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Service Authorization Submission 101

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OPTUM®

What are Medical Necessity Criteria (MNC)?

- Objective criteria that create individualized level of care determinations
- Nonproprietary
- Optum uses MNC that are from professional organizations such as AACAP and AACP:
  - LOCUS
  - CALOCUS-CASII
  - ECSII
  - ASAM

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

The ASAM Criteria®: Dimensions

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United Behavioral Health operating under the brand Optum

Level of Care instruments for BH Medical Necessity Determination

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

BH Medical Necessity Criteria (MNC) Functional Dimensions

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

II: Functional Status
- Capacity for self-care
- Ability to fulfill social responsibilities

III: Co-Occurring Conditions
- Presence and acuity of co-morbid conditions
- Impact of comorbid condition on presenting problem

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

V: Treatment and Recovery History
- History of mental health challenges
- Response to prior treatment

VI: Response to Treatment and Recovery Status
- Understanding of mental health condition
- Willingness to engage in treatment

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

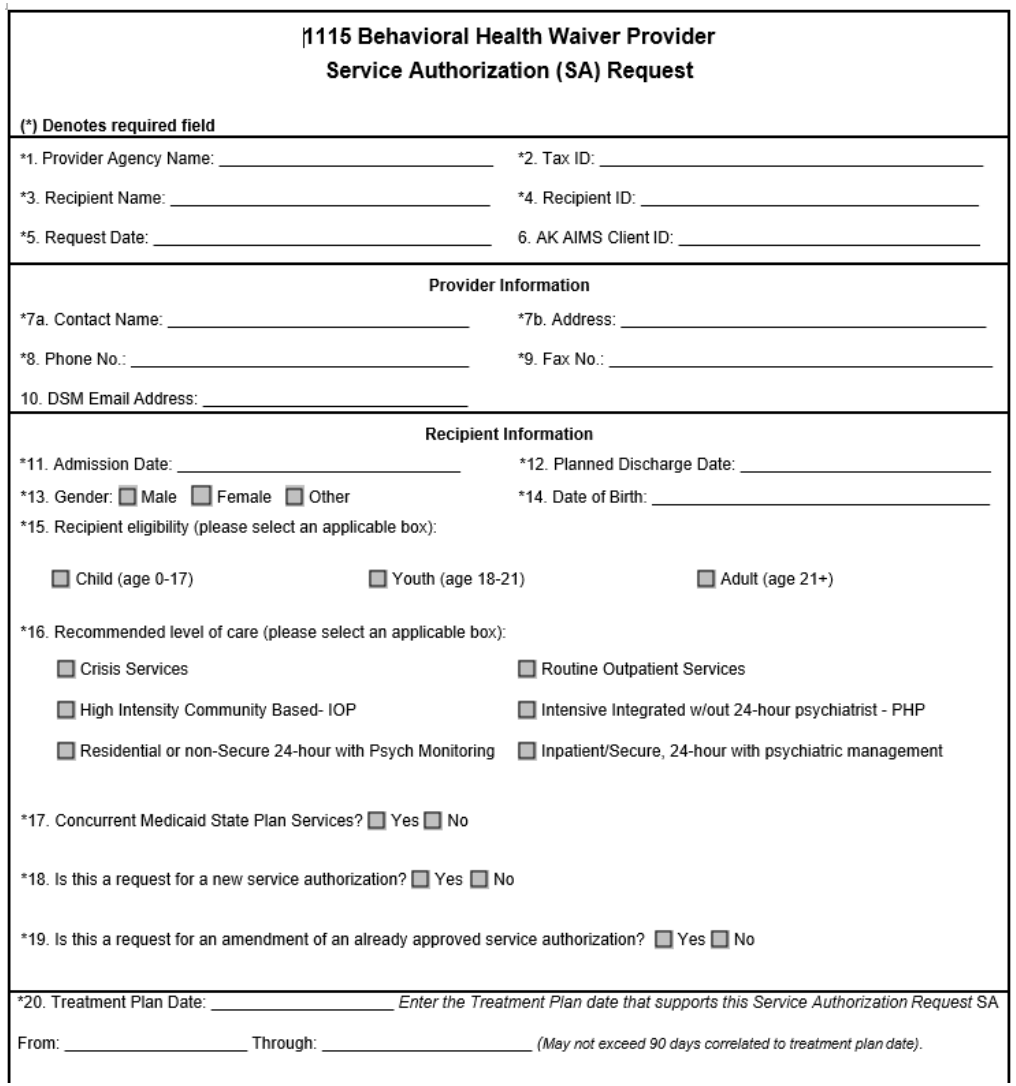
Special service authorization circumstances

Distance and availability of resources:

- The Optum team reviews special circumstances that may necessitate a higher level of care such as the lack of availability of SUD service options within a person's geographical region.
- 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.
- It will be important to note special circumstances when writing the medical necessity essay on your Service Authorization Request.

