



Service Authorization Submission 101

Heather Brady, LPC
Director, Clinical Operations
Optum Alaska

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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>

Previous Trainings

Technical Assistance Teleconference

Date	Description	Presentation Name
03/09/2022	Claims Status Summary How to Adjust, Correct and Void Claims; Top 5 Trending Denials.	Reprocessed Claims <ul style="list-style-type: none">◦ Slides ◦ Recording (40 min)
02/23/2022	Clinical Criteria: A clinical approach to understanding medical necessity Dr. Vanessa Venezia, Optum Chief Medical Officer Heather Brady, Optum Director of Clinical Operations	Clinical Criteria <ul style="list-style-type: none">◦ Slides ◦ Recording (45 min)

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[®]
<ul style="list-style-type: none">• Adults, 18+• American Association for Community Psychiatrist (AACCP)	<ul style="list-style-type: none">• Birth to 6 years• American Academy for Child and Adolescent Psychiatry (AACAP)• Published 2009	<ul style="list-style-type: none">• 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
<ul style="list-style-type: none">• Low Risk- Recovery and Health Maintenance• Moderate Risk• High Risk• Very High Risk• Secure Monitored	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• LOCUS/CASII 10-16; ESCII 9-17<ul style="list-style-type: none">• Treatment plan and review; psychotherapy services; HBFT level 1 or 2• LOCUS/CASII 17-19; ESCII 18-22<ul style="list-style-type: none">• BH IOP; HBFT level 3; ICM• LOCUS/CASII 20-23; ESCII 23-26<ul style="list-style-type: none">• BH PHP, ACT, TTH• LOCUS/CASII 23-17; ESCII 27-30<ul style="list-style-type: none">• Adult/Children's MH Residential level 1 or 2• LOCUS/CASII 28+<ul style="list-style-type: none">• 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

The screenshot shows the Optum Alaska website. At the top, there is a search bar with the text "Search" and a "Search" button. Below the search bar is a navigation menu with the following items: Home, For Participants (with a dropdown arrow), For Alaska Medicaid Providers (with a dropdown arrow), For Community Partners, About Us, and Contact Us (with a dropdown arrow). Below the navigation menu is a breadcrumb trail: Alaska - Optum Provider Portal > For Alaska Medicaid Providers > Service Authorizations. The main content area features a red heading: **Service Authorization are on hold until the end of the Federal Public Health Emergency.** Below this is a section titled **Service Authorization Request Forms**. The text under this section states: "Service authorizations are required for all services after participant state fiscal year limits have been exhausted. Providers can submit service authorizations either through an Online Portal or by completing a PDF and faxing to Optum. Providers are encouraged to use the forms used on this webpage as form versions may change." Below this text is another section titled **Service Authorization Online Submissions**, which includes a link: [Online Service Authorization Form](#) with an external link icon. The final section is titled **Service Authorization Fillable Forms** and contains a list of links to PDF forms:

- [1115 SUD Waiver Service Authorization \(pdf\)](#) with an external link icon
- [1115 BH Waiver Service Authorization \(pdf\)](#) with an external link icon
- [Autism Services Service Authorization \(SA\) Request Form \(pdf\)](#) with an external link icon
- [Mental Health Physician Clinic \(MHPC\) Service Authorization \(SA\) Request Form \(pdf\)](#) with an external link icon
- [Psychological and Neuropsychological Testing Service Authorization \(SA\) Request](#) with an external link icon
- [State Plan Service Authorization \(pdf\)](#) with an external link icon

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.



Optum Alaska Service Authorization Request Form

Important Note: Internet Explorer browser is not supported. Please use Google Chrome or Microsoft Edge. Use of Internet Explorer may result in performance issues including error messages and/or inability to view submitted forms.

Identification Info

IMPORTANT NOTES:

- Fields marked with * are mandatory to move forward
- The Information entered on this page will be used to store and retrieve your request(s) when needed. Incomplete Requests can be accessed and completed at a later time
- Verification Code needed to access Incomplete or Submitted requests will be sent to email used for "REQUEST RECOVERY EMAIL"
- Either a Tax ID or NPI needs to be entered here before next item can display. Do not use any special characters (examples are "-", "#, @, \$ etc.)

TAX ID

9 digit, no Text/Charac

Agency NPI

10 digit, no Text/Char:

*REQUEST RECOVERY EMAIL

Request Recovery Email

Save and Continue

Authorization does not guarantee payment. Payment is subject to recipient's eligibility. Be sure the identification card is current before rendering service.

