November 2021

Service Authorization Submission 101

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Chief Medical Officer

Optum Alaska

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BH3696_11/2021

United Behavioral Health operating under the brand 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

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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

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The ASAM Criteria®: Dimensions

1: Acute Intoxication and/or Withdrawal Potential

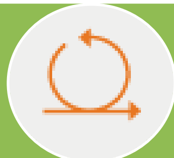
- Current withdrawal symptoms
- Past history of serious, life-threatening withdrawal

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

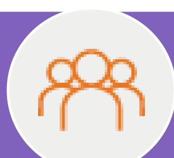


4: Readiness to Change

- 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+ • 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

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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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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 o 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 o BH IOP; HBFT level 3; ICM
• High Risk	• ASAM 2.5- PHP	• LOCUS/CASII 20-23; ESCII 23-26 o BH PHP, ACT, TTH
• Very High Risk	• ASAM 3.1/3.3/3.5	• LOCUS/CASII 23-17; ESCII 27-30 o Adult/Children's MH Residential level 1 or 2
• Secure Monitored	• ASAM 3.7/4.0	• LOCUS/CASII 28+ o Locked residential vs acute inpatient o This level not available for ESCII

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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.

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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. 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).*

1115 Substance Use Disorder 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):

☐ 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).*

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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 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:

***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.

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

Dimension 2: Biomedical Conditions and Complications
Risk Rating: ____________
Clinical Details to support rating:

Authorization does not guarantee payment. Review and subsequent approval (if any) is limited to the services requested. Payment is subject to recipient's eligibility. Be sure the identification card is current before rendering services. Requests for additional units should be in increments associated to that service code State Fiscal Limits.

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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 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:

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):

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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:

<u>For continued services requests only</u>, 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):

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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	

Units Requested				
Treatment Plan Services	**Code**	**Modifiers**	**Unit**	***23. Units Requested**
Treatment Plan Development/Review	T1007	V1	Per Assessment	
Treatment Plan Development/Review (Telehealth)	T1007	V1 GT	Per Assessment	
Outpatient SUD Services	**Code**	**Modifiers**	**Unit**	***24. Units Requested**
Outpatient Services ASAM 1.0 – Individual	H0007	V1	15 mins	
Outpatient Services ASAM 1.0 – Individual (Telehealth)	H0007	V1 GT	15 mins	
Outpatient Services ASAM 1.0 – Group Adolescent	H0007	HQ, HA, V1	15 mins	
Outpatient Services ASAM 1.0 – Group Adolescent (Telehealth)	H0007	V1 GT HQ HA	15 mins	
Outpatient Services ASAM 1.0 – Group Adult	H0007	HQ, HB, V1	15 mins	
Outpatient Services ASAM 1.0 – Group Adult (Telehealth)	H0007	V1 GT HQ HB	15 mins	
Intensive Outpatient ASAM 2.1 - Individual	H0015	V1	15 mins	
Intensive Outpatient ASAM 2.1 - Individual (Telehealth)	H0015	V1 GT	15 mins	
Intensive Outpatient ASAM 2.1 - Group	H0015	HQ, V1	15 mins	
Intensive Outpatient ASAM 2.1 - Group (Telehealth)	H0015	V1 GT HQ	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 - 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 - 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	

Authorization does not guarantee payment. Review and subsequent approval (if any) is limited to the services requested. Payment is subject to recipient's eligibility. Be sure the identification card is current before rendering services. Requests for additional units should be in increments associated to that service code State Fiscal Limits.

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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 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

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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.

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 TOOL

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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:

- 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
- 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.)
- Verification Code needed to access Incomplete or Submitted requests will be sent to email used for "REQUEST RECOVERY EMAIL"

TAX ID	Agency NPI	* REQUEST RECOVERY EMAIL	
333333333	10 digit, no Text/Characters	eula.crippen@optum.com	Save and Continue

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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. 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.

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 TOO

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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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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	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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Recipient Details

Provide recipient information on this page.

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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

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

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 modifiers and units you are requesting for each service.

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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.

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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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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

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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 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

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Questions?

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