# Service Authorization Submission 101

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Optum Alaska

**June 22, 2022**

# Agenda / Objectives

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


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# 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.


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# 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<br>◦ Slides<br>◦ Recording (40 min) |
| 02/23/2022 | Clinical Criteria: A clinical approach to understanding medical necessity<br>Dr. Vanessa Venezia, Optum Chief Medical Officer<br>Heather Brady, Optum Director of Clinical Operations | Clinical Criteria<br>◦ Slides<br>◦ Recording (45 min) |


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# 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.

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# 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


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# 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+<br>• American Association for Community Psychiatrist (AACP) | • Birth to 5 years<br>• American Academy for Child and Adolescent Psychiatry (AACAP)<br>• Published 2009 | • 6 to 18 years<br>• American Academy for Child and Adolescent Psychiatry (AACAP).<br>• Updated from CA-LOCUS, 2009<br>• Version 4.1, 2018 |


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# 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


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# Dimensions Case Example (BH)

- Dimension 1: John Doe has not had suicidal ideation, plan, intent, or action since 06/01/2019. In 06/2019, John made an attempt by hanging. John was found by partner and taken to hospital. John was placed into [LOC] at [Treatment Facility] from [start date] to [end date]. John attended [treatment groups/individual]. No homicidal ideation in history or current.
- Dimension 2: John has had decreased ability to maintain personal hygiene. John showers on average, 1 time per week, brushes teeth 2 times per month, combs hair 1 time per week and struggles to complete laundry. John's mother, Ann, washes John's clothing 1 time per month. John washes dishes 1 time per week or throws the dishes out. John has not maintained employment for over 1 month due to hygiene concerns. John reports he is "too sad" or "scared" to complete hygiene tasks and has identified 4 trauma triggers.
- Dimension 3: John does not use illicit substances or alcohol. John does not take prescribed medications as directed and often misses over 1 week at a time. John has been diagnosed with Type II diabetes and obesity. Upon receiving this diagnosis, May 2022, John's depressive symptoms and behaviors increased.
- Dimension 4: John has removed self from social supports and stopped attending peer support meetings in the past 30 days. John has been reporting he feels "anxious, embarrassed, judged" when attending trauma support group. John had a good relationship with peer support however, peer support left agency and John has not developed a relationship with new peer support. John's father does not believe in trauma and is not a support. John's mother supports as she is able but not consistently due to father's beliefs. John is not in a relationship. John's partner ended the relationship 12 months ago due to John not following treatment recommendations.
- Dimension 5: John responded positively to treatment received in 2019. John was engaged in follow up processes to include community supports. John experienced increase in depressive symptoms and behaviors 12 months ago after relationship ended. John entered outpatient treatment with the assistance of mother and support group. John has slowly been working through trauma utilizing DBT group and individual sessions 1, 60 minute session per week. With increase in symptoms and withdrawal from support system, therapist has requested John attend individual sessions 2 times per week and attend 2 additional groups.
- Dimension 6: John understands childhood trauma and depression diagnosis. John is struggling to identify how the diagnoses are affecting his daily behaviors and symptoms. John is willing to continue meeting with therapist and to "try" additional groups recommended.


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# Matching risk to level of care - a high level crosswalk

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

**Risk Level**

- Low Risk- Recovery and Health Maintenance
- Moderate Risk
- High Risk
- Very High Risk
- Secure Monitored

**ASAM/SUD**

- 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

**Behavioral Health**

- 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


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# How to Submit Service Authorizations

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

- Online
- Fillable Form

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Search: Search [Search]

Home | For Participants | For Alaska Medicaid Providers | For Community Partners | About Us | Contact Us

Alaska - Optum Provider Portal > For Alaska Medicaid Providers > Service Authorizations

***Service Authorization are on hold until the end of the Federal Public Health Emergency.***

## Service Authorization Request Forms

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.

## Service Authorization Online Submissions

Online Service Authorization Form

## Service Authorization Fillable Forms

- 1115 SUD Waiver Service Authorization (pdf)
- 1115 BH Waiver Service Authorization (pdf)
- Autism Services Service Authorization (SA) Request Form (pdf)
- Mental Health Physician Clinic (MHPC) Service Authorization (SA) Request Form (pdf)
- Psychological and Neuropsychological Testing Service Authorization (SA) Request
- State Plan Service Authorization (pdf)


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# 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 | Agency NPI | * REQUEST RECOVERY EMAIL | |
|---|---|---|---|
| 9 digit, no Text/Charac | 10 digit, no Text/Chara | 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.*

CPT copyright 2021 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association Applicable FARS/DFARS apply. CPT code description are shortened to 28 characters or less to comply with copyright restrictions. For full descriptions, please refer to your current CPT book.

