.

Item 10 Group (Payee) Name (MUST, IF APPLICABLE)

Enter the name of person, group, or organization designated to receive payment.

Item 11 Group ID NUMBER (MUST, IF APPLICABLE)

Enter the payee's 13-digit PROMISe™ Provider ID Number.

Items 12 through 15 refer to the Referring Practitioner/Prescriber, if applicable.

Item 12 Name of Referring Practioner or Prescriber (MUST, IF APPLICABLE)

Enter the name of the referring practioner/prescriber, if applicable. Enter the first name, middle initial (if any) and last name, followed by degree.

Item 13 License Number (MUST, IF APPLICABLE)

Item 14 Telephone Number (MUST, IF APPLICABLE)

Enter the referring practitioner's/prescriber's telephone number, including area code. The referring/prescribing practitioner may be contacted if additional information is needed by DPW.

Item 15 Practitioner's/Prescriber's Street Address/City/State/Zip Code (MUST, IF APPLICABLE)

Enter the referring practioner's/prescriber's street address to which the approval or itemized notice is to be mailed. Make sure the address is correct and complete.

Item 16 Primary Diagnosis (MUST)

Enter the recipient's primary diagnosis. For dental services, this item is LEAVE BLANK.

Item 17 ICD-9-CM Diagnosis Code (MUST)

Enter the ICD-9-CM Diagnosis Code that corresponds to the primary diagnosis entered in item 16. For Mental Health requests, use the DSM-IV Code. For dental services, this item is LEAVE BLANK.

Item 18 Secondary Diagnosis (MUST, IF APPLICABLE)

If applicable, enter the recipient's secondary diagnosis. For dental services, this item is LEAVE BLANK.

Item 19 ICD-9-CM Diagnosis Code (MUST, IF APPLICABLE)

Enter the ICD-9-CM Diagnosis Code that corresponds to the secondary diagnosis entered in item 18. For Mental Health requests, use the DSM-IV Code. For dental services, this item is LEAVE BLANK.

**REQUESTED SERVICES** (Items 20A through 29)

When requesting a single item or service, complete the appropriate items in Items 20A through 20G as follows:

Item 20A Description of Services/Supplies Requested (MUST)

Enter a description of the service/equipment/item, or use the DPW procedure name terminology found in the MA Program Fee Schedule. For dental services, use the appropriate CDT-4 procedure name terminology and procedure code, if available.

Prior Authorized Services Only (Item 1 was checked)

Item 20B Procedure Code (MUST, IF AVAILABLE)

Enter the 5-digit procedure code, if available, for the service/equipment/item requested. For dental services, this item is LEAVE BLANK.

Item 20C Must if applicable. Indicate pricing modifiers in block 1. If no pricing modifiers are needed, then enter additional modifiers starting with block 1. Use blocks 2, 3 and 4 to report any additional modifiers.

Item 20D Quantity (MUST)

Enter the exact units of service or number of items being requested. For dental services, this item is LEAVE BLANK.

1150 Waiver Services Only (Item 2 was checked)

Item 20E Amount Per Unit (MUST)

Enter the exact dollar amount requested for each service requested.

Item 20F Quantity Per Unit (MUST)

Enter the exact quantity of services requested for each month.

Item 20G Number of Months (MUST)

Enter the number of months for which the services are requested. For dental services, this item is LEAVE BLANK.

Items 21 through 25 are available for additional requested services/equipment /items and must be competed as described in 20A through 20G. **NOTE:** *FOR PRIOR AUTHORIZATION* ***ONLY****, USE ONE LINE FOR EACH MONTH BEING REQUESTED.*

Item 26A Estimated Length of Need (No. of Months) (MUST, IF APPLICABLE)

If the service will be needed over a period of months, enter the # of months the recipient is expected to need the services. Enter 1-99 (99=Lifetime).

Item 26B Initial Date of Service (MMDDCCYY) (MUST, IF APPLICABLE)

Enter the date the most recent uninterrupted service period began. For dental services, this item is LEAVE BLANK.

Item 26C Beginning Date of Service for This Request (MMDDCCYY) (MUST)

Enter the date that the service being requested is scheduled to begin using an 8-digit format. If the service will be provided only once, enter the date the service will be provided.

Item 27 What Other Alternatives Have Been Tried or Used to Meet This Patient's Needs? (MUST).

Attach documentation, as needed, of alternatives which have been tried and justify the need for the service(s) requested - 20A through 25H. If no alternatives have been tried or used, indicate "N/A".

Item 28 Check the Box Which Applies to This Patient's Current Residential Status (MUST).

Check the appropriate box to indicate where the recipient resides.