How to complete the service authorization request form

Paper form



1115 Behavioral Health Waiver Provider
Service Authorization (SA) Request

(*) Denotes required field

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

*3. Recipient Name: _____ *4. Recipient 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: _____

Recipient Information

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

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

*15. Recipient 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).*

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 Change Since Last Service Authorization Request

Is there a current risk of harm to self or other? ☐ Yes ☐ No ☐ No Change Since Last Authorization Request

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:

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 Change Since Last Service Authorization Request

Describe:

Are there comorbid medical issues? ☐ Yes ☐ No ☐ No Change Since Last Service Authorization Request

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 Change Since Last Service Authorization Request

If yes, describe co-occurring issues of cognition:

Are there co-occurring substance abuse issues? ☐ Yes ☐ No ☐ No Change Since Last Service Authorization Request

If yes, describe co-occurring substance abuse issues:

Are there any concerns related to home/living environment? ☐ Yes ☐ No ☐ No Change Since Last Service Authorization Request

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

How to complete the service authorization request - paper version

Is there a history with trauma/ACE? ☐ Yes ☐ No ☐ No Change Since Last Service Authorization Request

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 Change Since Last Service Authorization Request

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 Change Since Last Service Authorization Request

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 Change Since Last Service Authorization Request

Describe:

Is there progress being made on goals and objectives since the last service authorization request? ☐ Yes ☐ No ☐ No Change Since Last Service Authorization Request

Describe:

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

How to complete the service auth request - paper version

Units Requested				
Treatment Plan Services	**Code**	**Modifiers**	**Unit**	***23. Units Requested**
Treatment Plan Development/Review	T1007	V2	Per Assessment	
Treatment Plan Development/Review (Telehealth)	T1007	V2 GT	Per Assessment	
Mental Health Treatment 1115 Services	**Code**	**Modifiers**	**Unit**	***24. Units Requested**
Intensive Outpatient - Individual	H0015	V2	15 mins	
Intensive Outpatient - Individual (Telehealth)	H0015	V2 GT	15 mins	
Intensive Outpatient - Group	H0015	HQ V2	15 mins	
Intensive Outpatient -Group (Telehealth)	H0015	HQ V2 GT	15 mins	
Partial Hospitalization	H0035	V2	Daily	
Intensive Case Management	H0023	V2	15 mins	
Intensive Case Management (Telehealth)	H0023	V2 GT	15 mins	
Community & Recovery Support Services - Individual	H2021	V2	15 mins	
Community & Recovery Support Services - Individual (Telehealth)	H2021	V2 GT	15 mins	
Community & Recovery Support Services - Group	H2021	HQ V2	15 mins	
Community & Recovery Support Services - Group (Telehealth)	H2021	HQ V2 GT	15 mins	
Assertive Community Treatment Services	H0039	V2	15 mins	
Outpatient Mental Health Treatment 1115 Services: Home Based	**Code**	**Modifiers**	**Unit**	***25. 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**	***26 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	

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 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 & 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 recipient, I hereby:

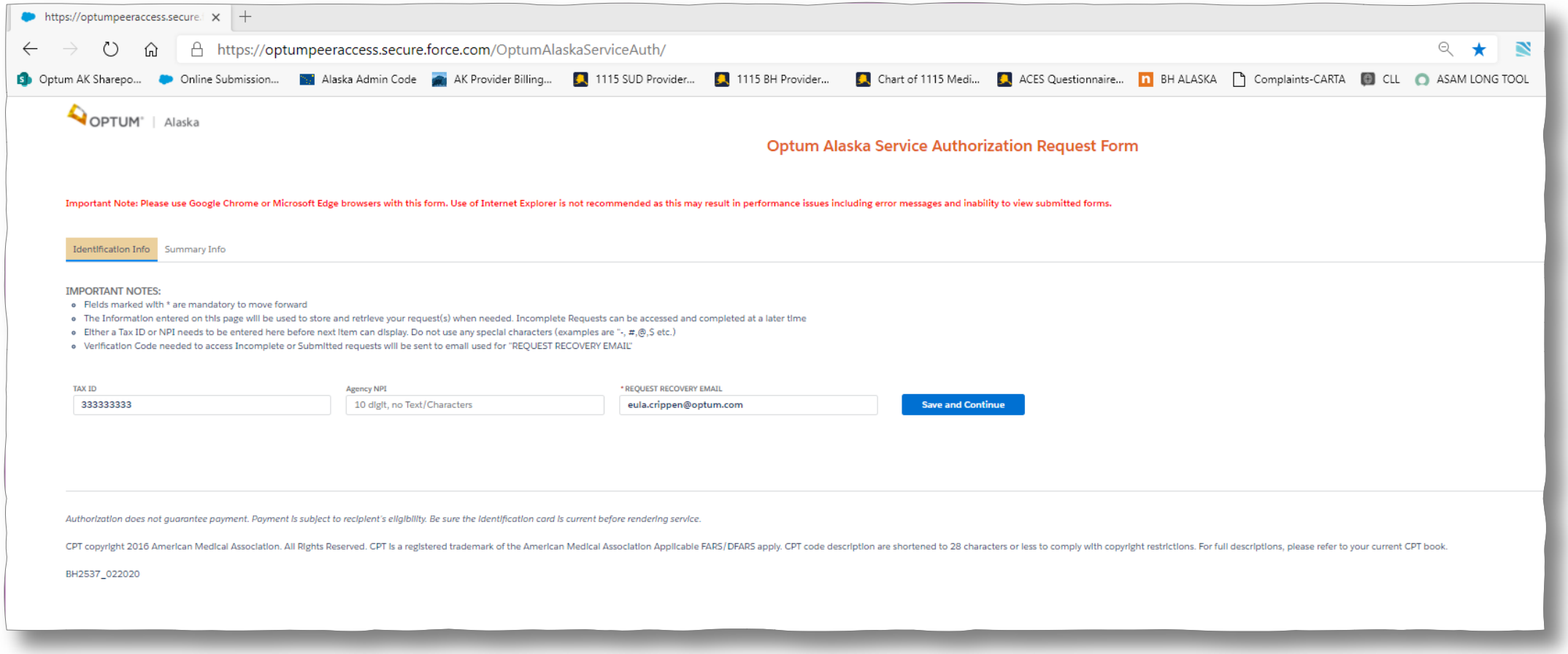
- Affirm that the above described clinical information is true and accurate, as provided by the directing clinician.
- Affirm that I am signing on behalf of the directing clinician with their knowledge and approval.
- Affirm the assessment of the recipient's symptomatology, current level of functionality 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 & 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

