

November 2021

Service Authorization Submission 101

Vanessa Venezia Heuer, MD

Chief Medical Officer

Optum Alaska





What are Medical Necessity Criteria (MNC)?

- Objective criteria that create individualized level of care determinations
- Nonproprietary
- Optum uses MNC that are from professional organizations such as AACAP and AACP:
 - LOCUS
 - CALOCUS-CASII
 - ECSII
 - ASAM



Why are medical necessity evaluations required?

- Improve the Quality of Care:
 - Organize clinical observations
 - Objective frame for evaluating risks and resiliencies of the person being evaluated
- Audits/Compliance
- Financial Sustainability

The ASAM Criteria®: Dimensions



1: Acute Intoxication and/or Withdrawal Potential

- Current withdrawal symptoms
- Past history of serious, life-threatening withdrawal



2: Biomedical Conditions/Complications

- Current health problems
- Medication interaction, abnormal labs



3: Emotional/Behavioral/Cognitive Conditions and Complications

- Presence of other psychiatric diagnosis, symptoms or behaviors
- Mental status and level of functioning



4: Readiness to Change

- Coerced, mandated, required assessment/treatment
- Motivation factors for treatment



5: Relapse/Continued Use/Continued Problem Potential

- Potential relapse triggers/relapse plan
- Past treatment results



6: Recovery Environment

- Immediate threats to safety, well-being, sobriety
- Availability and utilization of support systems

Level of Care instruments for BH Medical Necessity Determination

Level of Care Utilization System – LOCUS[®]

- Adults, 18+
- American Association for Community Psychiatrist (AACCP)

Early Childhood Service Intensity Instrument – ECSII[®]

- Birth to 6 years
- American Academy for Child and Adolescent Psychiatry (AACAP)
- Published 2009

Child and Adolescent Service Intensity Instrument – CALOCUS/CASII[®]

- 6 to 18 years
- American Academy for Child and Adolescent Psychiatry (AACAP).
- Updated from CA-LOCUS, 2009
- Version 4.1, 2018



BH Medical Necessity Criteria (MNC) Functional Dimensions

I: Risk of Harm

- Suicidal, Homicidal, Self-Harming or Violent Ideation, Intent or Plan
- Past history of serious, high risk behavior posing risk to self or others

II: Functional Status

- Capacity for self-care
- Ability to fulfill social responsibilities

III: Co-Occurring Conditions

- Presence and acuity of co-morbid conditions
- Impact of comorbid condition on presenting problem

IV: Recovery Environment

- Level of Stress: Presence of psychosocial stressors
- Level of Support: Availability and utilization of support systems

V: Treatment and Recovery History

- History of mental health challenges
- Response to prior treatment

VI: Response to Treatment and Recovery Status

- Understanding of mental health condition
- Willingness to engage in treatment



Matching Risk to Level of Care - a high level crosswalk

NOTE: This slide is to illustrate examples and is NOT prescriptive

Risk Level	ASAM/SUD	Behavioral Health
<ul style="list-style-type: none"> • Low Risk- Recovery and Health Maintenance • Moderate Risk • High Risk • Very High Risk • Secure Monitored 	<ul style="list-style-type: none"> • ASAM 1.0 Outpatient services • ASAM 2.1 Intensive Outpatient; SUD Care coordination; ICM • ASAM 2.5- PHP • ASAM 3.1/3.3/3.5 • ASAM 3.7/4.0 	<ul style="list-style-type: none"> • LOCUS/CASII 10-16; ESCII 9-17 <ul style="list-style-type: none"> ○ Treatment plan and review; psychotherapy services; HBFT level 1 or 2 • LOCUS/CASII 17-19; ESCII 18-22 <ul style="list-style-type: none"> ○ BH IOP; HBFT level 3; ICM • LOCUS/CASII 20-23; ESCII 23-26 <ul style="list-style-type: none"> ○ BH PHP, ACT, TTH • LOCUS/CASII 23-17; ESCII 27-30 <ul style="list-style-type: none"> ○ Adult/Children’s MH Residential level 1 or 2 • LOCUS/CASII 28+ <ul style="list-style-type: none"> ○ Locked residential vs acute inpatient ○ This level not available for ESCII



Special service authorization circumstances

Distance and availability of resources:

- The Optum team reviews special circumstances that may necessitate a higher level of care such as the lack of availability of SUD service options within a person's geographical region.
- You may need to request a higher LOC if the level you assess is not available. Ex: Person meets criteria for 3.1, but the only residential option available in the region is 3.5.
- It will be important to note special circumstances when writing the medical necessity essay on your Service Authorization Request.

