Optum

Service Authorization Submission 101

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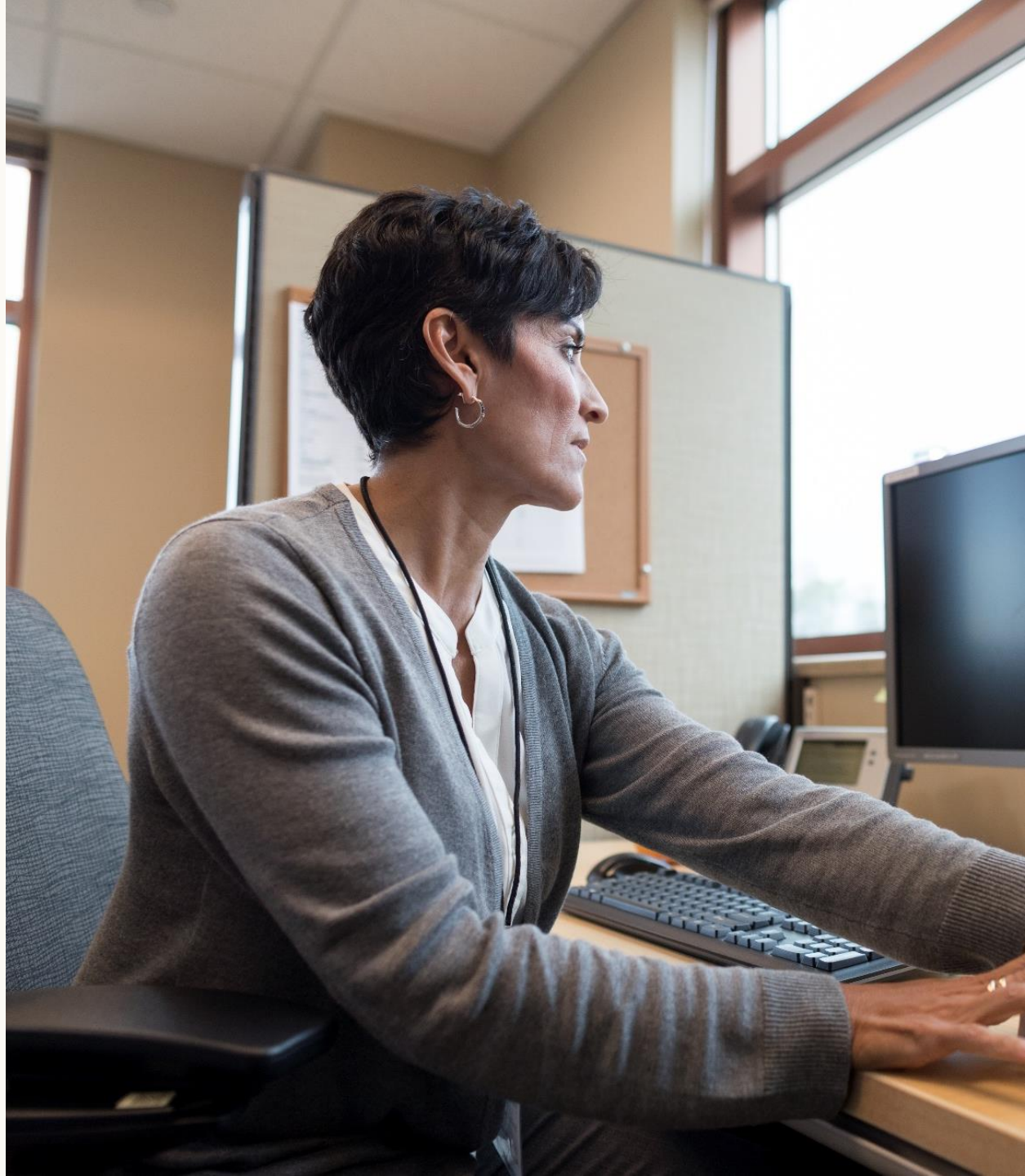
Optum Alaska

April 13, 2022



Agenda / Objectives

1. Overview of Medical Necessity
2. Level of Care Guidelines
3. Service Authorization Process/Electronic and Fillable PDF Submissions
4. Questions and Answers

The Right Service at the Right Time

- Person-centered and developmentally sensitive
- Clinically effective
- Least restrictive level of care
- Accessible to individual without causing undue hardship or prolonged separation from community and family

Medical Necessity

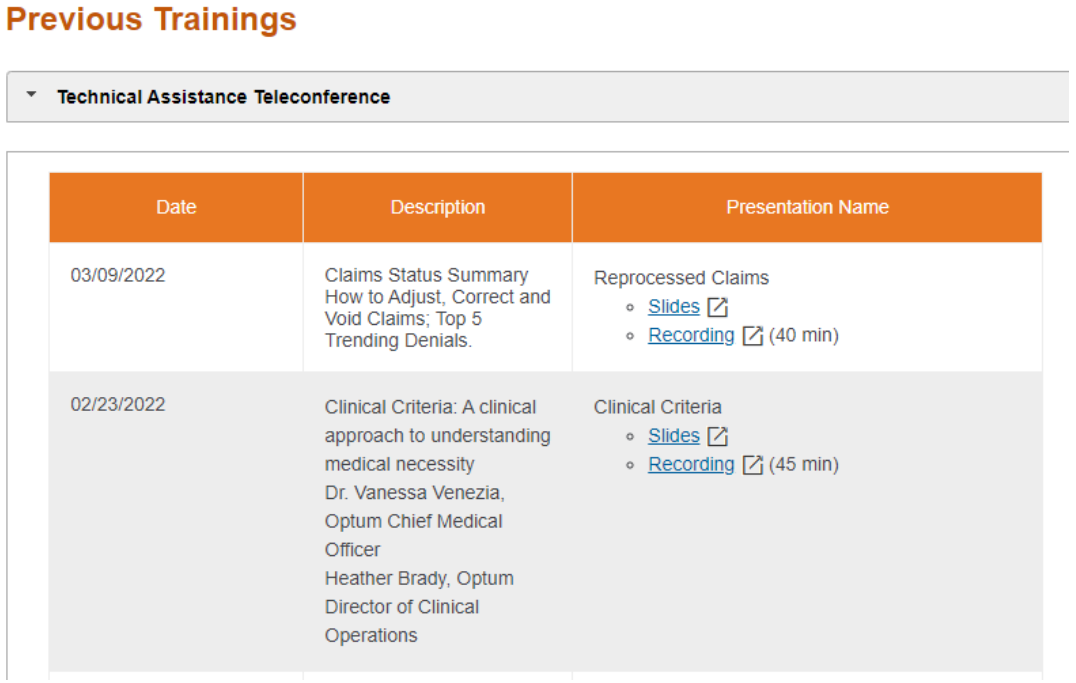
Is used to determine what is the appropriate level of care given an individual's unique set of medical or behavioral health circumstances.

Why are medical necessity evaluations required?

- Improve the Quality of Care:
  - Organize clinical observations
  - Objective frame for evaluating risks and resiliencies of the person being evaluated
- Audits/Compliance
- Financial Sustainability

For previous training on medical necessity, please visit:

https://alaska.optum.com/content/ops-alaska/alaska/en/providers/provider-trainings.html



Level of Care Guidelines

Optum Alaska will review service authorization requests using evidence-based level of care clinical guidelines approved for use by the Alaska Division of Behavioral Health:

- **ASAM:** The American Society for Addiction Medicine (ASAM) Criteria® adults and adolescents presenting with substance use disorders
- **LOCUS:** The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) by the American Association of Community Psychiatrists for adults,18 and older, with behavioral health disorders
- **CAL-LOCUS/CASI :** The Child and Adolescent Service Intensity Instrument by the American Academy of Child and Adolescent Psychiatry, for children, 6 to 18 with behavioral health disorders
- **ECSII:** The Early Childhood Service Intensity Instrument (ECSII), published by The American Academy of Child and Adolescent psychiatry for young children from birth to age 5.

The ASAM Criteria®: Dimensions

1: Acute Intoxication and/or Withdrawal Potential

- Current withdrawal symptoms
- Past history of serious, life-threatening withdrawal

2: Biomedical Conditions/Complications

- Current health problems
- Medication interaction, abnormal labs

3: Emotional/Behavioral/Cognitive Conditions and Complications

- Presence of other psychiatric diagnosis, symptoms or behaviors
- Mental status and level of functioning

4: Readiness to Change

- Coerced, mandated, required assessment/treatment
- Motivation factors for treatment

5: Relapse/Continued Use/Continued Problem Potential

- Potential relapse triggers/relapse plan
- Past treatment results

6: Recovery Environment

- Immediate threats to safety, well-being, sobriety
- Availability and utilization of support systems

Level of care instruments for BH medical necessity determination

Level of Care Utilization System – LOCUS©	Early Childhood Service Intensity Instrument – ECSII©	Child and Adolescent Service Intensity Instrument – CALOCUS/CASII©
• Adults, 18+ • American Association for Community Psychiatrist (AACP)	• Birth to 6 years • American Academy for Child and Adolescent Psychiatry (AACAP) • Published 2009	• 6 to 18 years • American Academy for Child and Adolescent Psychiatry (AACAP). • Updated from CA-LOCUS, 2009 • Version 4.1, 2018

BH Medical Necessity Criteria (MNC) functional dimensions

I: Risk of Harm

- Suicidal, Homicidal, Self-Harming or Violent Ideation, Intent or Plan
- Past history of serious, high risk behavior posing risk to self or others

II: Functional Status

- Capacity for self-care
- Ability to fulfill social responsibilities

III: Co-Occurring Conditions

- Presence and acuity of co-morbid conditions
- Impact of comorbid condition on presenting problem

IV: Recovery Environment

- Level of Stress: Presence of psychosocial stressors
- Level of Support: Availability and utilization of support systems

V: Treatment and Recovery History

- History of mental health challenges
- Response to prior treatment

VI: Response to Treatment and Recovery Status

- Understanding of mental health condition
- Willingness to engage in treatment

Matching risk to level of care - a high level crosswalk

NOTE: This slide is to illustrate examples and is NOT prescriptive

Risk Level	ASAM/SUD	Behavioral Health

• Low Risk- Recovery and Health Maintenance
• Moderate Risk
• High Risk
• Very High Risk
• Secure Monitored
	• ASAM 1.0 Outpatient services
	• ASAM 2.1 Intensive Outpatient; SUD Care coordination; ICM
	• ASAM 2.5- PHP
	• ASAM 3.1/3.3/3.5
	• ASAM 3.7/4.0
		• LOCUS/CASII 10-16; ESCII 9-17
		  • Treatment plan and review; psychotherapy services; HBFT level 1 or 2
		• LOCUS/CASII 17-19; ESCII 18-22
		  • BH IOP; HBFT level 3; ICM
		• LOCUS/CASII 20-23; ESCII 23-26
		  • BH PHP, ACT, TTH
		• LOCUS/CASII 23-17; ESCII 27-30
		  • Adult/Children's MH Residential level 1 or 2
		• LOCUS/CASII 28+
		  • Locked residential vs acute inpatient
		  • This level not available for ESCII

