

# Substance Abuse Services Prior Authorization Request Form

**Submit fax request for prior authorization to: 1-877-OK BY Fax (1-877-652-9329). If questions, call 1-888-827-2884. Requests may be submitted no earlier than 30 days prior to start of services, provided Enrollee is Medicaid eligible.**

<b>1. Date of Request: (mm/dd/yyyy)</b> _____/_____/_____	<b>2. Review Type: (Please check one, if applicable)</b> <input type="checkbox"/> Initial <input type="checkbox"/> Retrospective <input type="checkbox"/> Recertification: PA # _____ <input type="checkbox"/> Change: PA # _____ <input type="checkbox"/> Discharge: PA # _____			
<b>3. Enrollee's Medicaid ID Number (12 Digit number):</b> _____	<b>4. Enrollee's Last Name:</b> _____	<b>5. Enrollee's First Name:</b> _____	<b>6. Date of Birth: (mm/dd/yyyy)</b> _____/_____/_____	<b>7. Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>8. Requesting/Service Provider Name and Medicaid ID Number or NPI:</b> _____	<b>9. Treatment Setting:</b> <input type="checkbox"/> Provider's Office <input type="checkbox"/> MH Clinic <input type="checkbox"/> Other	<b>10. Primary Diagnosis Code/Description: (enter up to 5)</b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
<b>11. Severity of Illness (See instructions) and continue on Page 3 if more space is needed:</b>   				
<b>12. Intensity of Services (See instructions) and continue on Page 3 if more space is needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (For Initial Review Only) ASAM assessment of Level of Care completed prior to start of services?				
<b>13. Additional Comments (See instructions) and continue on Page 3 if more space is needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment plan completed and with dated signature of Licensed Mental Health Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment plan updates completed, with dated signatures, at least every 6 sessions, or every 90 days (whichever occurs first)?				

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Number	14. HCPCS/ CPT/ Revenue Code	15. Code Description	16. Must Include HF Modifier	17. Units Requested	18. Frequency	19. Dates of Service	
						From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
1.						___/___/___	___/___/___
2.						___/___/___	___/___/___
3.						___/___/___	___/___/___
4.						___/___/___	___/___/___
5.						___/___/___	___/___/___
6.						___/___/___	___/___/___
7.						___/___/___	___/___/___
8.						___/___/___	___/___/___
9.						___/___/___	___/___/___
10.						___/___/___	___/___/___

21. Contact Name: \_\_\_\_\_

22. Contact Telephone Number: \_\_\_\_\_

23. Contact Fax Number: \_\_\_\_\_

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## Additional Information

11. Severity of Illness (continued from Page 1) - See Instructions:

12. Intensity of Services (continued from Page 1) - See Instructions:

13. Additional Comments (continued from Page 1) - See Instructions:

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## INSTRUCTIONS FOR FAX FORM

This FAX submission form is required for Prior Authorization Review, Recertification Review and Retrospective Review. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Do **not** send attachments.

The prior authorization (PA) number provided by the DMAS Fiscal Agent will be sent to you through the normal letter notification.

1. **Date of Request:** The date you are submitting the prior authorization request.
2. **Request type:** Place a  or **X** in the appropriate box.
  - **Initial:** Use for all new requests.

**\*For ALL Recertification and Changes you must include existing PA number\***
  - **Retrospective:** A retrospective review is done when the enrollee obtains Medicaid coverage after services are provided. The request is processed the same as an initial request. The request must be submitted within 30 days of notification of Medicaid eligibility.
  - **Recertification:** A request for continued services beyond the expiration of the previous preauthorization would be a recertification request. This must be requested before the expiration of the existing services and prior to the start of all new services.
  - **Change:** a change to a previously approved request; the provider may change the quantity of units or dates of service due to changes in type of therapy or scheduling. If additional units are requested for the same dates of service, enter the total number of units needed and note only the increased amount. Any change request for increased services must include appropriate justification. The provider may not submit a "change" request for any item that has been denied or is pending.