How to complete the service authorization request form

Paper form

1115 Behavioral Health 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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	*14. Date of Birth: _____	
*15. Recipient eligibility (please select an applicable box):		
<input type="checkbox"/> Child (age 0-17)	<input type="checkbox"/> Youth (age 18-21)	<input type="checkbox"/> Adult (age 21+)
*16. Recommended level of care (please select an applicable box):		
<input type="checkbox"/> Crisis Services	<input type="checkbox"/> Routine Outpatient Services	
<input type="checkbox"/> High Intensity Community Based- IOP	<input type="checkbox"/> Intensive Integrated w/out 24-hour psychiatrist - PHP	
<input type="checkbox"/> Residential or non-Secure 24-hour with Psych Monitoring	<input type="checkbox"/> Inpatient/Secure, 24-hour with psychiatric management	
*17. Concurrent Medicaid State Plan Services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*18. Is this a request for a new service authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*19. Is this a request for an amendment of an already approved service authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*20. Treatment Plan Date: _____ <i>Enter the Treatment Plan date that supports this Service Authorization Request SA</i>		
From: _____ Through: _____ <i>(May not exceed 90 days correlated to treatment plan date).</i>		

How to complete the service authorization request - paper version

***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**

For BH requests, please complete only the BH section below. Additional attachments can be included as appropriate. Fully describe the medical necessity of this request using the behavioral health areas outlined below.

*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.

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

No Change Since Last Service Authorization Request

Is there a current risk of harm to self or other? Yes No No Change Since Last Authorization Request

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:

How to complete the service authorization request - paper version

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 Change Since Last Service Authorization Request

Describe:

Are there comorbid medical issues? Yes No No Change Since Last Service Authorization Request

If yes, describe current comorbid medical issues:

Are there co-occurring issues of cognition (i.e. dementia, traumatic brain injury, FAS, developmental disabilities, etc.)?

Yes No No Change Since Last Service Authorization Request

If yes, describe co-occurring issues of cognition:

Are there co-occurring substance abuse issues? Yes No No Change Since Last Service Authorization Request

If yes, describe co-occurring substance abuse issues:

Are there any concerns related to home/living environment? Yes No No Change Since Last Service Authorization Request

If yes, describe current home/living environment, including supports and areas of concern:

How to complete the service authorization request - paper version

Is there a history with trauma/ACE? Yes No No Change Since Last Service Authorization Request
If yes, briefly describe any history of trauma (include for initial request only, or if new and relevant information has been revealed):

Has the participant had any recent treatment history, including psychiatric or substance abuse hospitalizations?
 Yes No No Change Since Last Service Authorization Request
If yes, describe, include time periods, interventions that the participant has identified as successful or non-helpful treatment interventions:

Is the participant/Guardian willing to engage in services and/or motivated to change? Yes No No Change Since Last Service Authorization Request
Describe:

For continued services requests only, describe the level of participation in treatment and progress made on goals and objectives since last service authorization request:

Is the participant actively engaged in treatment? Yes No No Change Since Last Service Authorization Request
Describe:

Is there progress being made on goals and objectives since the last service authorization request? Yes No No Change Since Last Service Authorization Request
Describe:

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

How to complete the service auth request - paper version

Units Requested				
Treatment Plan Services	Code	Modifiers	Unit	*23. Units Requested
Treatment Plan Development/Review	T1007	V2	Per Assessment	■
Treatment Plan Development/Review (Telehealth)	T1007	V2 GT	Per Assessment	■
Mental Health Treatment 1115 Services	Code	Modifiers	Unit	*24. Units Requested
Intensive Outpatient - Individual	H0015	V2	15 mins	■
Intensive Outpatient - Individual (Telehealth)	H0015	V2 GT	15 mins	■
Intensive Outpatient - Group	H0015	HQ V2	15 mins	■
Intensive Outpatient -Group (Telehealth)	H0015	HQ V2 GT	15 mins	■
Partial Hospitalization	H0035	V2	Daily	■
Intensive Case Management	H0023	V2	15 mins	■
Intensive Case Management (Telehealth)	H0023	V2 GT	15 mins	■
Community & Recovery Support Services - Individual	H2021	V2	15 mins	■
Community & Recovery Support Services - Individual (Telehealth)	H2021	V2 GT	15 mins	■
Community & Recovery Support Services - Group	H2021	HQ V2	15 mins	■
Community & Recovery Support Services - Group (Telehealth)	H2021	HQ V2 GT	15 mins	■
Assertive Community Treatment Services	H0039	V2	15 mins	■
Outpatient Mental Health Treatment 1115 Services: Home Based	Code	Modifiers	Unit	*25. Units Requested
Home-based Family Treatment Level 1	H1011	V2	15 mins	■
Home-based Family Treatment Level 2	H1011	TF V2	15 mins	■
Home-based Family Treatment Level 3	H1011	TG V2	15 mins	■
Therapeutic Treatment Homes - Daily	H2020	V2	Daily	■
Residential BH Treatment Services	Code	Modifiers	Unit	*26 Units Requested
Adult Mental Health Residential Services Level 1	T2016	V2	Daily	■
Adult Mental Health Residential Services Level 2	T2016	TG V2	Daily	■
Children's Mental Health Residential Services Level 1	T2033	V2	Daily	■
Children's Mental Health Residential Services Level 2	T2033	TF V2	Daily	■