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# 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.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

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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.crippen@optum.com | Click Here |

Submitted Requests

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

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# 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 :

Cancel Submit



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# 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


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# 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.

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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 | Service Auth - 0016

- 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

| Field | Value |
|---|---|
| *Provider Agency Name | Second Nature |
| *Phone Number | 6126427882 |
| Agency NPI | Enter 10 digits, no text/special characters |
| Tax Identification Number | 333333333 |
| *DSM Email Address | eula.crippen@optum.com |
| Fax Number | |
| *Billing Office Contact Name | Eula Crippen |
| *Billing Office Address Line 1 | 408 Oja Way |
| Billing Office Address Line 2 | |
| *Billing Office City | Sitka |
| *Billing Office Address State | AK |
| *Billing Office Zip | 99835 |
| *Request Recovery Email | |


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# Participant details

Provide recipient information on this page.

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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 | Service Auth - 0016

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

*Recipient Name: Samantha Adams

*Recipient ID: 323232

AK AIMS Client ID:

*Gender: Female

*Date of Birth: Aug 28, 2000

*Recipient Eligibility: A Youth (age 0-21) w/SUD (eligible for clinical and rehab

*Other Concurrent Medicaid Services?: Yes

Submit

Save and Exit

Save and Next

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.



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# Services requested by level of care

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

Submit

Save and Exit

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 | 15 mins | |
| SUD Intensive Outpatient ASAM 1.0 - Group | H0007 | Select an option | 15 mins | |
| SUD Partial Hospitalization | H0035 | Select an option | Daily | |

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

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

Choose modifiers and units you are requesting for each service.



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# Need more than one SA type?

* Service(s) Requested

2 options selected

1115 BH Waiver Services | State Plan Services

**Recipient Eligibility for 1115 BH Waiver Services**

*Drop down*:

A child (0-17)

A youth (age 18-21)

An adult (age 21+)

* Is this request for concurrent Medicaid State Plan and 1115 SUD or 1115 BH services?

Yes

**Recipient Eligibility for State Plan Services:**

*Drop down*:

A youth (age 0-21) w/ED (eligible for clinical services ONLY)

An Adult (age 21+) w/ED (eligible for clinical services ONLY)

A youth (age 0-21) w/ SED (eligible for clinical and rehab services)

An Adult (age 21+) w/SMI (eligible for clinical and rehab services)

A youth (age 0-21) w/ SUD (eligible for clinical and rehab services)

An Adult (age 21+) w/SUD (eligible for clinical and rehab services)

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# Two types continued

* Recipient Eligibility for 1115 BH Waiver Services

A Child (age 0-17)

* Recipient Eligibility for State Plan Services

A youth (age 0-21) w/ ED (eligible for

* Type of Service Requested

Select an option...

1115 BH Residential Services

1115 BH Crisis Services

1115 BH Treatment: Home Based

1115 BH Treatment Services

State Plan Behavioral Health Assessment

State Plan Outpatient Psychotherapy

State Plan Community Behavioral Support Services

State Plan Peer Support Services

State Plan Crisis Intervention/Stabilization

* Type of Service Requested

2 options selected

1115 BH Treatment Services | State Plan Community Behavioral Support Services


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# What about the codes?

| 1115 BH Treatment Services | Code | * Modifier(s) | Unit | * Units Requested |
|---|---|---|---|---|
| Intensive Outpatient - Individual | H0015 | Select an option... | 15 mins | |
| Intensive Outpatient - Group | H0015 | Select an option... | 15 mins | |
| Intensive Case Management | H0023 | Select an option... | 15 mins | |
| Partial Hospitalization | H0035 | Select an option... | Daily | |
| Community & Recovery Support Svcs - Individual | H2021 | Select an option... | 15 mins | |
| Community & Recovery Support Svcs - Group | H2021 | Select an option... | 15 mins | |
| Assertive Community Treatment Services | H0039 | Select an option... | 15 mins | |