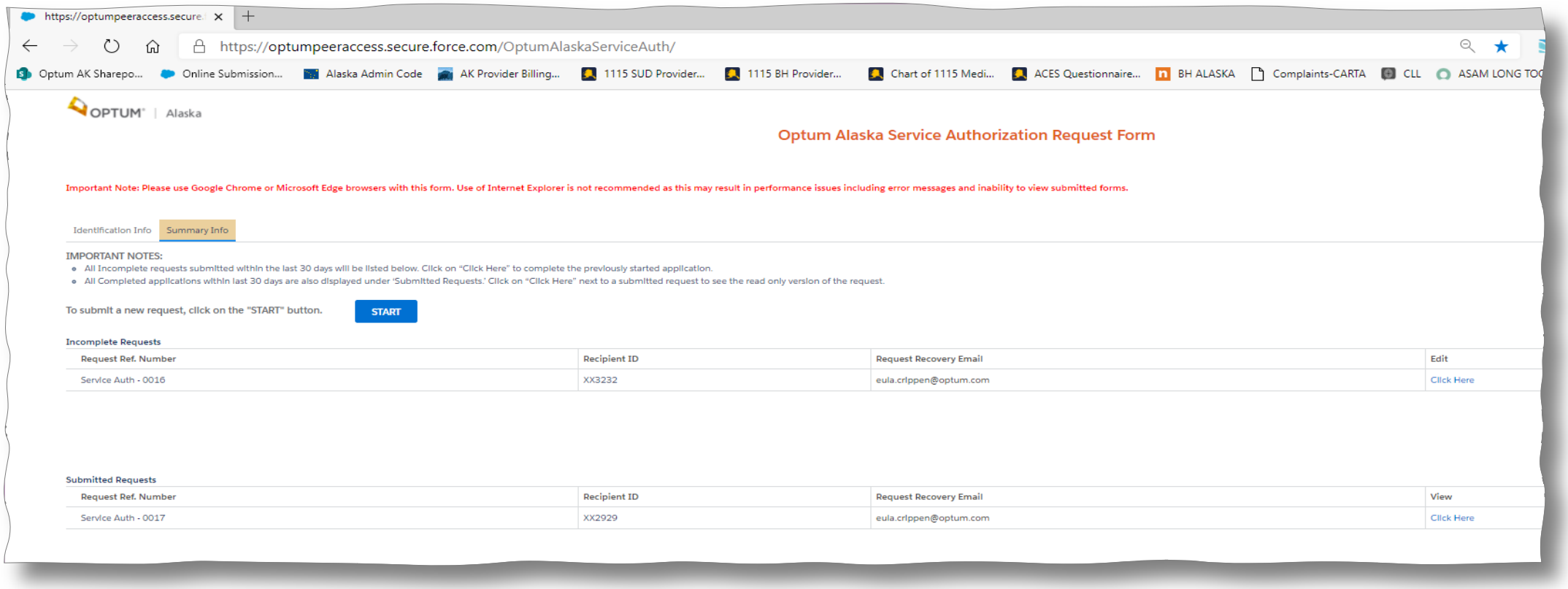
How to get started with an Online Service Authorization request submission