How to complete the service authorization request - paper version

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.

28a. _____
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.

28b. _____
Administrative Assistant Credentials Signature Date

How to get started with an Online Service Authorization request submission

Sign In: Provide Tax ID OR Agency NPI. We only need one. We will communicate with you through the email you provide on this form.

https://optumpeeraccess.secure... x +

https://optumpeeraccess.secure.force.com/OptumAlaskaServiceAuth/

Optum AK Sharepo... Online Submission... Alaska Admin Code AK Provider Billing... 1115 SUD Provider... 1115 BH Provider... Chart of 1115 Medi... ACES Questionnaire... BH ALASKA Complaints-CARTA CLL ASAM LONG TOOL

OPTUM | Alaska

Optum Alaska Service Authorization Request Form

Important Note: Please use Google Chrome or Microsoft Edge browsers with this form. Use of Internet Explorer is not recommended as this may result in performance issues including error messages and inability to view submitted forms.

Identification Info Summary Info

IMPORTANT NOTES:

- Fields marked with * are mandatory to move forward
- The Information entered on this page will be used to store and retrieve your request(s) when needed. Incomplete Requests can be accessed and completed at a later time
- Either a Tax ID or NPI needs to be entered here before next Item can display. Do not use any special characters (examples are ", #, @, \$ etc.)
- Verification Code needed to access Incomplete or Submitted requests will be sent to email used for "REQUEST RECOVERY EMAIL"

TAX ID 333333333 Agency NPI 10 digit, no Text/Characters *REQUEST RECOVERY EMAIL eula.crippen@optum.com Save and Continue

Authorization does not guarantee payment. Payment is subject to recipient's eligibility. Be sure the Identification card is current before rendering service.

CPT copyright 2016 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association Applicable FARS/DFARS apply. CPT code description are shortened to 28 characters or less to comply with copyright restrictions. For full descriptions, please refer to your current CPT book.

BH2537_022020

Service Authorization Summary Info

On this page, you will find all the service authorization requests submitted for this Tax ID or NPI. Service authorizations will be “Complete” or “Incomplete.” You can access them by following the link “Click Here.” When you click, An email will be immediately sent with a verification code. You must enter the verification code to continue.

Optum Alaska Service Authorization Request Form

Important Note: Please use Google Chrome or Microsoft Edge browsers with this form. Use of Internet Explorer is not recommended as this may result in performance issues including error messages and inability to view submitted forms.

Identification Info **Summary Info**

IMPORTANT NOTES:

- All Incomplete requests submitted within the last 30 days will be listed below. Click on “Click Here” to complete the previously started application.
- All Completed applications within last 30 days are also displayed under “Submitted Requests.” Click on “Click Here” next to a submitted request to see the read only version of the request.

To submit a new request, click on the “START” button. **START**

Incomplete Requests

Request Ref. Number	Recipient ID	Request Recovery Email	Edit
Service Auth - 0016	XX3232	eula.crippen@optum.com	Click Here

Submitted Requests

Request Ref. Number	Recipient ID	Request Recovery Email	View
Service Auth - 0017	XX2929	eula.crippen@optum.com	Click Here

Provider Details

Begin on the Provider page. All information with a red asterisk is mandatory. You cannot move forward until you have provided this information. When complete, click the blue “Save and Next” box. You also have the option to “Save and Exit” if you need to complete the form later.

The screenshot shows the 'Optum Alaska Service Authorization Request Form' with the 'Provider Details' section highlighted. The form includes a navigation menu on the left with options like 'Provider Details', 'Reclpent Details', 'Recommended Level of Care', 'Treatment Plan', 'Medical Necessity', 'Documents', and 'Attestation Information'. The main form area contains several input fields with red asterisks indicating mandatory information. The fields are: Provider Agency Name (Second Nature), Agency NPI (Enter 10 digits, no text/special characters), DSM Email Address (eula.crippen@optum.com), Billing Office Contact Name (Eula Crippen), Billing Office Address Line 2, Billing Office Address State (AK), Request Recovery Email, Phone Number (6126427882), Tax Identification Number (333333333), Fax Number, Billing Office Address Line 1 (408 Oja Way), Billing Office City (Sitka), and Billing Office Zip (99835). At the bottom, there are three buttons: 'Submit' (green), 'Save and Exit' (red), and 'Save and Next' (blue).