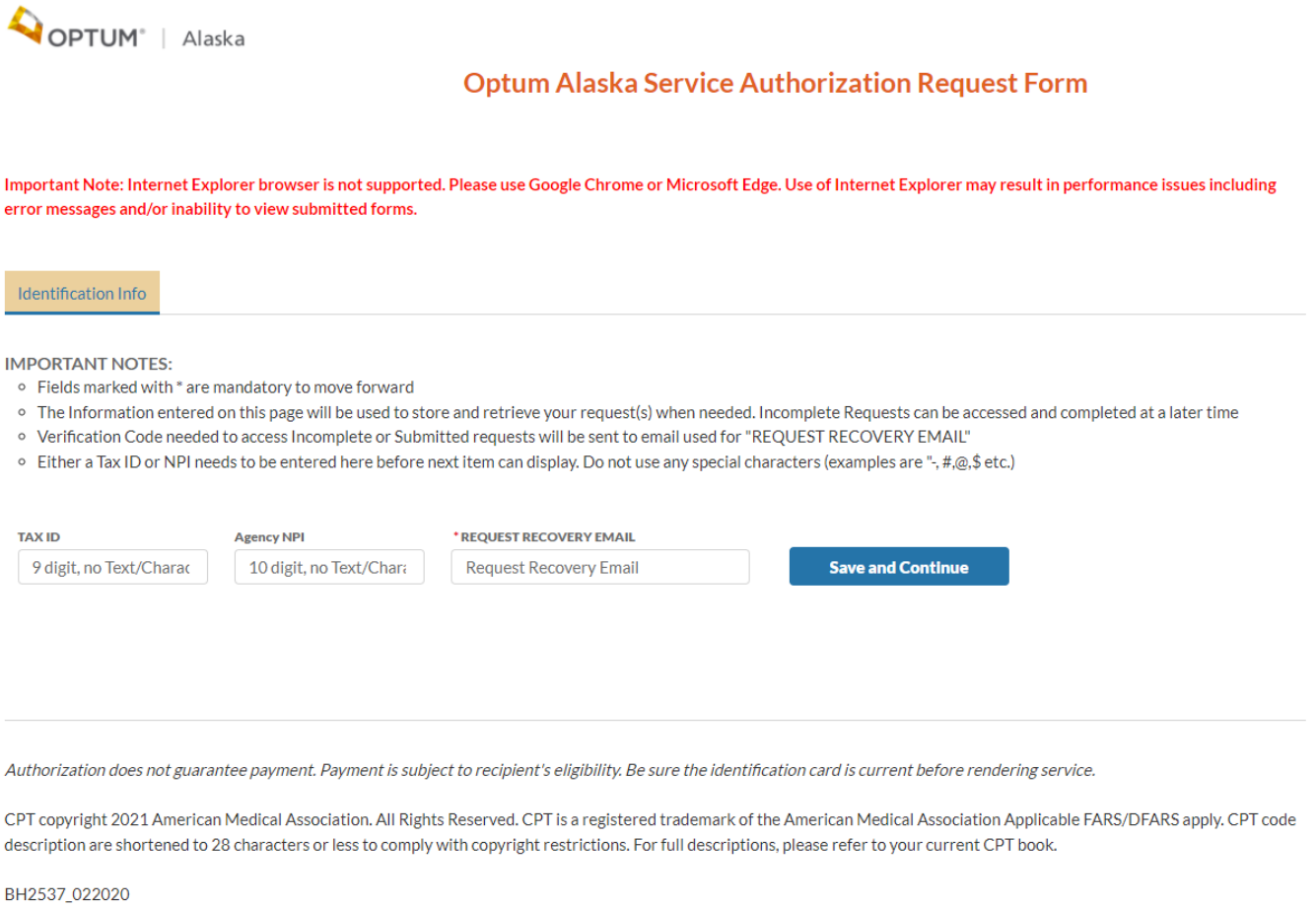
How to Submit Service Authorizations

https://alaska.optum.com/content/ops-alaska/alaska/en/providers/Service-Authorizations.html

- Online
- Fillable Form

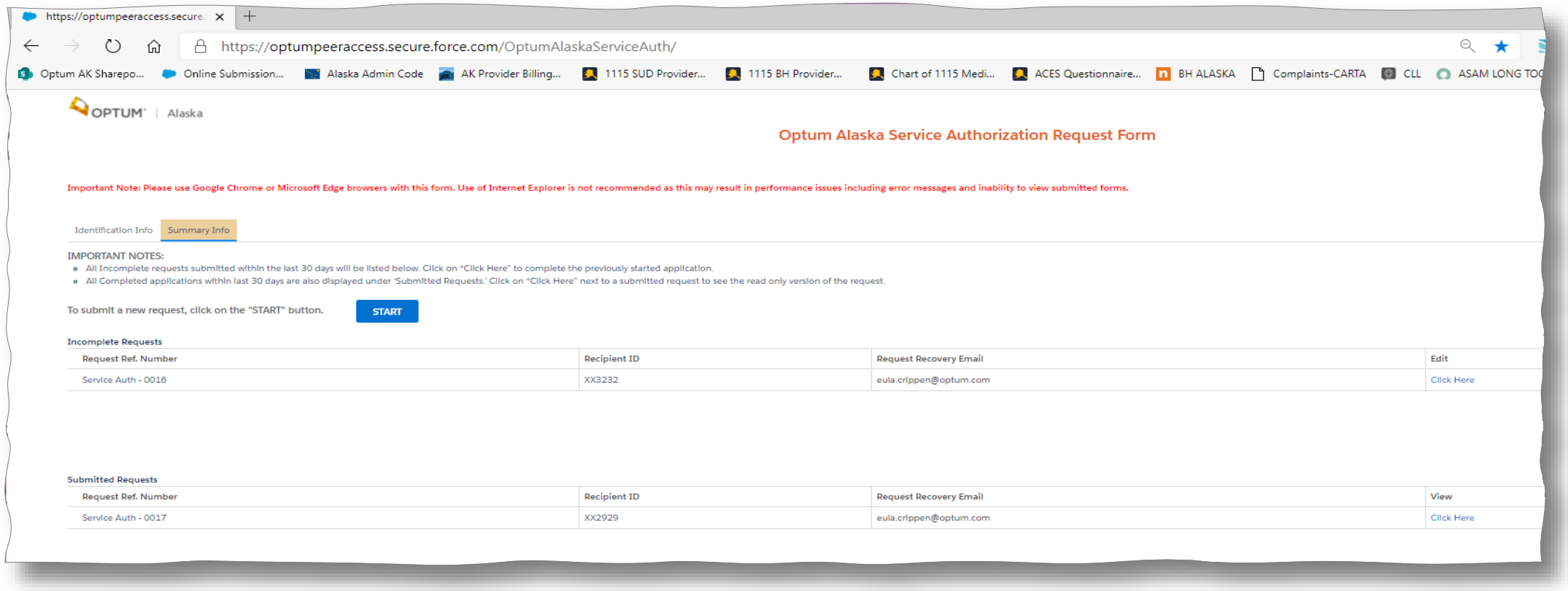
How to get started with an Online Service Authorization request submission

Sign In: Provide Tax ID OR Agency NPI. We only need one. We will communicate with you through the email you provide on this form.



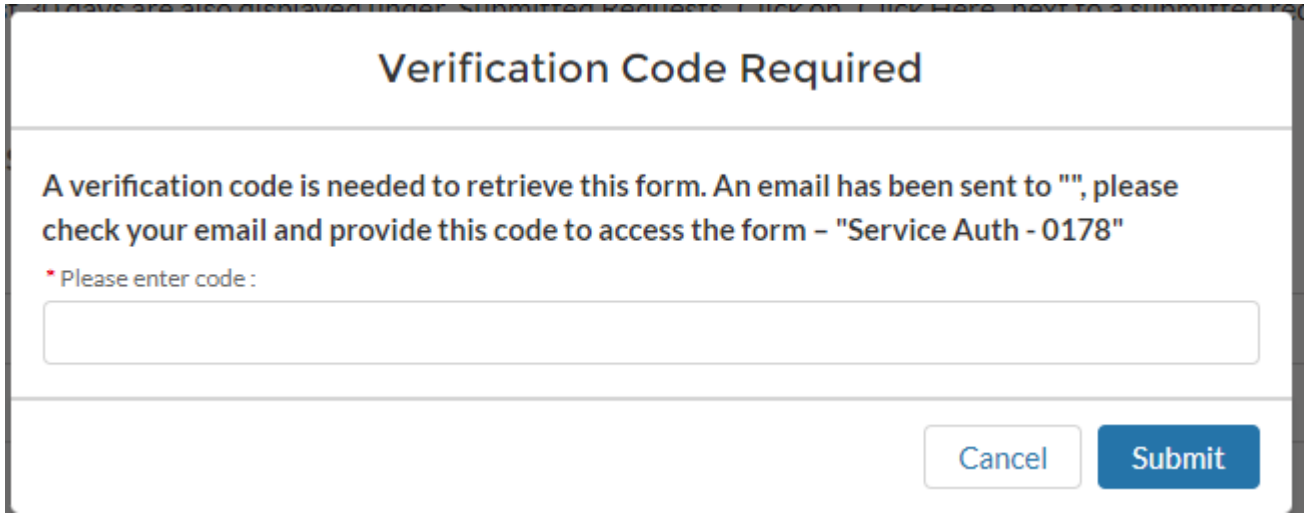
Service authorization summary info

On this page, you will find all the service authorization requests submitted for this Tax ID or NPI.

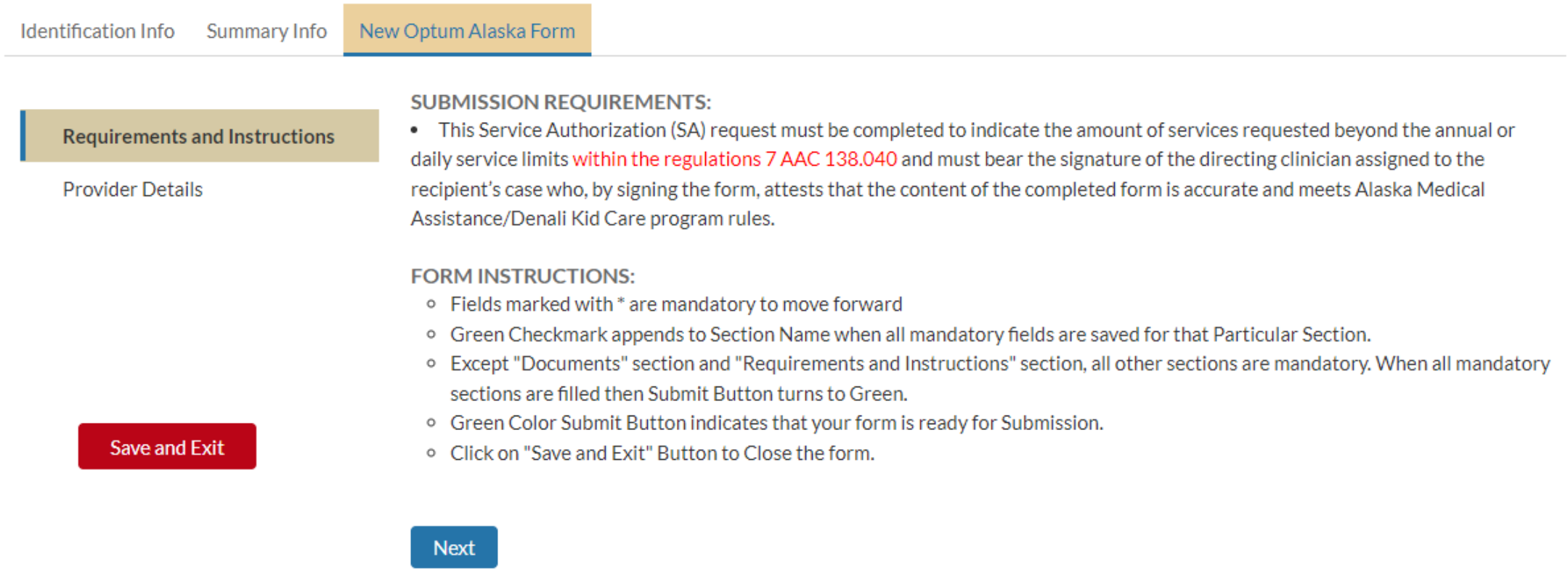


Service authorization summary info

Service authorizations will be “Complete” or “Incomplete.” You can access them by following the link “Click Here.” When you click, an email will be immediately sent with a verification code. You must enter the verification code to continue.