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



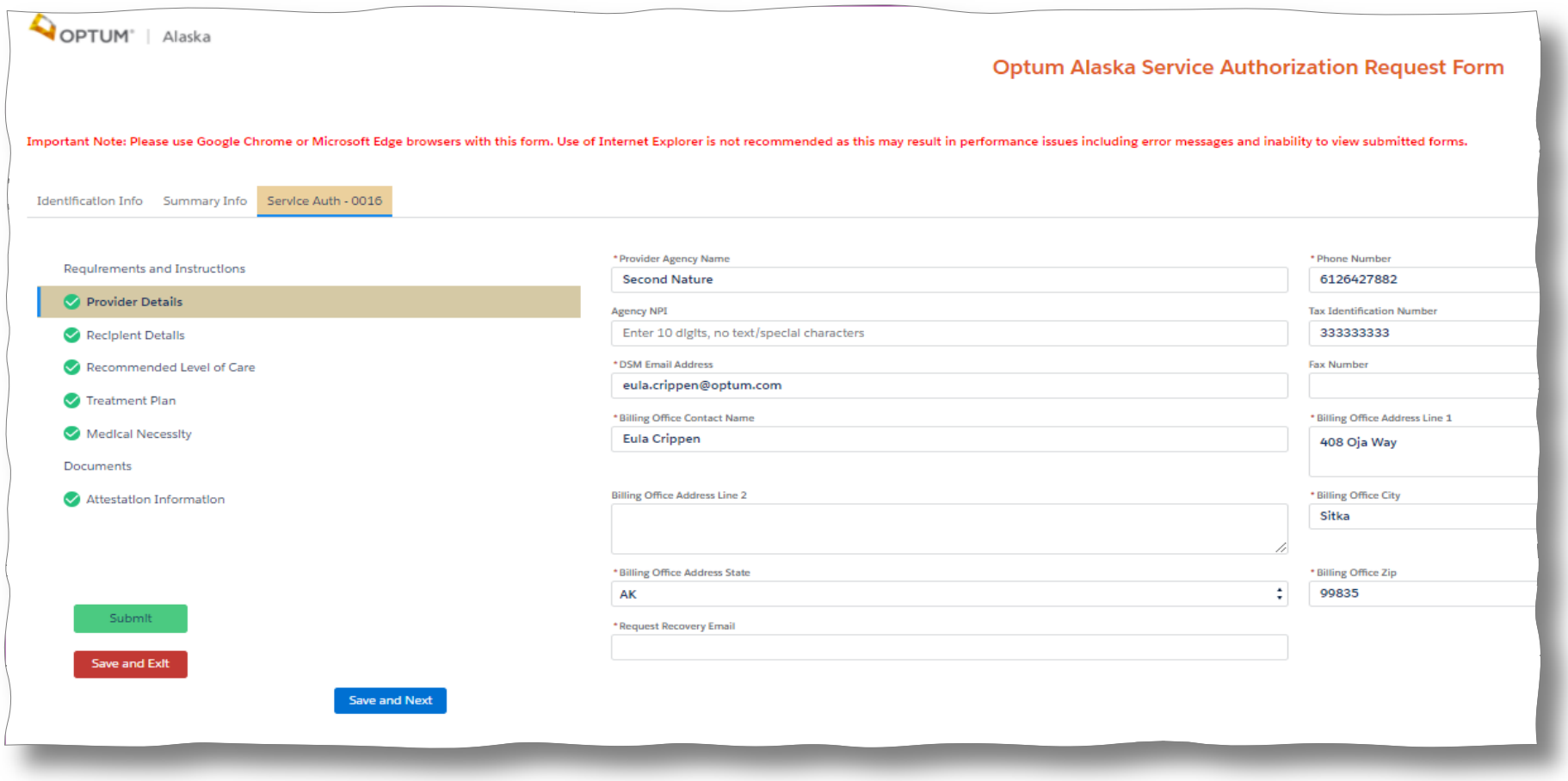
Service Authorization Summary Info

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