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BH2537_022020

Service authorization summary info

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

https://optumpeeraccess.secure: x +

https://optumpeeraccess.secure.force.com/OptumAlaskaServiceAuth/

Optum AK Sharepo... Online Submission... Alaska Admin Code AK Provider Billing... 1115 SUD Provider... 1115 BH Provider... Chart of 1115 Medi... ACES Questionnaire... BH ALASKA Complaints-CARTA CLL ASAM LONG TOC

OPTUM | Alaska

Optum Alaska Service Authorization Request Form

Important Note: Please use Google Chrome or Microsoft Edge browsers with this form. Use of Internet Explorer is not recommended as this may result in performance issues including error messages and inability to view submitted forms.

Identification Info **Summary Info**

IMPORTANT NOTES:

- All Incomplete requests submitted within the last 30 days will be listed below. Click on "Click Here" to complete the previously started application.
- All Completed applications within last 30 days are also displayed under "Submitted Requests." Click on "Click Here" next to a submitted request to see the read only version of the request.

To submit a new request, click on the "START" button. **START**

Incomplete Requests

Request Ref. Number	Recipient ID	Request Recovery Email	Edit
Service Auth - 0016	XX3232	eula.crlppen@optum.com	Click Here

Submitted Requests

Request Ref. Number	Recipient ID	Request Recovery Email	View
Service Auth - 0017	XX2929	eula.crlppen@optum.com	Click Here

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.

Verification Code Required

A verification code is needed to retrieve this form. An email has been sent to "", please check your email and provide this code to access the form - "Service Auth - 0178"

* Please enter code :

Submission Instructions

Identification Info

Summary Info

New Optum Alaska Form

Requirements and Instructions

Provider Details

Save and Exit

SUBMISSION REQUIREMENTS:

- This Service Authorization (SA) request must be completed to indicate the amount of services requested beyond the annual or daily service limits **within the regulations 7 AAC 138.040** and must bear the signature of the directing clinician assigned to the recipient's case who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance/Denali Kid Care program rules.

FORM INSTRUCTIONS:

- Fields marked with * are mandatory to move forward
- Green Checkmark appends to Section Name when all mandatory fields are saved for that Particular Section.
- Except "Documents" section and "Requirements and Instructions" section, all other sections are mandatory. When all mandatory sections are filled then Submit Button turns to Green.
- Green Color Submit Button indicates that your form is ready for Submission.
- Click on "Save and Exit" Button to Close the form.

Next

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.

The screenshot displays the 'Optum Alaska Service Authorization Request Form'. At the top left is the 'OPTUM | Alaska' logo. The title 'Optum Alaska Service Authorization Request Form' is centered at the top right. Below the title is an important note: 'Important Note: Please use Google Chrome or Microsoft Edge browsers with this form. Use of Internet Explorer is not recommended as this may result in performance issues including error messages and inability to view submitted forms.' The form has three tabs: 'Identification Info', 'Summary Info', and 'Service Auth - 0016'. The 'Service Auth - 0016' tab is active. On the left side, there is a sidebar with a 'Requirements and Instructions' section containing a list of items with checkmarks: 'Provider Details', 'Recipient Details', 'Recommended Level of Care', 'Treatment Plan', and 'Medical Necessity'. Below this is a 'Documents' section with 'Attestation Information'. At the bottom left of the sidebar are three buttons: 'Submit' (green), 'Save and Exit' (red), and 'Save and Next' (blue). The main form area contains several input fields with red asterisks indicating mandatory fields: 'Provider Agency Name' (value: Second Nature), 'Phone Number' (value: 6126427882), 'Agency NPI' (placeholder: Enter 10 digits, no text/special characters), 'Tax Identification Number' (value: 33333333), 'DSM Email Address' (value: eula.crippen@optum.com), 'Fax Number' (empty), 'Billing Office Contact Name' (value: Eula Crippen), 'Billing Office Address Line 1' (value: 408 Oja Way), 'Billing Office Address Line 2' (empty), 'Billing Office City' (value: Sitka), 'Billing Office Address State' (value: AK), 'Billing Office Zip' (value: 99835), and 'Request Recovery Email' (empty).

Recipient details

Provide recipient information on this page.

The screenshot shows the 'Optum Alaska Service Authorization Request Form' with the 'Recipient Details' section highlighted. The form includes a navigation menu on the left with sections like 'Provider Details', 'Recommended Level of Care', 'Treatment Plan', 'Medical Necessity', 'Documents', and 'Attestation Information', all marked with green checkmarks. The 'Recipient Details' section is currently active and highlighted in gold. The form fields include: Recipient Name (Samantha Adams), Recipient ID (323232), AK AIMS Client ID (empty), Date of Birth (Aug 28, 2000), Gender (Female), and Other Concurrent Medicaid Services? (Yes). A 'Submit' button is green, while 'Save and Exit' and 'Save and Next' are red and blue respectively. An important note at the top states: 'Important Note: Please use Google Chrome or Microsoft Edge browsers with this form. Use of Internet Explorer is not recommended as this may result in performance issues including error messages and inability to view submitted forms.'