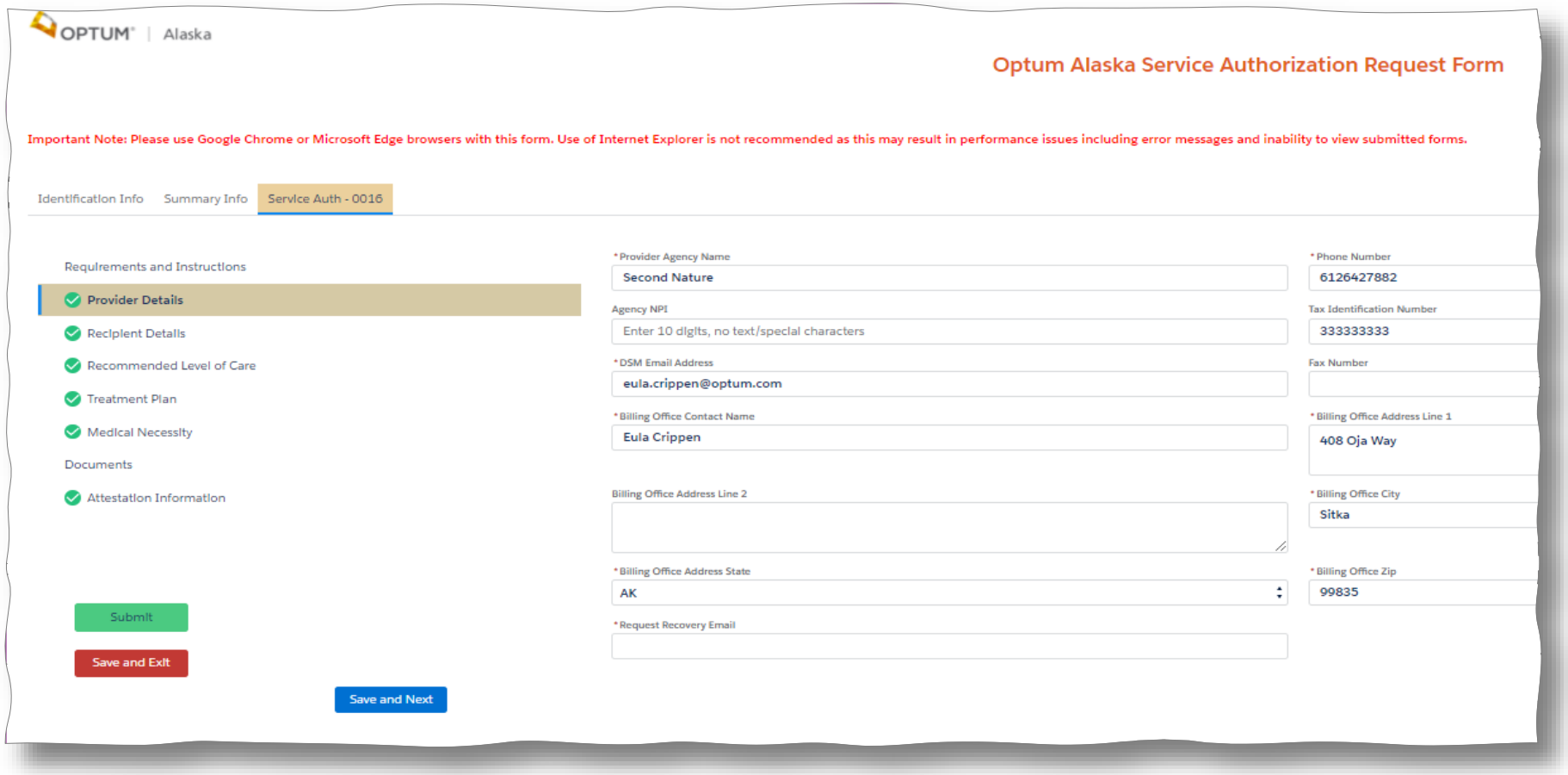


Submission Instructions



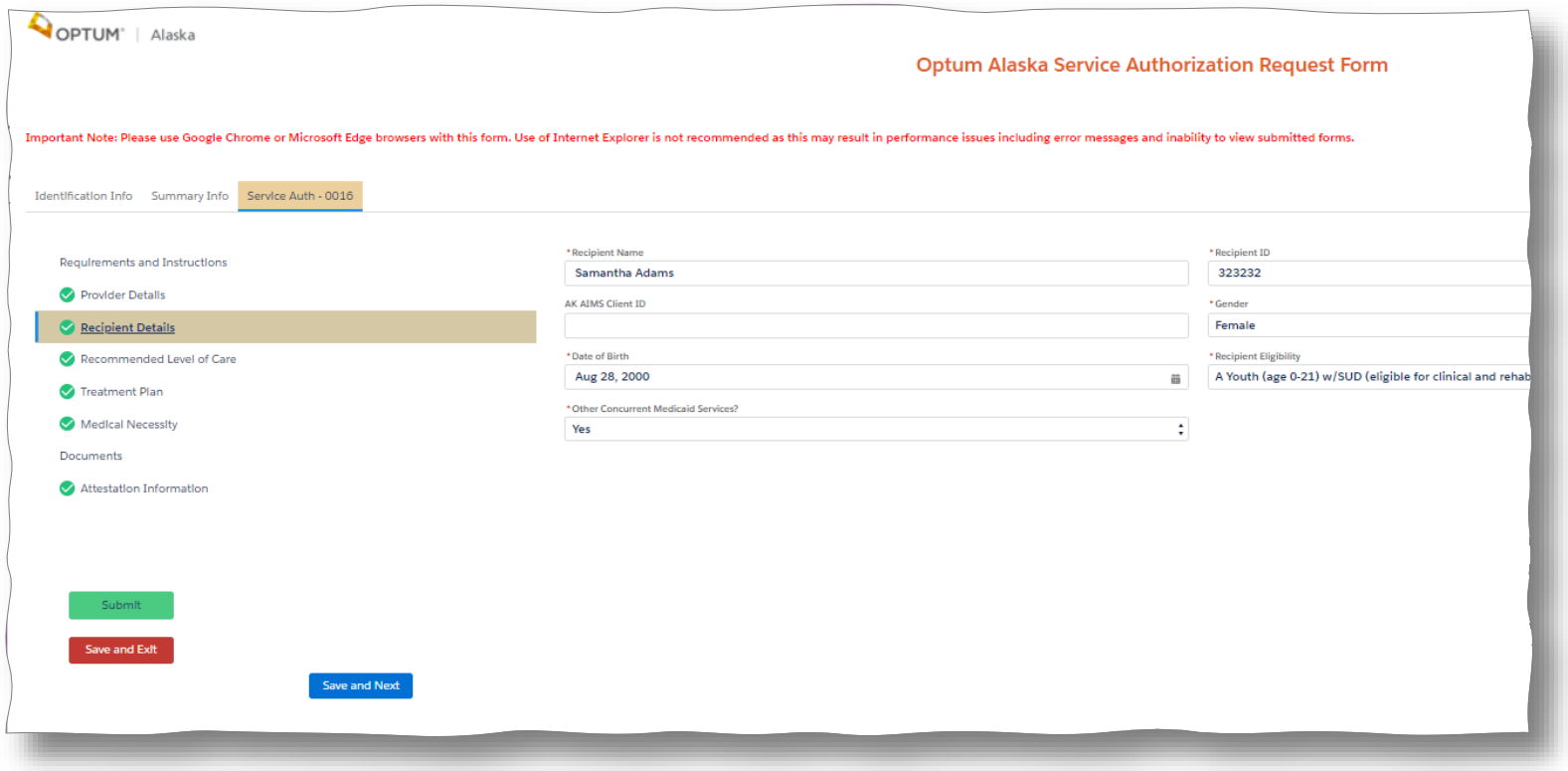
Provider details

Begin on the Provider page. All information with a red asterisk is mandatory. You cannot move forward until you have provided this information. When complete, click the blue “Save and Next” box. You also have the option to “Save and Exit” if you need to complete the form later.



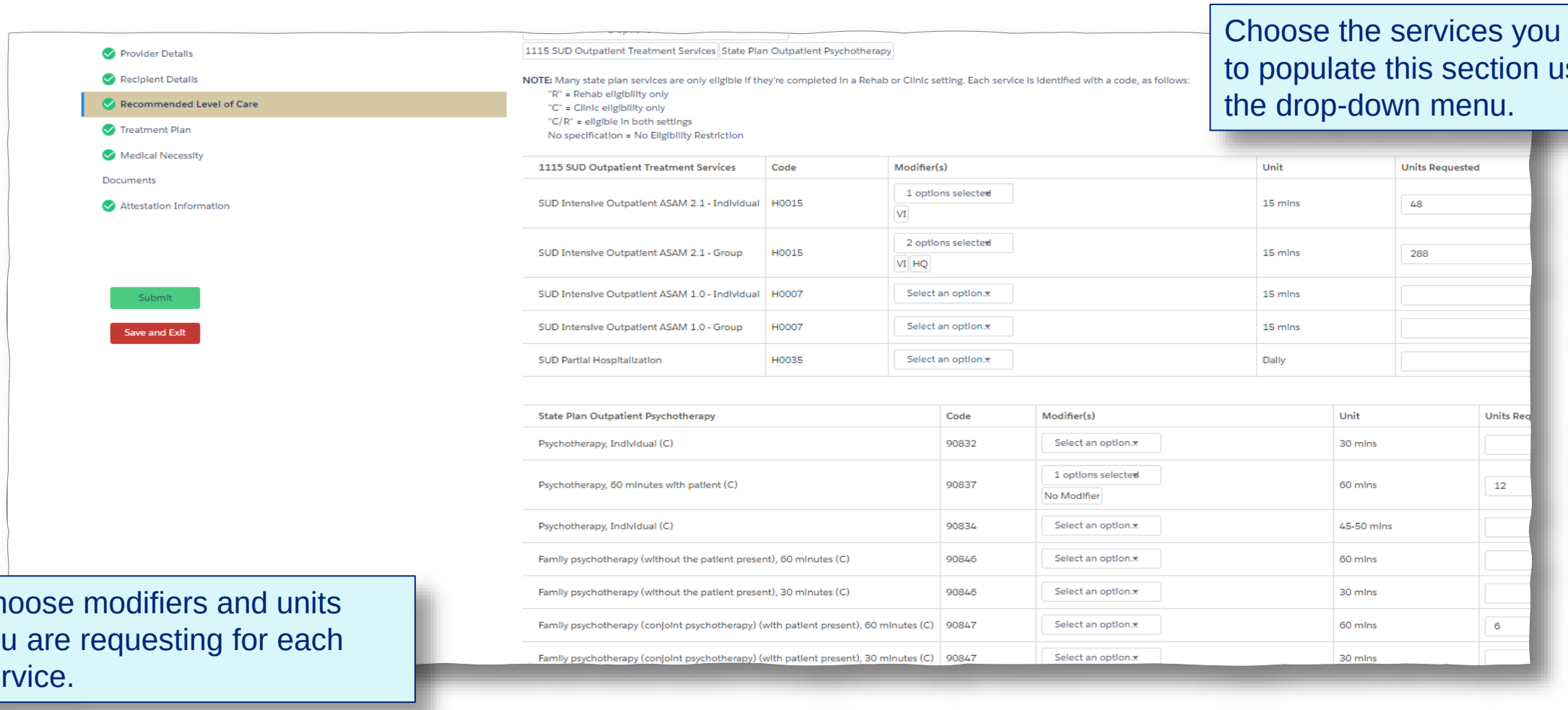
Recipient details

Provide recipient information on this page.