| State Plan Community Behavioral Support Services | Code | * Modifier(s) | Unit | * Units Requested |
|---|---|---|---|---|
| Day Treatment for Children (R) | H2012 | Select an option... | Hourly | |
| Recipient Support Services (R) | H2017 | Select an option... | 15 mins | |
| Therapeutic BH Services - Individual (R) | H2019 | Select an option... | 15 mins | |
| Therapeutic BH Services - Group (R) | H2019 | Select an option... | 15 mins | |
| Therapeutic BH Services - Family (w/patient present) (R) | H2019 | Select an option... | 15 mins | |
| Therapeutic BH Services - Family (w/out patient present) (R) | H2019 | Select an option... | 15 mins | |
| Case Management (R) | T1016 | Select an option... | 15 mins | |


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# 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.

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

**Treatment Plan Information**

| * Treatment Plan Date | * Requested Service Authorization Start Date | * Requested Service Authorization End Date |
| --- | --- | --- |
| Oct 26, 2020 | Nov 2, 2020 | 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 |
| --- | --- | --- |
| | | |

Save and Next


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# 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


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# 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



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# 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.

Choose File No file chosen

Save Documents

UPLOADED ATTACHMENTS

| NAME | DELETE |
| --- | --- |

Next


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# Submission complete

- This is what it looks like…..

* I am the:

Directing Clinician

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 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 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

* Credentials

* Date of Review by Directing Clinician

* Direct Phone Number

Save Submit

* I am the:

Administrator

As the Assigned Administrator for the above named recipient, 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 recipient's symptomatology, current level of functionality is documented in the recipient'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 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; and
- Acknowledge that approval of this authorization request does not guarantee payment.

* Assigned Administrator Electronic Signature

* Assigned Administrator Credentials

* Date of Review by Assigned Administrator

* Direct Phone Number

Save Submit

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.


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# 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

Application No : Service Auth - 0188

Submitted Date :03/31/2022

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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 | |

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

Close


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# 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
  - (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


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# 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: ☐ 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).*

**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).*

Fill out demographic information entirely.

Remember that the address will be the servicing location

Include admission date and planned date of discharge

Treatment plan dates should be included.

As a reminder: the SA form is referred to as Autism Services which is used interchangeably with ABA (Applied Behavior Analysis)


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# 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:** ____________

Include all behavioral health diagnosis codes.

Include all medical information. If medical conditions impact behavioral health, be sure to include this information.

Include **all** medications, if the patient is compliant with medications, any changes to medications, and any barriers to compliance.

For Risk of harm, include frequency and intensity behaviors, if there are changes to behaviors and if there is a safety plan in place. Can include history as well.


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# 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):

As above, include comorbid medical conditions and how they are impacting the participant's functioning.

If testing is scheduled for issues of cognition include that information. Additionally, if there are barriers to testing include that information. Include what impact this has on functioning.

For substance use, include the date of last use and if there appears to be an adverse effect on functioning.

Issues related to home could include transitions that led to placement. Also include what does the recovery environment look like?


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# 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):

Include trauma history for the participant, including history of OCS or APS involvement.

For treatment history, include dates and levels of care (not just provider name) for all treatment that the participant has received. Provide information on participant engagement if known.

For engagement, include information for both participant and guardian (if applicable). If in OCS or DJJ custody, include this information as well.

For progress and objectives, include information related to the treatment plan and goals. How is the participant doing with reaching their goals?

Under additional medical information, include information regarding discharge planning and potential barriers to discharge. Include coordination of care plans. Highlight current symptoms at time of review and related functional impairments (MSE).


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# 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 | |

Units requested should be filled out for each type of service the participant requires.

Remember, if services will be provided under State Plan and 1115 Waiver, both forms will need to be submitted.


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# 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 |
|---|---|---|---|


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# 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.


