Optum

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
- ☐ Intensive Outpatient
- ☐ Partial Hospitalization
- ☐ Residential and Inpatient SUD Treatment Services
- ☐ Alcohol and Drug Withdrawal Management Services
- ☐ Community Based Support Services
- ☐ Crisis 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).*

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.

***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: _____

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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):

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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	

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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.

30a. _____ _____ _____ _____
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.

30b. _____ _____ _____ _____
Administrative Assistant | Credentials | Signature | Date

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1115 Substance Use Disorder Waiver Provider
Service Authorization (SA) Form Instructions

Submission Requirements: This Service Authorization (SA) request must be completed to indicate the amount of the 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 or administrative assistant 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 at 1-844-881-3753 or by calling 1-800-225-8764 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 SUD Waiver services provider.
2. **Tax ID:** Enter the Tax Identification number assigned to the 1115 SUD 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 SUD Waiver Service eligibility category.
16. **Recommended level of care:** Check the appropriate box indicating the recommended level of care for 1115 SUD 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 SUD 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 this request including a description of the recipient's (a) current maladaptive behavior, (b) functional status, and (c) reasons the recipient is unable to maintain without these services. Use (d) if additional space is needed to describe Psychosocial ICD-10 Diagnosis Code(s). Attach separate paper if necessary.

    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.**

23-29. **Units Requested (1115 SUD 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 authorization.

30. **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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