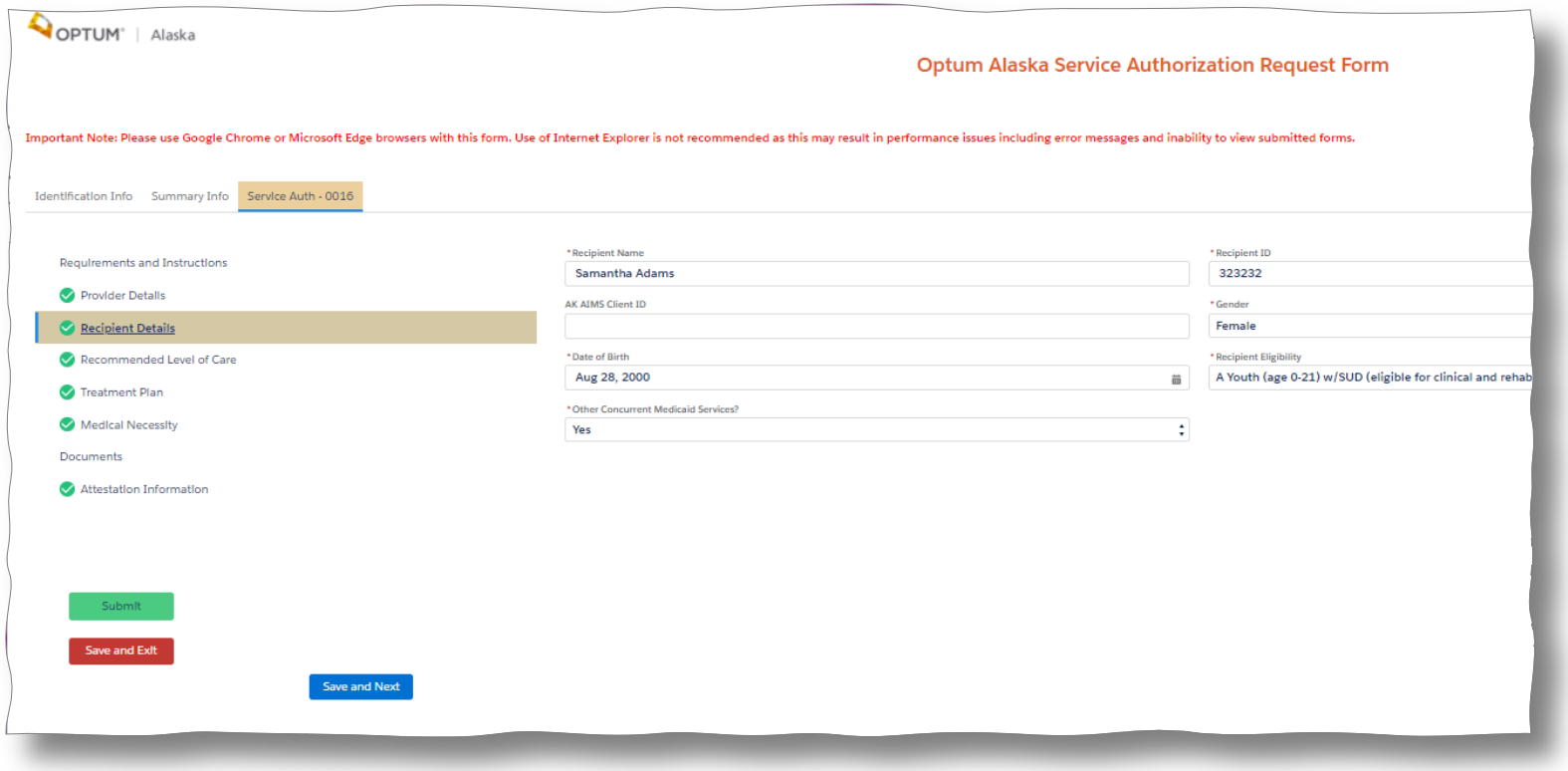
Provider Details

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



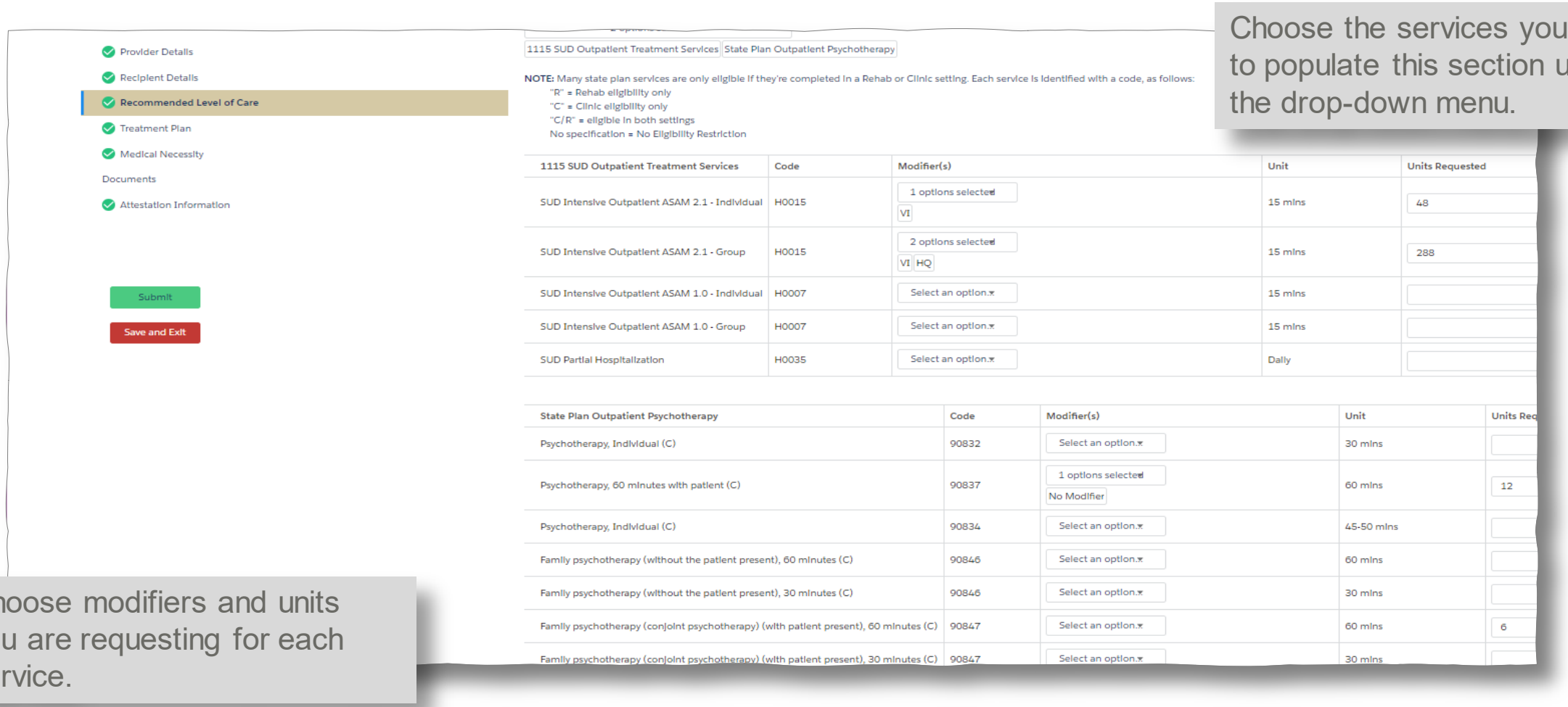
Recipient Details

Provide recipient information on this page.