As you save, each section completed will show up on the left with a green check mark next to it. Until you submit this form, you can move around the form by clicking on the sections.

Services requested by level of care

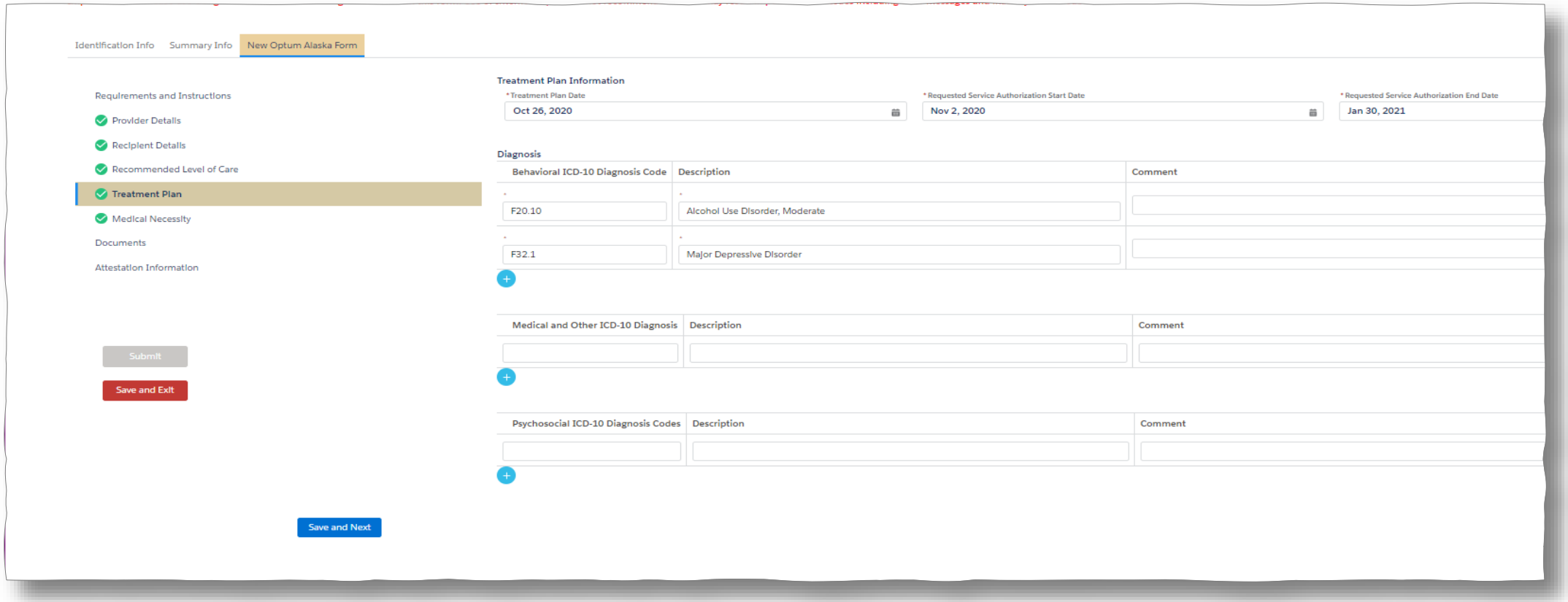


Choose the services you want to populate this section using the drop-down menu.

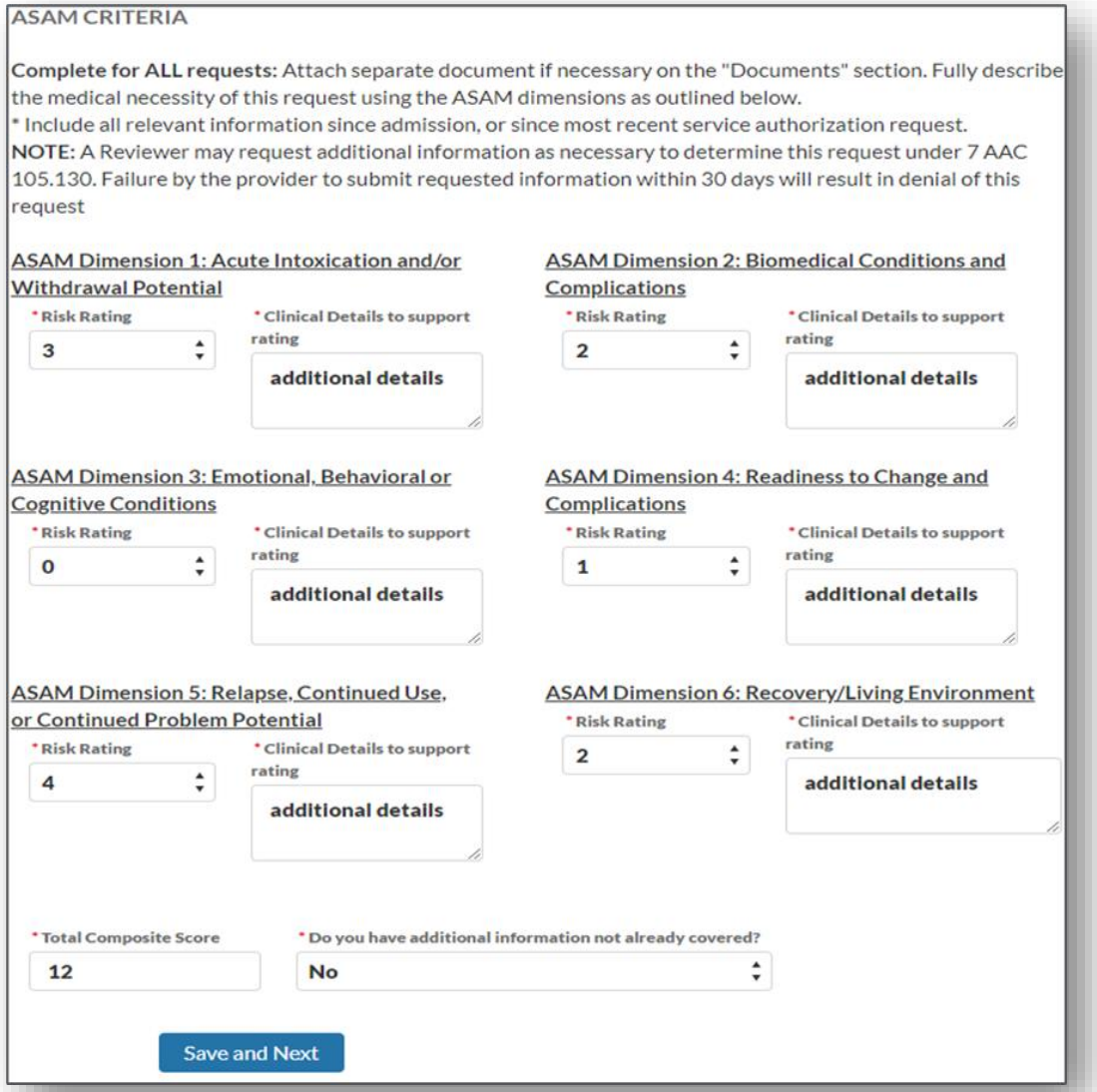
Choose modifiers and units you are requesting for each service.

Diagnoses and treatment plan

Provide the Treatment Plan dates, the date on which services will begin, the date by which the services will end and all relevant diagnoses. **MORE INFO on TREATMENT PLAN per discussion**



Online submission SUD clinical criteria



ASAM CRITERIA

Complete for ALL requests: Attach separate document if necessary on the "Documents" section. Fully describe the medical necessity of this request using the ASAM dimensions as outlined below.
* Include all relevant information since admission, or since most recent service authorization request.
NOTE: A Reviewer may request additional information as necessary to determine this request under 7 AAC 105.130. Failure by the provider to submit requested information within 30 days will result in denial of this request

