arizona complete health

PSYCHOLOGICAL/NEUROPSYCHOLOGICAL*
TESTING PRIOR AUTH PROVIDER ASSISTANCE TOOL

BACKGROUND:

The following is a guide intended to help ensure that your prior authorization (PA) for psychological or neuropsychological evaluation is approved. To ensure you are using this guide correctly, first enter the codes you plan to request authorization for at https://www.azcompletehealth.com/providers/preauth-check.html. The information you provide allows our team to review and determine if the member, case, and/or situation meets our standards for Medical Necessity Criteria (MNC).

You do not need to complete and submit this form with your PA request. You may do so if you like, however, please ensure that the medical/clinical documentation you are submitting to justify your requests tells us the bulk of the information in this guide.

Arizona Complete Health (all lines of business) has specific criteria to ensure that all psychological/neuropsychological testing provided is specific and focused, to ensure the best use of funding, as well as member and staff time.

***For Medicaid members:** all *neuropsychological* PA's will be reviewed considering the information below, as well as AMPM PE 300-1. Please make sure you have reviewed and understand AHCCCS AMPM Policy Exhibit 300-1 *AHCCCS Covered Services with Special Circumstances*, (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/Exhibit300-1.pdf).

DSM-V DIAGNOSIS:

The provider must report all diagnoses being considered for this patient.
Primary: _____ R/O: _____ R/O: _____
Secondary: _____
Tertiary: _____ Additional(s): _____

What is/are the question(s) to be answered by testing, *which cannot be determined by a diagnostic interview, review of previous psychological/psychiatric records or review of collateral information*? How will testing affect the care and treatment in a *meaningful* way? _____

Previous psychological or neuropsychological testing completed? ☐ Yes ☐ No Date: _____

If yes: what were the diagnosis/es and results. _____

Provider confirms that there is no existing medical condition(s), substance use, psychotic features, or recent trauma that would contra-indicate testing: ☐ Yes ☐ No (explain) _____

Provider has assessed and confirms that patient has the cognitive and language skills for the proposed tests.
☐ Yes ☐ No (explain) _____

SYMPTOMS PROMPTING REQUEST FOR TESTING

☐ Anxiety ☐ Depression ☐ Self-Injurious Behavior
☐ Mood Instability (describe) ☐ Bizarre Behavior ☐ Hyperactivity
☐ Withdrawn/poor social skills ☐ Psychosis/Hallucinations ☐ Inattention
☐ Unprovoked agitation/aggression ☐ Cognitive Impairment ☐ Other:
☐ Behavior Problems at home ☐ Differential Diagnosis Needed
☐ Eating Disorder Symptoms ☐ ASD/Developmental Diagnoses
☐ Lack of progress in spite of EB intervention
☐ Seizures with suspected psychogenic etiology
☐ Screenings prior to a medical/surgical intervention (Bariatric Screening, Spinal Cord Stimulation, etc.)

MEMBER HISTORY

Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures, including in utero exposure? ☐Yes ☐ No Explain:

Does the member have a history of substance use/misuse and/or exposure?
☐Yes ☐No Explain: Date of last known/reported use: _____

Is there significant/relevant family psychiatric and/or medical history? If yes, summarize:

Has the patient had a Psychiatric Evaluation? ☐ Yes ☐ No If yes, date:

Total time estimated for testing, scoring and interpreting (this should be included in your cover sheet with number of units. The number of units are aligned with the purpose and extent of testing, for example, we would expect no more than 4 hours requested for pre-surgical screening)

*Attaching relevant clinical documentation that *directly* supports the request (i.e. explains the detail in this outline) helps our team determine Medical Necessity Criteria).