Optum

Psychological and Neuropsychological Testing
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: _____

*11. Type of License:

☐ Psychologist ☐ Neuropsychologist ☐ Other: _____

*12. Degree:

☐ PhD ☐ PsyD ☐ Other: _____

Recipient Information

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

*15. Has testing been started? ☐ Yes ☐ No Testing Start Date:_____ Testing Through 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.

***16. Diagnosis Codes**

(a) Behavioral ICD-10 Diagnosis Code(s) *Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)*:

ICD-10 Code	Description	Comment

(b) Rule-Out Behavioral ICD-10 Diagnosis Code(s) *Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99) to be evaluated*:

ICD-10 Code	Description	Comment

(c) Medical and other ICD-10 Diagnosis Code(s):

ICD-10 Code	Description	Comment

(d) 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

***17. 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: 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. Case background (*please include Recipient's current level of care, specific behaviors and symptoms of concern and impacts on current functioning, assessment/testing history including dates and types of prior evaluation, co-existing medical, psychiatric etc.):*

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.

b. Purpose of testing (*specify referral questions, outstanding issues related to differential diagnosis, contributions to the clinical treatment plan.*):

c. List ALL tests required (*please spell out names of tests. Indicate if administering select or supplementary subtests.)*:

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

***19. Specific Services Requested**

Psychological and Neuropsychological Testing Evaluation	**Code**	**Modifiers**	**Unit**	**Units Requested**
Psychological testing evaluation services, first hour	96130	☐ None ☐ HO	60 mins	
Psychological testing evaluation services, each additional hour	96131	☐ None ☐ HO	60 mins	
Neuropsychological testing evaluation services, first hour	96132	☐ None ☐ HP	60 mins	
Neuropsychological testing evaluation services, each additional hour	96133	☐ None ☐ HP	60 mins	
Psychological and Neuropsychological Test Admin & Scoring	**Code**	**Modifiers**	**Unit**	**Units Requested**
Psychological test admin and scoring, first 30 minutes	96136	☐ None ☐ HO	30 mins	
Neuropsychological test admin and scoring, first 30 minutes	96136	☐ None ☐ HP	30 mins	
Psychological test admin and scoring, each additional 30 minutes	96137	☐ None ☐ HO	30 mins	
Neuropsychological test admin and scoring, each additional 30 minutes	96137	☐ None ☐ HP	30 mins	

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.

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.

*20a. _____ _____ _____ _____
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.

*20b. _____ _____ _____ _____
Admin Assistant | Credentials | Signature | 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.

Psychological and Neuropsychological Testing
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 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: 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. **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. **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. **Type of License:** Check appropriate box indicating type of license.
12. **Degree:** Check appropriate box indicating degree.
13. **Gender:** Check appropriate box indicating gender.
14. **Date of Birth:** Enter the Recipient's date of birth.
15. **Has testing been started?:** Check appropriate box indicating if testing has been started. Indicate testing start date and testing through date.
16. **Diagnosis Codes:** Enter ICD-10 codes, descriptions, and comments.
17. **Medical Necessity Description – Complete a.- c. for service authorization 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.**
18. **Additional Information:** Include any additional information that may be relevant for the Recipient'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.
19. **Specific Services Requested:** Enter the requested number of units for each service requested.
20. **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.

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.

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.