Item 29 Give a Narrative Description of the Specific Symptoms or Abnormalities the Service/Equipment/Supplies are Intended to Alleviate. Provide the Medical Justification Needed for the Evaluation of This Request. (MUST)

This item must contain sufficient documentation to justify the medical necessity for all requested services. If additional space is needed, please attach additional sheets of paper. The additional pages should be 8 ½ x 11.

For dental services, the Program Exception request must be performed as part of a complete dental treatment program and must be accompanied by a detailed treatment plan. The treatment plan must include all of the following:

1. pertinent dental history;
2. pertinent medical history, if applicable;
3. the strategic importance of the tooth;
4. the condition of the remaining teeth;
5. the existence of all pathological conditions;
6. preparatory services performed and completion date(s);
7. documentation of all missing teeth in the mouth;
8. the oral hygiene of the mouth;
9. all proposed dental work;
10. identification of existing crowns, periodontal services, etc.;
11. identification of the existence of full and/or partial denture(s), with the date of initial insertion;
12. the periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality and prognosis;
13. identification of abutment teeth by number.

**NOTE**: *FOR THOSE SERVICE PROGRAMS WHERE DENTAL SERVICES ARE LIMITED TO SERVICES PROVIDED IN AN INPATIENT HOSPITAL, HOSPITAL SHORT PROCEDURE UNIT OR AMBULATORY SURGICAL CENTER, PLEASE INCLUDE A STATEMENT IDENTIFYING WHERE THE SERVICE WILL BE PROVIDED.*

When requesting Mental Health services, all of the following clinical information from the prescribing mental health professional (psychologist/psychiatrist) is essential in order to establish the clinical necessity for the services:

1. current psychological/psychiatric evaluation including DSM-IV ACIS I-V (within 30 or 45 days from date of request);
2. current treatment plan;
3. plan of care summary;
4. service description (unless approved and on file; attach copy of approval letter)

Item 30 Number of Attachments (MUST, IF APPLICABLE)

Indicate the number of attachments, including radiographs, that are being submitted with the MA 97. For example, if you attached two additional pages to include additional treatment plan information and a Panorex, you would enter a "3".

Item 31 & 32 Inital Request/Resubmission of Previously Denied Request (MUST, IF APPLICABLE)

If this is the initial request, enter an "X" in Item 31. If this is a resubmission of a previously denied request, enter an "X" in Item 32 and the previously denied Prior Authorization/Program Exception Reference Number from the "Prior Authorization Notice" or "Program Exception Notice" in the space provided.

Item 33 Signature of Patient/Authorized Representative (MUST)

The patient or authorized representative MUST sign the MA 97.

Item 34 Date (MUST)

The patient or authorized representative must enter the date the MA 97 was signed in 8-digit format (mmddccyy).

Item 35 Practioner's/Prescriber's Signature (MUST)

It is essential that the practioner requesting the service/item sign or use his/her signature stamp on the MA 97.

Item 36 Date (MMDDCCYY) (MUST)

The practitioner must enter the date the MA 97 was completed in 8-digit format.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

LEAVE THIS AREA BLANK

# OUTPATIENT SERVICES AUTHORIZATION REQUEST

1 ☐ PRIOR AUTHORIZATION  2 ☐ 1150 WAIVER (PROGRAM EXCEPTION)

## PATIENT INFORMATION

| 3 RECIPIENT NUMBER | 4 PATIENT LAST NAME | FIRST NAME | M.I. | 5 BIRTHDATE | 6 ☐ M ☐ F |
|---|---|---|---|---|---|
| | | | | | |

## PROVIDER / PRESCRIBER INFORMATION

| 7 PROVIDER NAME | | 8 PROVIDER ID | | 9 PROVIDER'S OWN REFERENCE NUMBER | |
|---|---|---|---|---|---|
| 10 GROUP NAME | | 11 GROUP ID NUMBER | | | |
| 12 NAME OF REFERRING PRACTITIONER OR PRESCRIBER | | 13 LICENSE NUMBER | | 14 TELEPHONE NUMBER | |
| 15 PRACTITIONER'S / PRESCRIBER'S STREET ADDRESS | | CITY | | STATE | ZIP CODE |
| 16 PRIMARY DIAGNOSIS | 17 ICD-9CM/DSM-IV CODE | 18 SECONDARY DIAGNOSIS | | 19 ICD-9CM/DSM-IV CODE | |