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.

- Provider Details
- Recipient Details
- Recommended Level of Care
- Treatment Plan
- Medical Necessity
- Documents
- Attestation Information

1115 SUD Outpatient Treatment Services
State Plan Outpatient Psychotherapy

NOTE: Many state plan services are only eligible if they're completed in a Rehab or Clinic setting. Each service is identified with a code, as follows:
 "R" = Rehab eligibility only
 "C" = Clinic eligibility only
 "C/R" = eligible in both settings
 No specification = No Eligibility Restriction

1115 SUD Outpatient Treatment Services	Code	Modifier(s)	Unit	Units Requested
SUD Intensive Outpatient ASAM 2.1 - Individual	H0015	1 options selected VI	15 mins	48
SUD Intensive Outpatient ASAM 2.1 - Group	H0015	2 options selected VI HQ	15 mins	288
SUD Intensive Outpatient ASAM 1.0 - Individual	H0007	Select an option.x	15 mins	
SUD Intensive Outpatient ASAM 1.0 - Group	H0007	Select an option.x	15 mins	
SUD Partial Hospitalization	H0035	Select an option.x	Daily	

State Plan Outpatient Psychotherapy	Code	Modifier(s)	Unit	Units Requested
Psychotherapy, Individual (C)	90832	Select an option.x	30 mins	
Psychotherapy, 60 minutes with patient (C)	90837	1 options selected No Modifier	60 mins	12
Psychotherapy, Individual (C)	90834	Select an option.x	45-50 mins	
Family psychotherapy (without the patient present), 60 minutes (C)	90846	Select an option.x	60 mins	
Family psychotherapy (without the patient present), 30 minutes (C)	90846	Select an option.x	30 mins	
Family psychotherapy (conjoint psychotherapy) (with patient present), 60 minutes (C)	90847	Select an option.x	60 mins	6
Family psychotherapy (conjoint psychotherapy) (with patient present), 30 minutes (C)	90847	Select an option.x	30 mins	

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****

Identification Info Summary Info **New Optum Alaska Form**

Requirements and Instructions

- ✓ Provider Details
- ✓ Recipient Details
- ✓ Recommended Level of Care
- ✓ Treatment Plan**
- ✓ Medical Necessity

Documents

Attestation Information

Submit

Save and Exit

Save and Next

Treatment Plan Information

*Treatment Plan Date: Oct 26, 2020

*Requested Service Authorization Start Date: Nov 2, 2020

*Requested Service Authorization End Date: Jan 30, 2021

Diagnosis

Behavioral ICD-10 Diagnosis Code	Description	Comment
F20.10	Alcohol Use Disorder, Moderate	
F32.1	Major Depressive Disorder	

+

Medical and Other ICD-10 Diagnosis	Description	Comment

+

Psychosocial ICD-10 Diagnosis Codes	Description	Comment

+

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

<p>ASAM Dimension 1: Acute Intoxication and/or Withdrawal Potential</p> <p>* Risk Rating 3</p> <p>* Clinical Details to support rating additional details</p>	<p>ASAM Dimension 2: Biomedical Conditions and Complications</p> <p>* Risk Rating 2</p> <p>* Clinical Details to support rating additional details</p>
<p>ASAM Dimension 3: Emotional, Behavioral or Cognitive Conditions</p> <p>* Risk Rating 0</p> <p>* Clinical Details to support rating additional details</p>	<p>ASAM Dimension 4: Readiness to Change and Complications</p> <p>* Risk Rating 1</p> <p>* Clinical Details to support rating additional details</p>
<p>ASAM Dimension 5: Relapse, Continued Use, or Continued Problem Potential</p> <p>* Risk Rating 4</p> <p>* Clinical Details to support rating additional details</p>	<p>ASAM Dimension 6: Recovery/Living Environment</p> <p>* Risk Rating 2</p> <p>* Clinical Details to support rating additional details</p>

* Total Composite Score: 12

* Do you have additional information not already covered? No

Save and Next

Online submission BH clinical criteria

MENTAL HEALTH CRITERIA

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 participant current medications:

* Is there a current risk of harm to self or others?

choose one...

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

Select an option...

* Are there current comorbid medical issues?

choose one...

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

choose one...

* Are there co-occurring substance abuse issues?

choose one...

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

Select an option...

- 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

Uploading supporting documents

INSTRUCTIONS FOR DOCUMENTS UPLOAD:

- Please click on the "choose file" button below to select and attach documents to this request.
- Include documentation supporting your request, for example: Most recent Individual Care/Service/Treatment Plan, doctor's notes, medication updates.
- You can use this feature multiple times to attach multiple documents.
- Saved documents will reflect under the "Uploaded Attachments" section.

