Optum

Alaska Medicaid Autism Services Service Authorization (SA) Request Form

(*) 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

7. Provider Type:

- ☐ Behavior Analyst
- ☐ Behavior Analyst Group Practice
- ☐ Assistant Behavior Analyst
- ☐ Community Behavioral Health Services Provider
- ☐ Autism Behavior Technician

8. Is provider Autism certified? ☐ Yes ☐ No

*9. Billing Office Contact Name:_____Address: _____

*10. Phone #:_____*11. Fax #:_____12. DSM E-Mail Address: _____

Participant Information

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

15. Participant eligibility (please select an applicable box):

- ☐ A child (age 0-5) diagnosed with Autism Spectrum Disorder (ASD)
- ☐ A child (age 6-12) diagnosed with Autism Spectrum Disorder (ASD)
- ☐ A youth (age 13-under 21) diagnosed with Autism Spectrum Disorder (ASD)

*16. Current Living Situation *(choose one)*:

- ☐ Assisted Living Home licensed under AS 47.32
- ☐ Residential Child Care Facility licensed under 7 AAC 50.005 – 7 AAC 50.790
- ☐ Foster Home licensed under 7 AAC 56
- ☐ Participant's Private Residence
- ☐ Other _____

*17. Concurrent Services? ☐ Yes ☐ No

If yes, indicate concurrent services recipient is receiving:

- ☐ Behavioral Residential Treatment Services for Children under 7 AAC 139.325: ☐ Level 1 ☐ Level 2
- ☐ Therapeutic Treatment Home Services under 7 AAC 139.400
- ☐ Home and Community-Based Waiver Services under 7 AAC 130.205 (d)(1) and (3)

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☐ Residential Supported Living Services under 7 AAC 130.255

☐ Residential Habilitation Services under 7 AAC 130.265:

☐ Family Home Habilitation Services

☐ Supported Living Habilitation Services - Hours per Day: _____

☐ Group Home Habilitation Services

☐ In-Home Support Habilitation Services - Hours per Day: _____

☐ Residential Substance Use Disorder Treatment under 7 AAC 135.280

Treatment Request Information

*18. Treatment Plan Date:_____ (*Enter the Treatment Plan date that supports this Service Authorization Request)*

Note: Participants receiving Autism Services must have a written individualized treatment plan. Please attach Participant's individualized treatment plan with this SA request.

☐ New Request: SA From:_____ Through:_____ *(May not exceed 90 days correlated to treatment plan date)*.

☐ Update to existing SA (*requesting additional service codes and/or units, no change to current SA dates*): SA#: _____

***19. Diagnosis Codes**

a) Qualifying diagnosis of Autism Spectrum Disorder (ASD) *and any other 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

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20. Medical Necessity Criteria

Additional attachments can be included as appropriate.

Note: Participants receiving Autism Services must have a written individualized treatment plan. Please attach Participant's individualized treatment plan with this SA 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.

*Was the Participant's ASD diagnosis a result of a comprehensive diagnostic evaluation? ☐ Yes No Unknown

*Who Gave the ASD diagnosis?_____ *Date of ASD diagnosis:_____

*How long has the Participant been receiving Autism Services (length of time in years)? _____

Domains:

***Are communication skills targeted? ☐ Yes ☐ No**

What are the Participant's communication abilities (e.g., are they verbal?):

What is the severity of the Participant's communication deficits as outlined by the DSM-5?

☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ None

Main deficit:

Participant's progress toward treatment goals within this domain over the past 6 months:

What is the target mastery skill within this domain?

***Are social skills targeted? ☐ Yes ☐ No**

What is the severity of the recipient's social interaction deficits as outlined by the DSM-5?

☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ None

Main deficit:

Participant's progress toward treatment goals within this domain over the past 6 months:

What is the target mastery skill within this domain?

***Are restricted, repetitive patterns of behavior targeted? ☐ Yes ☐ No**

What is the severity of the Participant's restricted, repetitive patterns of behavior, interests or activities as outlined by the DSM-5?

☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ None

Main deficit:

Participant's progress toward treatment goals within this domain over the past 6 months:

What is the target mastery skill within this domain?

***Are destructive/maladaptive behavior(s) targeted? ☐ Yes ☐ No**

What is the severity of the Participant's destructive/maladaptive behaviors such as aggression or self-injurious behavior as outlined by the DSM-5?

☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ None

Main deficit:

Participant's progress toward treatment goals within this domain over the past 6 months:

What is the target mastery skill within this domain?

Other:

Domain Area: _____

Main deficit:

Participant's progress toward treatment goals over the past 6 months within this domain:

What is the target mastery skill within this domain?