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

Services requested by Level of Care

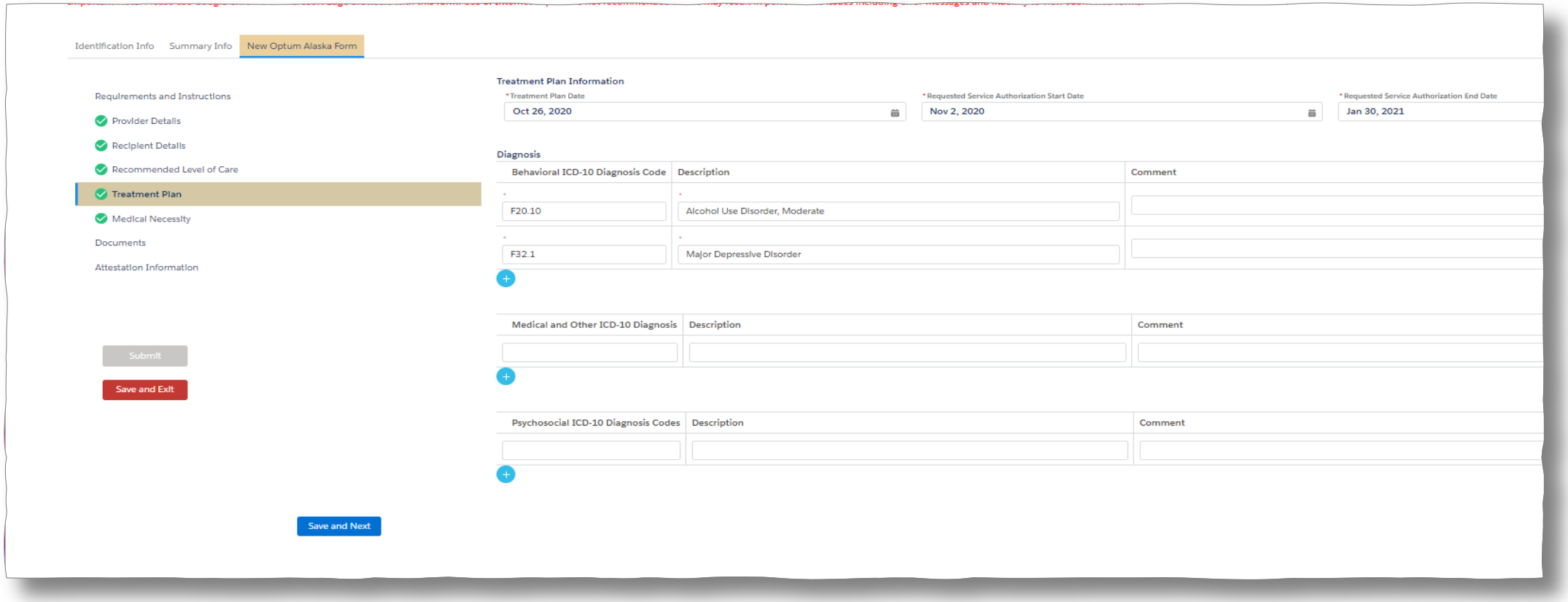


Choose the services you want to populate this section using the drop-down menu.