OPTUM | Alaska

Optum Alaska Service Authorization Request Form

Important Note: Please use Google Chrome or Microsoft Edge browsers with this form. Use of Internet Explorer is not recommended as this may result in performance issues including error messages and inability to view submitted forms.

Identification Info Summary Info **Service Auth - 0016**

Requirements and Instructions

- ✓ **Provider Details**
- ✓ Reclpent Details
- ✓ Recommended Level of Care
- ✓ Treatment Plan
- ✓ Medical Necessity

Documents

- ✓ Attestation Information

Submit

Save and Exit

Save and Next

* Provider Agency Name
Second Nature

Agency NPI
Enter 10 digits, no text/special characters

* DSM Email Address
eula.crippen@optum.com

* Billing Office Contact Name
Eula Crippen

Billing Office Address Line 2

* Billing Office Address State
AK

* Request Recovery Email

* Phone Number
6126427882

Tax Identification Number
333333333

Fax Number

* Billing Office Address Line 1
408 Oja Way

* Billing Office City
Sitka

* Billing Office Zip
99835

Recipient Details

Provide recipient information on this page.

The screenshot shows the 'Optum Alaska Service Authorization Request Form' with the 'Recipient Details' section highlighted. The form includes a navigation menu on the left with sections: Requirements and Instructions, Provider Details, Recipient Details (highlighted), Recommended Level of Care, Treatment Plan, Medical Necessity, Documents, and Attestation Information. The main form area contains fields for Recipient Name (Samantha Adams), Recipient ID (323232), AK AIMS Client ID, Date of Birth (Aug 28, 2000), Gender (Female), and Other Concurrent Medicaid Services? (Yes). A Recipient Eligibility note states: 'A Youth (age 0-21) w/SUD (eligible for clinical and rehab)'. At the bottom, there are buttons for 'Submit', 'Save and Exit', and 'Save and Next'.

As you save, each section completed will show up on the left with a green check mark next to it. Until you submit this form, you can move around the form by clicking on the sections.

Services requested by Level of Care

Choose the services you want to populate this section using the drop-down menu.

- Provider Details
- Recipient Details
- Recommended Level of Care
- Treatment Plan
- Medical Necessity
- Documents
- Attestation Information

1115 SUD Outpatient Treatment Services
State Plan Outpatient Psychotherapy

NOTE: Many state plan services are only eligible if they're completed in a Rehab or Clinic setting. Each service is identified with a code, as follows:
 "R" = Rehab eligibility only
 "C" = Clinic eligibility only
 "C/R" = eligible in both settings
 No specification = No Eligibility Restriction

1115 SUD Outpatient Treatment Services	Code	Modifier(s)	Unit	Units Requested
SUD Intensive Outpatient ASAM 2.1 - Individual	H0015	1 options selected VI	15 mins	48
SUD Intensive Outpatient ASAM 2.1 - Group	H0015	2 options selected VI HQ	15 mins	288
SUD Intensive Outpatient ASAM 1.0 - Individual	H0007	Select an option.x	15 mins	
SUD Intensive Outpatient ASAM 1.0 - Group	H0007	Select an option.x	15 mins	
SUD Partial Hospitalization	H0035	Select an option.x	Daily	

State Plan Outpatient Psychotherapy	Code	Modifier(s)	Unit	Units Requested
Psychotherapy, Individual (C)	90832	Select an option.x	30 mins	
Psychotherapy, 60 minutes with patient (C)	90837	1 options selected No Modifier	60 mins	12
Psychotherapy, Individual (C)	90834	Select an option.x	45-50 mins	
Family psychotherapy (without the patient present), 60 minutes (C)	90846	Select an option.x	60 mins	
Family psychotherapy (without the patient present), 30 minutes (C)	90846	Select an option.x	30 mins	
Family psychotherapy (conjoint psychotherapy) (with patient present), 60 minutes (C)	90847	Select an option.x	60 mins	6
Family psychotherapy (conjoint psychotherapy) (with patient present), 30 minutes (C)	90847	Select an option.x	30 mins	

Choose modifiers and units you are requesting for each service.