ASAM Dimension 1: Acute Intoxication and/or Withdrawal Potential

* Risk Rating: 3
* Clinical Details to support rating: additional details

ASAM Dimension 2: Biomedical Conditions and Complications

* Risk Rating: 2
* Clinical Details to support rating: additional details

ASAM Dimension 3: Emotional, Behavioral or Cognitive Conditions

* Risk Rating: 0
* Clinical Details to support rating: additional details

ASAM Dimension 4: Readiness to Change and Complications

* Risk Rating: 1
* Clinical Details to support rating: additional details

ASAM Dimension 5: Relapse, Continued Use, or Continued Problem Potential

* Risk Rating: 4
* Clinical Details to support rating: additional details

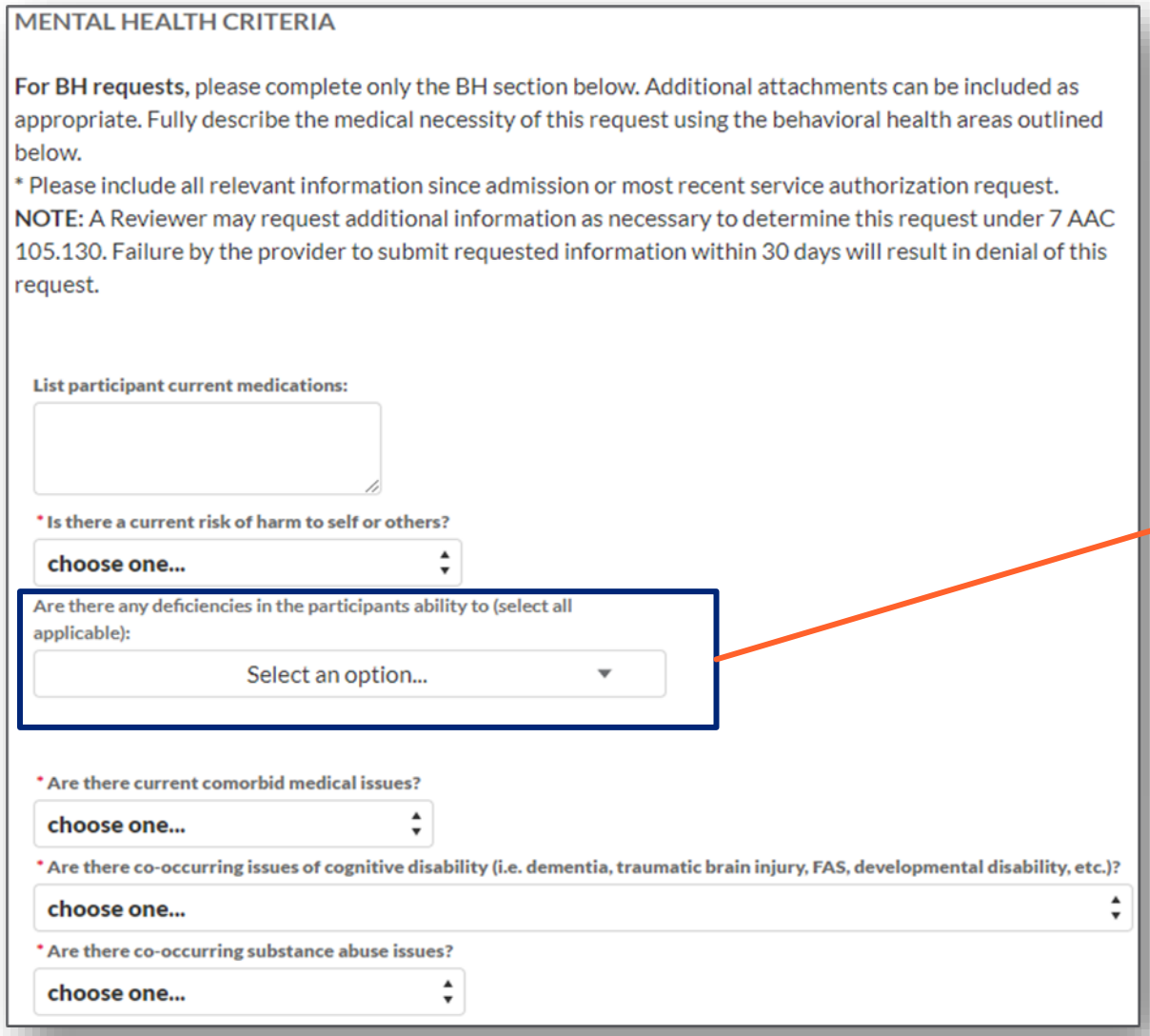
ASAM Dimension 6: Recovery/Living Environment

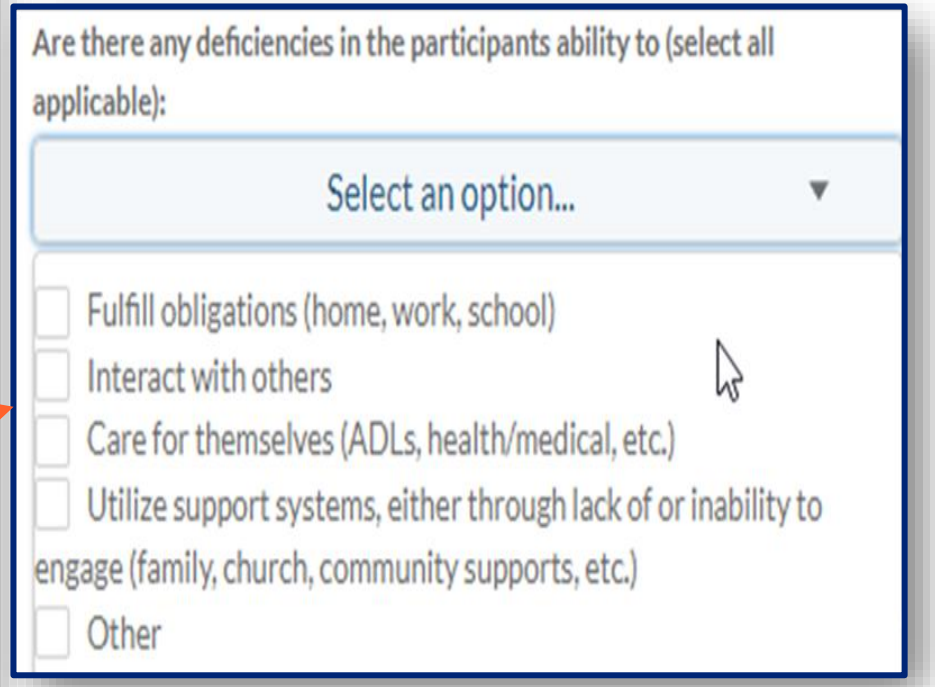
* Risk Rating: 2
* Clinical Details to support rating: additional details

* Total Composite Score: 12
* Do you have additional information not already covered?: No

