



A **xerox** Company

# SUBSTANCE ABUSE PRIOR AUTHORIZATION REQUEST

Page 1 of 2

### Provider Information

1. Request Date \_\_\_\_\_
2. Provider Name \_\_\_\_\_
3. Provider ID No. \_\_\_\_\_
4. Contact Name and Address  
(decision will be returned to this address)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Phone No. \_\_\_\_\_
6. Fax No. \_\_\_\_\_
7. E-Mail Address \_\_\_\_\_

### Recipient Information

8. Recipient Name \_\_\_\_\_
9. Date of Birth \_\_\_\_\_ 10. Recipient ID No. \_\_\_\_\_
11. Gender  Male  Female
12. Recipient Address \_\_\_\_\_  
\_\_\_\_\_
- a.  Private Home      b.  Foster Home
- c.  Office of Children's Services Rehabilitation Home
- d.  Transitional/Supported Living Home
- e.  Residential Substance Abuse Treatment Center
- f.  Homeless/Shelter
- g.  Other – Explain: \_\_\_\_\_

13.  **New Request** Requested Dates: From: \_\_\_\_\_ Thru: \_\_\_\_\_
14.  **Update to existing PA** a. Update From: \_\_\_\_\_ Thru: \_\_\_\_\_ b. PA No. \_\_\_\_\_  
(Required for PA updates only.)

Services	Code	Unit	15.UnitsReq	Prior to 12/26/08	After 12/26/08	16. \$ Req
Drug screen, qualitate/multi [multiple drug]	80100*	1 screening	_____		+	_____
Medication management	90862*	1 visit	_____	X	\$35.00	\$75.00 _____
Substance abuse treatment, individual. Counseling. Mental Health Service, Practice specialties	CDADK	15 min	_____	X	\$12.50	\$17.00 _____
Alcohol and/or drug assessment	H0001	1 session	_____	X	\$50.00	\$100.00 _____
Alcohol and/or drug services; group counseling by a clinician	H0005	15 min	_____	X	\$5.00	\$9.00 _____
Alcohol and/or drug services; case management	H0006	15 min	_____	X	\$7.50	\$16.00 _____
Alcohol and/or drug services; acute detoxification [residential additional program outpatient]	H0013	1 day	_____	X	\$150.00	\$300.00 _____
Alcohol and/or drug services; intensive outpatient [See ABC Code Book or Provider Billing Manual for complete description]	H0015	15 min	_____	X	\$11.25	\$17.00 _____
Alcohol and/or drug intervention service [planned facilitation]	H0022	15 min	_____	X	\$12.50	\$17.00 _____
Alcohol and/or substance abuse services, family/couple counseling	T1006	15 min	_____	X	\$11.25	\$17.00 _____
Alcohol and/or substance abuse services, skills development	T1012	15 min	_____	X	\$10.00	\$17.00 _____
<b>17. Total \$ Requested</b>						_____

**Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.**

\*Per Medicare fee schedule.

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Revised 12/04/09



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Page 2 of 2

**Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.**

### Provider Information

Request Date \_\_\_\_\_

Provider Name \_\_\_\_\_

Provider ID No. \_\_\_\_\_

Contact Name \_\_\_\_\_

Contact Phone No. \_\_\_\_\_

### Recipient Information

Recipient Name \_\_\_\_\_

Recipient ID No. \_\_\_\_\_

**18.** Client meets American Society of Addiction Medicine (ASAM) criteria for medical necessity as evidenced by:

ASAM Dimension	Level of Care	Criteria
1		
2		
3		
4		
5		
6		

By submission of this form, the provider:

- affirms the assessment of the recipient's symptomatology and current level of functionality is documented in the recipient's record and indicates the units and duration of services requested are medically necessary,
- affirms the recipient's record includes documentation of the clinical team recommendation of the requested services as medically necessary, and
- acknowledges the services are subject to post-payment review for medical necessity and completeness of documentation according to Medicaid/Denali KidCare program rules.

The Department of Health and Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid/Denali KidCare program rules.

19. Signature \_\_\_\_\_ Title \_\_\_\_\_

If this form requests more than \$10,000 of services in field 17, it must be approved by the Division of Behavioral Health (DBH) Treatment & Recovery staff before it is submitted to Affiliated Computer Services, Inc.

20. DBH Signature \_\_\_\_\_ Date \_\_\_\_\_



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## SUBSTANCE ABUSE PRIOR AUTHORIZATION REQUEST INSTRUCTIONS

**Submission Requirements:** This prior authorization (PA) form must be completed to indicate the amount of services requested beyond the service limitations set out in the Provider Billing Manual and must bear the signature of a person authorized to bind the requesting facility. **If field 17 (Total \$ Requested) is less than \$10,000, submit the request directly to Affiliated Computer Services, Inc. (ACS) If field 17 is \$10,000 or more, submit the request to your DBH Treatment and Recovery Regional Office.**

### Page 1:

1. **Request Date:** Enter the date that the authorization request is being submitted.
2. **Provider Name:** Enter the name of the enrolled substance abuse facility.
3. **Provider ID No.:** Enter the Medical Assistance identification number assigned to the substance abuse facility.
4. **Contact Name and Address:** Enter the name and address of the person ACS should contact regarding the authorization request. The authorization decision will be returned to the address entered here.
5. **Phone No.:** Enter the contact person's telephone number.
6. **Fax No.:** Enter the contact person's fax number, if applicable.
7. **E-Mail Address:** Enter the contact person's e-mail address, if applicable.
8. **Recipient Name:** Enter the name of the recipient for whom the authorization is being requested.
9. **Date of Birth:** Enter the recipient's date of birth.
10. **Recipient ID No.:** Enter the recipient's Medical Assistance identification number.
11. **Gender (recipient's):** Check appropriate box for male or female.
12. **Recipient Address:** Enter the recipient's address **and check the appropriate box** (a, b, c, d, e, f, or g).
13. **New Request:** Mark this box if the prior authorization request is a request to initially exceed the annual service limits identified in the Provider Billing Manual. Enter the dates requested for the initial prior authorization. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.
14. **Update to existing PA:** Mark this box when:
  - Requesting an update to add additional units of service to the existing PA record referred to in Field 14b.
  - Adding services not already included in the existing PA record referred to in Field 14b.
  - Extending the "thru" date of the authorization period for the existing PA record referred to in Field 14b.
  - a. **Update:** Enter the "from" and "thru" dates for the authorization period being requested. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.
  - b. **PA Number:** Enter the number of the PA record being updated.
15. **Units Req:** Enter the number of **additional units** of services being requested.
16. **\$ Req:** Multiply the units requested (field 15) by the maximum allowed dollar amount (Max \$).
17. **Total \$ Requested:** Enter the sum of the \$ Req column (field 16).

**Page 2:** Enter the request date, Provider name and ID number, Contact person and phone number, recipient name and ID number as entered on page 1. **If you do not enter this information, ACS may not be able to process your authorization.**

18. **Client meets American Society of Addiction Medicine (ASAM) criteria for medical necessity as evidenced by:** Indicate the clinical justification for the extension.
19. **Signature:** The signature must be by a person authorized to bind the facility to the completed form as accurate and subject to Medical Assistance program rules. Please include the title of the person signing the prior authorization request form.
20. **DBH Signature:** The DBH signature indicates DBH reviewed the form and may have discussed the request with the clinic staff for clarification. The signature does not indicate acceptance of the requested services or units as medically necessary. Medical necessity may be determined during a post-payment review according to Medical Assistance program rules. The division may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medical Assistance program rules.