Optum

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).*

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***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:

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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:

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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):

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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	

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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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1115 Behavioral Health Waiver Provider
Service Authorization (SA) Form Instructions

Submission Requirements: Only one service code per authorization. This Service Authorization (SA) request must be completed to indicate the amount of the one service 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. **Submit Service Authorization requests directly to Optum Alaska**, by fax: 1-844-881-3753 or by calling (800) 225-8764 to complete a telephonic review or by mail: 911 W. 8th Ave STE 101 Anchorage AK 99501.

1. **Provider Agency Name:** Enter the name of the enrolled 1115 BH Waiver services provider.
2. **Provider ID:** Enter the Alaska Medical Assistance identification number assigned to the 1115 BH Waiver services provider.
3. **Recipient Name:** Enter the name of the recipient for whom the authorization is being requested.
4. **Recipient ID:** Enter the recipient's Alaska Medical Assistance identification number.
5. **Request Date:** Enter the date the authorization request is being submitted.
6. **AK AIMS Client ID:** Enter the Client ID number referenced within the Alaska Automated Information System (AK AIMS) for this recipient.
7. **Billing Office Contact Name and Address:** Enter the name and address of the person Optum staff should contact regarding the authorization request.
8. **Phone No.:** Enter the contact person's telephone number.
9. **Fax No.:** Enter the contact person's fax number, if applicable.
10. **Direct Secure Messaging (DSM) E-Mail Address:** Enter the contact person's e-mail address, if applicable.
11. **Admission Date:** Enter admission date, if applicable.
12. **Planned Discharge Date:** Enter planned discharge date, if applicable.
13. **Gender:** Check appropriate box indicating gender.
14. **Date of Birth:** Enter the recipient's date of birth.
15. **Recipient eligibility:** Check the appropriate box indicating the recipient's 1115 BH Waiver Service eligibility category.
16. **Recommended level of care:** Check the appropriate box indicating the recommended level of care for 1115 BH Waiver services.
17. **Concurrent Services:** Check the appropriate box to indicate whether the recipient receives concurrent state plan services.
18. **New Request:** Check the appropriate box to indicate whether this is a new service authorization request for this recipient.
19. **Request to Amend:** Check the appropriate box to indicate if this is a request to amend an authorization request that was already approved.
20. **Treatment Plan Date:** Enter the Treatment Plan date that supports this 1115 BH Waiver Services Service Authorization (SA) Request.
21. **Diagnosis Codes:** Enter ICD-10 codes, descriptions, and comments.
22. **Medical Necessity Description – Complete for ALL requests:** Fully describe the medical necessity for each section. Additional attachments can be included as appropriate.

    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.**

23-27. **Units Requested (1115 BH Waiver services):** Enter the cumulative total units of service that are being requested including the number of units previously requested if this is an amendment of an already approved service.

28. **Directing Clinician(a) or Assigned Administrator(b) Signature:** The signature must be that of the directing clinician assigned to the recipient's case or an administrator acting on behalf of the directing clinician, who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements. Only one signature is necessary.

    Note: Medical necessity may be reviewed during post-payment review activities according to Alaska Medical Assistance program rules. DHSS may initiate recovery of funds paid for any services that are not medically necessary, not properly documented, or not in compliance with Alaska Medical Assistance program rules.

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