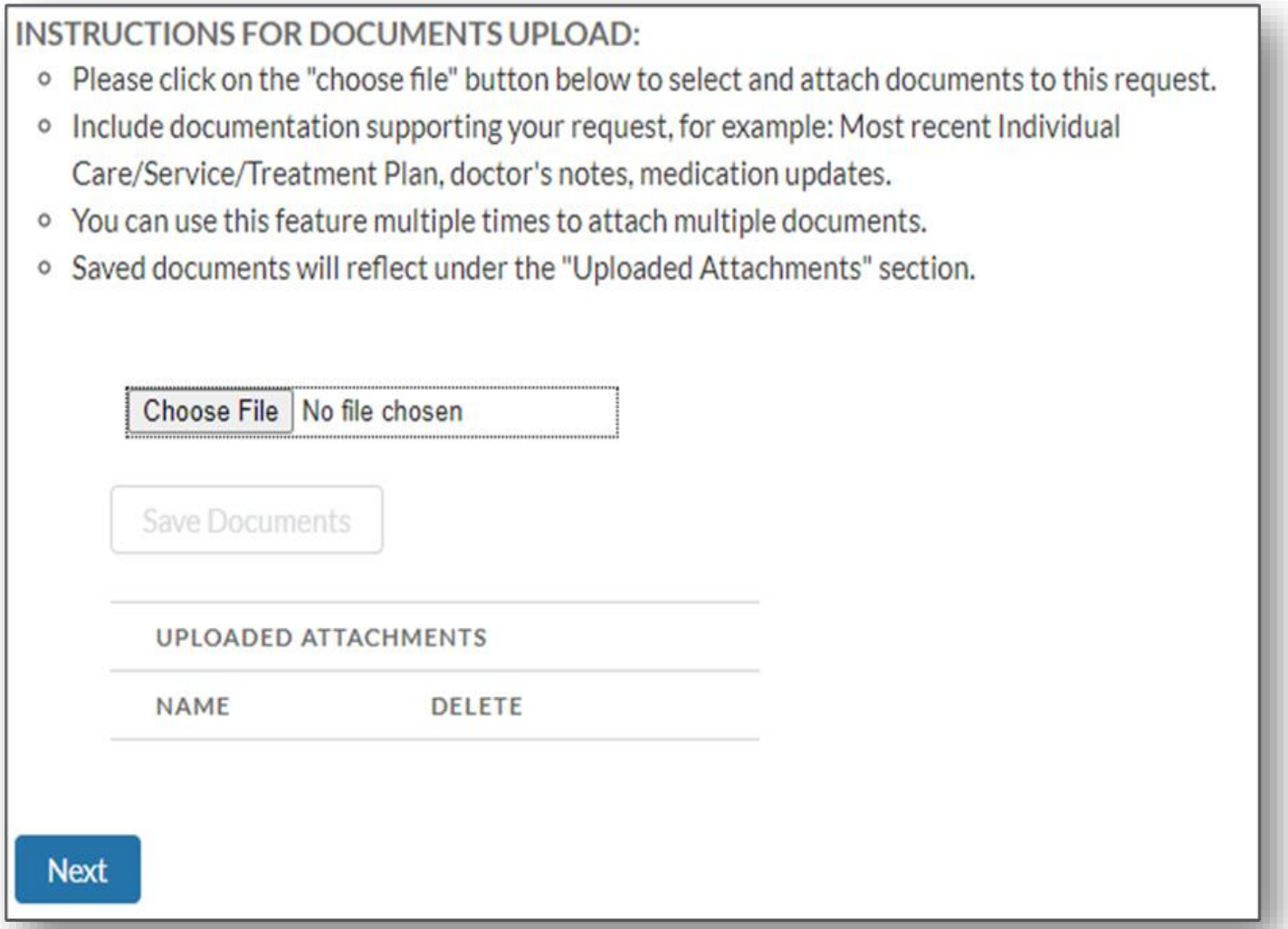
Save and Next

Online submission BH clinical criteria



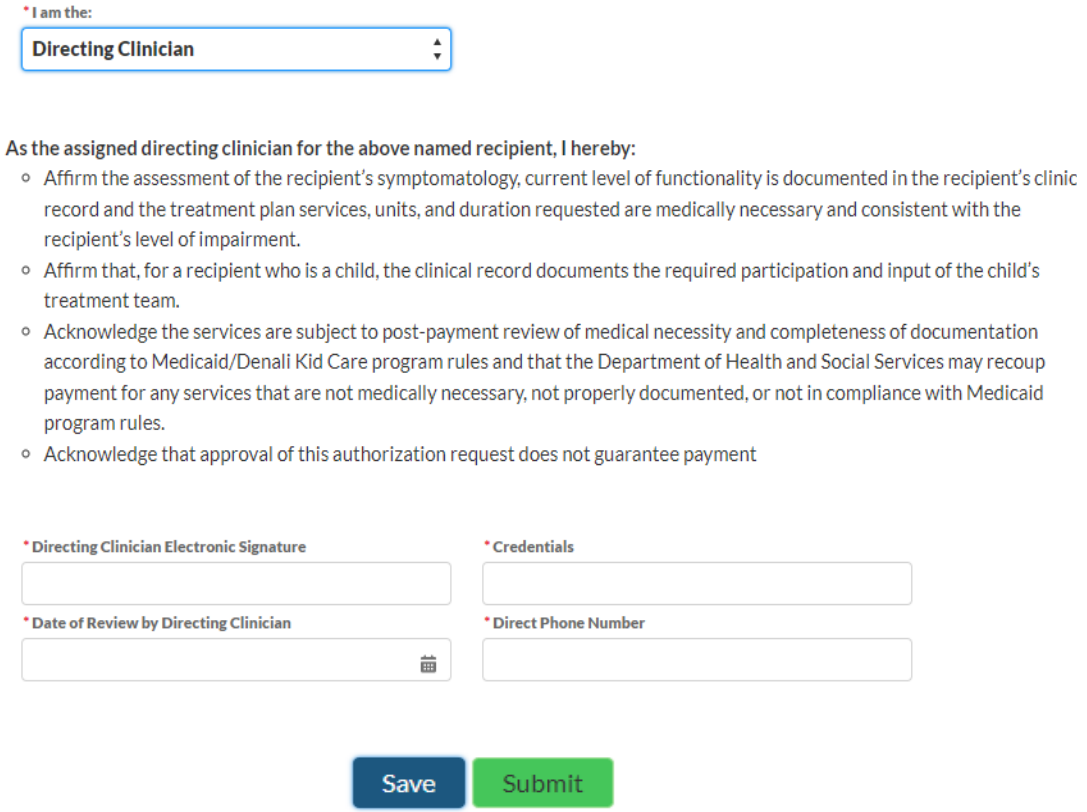


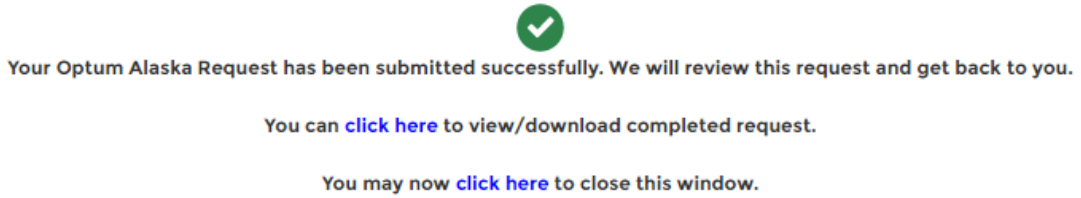
Uploading supporting documents



Submission complete

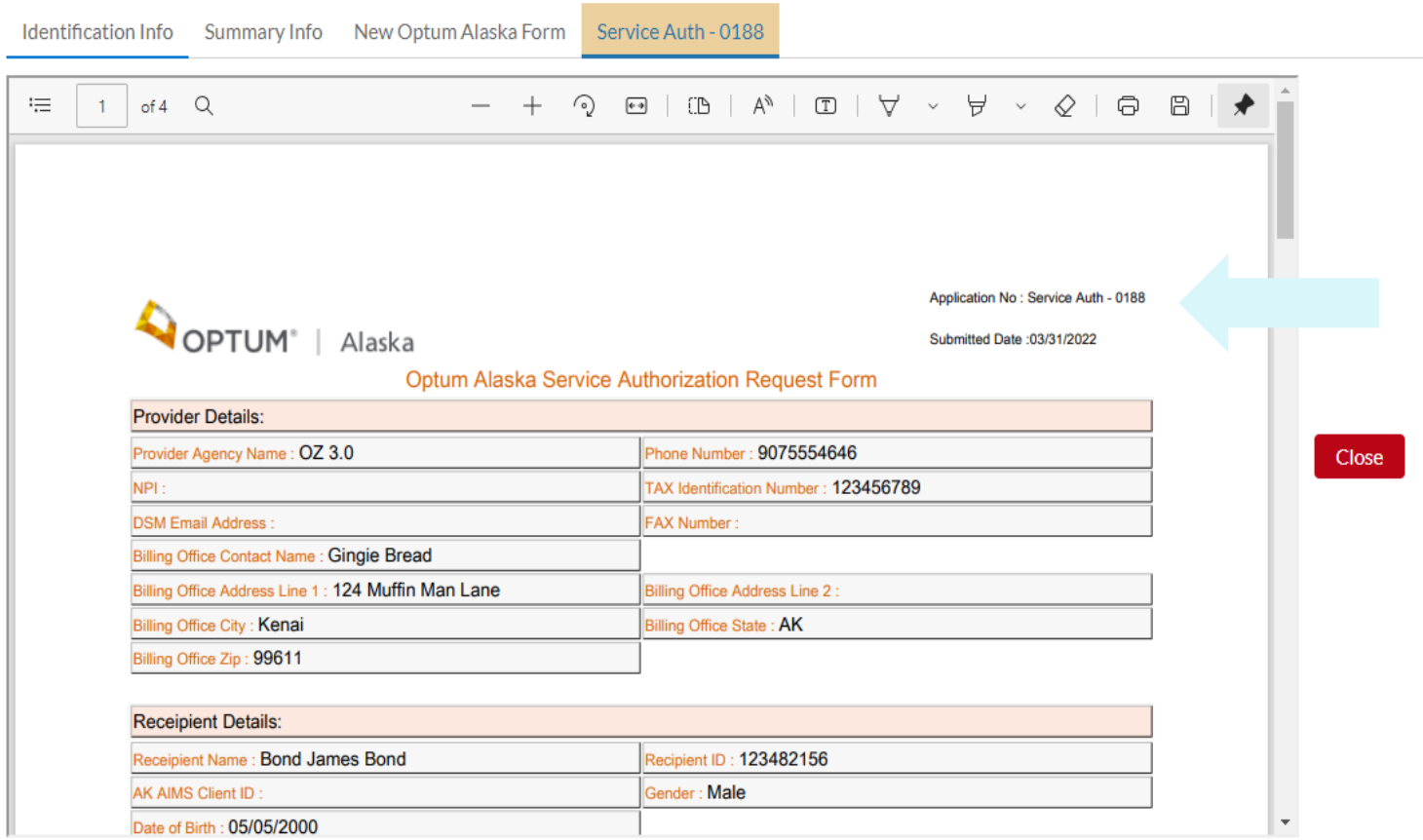
This is what it looks like…..





Other click options

If you click “to view/download” as mentioned, you will see your entire service authorization form to include the application number



Fillable PDF Submission

- Fax Number: 1-844-881-3753

- Telephone: 1-800-225-8764
  - A Care Advocate will fill out the service authorization form while provider is on the phone providing information. This process takes a minimum of 30 minutes

- USPS/Surface Mail: 911 W. 8th Ave Ste 101 Anchorage AK 99501
  - Note: this is a very slow process however, if a provider finds themselves in a no internet, no phone situation, this is available
  - An AK local Optum team member will fax the paper application received in the mail, to the above fax

How to complete the service authorization request form

Optum

1115 Behavioral Health Waiver Provider
Service Authorization (SA) Request

(*) Denotes required field

*1. Provider Agency Name: _____ *2. Tax ID: _____

*3. Participant Name: _____ *4. Participant ID: _____

*5. Request Date: _____ 6. AK AIMS Client ID: _____

Provider Information

*7a. Contact Name: _____ *7b. Address: _____

*8. Phone No.: _____ *9. Fax No.: _____

10. DSM Email Address: _____

Participant Information

*11. Admission Date: _____ *12. Planned Discharge Date: _____

*13. Gender: ☐ Male ☐ Female ☐ Other *14. Date of Birth: _____

*15. Participant eligibility (please select an applicable box):

☐ Child (age 0-17) ☐ Youth (age 18-21) ☐ Adult (age 21+)

*16. Recommended level of care (please select an applicable box):

☐ Crisis Services ☐ Routine Outpatient Services

☐ High Intensity Community Based- IOP ☐ Intensive Integrated w/out 24-hour psychiatrist - PHP

☐ Residential or non-Secure 24-hour with Psych Monitoring ☐ Inpatient/Secure, 24-hour with psychiatric management

*17. Concurrent Medicaid State Plan Services? ☐ Yes ☐ No

*18. Is this a request for a new service authorization? ☐ Yes ☐ No

*19. Is this a request for an amendment of an already approved service authorization? ☐ Yes ☐ No

*20. Treatment Plan Date: _____ *Enter the Treatment Plan date that supports this Service Authorization Request* SA

From: _____ Through: _____ *(May not exceed 90 days correlated to treatment plan date).*

Optum

1115 Substance Use Disorder Waiver Provider
Service Authorization (SA) Request

(*) Denotes required field

*1. Provider Agency Name: _____ *2. Tax ID: _____

*3. Participant Name: _____ *4. Participant ID: _____

*5. Request Date: _____ 6. AK AIMS Client ID: _____

Provider Information

*7a. Contact Name: _____ *7b. Address: _____

*8. Phone No.: _____ *9. Fax No.: _____

10.DSM Email Address: _____

Participant Information

*11. Admission Date: _____ *12. Planned Discharge Date: _____

*13. Gender: ☐ Male ☐ Female ☐ Other *14. Date of Birth: _____

*15. Participant eligibility (please select an applicable box):

☐ A child (age 12-17) who may have a substance use disorder

☐ A youth (age 18-21) who may have a substance use disorder

☐ An adult with a substance use disorder

*16. Recommended level of care (please select an applicable box):

☐ Outpatient ☐ Alcohol and Drug Withdrawal Management Services

☐ Intensive Outpatient ☐ Community Based Support Services

☐ Partial Hospitalization ☐ Crisis Services

☐ Residential and Inpatient SUD Treatment Services

*17. Concurrent Medicaid State Plan Services? ☐ Yes ☐ No

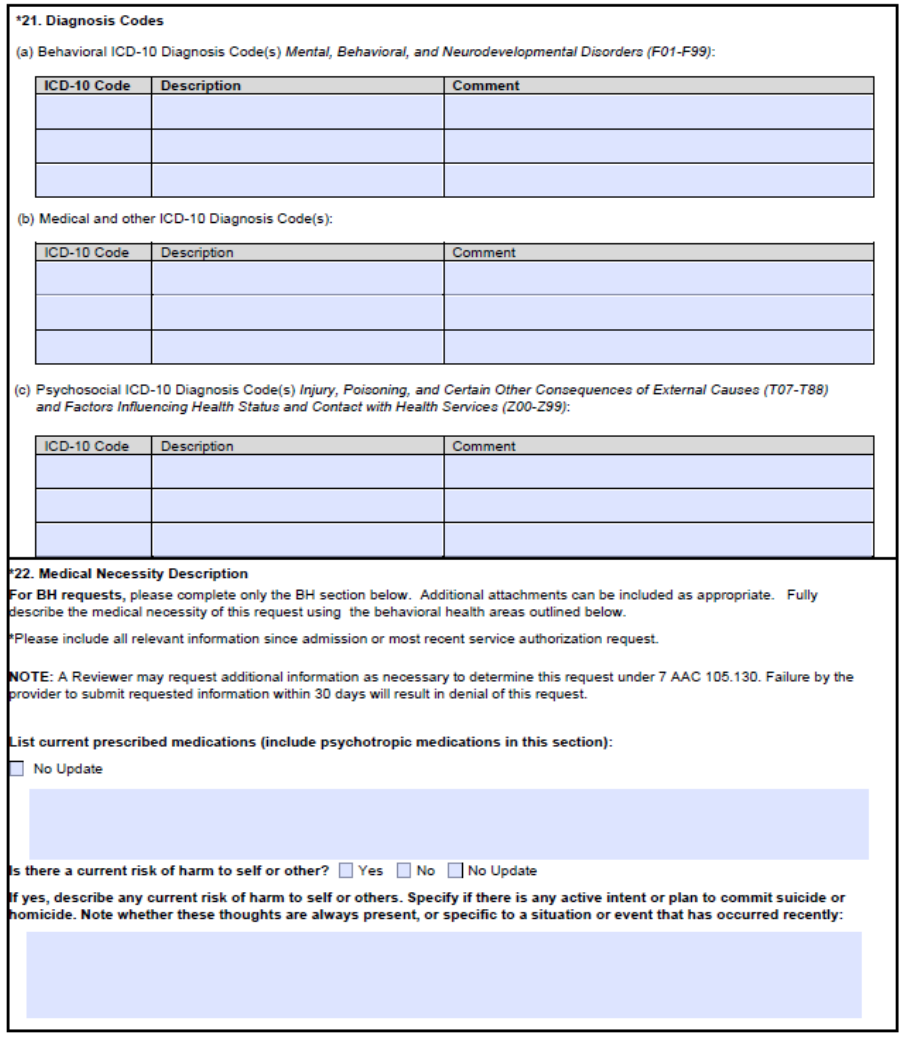
*18. Is this a request for a new service authorization? ☐ Yes ☐ No

*19. Is this a request for an amendment of an already approved service authorization? ☐ Yes ☐ No

*20. Treatment Plan Date: _____ *Enter the Treatment Plan date that supports this Service Authorization Request* SA

From: _____ Through: _____ *(May not exceed 90 days correlated to treatment plan date).*

How to complete the service authorization request - paper version



***21. Diagnosis Codes**

(a) Behavioral ICD-10 Diagnosis Code(s) *Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)*:

ICD-10 Code	Description	Comment

(b) Medical and other ICD-10 Diagnosis Code(s):

ICD-10 Code	Description	Comment

(c) Psychosocial ICD-10 Diagnosis Code(s) *Injury, Poisoning, and Certain Other Consequences of External Causes (T07-T88) and Factors Influencing Health Status and Contact with Health Services (Z00-Z99)*:

ICD-10 Code	Description	Comment

***22. Medical Necessity Description**

For BH requests, please complete only the BH section below. Additional attachments can be included as appropriate. Fully describe the medical necessity of this request using the behavioral health areas outlined below.