A change is to be indicated for a discharge notification. If there are units or dates of service that will no longer be provided to the recipient.
  - **Cancel:** Use to cancel all or some of the items under one preauthorization number. An example of canceling all lines is when an authorization is requested under the wrong enrollee number.
3. **Enrollee's Medicaid ID Number:** It is the provider's responsibility to ensure the enrollee's Medicaid number is valid. This should contain 12 numbers.
4. **Enrollee's Last Name:** Enter the enrollee's last name exactly as it appears on the Medicaid card.
5. **Enrollee's First Name:** Enter the enrollee's first name exactly as it appears on the Medicaid card.
6. **Date of Birth:** Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
7. **Sex:** Please place a  or **X** to indicate the sex of the patient.
8. **Requesting/Service Provider Name and Medicaid ID Number/NPI:** Enter the requesting/service provider name and Medicaid ID number or national provider identifier.
9. **Treatment Setting:** Place a  or **X** to indicate the place of service.
10. **Primary Diagnosis Code/Description:** Provide the primary diagnosis code and description indicating the reason for service(s). You can enter up to 5 descriptions and DSM-IV codes.

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**11. Severity of Illness (Clinical indicators of illness including abnormal findings)\*:**

- One of the most important blocks on the form is the Severity of Illness. Knowledge of DMAS criteria will be helpful to provide pertinent information.
- Provide the clinical information of chief complaint, history of present illness, pertinent past medical history (supportive diagnostic outpatient procedures), previous treatment, to substantiate the need for service and level of service requested. (Always include dates).
- Consider discharge criteria described in the DMAS Psychiatric Services Manual, Appendix C, available on the DMAS website, [www.dmas.virginia.gov](http://www.dmas.virginia.gov)
- Service Type specific instructions:

<i>Substance Abuse Services</i>	<p>List all symptoms and behaviors supporting the need for treatment. Clinical documentation must address safety risks (immediate or potential), level of functioning, adequacy of support system, social factors and medication compliance (if applicable).</p> <p>For recertification, include clinical findings within the last 5 authorized visits and progress towards treatment goals. If no progress, describe how this will be addressed. Clinical updates must describe treatment and medication compliance and any related changes to the individual's psychosocial and medical status.</p> <p>For substance abuse services, specify what impact on ADLs the SA has on the recipient. Be specific.</p>
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**12. Intensity of Services (Proposed/Actual monitoring and therapeutic services)\*:**

- This is another critical area of the form. Knowledge of the DMAS criteria will be helpful to provide pertinent information and InterQual Chemical Dependency & Dual Diagnosis Criteria.
- This field must include the treatment plan information for the patient. List the services, procedures, or treatments that will be provided to the patient.
- Identify the treatment modality (i.e. individual, family, or group), number and frequency of sessions and anticipated duration of treatment.

**13. Additional Comments** This area should be used for further information and other considerations and circumstances to justify your request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information to meet the criteria in the regulations, DMAS manual, American Society of Addiction Medicine (ASAM) placement criteria for the treatment of substance-related disorders, and InterQual criteria.

<i>Substance Abuse Services</i>	Additional information from the ASAM assessment, treatment plan and updates provided in this section must support the request for services.
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**14. HCPCS/CPT/Revenue Code:** Provide the HCPCS/CPT/Revenue procedure code.

**15. Code Description:** Provide the HCPCS/CPT/Revenue procedure code description.

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16. **Modifiers:** Enter modifier HF when requesting Substance Abuse Services.

90804 through 90815, 90846, 90847, 90853 and 90857 are codes available for Substance Abuse Services, with the HF modifier.

90805, 90807, 90809, 90811, 90813, and 90815 are codes that include medical evaluation and management and only psychiatrists, psychiatric nurse practitioners and psychiatric clinical nurse specialists may bill these codes when appropriate.

Substance Abuse Treatment Practitioners are only eligible to provide CPT codes with HF modifiers, excluding the evaluation and management codes.

Professional licensure and DMAS system edits will determine final eligibility for CPT codes requested.

17. **Units Requested:** Based on plan of care, provide the number of services/visits requested. Knowledge of DMAS criteria will be extremely helpful.

18. **Frequency:** Enter the frequency of the sessions from the plan of care.

19. **Dates of Service:** Indicate the planned service dates using the mm/dd/yyyy format. The From and Thru date must be completed even if they are the same date.

20. **Contact Name:** Enter the name of the person to contact if there are any questions regarding this fax form.

21. **Contact Phone Number:** Enter the phone number with area code of the contact name.

22. **Contact Fax Number:** Enter the fax number with the area code this is how we will correspond with you regarding your request.

***\*Note: Incomplete data may result in the request being denied; therefore, it is very important that this field be completed as thoroughly as possible with the pertinent medical/clinical information.***

***The purpose of preauthorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the service limit; the enrollee's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.***