Optum

Mental Health Physician Clinic
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. Gender: ☐ Male ☐ Female ☐ Other *12. Date of Birth: _____

*13. Participant eligibility (please select an applicable box):

- ☐ Child (under 21 years of age) experiencing an emotional disturbance
- ☐ Adult (21 years of age or older) experiencing an emotional disturbance
- ☐ Child (under 21 years of age) experiencing a severe emotional disturbance
- ☐ Adult (21 years of age or older) experiencing a serious mental illness
- ☐ Child (under 21 years of age) experiencing a substance use disorder
- ☐ Adult (21 years of age or older) experiencing a substance use disorder

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

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

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

*16. Treatment Plan Dates: *Enter the Treatment Plan date that supports this Service Authorization Request*

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

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***17. 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

***18. 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. **If requesting assessment ONLY**: write "N/A" in sections a. through j. and complete Section 17.

*****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

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:

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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:

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):

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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:

19. FOR ASSESSMENTS ONLY, with no additional services being requested - Include relevant information to support request for assessments more than the state fiscal year limit:

20. 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:

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

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***22. Specific Services 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.

Behavioral Health Assessment	**Code**	**Modifiers**	**Unit**	**Units Requested**
Mental Health Intake Assessment	H0031		1 Assessment	
Integrated Mental Health & Substance Use Intake Assessment	H0031	HH	1 Assessment	
Psychiatric Assessment - Diagnostic Interview	90791		1 Eval	
Outpatient Psychotherapy	**Code**	**Modifiers**	**Unit**	**Units Requested**
Psychotherapy, Individual	90832		30 minutes	
Psychotherapy, Individual	90834		45 minutes	
Psychotherapy, Individual	90837		60 minutes	
Psychotherapy, Family (w/o patient present)	90846		50 minutes	
Psychotherapy, Family (w/o patient present)	90846	U7	30 minutes	
Psychotherapy, Family (with patient present)	90847		50 minutes	
Psychotherapy, Family (with patient present)	90847	U7	30 minutes	
Psychotherapy, Multi-family group	90849		60 minutes	
Psychotherapy, Multi-family group	90849	U7	30 minutes	
Psychotherapy, Group	90853		60 minutes	
Psychotherapy, Group	90853	U7	30 minutes	
Crisis Intervention/Stabilization	**Code**	**Modifiers**	**Unit**	**Units Requested**
Short-term Crisis Intervention Service	S9484		1 hour	
Short-term Crisis Intervention Service	S9484	U6	15 minutes	

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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 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.

*23a. _____ _____ _____ _____
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.

*23b. _____ _____ _____ _____
Admin Assistant | Credentials | Signature | Date

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Mental Health Physician Clinic
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 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 MHPC service provider.
2. **Tax ID:** Enter the tax identification number assigned to the MHPC service 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 or DBH 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) Email Address:** Enter the contact person's e-mail address, if applicable.
11. **Gender:** Check appropriate box indicating gender.
12. **Date of Birth:** Enter the participant's date of birth.
13. **Participant eligibility:** Check the appropriate box indicating the participant's MHPC service eligibility category.
14. **New Request:** Check the appropriate box to indicate whether this is a new service authorization request for this participant.
15. **Request to Amend:** Check the appropriate box to indicate if this is a request to amend an authorization request that was already approved.
16. **Treatment Plan Date:** Enter the Treatment Plan date that supports this MHPC Service Authorization (SA) Request.
17. **Diagnosis Codes:** Enter ICD-10 codes, descriptions, and comments.
18. **Medical Necessity Description – Complete a.- h. for service authorization requests (except for 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.**
19. **For Assessment Requests Only:** Complete this field for assessment requests only, when no other services are being requested. Item 14 can be skipped when this item is completed.
20. **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.
21. **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.
22. **Specific Services Requested:** Enter the requested number of units for each service 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.
23. **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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