Diagnoses and Treatment Plan

Provide the Treatment Plan dates, the date on which services will begin, and the date by which the services will end and all relevant diagnoses.

Identification Info Summary Info **New Optum Alaska Form**

Requirements and Instructions

- ✓ Provider Details
- ✓ Recipient Details
- ✓ Recommended Level of Care
- ✓ Treatment Plan**
- ✓ Medical Necessity

Documents

Attestation Information

Submit

Save and Exit

Save and Next

Treatment Plan Information

* Treatment Plan Date: Oct 26, 2020

* Requested Service Authorization Start Date: Nov 2, 2020

* Requested Service Authorization End Date: Jan 30, 2021

Diagnosis

Behavioral ICD-10 Diagnosis Code	Description	Comment
F20.10	Alcohol Use Disorder, Moderate	
F32.1	Major Depressive Disorder	

Medical and Other ICD-10 Diagnosis

Medical and Other ICD-10 Diagnosis	Description	Comment

Psychosocial ICD-10 Diagnosis Codes

Psychosocial ICD-10 Diagnosis Codes	Description	Comment

Online submission SUD clinical criteria

ASAM CRITERIA

Complete for ALL requests: Attach separate document if necessary on the "Documents" section. Fully describe the medical necessity of this request using the ASAM dimensions as outlined below.
* Include all relevant information since admission, or since 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

<p><u>ASAM Dimension 1: Acute Intoxication and/or Withdrawal Potential</u></p> <p>* Risk Rating 3</p> <p>* Clinical Details to support rating additional details</p>	<p><u>ASAM Dimension 2: Biomedical Conditions and Complications</u></p> <p>* Risk Rating 2</p> <p>* Clinical Details to support rating additional details</p>
<p><u>ASAM Dimension 3: Emotional, Behavioral or Cognitive Conditions</u></p> <p>* Risk Rating 0</p> <p>* Clinical Details to support rating additional details</p>	<p><u>ASAM Dimension 4: Readiness to Change and Complications</u></p> <p>* Risk Rating 1</p> <p>* Clinical Details to support rating additional details</p>
<p><u>ASAM Dimension 5: Relapse, Continued Use, or Continued Problem Potential</u></p> <p>* Risk Rating 4</p> <p>* Clinical Details to support rating additional details</p>	<p><u>ASAM Dimension 6: Recovery/Living Environment</u></p> <p>* Risk Rating 2</p> <p>* Clinical Details to support rating additional details</p>

* Total Composite Score: 12

* Do you have additional information not already covered?: No

Save and Next

Online submission BH clinical criteria

MENTAL HEALTH CRITERIA

For BH requests, please complete only the BH section below. Additional attachments can be included as appropriate. Fully describe the medical necessity of this request using the behavioral health areas outlined below.

* 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.

List participant current medications:

* Is there a current risk of harm to self or others?

choose one...

Are there any deficiencies in the participants ability to (select all applicable):

Select an option...

* Are there current comorbid medical issues?

choose one...

* Are there co-occurring issues of cognitive disability (i.e. dementia, traumatic brain injury, FAS, developmental disability, etc.)?

choose one...

* Are there co-occurring substance abuse issues?

choose one...

Are there any deficiencies in the participants ability to (select all applicable):

Select an option...

- 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

Uploading supporting documents

INSTRUCTIONS FOR DOCUMENTS UPLOAD:

- Please click on the "choose file" button below to select and attach documents to this request.
- Include documentation supporting your request, for example: Most recent Individual Care/Service/Treatment Plan, doctor's notes, medication updates.
- You can use this feature multiple times to attach multiple documents.
- Saved documents will reflect under the "Uploaded Attachments" section.

Choose File No file chosen

Save Documents

UPLOADED ATTACHMENTS

NAME	DELETE
------	--------

Next



What happens next?

Two routes for next steps

*Authorization approved

- Verbal notification by Care Advocate
- Authorization letter mailed

*Not enough information to approve

- Case staffing with Chief Medical Officer (CMO) **then**,
- Request for additional information **then**,
- Peer to peer scheduled with CMO and provider/agency **then**,
- Denial letter issue with appeals rights provided



In summary:

- Service authorizations will be required at the end of the Federal Public Health Emergency
- Service authorizations are required when the participant's SFY limits are exhausted but can be requested if participant's SFY limit is unknown to avoid a claim denial
- There are two options of submitting service auth requests: paper or online
- Approved authorizations units will be tracked by participant and by provider within the claims system automatically. Authorization number is NOT needed on the claim submission



Questions?





Optum® is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions. All other brand or product names are the property of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.

© 2021 Optum, Inc. All rights reserved.