No file chosen

UPLOADED ATTACHMENTS

NAME	DELETE
------	--------

Submission complete

This is what it looks like.....

* I am the:

As the assigned directing clinician for the above named recipient, I hereby:

- Affirm the assessment of the recipient's symptomatology, current level of functionality is documented in the recipient's clinic 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 recipient 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 and Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid program rules.
- Acknowledge that approval of this authorization request does not guarantee payment

* Directing Clinician Electronic Signature <input type="text"/>	* Credentials <input type="text"/>
* Date of Review by Directing Clinician <input type="text" value=""/>	* Direct Phone Number <input type="text"/>



Your Optum Alaska Request has been submitted successfully. We will review this request and get back to you.

You can [click here](#) to view/download completed request.

You may now [click here](#) to close this window.

Other click options

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

Identification Info Summary Info New Optum Alaska Form **Service Auth - 0188**

1 of 4

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Application No : Service Auth - 0188
Submitted Date :03/31/2022

Optum Alaska Service Authorization Request Form

Provider Details:	
Provider Agency Name : OZ 3.0	Phone Number : 9075554646
NPI :	TAX Identification Number : 123456789
DSM Email Address :	FAX Number :
Billing Office Contact Name : Gingie Bread	
Billing Office Address Line 1 : 124 Muffin Man Lane	Billing Office Address Line 2 :
Billing Office City : Kenai	Billing Office State : AK
Billing Office Zip : 99611	

Recipient Details:	
Recipient Name : Bond James Bond	Recipient ID : 123482156
AK AIMS Client ID :	Gender : Male
Date of Birth : 05/05/2000	

Close

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



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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	*14. Date of Birth: _____
*15. Participant eligibility (please select an applicable box):	
<input type="checkbox"/> Child (age 0-17) <input type="checkbox"/> Youth (age 18-21) <input type="checkbox"/> Adult (age 21+)	
*16. Recommended level of care (please select an applicable box):	
<input type="checkbox"/> Crisis Services <input type="checkbox"/> Routine Outpatient Services <input type="checkbox"/> High Intensity Community Based- IOP <input type="checkbox"/> Intensive Integrated w/out 24-hour psychiatrist - PHP <input type="checkbox"/> Residential or non-Secure 24-hour with Psych Monitoring <input type="checkbox"/> Inpatient/Secure, 24-hour with psychiatric management	
*17. Concurrent Medicaid State Plan Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*18. Is this a request for a new service authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*19. Is this a request for an amendment of an already approved service authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*20. Treatment Plan Date: _____ <i>Enter the Treatment Plan date that supports this Service Authorization Request SA</i>	
From: _____ Through: _____ <i>(May not exceed 90 days correlated to treatment plan date).</i>	



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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	*14. Date of Birth: _____
*15. Participant eligibility (please select an applicable box):	
<input type="checkbox"/> A child (age 12-17) who may have a substance use disorder <input type="checkbox"/> A youth (age 18-21) who may have a substance use disorder <input type="checkbox"/> An adult with a substance use disorder	
*16. Recommended level of care (please select an applicable box):	
<input type="checkbox"/> Outpatient <input type="checkbox"/> Alcohol and Drug Withdrawal Management Services <input type="checkbox"/> Intensive Outpatient <input type="checkbox"/> Community Based Support Services <input type="checkbox"/> Partial Hospitalization <input type="checkbox"/> Crisis Services <input type="checkbox"/> Residential and Inpatient SUD Treatment Services	
*17. Concurrent Medicaid State Plan Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*18. Is this a request for a new service authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*19. Is this a request for an amendment of an already approved service authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*20. Treatment Plan Date: _____ <i>Enter the Treatment Plan date that supports this Service Authorization Request SA</i>	
From: _____ Through: _____ <i>(May not exceed 90 days correlated to treatment plan date).</i>	

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

The screenshot shows a web browser window with the URL <https://www.providerexpress.com/trans/authInquiryNonFacility.uol>. The page header includes the Optum logo and navigation links: Elig & Benefits, Claims, Auths, Appeals, My Practice Info, and More. A user is logged in as John Doe (provider). The main content area is titled "Authorization Inquiry" and includes a red warning: "Authorization Inquiry * - indicates required field(s)". Below this is a search form with tabs for "My Patients", "Member ID Search", "Name/DOB Search", and "Authorization # Search". The "Authorization # Search" tab is active, showing a text input field for "Authorization Number" and a "Search" button. A red asterisk next to the label indicates a required field. The footer contains links for Security Notice, Privacy, Site Use Agreement, and Site Map.

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.

Treatment Plan Information

* Is this a request for a new service authorization?

Choose one..

Treatment Plan Information

* Is this a request for a new service authorization?

No

* Is this a request for an amendment of an already approved service authorization?

No

* Current Service Authorization Number

|

Complete this field.

- 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

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