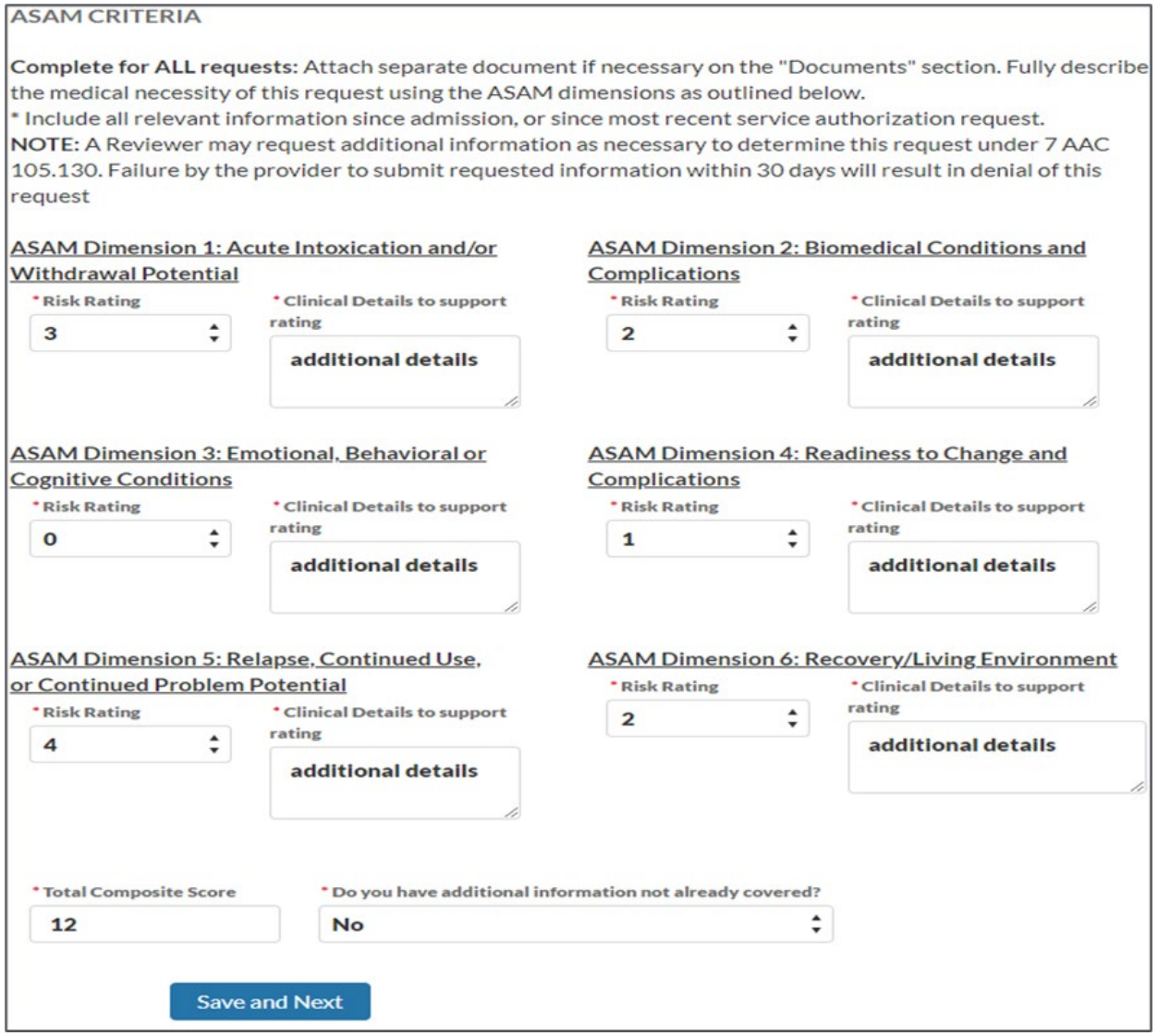
Choose modifiers and units you are requesting for each service.

Diagnoses and Treatment Plan

Provide the Treatment Plan dates, the date on which services will begin, and the date by which the services will end and all relevant diagnoses.



Online submission SUD clinical criteria



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?**

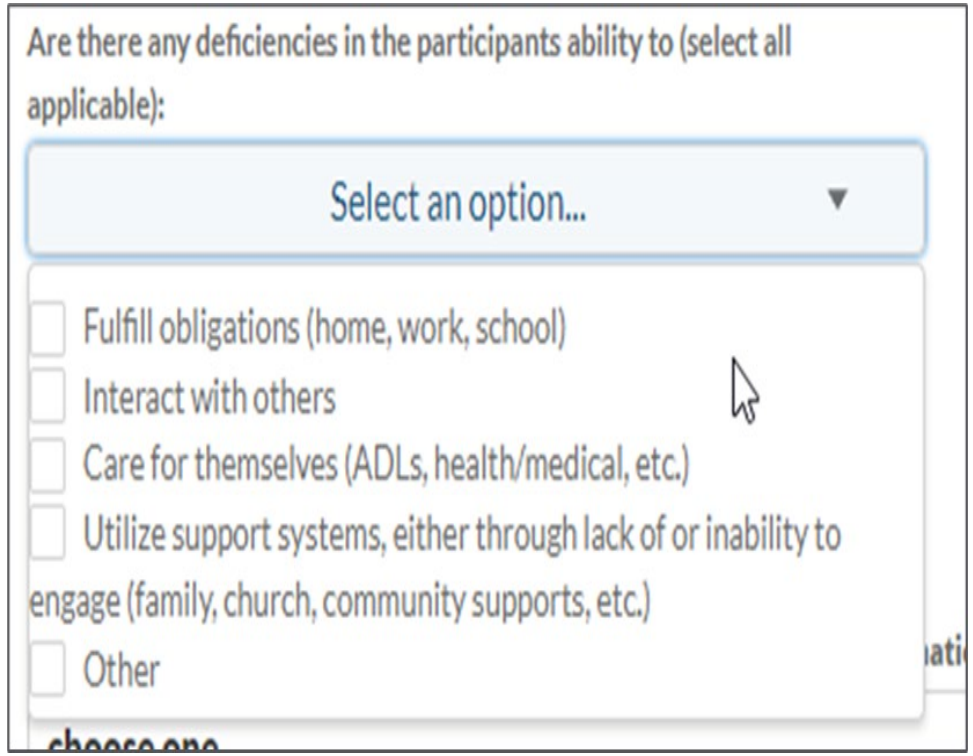
choose one...