*Please include all relevant information since admission or most recent service authorization request.

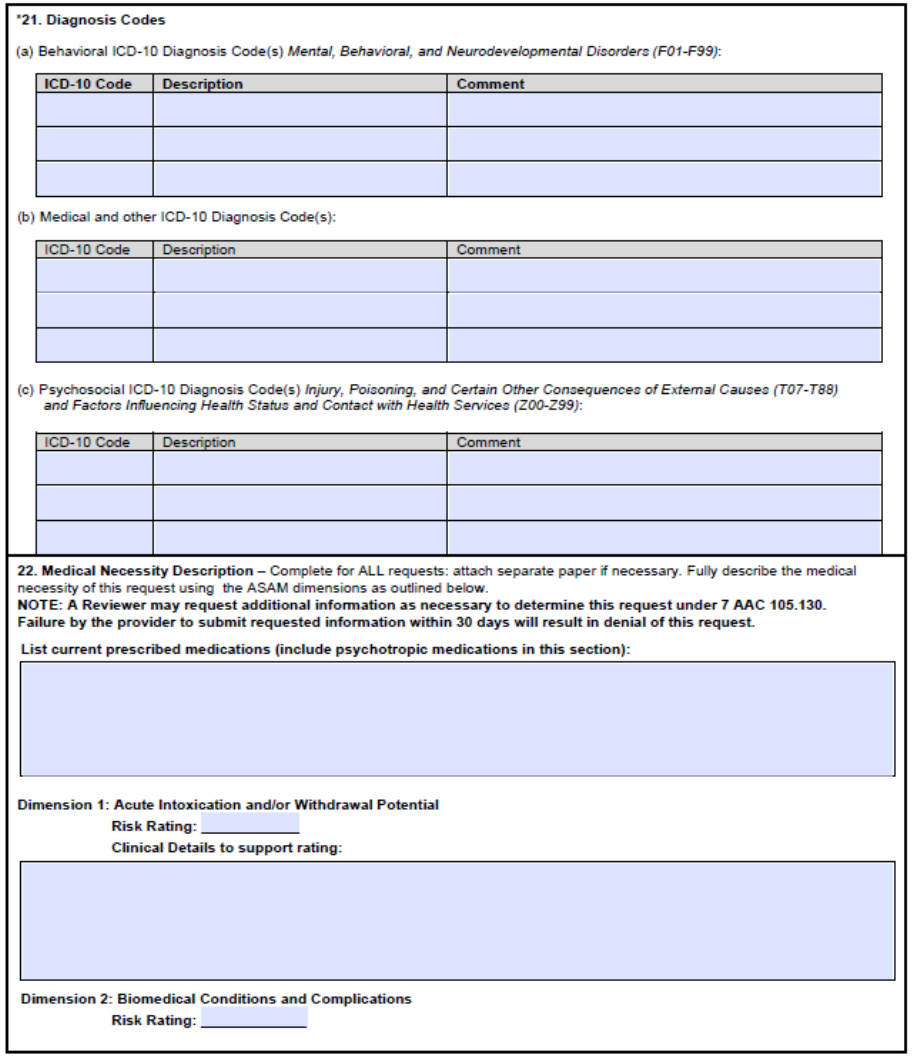
NOTE: A Reviewer may request additional information as necessary to determine this request under 7 AAC 105.130. Failure by the provider to submit requested information within 30 days will result in denial of this request.

List current prescribed medications (include psychotropic medications in this section):

☐ No Update

Is there a current risk of harm to self or other? ☐ Yes ☐ No ☐ No Update

If yes, describe any current risk of harm to self or others. Specify if there is any active intent or plan to commit suicide or homicide. Note whether these thoughts are always present, or specific to a situation or event that has occurred recently:



***21. Diagnosis Codes**

(a) Behavioral ICD-10 Diagnosis Code(s) *Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)*:

ICD-10 Code	Description	Comment

(b) Medical and other ICD-10 Diagnosis Code(s):

ICD-10 Code	Description	Comment

(c) Psychosocial ICD-10 Diagnosis Code(s) *Injury, Poisoning, and Certain Other Consequences of External Causes (T07-T88) and Factors Influencing Health Status and Contact with Health Services (Z00-Z99)*:

ICD-10 Code	Description	Comment

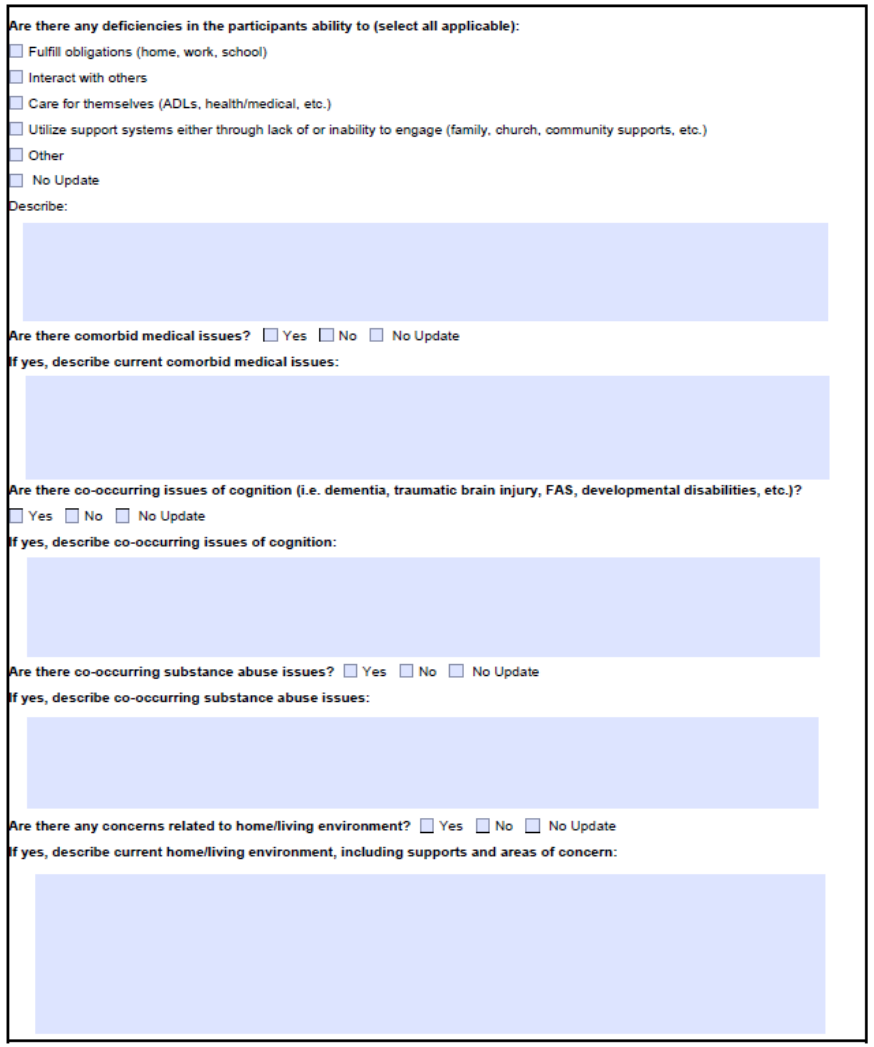
22. Medical Necessity Description – Complete for ALL requests: attach separate paper if necessary. Fully describe the medical necessity of this request using the ASAM dimensions as outlined below.
NOTE: A Reviewer may request additional information as necessary to determine this request under 7 AAC 105.130.
Failure by the provider to submit requested information within 30 days will result in denial of this request.

List current prescribed medications (include psychotropic medications in this section):

Dimension 1: Acute Intoxication and/or Withdrawal Potential
Risk Rating: _____
Clinical Details to support rating:

Dimension 2: Biomedical Conditions and Complications
Risk Rating: _____

How to complete the service authorization request - paper version



Are there any deficiencies in the participants ability to (select all applicable):

- ☐ Fulfill obligations (home, work, school)
- ☐ Interact with others
- ☐ Care for themselves (ADLs, health/medical, etc.)
- ☐ Utilize support systems either through lack of or inability to engage (family, church, community supports, etc.)
- ☐ Other
- ☐ No Update

Describe:

Are there comorbid medical issues? ☐ Yes ☐ No ☐ No Update

If yes, describe current comorbid medical issues:

Are there co-occurring issues of cognition (i.e. dementia, traumatic brain injury, FAS, developmental disabilities, etc.)?

☐ Yes ☐ No ☐ No Update

If yes, describe co-occurring issues of cognition:

Are there co-occurring substance abuse issues? ☐ Yes ☐ No ☐ No Update

If yes, describe co-occurring substance abuse issues:

Are there any concerns related to home/living environment? ☐ Yes ☐ No ☐ No Update

If yes, describe current home/living environment, including supports and areas of concern:

Clinical Details to support rating:

Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications

Risk Rating: _____

Clinical Details to support rating:

Dimension 4: Readiness to Change

Risk Rating: _____

Clinical Details to support rating:

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

Risk Rating: _____

Clinical Details to support rating:

Dimension 6: Recovery/Living Environment

Risk Rating: _____

Clinical Details to support rating:

Additional Medical Necessity Information (include any relevant information not mentioned above):

How to complete the service authorization request - paper version

Is there a history with trauma/ACE? ☐ Yes ☐ No ☐ No Update

If yes, briefly describe any history of trauma (include for initial request only, or if new and relevant information has been revealed):

Has the participant had any recent treatment history, including psychiatric or substance abuse hospitalizations?