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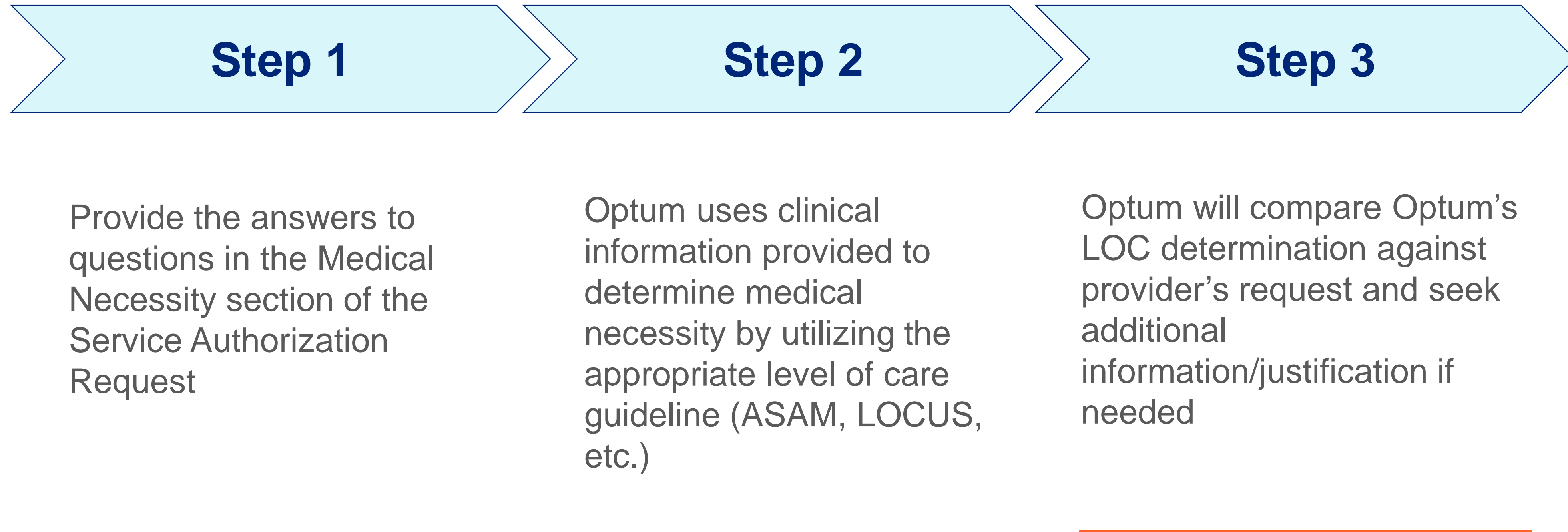
# Making Level of Care Determinations





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# Care Advocates

## Care Advocate Role

Receive and process service authorization requests using level of care guidelines criteria to make determinations, in collaboration with the Medical Directors

## Care Advocate Tools/Medical Necessity Criteria

**ASAM** (SUD), **ECSII** (birth to 6), **LOCUS** (age 18+), **CALOCUS/CASII** (6-18), **Supplemental Clinical Criteria** (Autism services), **APA Guidelines** (Psych/Neuropsych testing services)

## Access: Call, Portal, Fax Coverage

24/7 UM (and Call) Coverage: Operational during AK business hours, after hours, evenings, weekends, and holidays

Initial Service Authorizations can come in via Phone, Fax, Salesforce, or mail

Care Advocates maintain Independent and unrestricted clinical behavioral health licensure. Dependent upon the specialty team in which they work, they may work directly with participants or providers. Care Advocates review requests for clinical or community-based services and determine best service and fit based upon available resources and Level of Care Guideline (LOCG) criteria. Care Advocates collaborate with treating providers and facilities to ensure participants are receiving treatment in line with best practice and clinical guidelines. Additionally, Care Advocates work to coordinate benefits and transitions between various levels of care.


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# Check the Status

## Provider Express

Sparq Online - Home | Features for Provider Express | Auth Inquiry | How can I tell if the website is 5

https://www.providerexpress.com/trans/authInquiryNonFacility.uol

Apps | main menu | Login | Qualtrics | Login | Home | Provider Search | NPPES NPI Registry | Provider Express -... | Genesys | PE Aha! | Reading list

Public Home | Welcome, John Doe (provider) | In-Network | Contact Us | Sign Out

OPTUM® | Provider Express

Elig & Benefits | Claims | Auths | Appeals | My Practice Info | More

Authorization Inquiry * - indicates required field(s)

My Patients | Member ID Search | Name/DOB Search | Authorization # Search

Please complete the form below and click "Search"

* - indicates a required field

Authorization Number *

Search

Security Notice | Privacy | Site Use Agreement | Site Map



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# 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 Optum CMO and provider/agency *then*,
- Denial letter issue with appeals rights provided


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# 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 al-ready 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.


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# Continued Stay

FOR CONTINUED SERVICE REQUESTS ONLY

Is the participant actively engaged in treatment?

choose one...