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

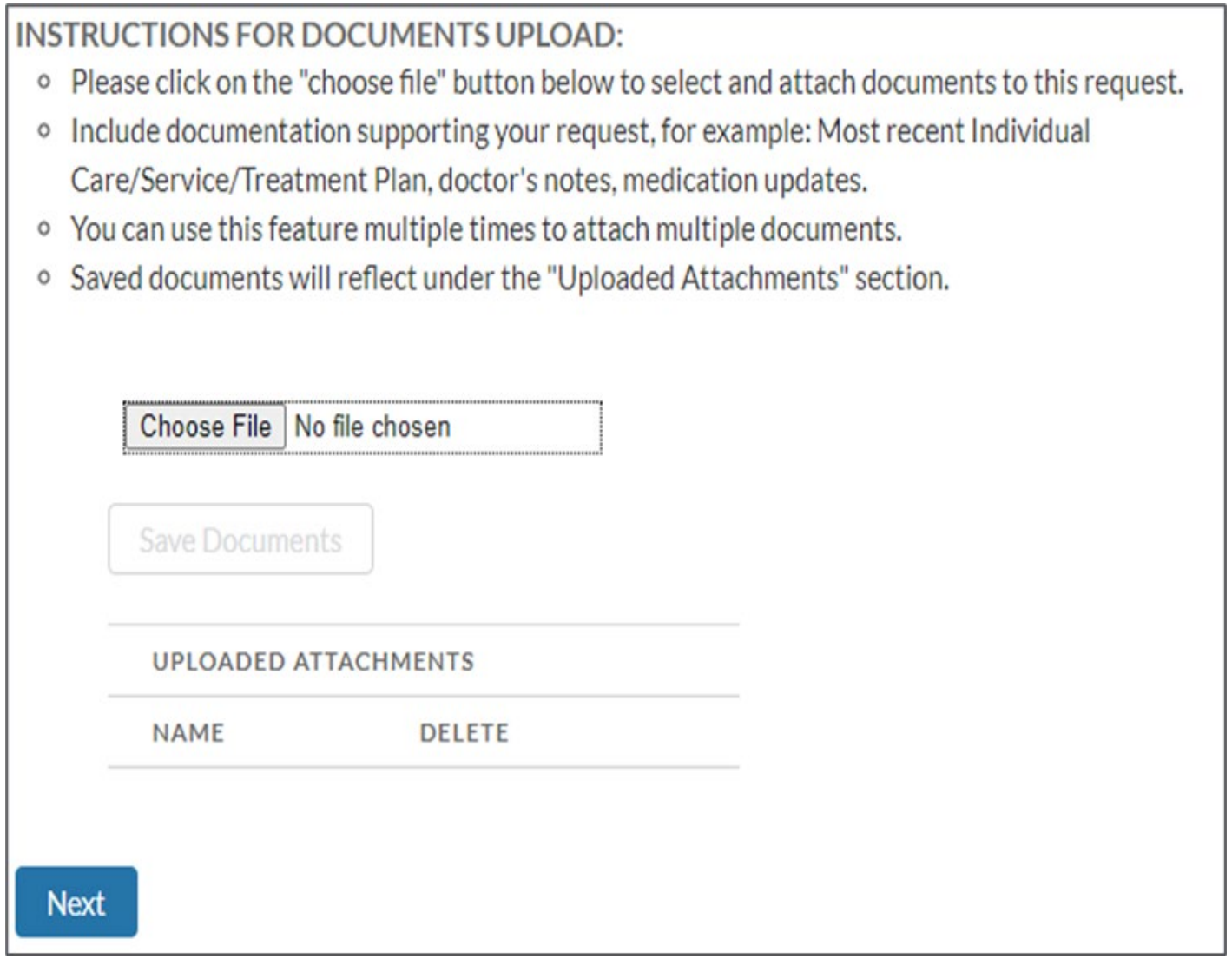
choose one...

*** Are there co-occurring substance abuse issues?**

choose one...



Uploading supporting documents



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

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

Questions?