Optum

State Plan Behavioral Health
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):

Eligible for Clinical Services ONLY	**Eligible for Clinical and Rehabilitation Services**
☐ Youth (age 0-21) w/ED ☐ Adult (age 21+) w/ED	☐ Youth (age 0-21) w/SED ☐ Youth (age 0-21) w/SUD ☐ Adult (age 21+) w/SMI ☐ Adult (age 21+) w/SUD

*16. Is this request for concurrent Medicaid State Plan and 1115 SUD or 1115 BH? ☐ Yes ☐ No

*17. Is this a request for a new service authorization? ☐ Yes ☐ No

*18. Is this a request for an amendment of an already approved service authorization? ☐ Yes ☐ No

*19. Is this a request for combined clinical and rehab services in excess of 12 hours/day? ☐ Yes ☐ No

If this request is for an assessment *only*, Treatment Plan information is not required.

*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**

Please complete each section below. Additional attachments can be included as appropriate. Fully describe the medical necessity of this request using the behavioral health areas outlined below.

NOTE: If requesting assessment ONLY: write "N/A" in sections a. through j. and complete Section 23.

*****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.

a. List current prescribed medications (include psychotropic medications in this section):

☐ No Update

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b. Is there a current risk of harm to self or others? ☐ 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:

c. 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:

d. Are there comorbid medical issues? ☐ Yes ☐ No ☐ No Update

If yes, describe current comorbid medical issues:

e. 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:

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f. Are there co-occurring substance abuse issues? ☐ Yes ☐ No ☐ No Update

If yes, describe co-occurring substance abuse issues:

g. 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:

h. 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):

i. 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:

j. Is the participant/Guardian willing to engage in services and/or motivated to change? ☐ Yes ☐ No ☐ No Update

Describe:

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23. FOR ASSESSMENTS ONLY, with no additional services being requested - Include relevant information to support request for assessments in excess of the state fiscal year limit:

24. FOR CONTINUED SERVICE REQUESTS ONLY

a. Is the participant actively engaged in treatment? ☐ Yes ☐ No ☐ No Update

Describe:

b. Is there progress being made on goals and objectives since the last service authorization request? ☐ Yes ☐ No ☐ No Update

Describe:

25. Additional information which may support medical necessity for services requested:

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Please sign the attestation appropriate to your role (only one signature is necessary for submission):

*26. Specific Services Requested						
Behavioral Health Assessment	**SERVICE TYPE**		**Code**	**Modifiers**	**Unit**	**Units Requested**
	Clinic	**Rehab**				
Mental Health Intake Assessment	✓		H0031		1 Assessment	
Integrated Mental Health & Substance Use Assessment	✓		H0031	HH	1 Assessment	
Alcohol and/or Drug Assessment		✓	H0001		1 Assessment	
Psychiatric Assessment -Diagnostic Interview	✓		90791		1 Eval	
Outpatient Psychotherapy	**Service Type**		**Code**	**Modifiers**	**Unit**	**Units Requested**
	Clinic	**Rehab**				
Psychotherapy, Individual	✓		90832		30 mins	
Psychotherapy, Individual	✓		90834		45 mins	
Psychotherapy, Individual	✓		90837		60 mins	
Family psychotherapy (without the patient present)	✓		90846		50 mins	
Family psychotherapy (without the patient present)	✓		90846	U7	30 mins	
Family psychotherapy (with patient present) (conjoint psychotherapy)	✓		90847		50 mins	
Family psychotherapy (with patient present) (conjoint psychotherapy)	✓		90847	U7	30 mins	
Multiple-family group psychotherapy	✓		90849		60 mins	
Multiple-family group psychotherapy	✓		90849	U7	30 mins	
Group psychotherapy (other than of a multiple-family group)	✓		90853		60 mins	
Group psychotherapy (other than multiple-family group)	✓		90853	U7	30 mins	
Community Behavioral Support Services (Rehabilitation)	**Service Type**		**Service Type**	**Modifiers**	**Unit**	**Units Requested**
	Clinic	**Rehab**				
Day Treatment for Children		✓	H2012		60 mins	
Therapeutic BH Services - Individual		✓	H2019		15 mins	
Therapeutic BH Services - Group		✓	H2019	HQ	15 mins	
Therapeutic BH Services - Family (with patient present)		✓	H2019	HR	15 mins	
Therapeutic BH Services - Family (w/o patient present)		✓	H2019	HS	15 mins	
Case Management		✓	T1016		15 mins	

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Peer Support Services	Service Type		Service Type	Modifiers	Unit	Units Requested
	Clinic	Rehab				
Peer Support Services - Individual		✓	H0038		15 mins	
Peer Support Services - Family (with patient present)		✓	H0038	HR	15 mins	
Peer Support Services - Family (w/o patient present)			H0038	HS	15 mins	
Crisis Intervention/ Stabilization	**Service Type**		**Service Type**	**Modifiers**	**Unit**	**Units Requested**
	Clinic	**Rehab**				
Short-term Crisis Stabilization Service		✓	H2011		15 mins	
Short-term Crisis Intervention Service	✓		S9484		60 mins	
Short-term Crisis Intervention Service	✓		S9484	U6	15 mins	

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.

*27a. _____ _____ _____ _____
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 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.

*27b. _____ _____ _____ _____
Administrative Assistant | Credentials | Signature | Date

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State Plan Behavioral Health
Service Authorization (SA) Form Instructions

Submission Requirements: This Service Authorization (SA) request must be completed to indicate the amount of 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 or administrative assistant assigned to the participant'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: 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 State Plan services provider.
2. **Tax ID:** Enter the tax identification number assigned to the State Plan services provider.
3. **Participant Name:** Enter the name of the participant for whom the authorization is being requested.
4. **Participant ID:** Enter the participant'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 participant.
7. **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 participant's date of birth.
15. **Participant eligibility:** Check the appropriate box indicating the participant's State Plan Service eligibility category.
16. **Concurrent Services:** Check the appropriate box to indicate whether the participant receives concurrent 1115 Waiver services.
17. **New Request:** Check the appropriate box to indicate whether this is a new service authorization request for this participant.
18. **Request to Amend:** Check the appropriate box to indicate if this is a request to amend an authorization request that was already approved.
19. **Request for more than 12 hours combined services:** Check the appropriate box to indicate if this is a request for combined clinical and rehab services in excess of 12 hours/day.
20. **Treatment Plan Date:** Enter the Treatment Plan date that supports this State Plan Service Authorization (SA) Request.
21. **Diagnosis Codes:** Enter ICD-10 codes, descriptions, and comments.
22. **Medical Necessity Description – Complete a.-h. for service authorization requests (except for psychological testing or assessment only 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. **For Assessment Requests Only:** Complete this field for assessment requests only, when no other services are being requested. Item 20 can be skipped when this item is completed.
24. **For Continued Service Requests Only:** Enter relevant information about the participant, focusing on what has occurred since last review. Do not complete if request is an initial request for services.
25. **Additional Information:** Include any additional information that may be relevant for the participant's care and needs, that may not have been covered in the previous Medical Necessity sections. This is not a required field and should be completed as needed.
26. **Specific Services Requested:** Enter the appropriate number of units for each service requested. Some state plan services are only available in a clinic setting and some are only available in a rehabilitation setting. Each service has a corresponding check mark to indicate which setting is eligible to provide the service. Requests for services must correspond with requesting provider setting.
27. **Directing Clinician(a) or Assigned Administrator(b) Signature:** The signature must be that of the directing clinician assigned to the participant'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.

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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