Optum

# 1115 Waiver Behavioral Health and/or Substance Use Disorder Waiver Provider Service Authorization (SA) Request Form

**(*) Denotes required field**

## Provider Information

*1. Provider Agency Name_____ *2. Tax ID: _____

*3.NPI: _____ *4. Request Date: _____

*5. Contact Name: _____ *6. Address: _____

*7. Phone No.: _____ *8. Fax No.:_____

9. DSM Email Address: _____

## Recipient Information

*10. Recipient Name: _____ *11. Recipient ID: _____

*12. Admission Date: _____ *13. Planned Discharge Date: _____

*14. Gender: ☐Male ☐Female ☐Other *15. Date of Birth: _____

*16. Recipient eligibility (please select an applicable box):

☐ Child (age 0-17) ☐Youth (age 18-21) ☐Adult (age 21+)

*17. Recommended level of care (please select an applicable box):

☐ 1115 BH Crisis Services ☐1115 SUD Residential and Inpatient Treatment Services

☐ 1115 BH Therapeutic Treatment Home ☐1115 SUD Withdrawal Management

☐ 1115 BH Residential and Inpatient Treatment Services ☐1115 SUD Crisis Services

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

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

20. Current Service Authorization Number: _____

*21. 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. Service Authorization dates will correspond with current treatment plan dates).*

***22. 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 |
|---|---|---|
| | | |
| | | |
| | | |

***23. Medical Necessity Description**

**For BH requests,** please complete only the BH section below. Fully describe the medical necessity of this request using the behavioral health areas outlined below.

*****Adult Mental Health Residential (AMHR) Level 1 & 2: Providers must submit a copy of the Psychiatric or Psychological assessment with Service Authorization request.

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

☐ No Update

(a) **Is there a current risk of harm to self or other?** ☐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:**

(b) **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 or inability to engage (family, church, community supports, etc.)

☐ Other

☐ No Update

Describe:

(c) **Are there comorbid medical issues?** ☐Yes ☐No ☐ No Update

**If yes, describe current comorbid medical issues:**

(d) **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:**

(e) **Are there co-occurring substance abuse issues?** ☐Yes ☐No ☐ No Update

**If yes, describe co-occurring substance abuse issues:**

(f) **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:**

(g) **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):**

(h) **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:**

(i) **Is the participant/Guardian willing to engage in services and/or motivated to change?** ☐Yes ☐No ☐No Update

**Describe:**

**For continued services requests only:**

(j) **Is the participant actively engaged in treatment?** ☐Yes ☐No ☐No Update

**Describe:**

(k) **Is there progress being made on goals and objectives since the last service authorization request?**