☐ Yes ☐ No ☐ No Update

If yes, describe, include time periods, interventions that the participant has identified as successful or non-helpful treatment interventions:

Is the participant/Guardian willing to engage in services and/or motivated to change? ☐ Yes ☐ No ☐ No Update

Describe:

For continued services requests only, describe the level of participation in treatment and progress made on goals and objectives since last service authorization request:

Is the participant actively engaged in treatment? ☐ Yes ☐ No ☐ No Update

Describe:

Is there progress being made on goals and objectives since the last service authorization request? ☐ Yes ☐ No ☐ No Update

Describe:

Additional Medical Necessity Information (include any relevant information not mentioned above):

How to complete the service auth request - paper version

Units Requested				
Mental Health Treatment 1115 Services	**Code**	**Modifiers**	**Unit**	***23. Units Requested**
Intensive Outpatient - Individual	H0015	V2	15 mins	
Intensive Outpatient - Group	H0015	HQ V2	15 mins	
Partial Hospitalization	H0035	V2	Daily	
Intensive Case Management	H0023	V2	15 mins	
Community & Recovery Support Services - Individual	H2021	V2	15 mins	
Community & Recovery Support Services - Group	H2021	HQ V2	15 mins	
Assertive Community Treatment Services	H0039	V2	15 mins	
Outpatient Mental Health Treatment 1115 Services: Home Based	**Code**	**Modifiers**	**Unit**	***24. Units Requested**
Home-based Family Treatment Level 1	H1011	V2	15 mins	
Home-based Family Treatment Level 2	H1011	TF V2	15 mins	
Home-based Family Treatment Level 3	H1011	TG V2	15 mins	
Therapeutic Treatment Homes - Daily	H2020	V2	Daily	
Residential BH Treatment Services	**Code**	**Modifiers**	**Unit**	***25. Units Requested**
Adult Mental Health Residential Services Level 1	T2016	V2	Daily	
Adult Mental Health Residential Services Level 2	T2016	TG V2	Daily	
Children's Mental Health Residential Services Level 1	T2033	V2	Daily	
Children's Mental Health Residential Services Level 2	T2033	TF V2	Daily	
Crisis Services	**Code**	**Modifiers**	**Unit**	***26. Units Requested**
Crisis Residential Stabilization	S9485	V2	Daily	

Units Requested				
Outpatient SUD Services	Code	Modifiers	Unit	*24. Units Requested
Outpatient Services ASAM 1.0 – Individual	H0007	V1	15 mins	
Outpatient Services ASAM 1.0 – Group Adolescent	H0007	HQ, HA, V1	15 mins	
Outpatient Services ASAM 1.0 – Group Adult	H0007	HQ, HB, V1	15 mins	
Intensive Outpatient ASAM 2.1 - Individual	H0015	V1	15 mins	
Intensive Outpatient ASAM 2.1 - Group	H0015	HQ, V1	15 mins	
Partial Hospitalization ASAM 2.5	H0035	V1	Daily	
Residential SUD Treatment Services	Code	Modifiers	Unit	*25. Units Requested
SUD Residential 3.1 - Adolescent	H2036	HA, V1	Daily	
SUD Residential 3.1 - Ages 18-21	H2036	CG, HA, V1	Daily	
SUD Residential 3.1 - Adult	H2036	HF, V1	Daily	
SUD Residential 3.3	H0047	HF, V1	Daily	
SUD Residential 3.5 - Adolescent	H0047	HA, V1, TF	Daily	
SUD Residential 3.5 - Ages 18-21	H0047	CG, V1, HA, TF	Daily	
SUD Residential 3.5 - Adult	H0047	TG, V1	Daily	
Inpatient SUD Treatment				*26. Units Requested
Med Monitored Intensive Inpatient Services 3.7	H0009	TF, V1	Daily	
Med Managed Intensive Inpatient Services 4.0	H0009	TG, V1	Daily	
Alcohol and Drug Withdrawal Management Services	Code	Modifiers	Unit	*27. Units Requested
Ambulatory Withdrawal Management	H0014	V1	15 MIN	
Clinically Managed Residential Withdrawal Management	H0010	V1	Daily	
Med Monitored IP Withdrawal Management 3.7 WD	H0010	TG, V1	Daily	
Med Mng Intensive IP Withdrawal Management 4.0 WD	H0011	V1	Daily	
Community Based Support Services	Code	Modifiers	Unit	*28. Units Requested
Community & Recovery Support Svcs - Individual	H2021	V1	15 mins	
Community & Recovery Support Svcs - Group	H2021	HQ, V1	15 mins	
SUD Care Coordination	H0047	V1	Monthly	
Intensive Case Management	H0023	V1	15 mins	
Crisis Services	Code	Modifiers	Unit	*29. Units Requested
Crisis Residential Stabilization	S9485	V1	Daily	

How to complete the service authorization request - paper version

Please sign the attestation appropriate to your role (only one signature is necessary for submission):
As the Directing Clinician working for the above-named participant, I hereby:

- Affirm the assessment of the participant's symptomatology, current level of functionality is documented in the participant's clinical record and the treatment plan services, units, and duration requested are medically necessary and consistent with the participant's level of impairment.
- Affirm that, for a participant who is a child, the clinical record documents the required participation and input of the child's treatment team.
- Acknowledge the services are subject to post-payment review of medical necessity and completeness of documentation according to Medicaid/Denali Kid Care program rules and that the Department of Health & Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid program rules; and
- Acknowledge that approval of this authorization request does not guarantee payment.

28a. Directing Clinician | Credentials | Signature | Date

As the Assigned Administrator for the above-named participant, I hereby:

- Affirm that the above described clinical information is true and accurate, as provided by the directing clinician.
- Affirm that I am signing on behalf of the directing clinician with their knowledge and approval.
- Affirm the assessment of the participant's symptomatology, current level of functionality is documented in the participant's clinical record and the treatment plan services, units, and duration requested are medically necessary and consistent with the recipient's level of impairment.
- Affirm that, for a participant who is a child, the clinical record documents the required participation and input of the child's treatment team.
- Acknowledge the services are subject to post-payment review of medical necessity and completeness of documentation according to Medicaid/Denali Kid Care program rules and that the Department of Health & Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid program rules; and
- Acknowledge that approval of this authorization request does not guarantee payment.

28b. Administrative Assistant | Credentials | Signature | Date

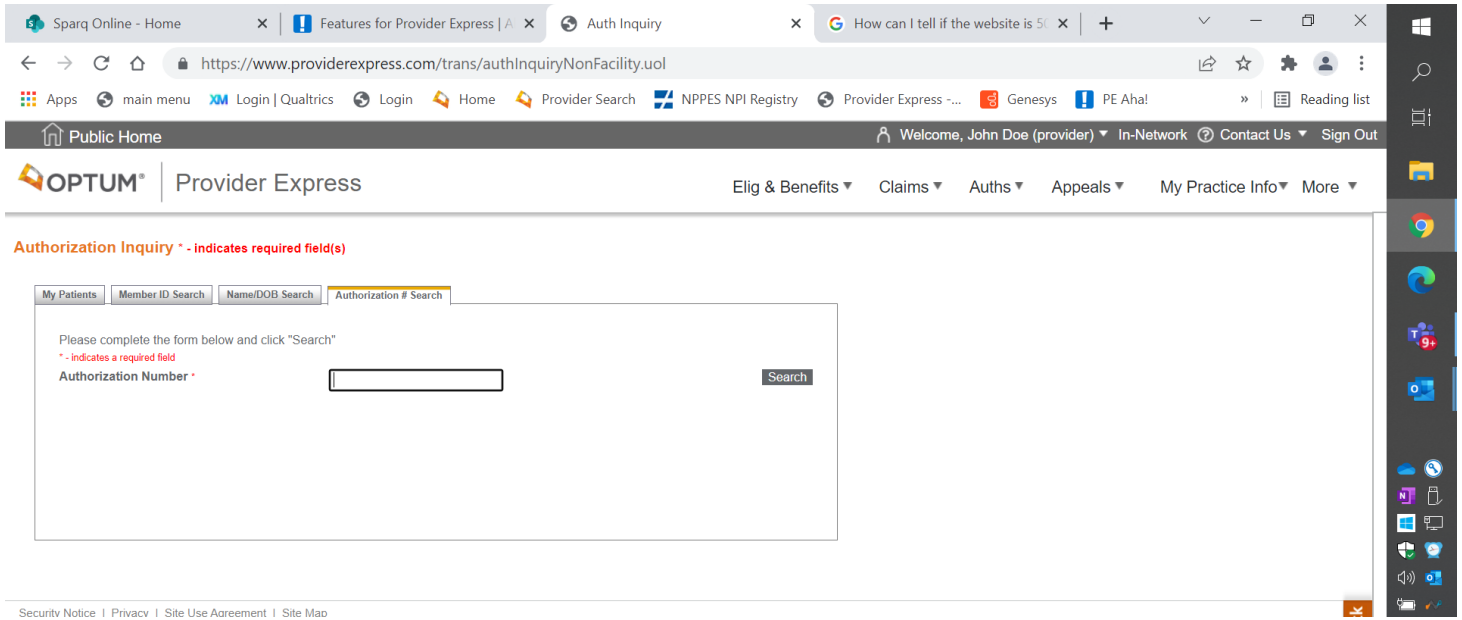
Special service authorization circumstances

Distance and availability of resources:

- It will be important to note special circumstances when writing the medical necessity essay on your Service Authorization Request.
- Providers are encouraged to acknowledge extenuating circumstances for extended stay at current level of care if impacted by geographic, weather, transportation or other special or unavoidable circumstance.
- Example: Currently in OP, need IOP or PHP but request is for Inpatient LOC. You may need to request a higher LOC if the level you assess is not available. Ex: Person meets criteria for 3.1, but the only residential option available in the region is 3.5.
- Extenuating circumstances DO NOT GUARANTEE APPROVAL of Service Authorization but should be pointed out for consideration of the request.

Check the Status

Provider Express



What happens next?

Two routes for next steps

Authorization approved

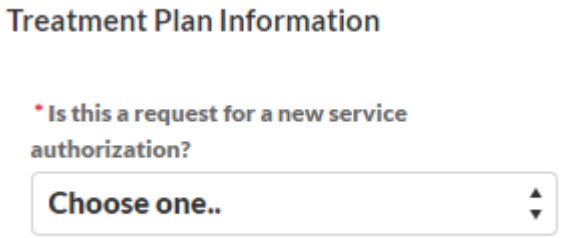
- Verbal notification by Care Advocate
- Authorization letter mailed

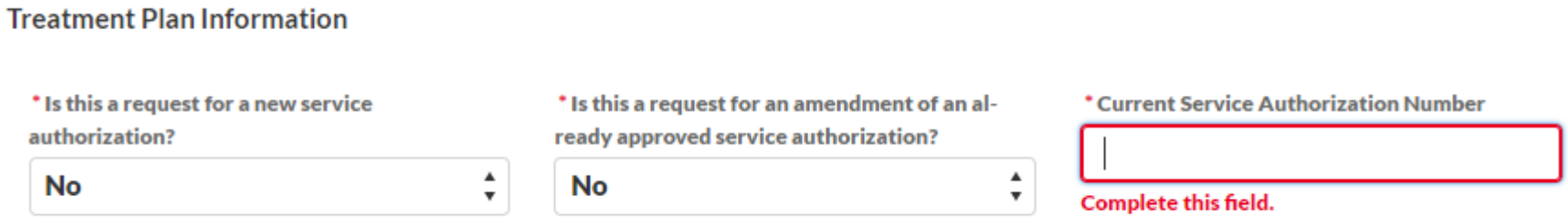
Not enough information to approve

- Case staffing with Chief Medical Officer (CMO) *then*,
- Request for additional information *then*,
- Peer to peer scheduled with CMO and provider/agency *then*,
- Denial letter issue with appeals rights provided

Your SA is about to expire: Now what?

- If medical necessity indicates extended stay is recommended/warranted, please follow the same steps previously until the Treatment Plan Information section.





- If the participant is transitioning to a new level of care, the receiving level of care provider is responsible for requesting a service authorization.

In summary:

- Service authorizations will be required at the end of the Federal Public Health Emergency
- Service authorizations are required when the participant's SFY limits are exhausted but can be requested if participant's SFY limit is unknown to avoid a claim denial
- There are two options of submitting service auth requests: paper or online
- Approved authorizations units will be tracked by participant and by provider within the claims system automatically. Authorization number is NOT needed on the claim submission

Q&A

Duration of segment