## REQUESTED SERVICES

| A DESCRIPTION OF SERVICES/SUPPLIES REQUESTED | FOR PRIOR AUTHORIZED SERVICES ONLY | | | | | | FOR 1150 WAIVER ONLY | | |
|---|---|---|---|---|---|---|---|---|---|
| | B PROCEDURE CODE | C MODIFIER MOD 1 | MOD 2 | MOD 3 | MOD 4 | D QUANTITY | E AMOUNT PER UNIT | F QUANTITY PER MONTH | G NUMBER OF MONTHS |
| 20 | | | | | | | | | |
| 21 | | | | | | | | | |
| 22 | | | | | | | | | |
| 23 | | | | | | | | | |
| 24 | | | | | | | | | |
| 25 | | | | | | | | | |

26 A ESTIMATED LENGTH OF NEED (No. of Months): 1-99 (99= Lifetime) ▶ | B INITIAL DATE OF SERVICE ▶ | C BEGINNING DATE OF SERVICE FOR THIS REQUEST ▶

27 WHAT OTHER ALTERNATIVES HAVE BEEN TRIED OR USED TO MEET THIS PATIENT'S NEEDS?

28 CHECK THE BOX WHICH APPLIES TO THIS PATIENT'S CURRENT RESIDENTIAL STATUS:
☐ LONG TERM CARE ☐ MENTAL HEALTH ☐ RESIDENTIAL ☐ FOSTER CARE ☐ INPATIENT HOSPITAL ☐ HOME
☐ OTHER IF IN A FACILITY, PLEASE LIST THE NAME TO THE RIGHT_____

29 GIVE A NARRATIVE DESCRIPTION OF THE SPECIFIC SYMPTOMS OR ABNORMALITIES THE SERVICE/EQUIPMENT/SUPPLIES ARE INTENDED TO ALLEVIATE. PROVIDE THE MEDICAL JUSTIFICATION NEEDED FOR THE EVALUATION OF THIS REQUEST.

30 NUMBER OF ATTACHMENTS ▶

31 ☐ INITIAL REQUEST

32 ☐ RESUBMISSION OF PREVIOUSLY DENIED REQUEST
ENTER DENIED PA/PE REFERENCE NUMBER

I ATTEST THAT IN MY PROFESSIONAL JUDGEMENT, ACTING WITHIN THE SCOPE OF MY PROFESSIONAL TRAINING AND CERTIFICATION, THAT THE PRESCRIBED SERVICE AS DEFINED ON THIS FORM IS MEDICALLY NECESSARY AND THAT THE INFORMATION PROVIDED AND STATEMENTS MADE HEREIN ARE TRUE, ACCURATE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

I AUTHORIZE RELEASE OF INFORMATION RELATIVE TO THIS REQUEST

33 SIGNATURE OF PATIENT / AUTHORIZED REPRESENTATIVE

34 DATE

35 PRACTITIONER / PRESCRIBER SIGNATURE

36 DATE



**DPW COPY**

# DURABLE MEDICAL EQUIPMENT (DME) REQUEST FOR NURSING FACILITY RESIDENT

| NURSING FACILTY NAME: | SERVICE PROVIDER ID - SERVICE LOCATION NUMBERS: |
|---|---|
| AUTHORIZED REPRESENTATIVE: | AUTHORIZED REPRESENTATIVE ADDRESS: |

The following checklist is to be used to assist you in submitting documentation for your Durable Medical Equipment (DME) request. Please attach these items, in the order listed, to the Outpatient Services Authorization Request (MA 97).

- This form, MA 97LTC, with the Attestation portion completed, signed, and dated;
- A copy of the attending physician's prescription for the DME;
- The recipient's acknowledgement and/or consent, if possible;
- Current medical information of the client;
- If request is for a motorized wheelchair, include the original "Consideration for Motorized Wheelchair Prescription," and the wheelchair evaluation performed by a certified rehab facility stating what equipment is requested and what it will achieve for the resident;;
- Procedure codes with MSRP pricing;
- List equipment tried and describe why it is not satisfactory to meet the resident's needs. Also, include documentation as to how services are provided currently and what alternatives are presently being employed;
- The most recent annual and quarterly MDS; and
- Any other information that supports your request

**Evidence that other forms of insurance have been exhausted, including HMO, Managed Care and Medicare will be required at the time of submission of the Medical Services Invoice (CMS 1500).**

In your request for DME for your resident, you must sign the attestation and include all of the information listed above. Incomplete or missing information may result in processing delays of your request.

**ATTESTATION**:

I attest that I have reviewed the attached Outpatient Services Authorization Request (MA 97) requesting authorization for DME for:

_____ ,a resident of
_____ (name of nursing facility)
_____ (provider number).

Admission Date:_____Date of MA Eligibility:_____
Authorized staff of_____(nursing facility) completed, or provided the information necessary to complete, fields 32 and 34 on the MA 97, and provided the related attachments. The DME supplier is not a related party as defined in Chapter §1187.2.

_____ _____

NURSING HOME ADMINISTRATOR'S SIGNATURE DATE