☐ Yes ☐No ☐No Update

**Describe:**

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

| Units Requested | | | | |
|---|---|---|---|---|
| **1115 SUD Residential Treatment Services** | **Code** | **Modifiers** | **Unit** | ***24. Units Requested** |
| ASAM Level 3.1 Clinically Managed Low-intensity Residential Services Adolescents and Adults (Age 13-17) | H2036 | HA V1 | Daily | |
| ASAM Level 3.1 Clinically Managed Low-intensity Residential Services Adolescents and Adults (Age 18-21) | H2036 | CG HA V1 | Daily | |
| ASAM Level 3.1 Clinically Managed Low-intensity Residential Services Adolescents and Adults (Age 22 and up) | H2036 | HF V1 | Daily | |
| ASAM Level 3.3 Clinically Managed Population Specific High-Intensity Residential Services Adult | H0047 | HF V1 | Daily | |
| ASAM Level 3.3 Clinically Managed Population Specific High-Intensity Residential Services (ASAM Level 3.3 Adolescents and Adults Serviced in an Adolescent Setting) | H0047 | V1 HA TF | Daily | |
| ASAM Level 3.3 Clinically Managed Population Specific High-Intensity Residential Services (ASAM Level 3.3 Adolescents and Adults Serviced in an Adolescent Setting) | H0047 | CG V1 HA TF | Daily | |
| ASAM Level 3.5 Clinically Managed Medium-Intensity Residential Services-Adolescents and Adults Served in an Adolescent Setting (Age 12-17) | H0047 | HA V1 TF | Daily | |
| ASAM Level 3.5 Clinically Managed Medium-Intensity Residential Services-Adolescents and Adults Served in an Adolescent Setting (Age 18-21) | H0047 | TG V1 | Daily | |
| ASAM Level 3.5 Clinically Managed Medium-Intensity Residential Services-Adolescents and Adults Served in an Adolescent Setting (Age 22 and up) | H0047 | CG V1 HA TF | Daily | |
| **1115 SUD Inpatient Treatment** | **Code** | **Modifiers** | **Unit** | ***25. Units Requested** |
| ASAM Level 3.7 Medically Monitored High Intensity Inpatient Services- Adolescents and Adults Served in Adolescent Setting (Age 12-17) | H0009 | TF HA V1 | Daily | |
| ASAM Level 3.7 Medically Monitored High Intensity Inpatient Services- Adolescents and Adults Served in Adolescent Setting (Age 18-21) | H0009 | CG V1 HA TF | Daily | |
| ASAM Level 4.0 Medically Managed Intensive Services for Adolescents and Adults | H0009 | TG V1 | Daily | |
| **1115 SUD Alcohol and Drug Withdrawal Management Services** | **Code** | **Modifiers** | **Unit** | ***26. Units Requested** |
| ASAM Level 3.2 WM: Clinically Managed Residential Withdrawal Management for Adolescents and Adults | H0010 | V1 | Daily | |
| ASAM Level 3.7 WM: Medically Monitored Inpatient Withdrawal Management for Adolescents and Adults | H0010 | TG V1 | Daily | |
| ASAM Level 4.0 WM: Medically Managed Intensive Inpatient Withdrawal Management for Adolescents and Adults | H0011 | V1 | Daily | |
| **1115 SUD Crisis Services** | **Code** | **Modifiers** | **Unit** | ***27. Units Requested** |
| Crisis Residential and Stabilization Services (CSS) | S9485 | V1 | Daily | |
| **1115 Behavioral Health Treatment: Home Based** | **Code** | **Modifiers** | **Unit** | ***28. Units Requested** |
| Therapeutic Treatment Homes - Daily | H2020 | V2 | Daily | |
| **1115 Behavioral Health Residential Services** | **Code** | **Modifiers** | **Unit** | ***29. Units Requested** |
| Adult Mental Health Residential Services (AMHR) Level 1 | T2016 | V2 | Daily | |
| Adult Mental Health Residential Services (AMHR) Level 2 | T2016 | TG V2 | Daily | |
| Children's Residential Treatment Level 1 | T2033 | V2 | Daily | |

| | | | | |
|---|---|---|---|---|
| Children's Residential Treatment Level 2 | T2033 | TF V2 | Daily | |
| **1115 Behavioral Health Crisis Services** | **Code** | **Modifiers** | **Unit** | ***30. Units Requested** |
| Crisis Residential and Stabilization Services (CSS) | S9485 | V2 | Daily | |

**Please sign the attestation appropriate to your role (only one signature is necessary for submission):**
As the Directing Provider 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.

31a.

| Directing Provider | 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 provider.
- Affirm that I am signing on behalf of the directing provider 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.

31b.

| Administrative Assistant | Credentials | Signature | Date |
|---|---|---|---|
| | | | |

# 1115 Behavioral Health Waiver Provider
# Service Authorization (SA) Form Instructions

**Submission Requirements:** Only one service code per authorization. This Service Authorization (SA) request must be completed to indicate the amount of the one service requested beyond the annual or daily service limits within the regulations 7 AAC 138.040 and must bear the signature of the directing provider 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 (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 1115 BH Waiver services provider.
2. **Provider ID:** Enter the Alaska Medical Assistance identification number assigned to the 1115 BH Waiver services 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 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 recipient's date of birth.
15. **Recipient eligibility:** Check the appropriate box indicating the recipient's 1115 BH Waiver Service eligibility category.
16. **Recommended level of care:** Check the appropriate box indicating the recommended level of care for 1115 BH Waiver services.
17. **Concurrent Services:** Check the appropriate box to indicate whether the recipient receives concurrent state plan services.
18. **New Request:** Check the appropriate box to indicate whether this is a new service authorization request for this recipient.
19. **Request to Amend:** Check the appropriate box to indicate if this is a request to amend an authorization request that was already approved.
20. **Treatment Plan Date:** Enter the Treatment Plan date that supports this 1115 BH Waiver Services Service Authorization (SA) Request.
21. **Diagnosis Codes:** Enter ICD-10 codes, descriptions, and comments.
22. **Medical Necessity Description – Complete for ALL 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.**

23-27. **Units Requested (1115 BH Waiver services):** Enter the cumulative total units of service that are being requested including the number of units previously requested if this is an amendment of an already approved service.

28. **Provider(a) or Assigned Administrator(b) Signature:** The signature must be that of the Provider assigned to the recipient's case or an administrator acting on behalf of the directing provider, 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.

*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.*