Is there progress being made on goals and objectives since the last service authorization request?

choose one...

Additional information which may support medical necessity for services requested:

Save and Next


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# 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 completing service auth requests: paper/fillable form or online (via Alaska Optum website)
- 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


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# Clinical Retrospective Review

Retrospective (retro) review is a request for a review of services that have already been delivered and a service authorization has not previously been submitted for clinical review.

Retro reviews may be submitted if a provider was approved by the state to retrospectively cover the time of the service and/or if the participant had Medicaid eligibility retroactively approved to cover dates of service.

If a provider has received a claims denial for lack of service authorization, the claim will be considered out-of-scope for a retro review and the provider would have to submit an appeal instead.

Optum must receive retro review requests in writing via fax or mail. Online salesforce submissions for retrospective reviews are out-of-scope for this process.


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# Clinical Retrospective Review

In order for a request to be considered a Retrospective Review, there are certain requirements that must be met:

- The request must be received **after the member has ended or has been discharged** from the service.
- **No previous approvals or Non-Coverage Determinations (NCD)** can be issued for the episode of care (treatment type, treating provider, and dates of service) identified in the request.
- The request must be received within **180 days after the last date of service.**


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## Required Documentation for a Retrospective Review

- Complete an Optum Alaska retro-review cover sheet. The cover sheet MUST be completed and submitted with all retro-review requests. The cover sheet is located on the provider website at: Alaska.optum.com. Please see below:

I. Once on the site select the "For Alaska Medicaid Providers" tab at the top in the grey
II. Once the drop down opens you will then click "service authorizations"
III. At the bottom of the page, under "Appeals Form" you will find the Retrospective Cover Sheet

- Please include any supporting documentation considered relevant (e.g., admission/intake assessment, biopsychosocial, treatment plan, chart notes, medical records, etc.)


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# Clinical Retrospective Review Cover Sheet

Optum Alaska
Attn: Retroactive Reviews
911 W. 8th Ave Ste 101
Anchorage, Alaska 99501
Fax# 1-855-508-9353

**Retrospective Review Cover Sheet**

**Retrospective reviews must be received in writing and can be requested via fax or mail.**

**Note: Do not submit a Service Authorization form.**

***Only use this cover sheet for Retrospective Review Requests Only**

Participant Name: ____________________________

Participant ID: ______________________________

Participant DOB: _____________________________

Health Plan/Group: STATE OF ALASKA

Provider/Facility Name: _________________________

Provider/Facility NPI: ___________________________

Dates of Service for retro request **ONLY**: ______________________________
(Do not include future dates)

Number of Days/Sessions Requested: ______________________________

Reason prior authorization was not obtained: ___________________________

_____________________________________________________________________

_____________________________________________________________________

**Please include:**

☐ **Treatment plan**

☐ **Any other supporting documentation for this request**

**If documents are not submitted, a review cannot be completed.**


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# How to Submit a Retrospective Review Request to Optum

- There are two options to submit a retrospective review:

I. You may fax the request to the following number: 855.508.9353 OR

II. Mail the request to the following address:

Optum Alaska Attn: Retrospective Reviews

911 W 8th Avenue, Suite 101,
Anchorage, AK 99501


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# Clinical Retrospective Review Determination

Optum will notify providers in writing of the retrospective review decision within 30 days of receipt of the retro-review submission.

To contact the Optum Appeals Department, call 866.245.3040.

If the reviewer upholds the initial decision, providers have the right to file a second level appeal

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# Provider Resources

### Provider Training and Outreach Plan

Onboarding of providers takes place with Provider Relations team. Trainings are located on Alaska Optum Website under Technical Assistance Trainings.

### Call Center

Providers can contact the call center to ask questions or receive assistance with service authorizations 24/7. Contact number: 1-800-225-8764.

### Provider Questions

Issues with: Provider Express or Salesforce: 1-800-225-8764

To complete Service Authorization via phone: 1-800-225-8764

Fax fillable form: 1-844-881-0959

Providers are welcome to email akmedicaid@optum.com during business hours to alert Optum of any issues

Our provider relations department is here to create long-term relationships with providers and engage with them regularly to ensure they are appropriately informed and updated on products, service offerings, and the latest technology available to them.

Provider Relations specialists partner with providers to help them navigate the managed care system and are resources for Provider questions.


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# Q&A


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