Domain Area: _____

Main deficit:

Participant's progress toward treatment goals over the past 6 months within this domain:

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What is the target mastery skill within this domain?

Caregiver Involvement:

Provide a brief description of caregiver involvement (i.e. separate training sessions, shadowing in sessions, etc.):

*What is the caregiver(s) proficiency level in implementing treatment strategies with the Participant?

☐ Low ☐ Moderate ☐ High ☐ Proficient

*How many hours per week are the Participant's caregivers involved in either treatment sessions or caregiver training?

☐ 0-10 ☐ 11-20 ☐ 21-30 ☐ 31+

*Location of Autism Service delivery:

☐ Primarily home/community
☐ Primarily center
☐ Primarily school
☐ Mix home/community & center
☐ Mix center & school
☐ Mix home/community, school & center
☐ Mix home/community & school
☐ Unknown

Coordination of Care:

*Is the Participant receiving additional services (in addition to concurrent services listed above)? ☐ Yes ☐ No

(if Yes, please indicate additional services below)

☐ Medication Management ☐ Speech Therapy ☐ School Services
☐ Mental Health Therapy ☐ Occupational Therapy ☐ Other: _____

*Describe how coordination of care is occurring (including, but not limited to: concurrent services, psychiatrist, mental health therapists, speech therapist, occupational therapist, school/Individualized Education Plan, medical provider, etc.):

Transition/Discharge Plan: Describe transition and/or discharge plan:

Behavior Intervention Plan/Crisis Plan: Describe behavior intervention plan and/or crisis plan:

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

Autism Services – Service Description	Procedure Code	Duration/Unit	*21. Units Requested**
Beh Identification Assessment	97151	15 mins/unit	
Adaptive Beh Tx by protocol	97153	15 mins/unit	
Group Adaptive Beh Tx by protocol	97154	15 mins/unit	
Adaptive Beh Tx protocol mod	97155	15 mins/unit	
Family Adaptive Beh Tx	97156	15 mins/unit	
Group Family Adaptive BehTx	97157	15 mins/unit	
Group Adaptive Behavior Tx Protocol Mod	97158	15 mins/unit	
***Units Requested:** Enter the cumulative total units of service that are being requested including the number of units previously requested if this is an update to an existing SA.			

As the assigned directing clinician 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.

*22 (a). _____ _____ _____ _____
Directing Clinician Printed Name | Credential | 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 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.

22 (b). _____ _____ _____ _____
Administrative Assistant | Credential | Signature | Date

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Alaska Medicaid Autism Services
Service Authorization (SA) Form Instructions

Submission Requirements: This Service Authorization (SA) request must be completed to indicate the amount of 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 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 all Service Authorization requests directly** to Optum Alaska, by fax: (877) 217-6068 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 Autism Services provider.
2. **Tax ID:** Enter the Alaska Medical Assistance identification number assigned to the Autism 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 recipient.
7. **Provider Type:** Choose the applicable provider type.
8. **Is provider Autism Certified?** Check appropriate box indicating whether provider is Autism Certified or not.
9. **Billing Office Contact Name & Address:** Enter the name and address of the person Optum staff should contact regarding the authorization request.
10. **Phone #:** Enter the contact person's telephone number
11. **Fax #:** Enter the contact person's fax number, if applicable.
12. **Direct Secure Messaging (DSM) E-Mail Address:** Enter the contact person's e-mail address, 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 Autism Services eligibility category.
16. **Current Living Situation:** Enter applicable Participant living situation.
17. **Concurrent Services:** Check all concurrent services that Participant receives. Enter number of hours per day and planned discharge from residential to outpatient services, if applicable.
18. **Treatment Plan Date:** Enter the Treatment Plan date that supports this Autism Services Service Authorization (SA) Request.

    New Request: Mark this box if the service authorization request is to initially exceed the service limits identified in regulation (7 AAC 135.040).

    Enter the dates requested for the service authorization. Requests will only be accepted if they do not exceed 90 days from the treatment plan date.

    Update to Existing SA: Mark this box when:

    - Requesting an update to add additional units of service to an existing SA record.
    - Adding services not already included in the existing SA.

    Enter the authorization number of the SA being updated, and then enter the cumulative total of units requested in section 21. The total should include any new units requested plus previous units, if applicable.

19. **Diagnosis Codes:** Enter ICD-10 codes, descriptions, and comments.
20. **Medical Necessity Description**
    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.
21. **Units Requested (Autism Services):** Enter the cumulative total units of service that are being requested including the number of units previously requested if this is an update to an existing SA.
22. **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. 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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