Michigan Department of Health and Human Services

Genetic and Molecular Laboratory Test Authorization Request - Completion Instructions

The MSA-2081 is used by Medicaid-enrolled medical practitioners and laboratory providers to request genetic and molecular laboratory testing services that require MDHHS approval. Authorization must be requested within 30 days of the specimen collection date. Specimen processing should not be completed until after the authorization has been approved.

Authorization requests will be reviewed for medical necessity based on the genetic and molecular testing standards of coverage available in the Laboratory chapter of the MDHHS Medicaid Provider Manual. Authorization requests require medical documentation from the beneficiary's Medicaid-enrolled treating provider. Medical necessity letters or test request forms created by the performing laboratory and signed by the treating provider will not be accepted as a substitute for clinical documentation or completion of the MSA-2081.

The completed MSA-2081 and/or clinical records from the treating provider must document the following:

- Indication for the test. This should be beneficiary-specific and medical in nature.
- Beneficiary's related signs and symptoms and/or family history relevant to the requested test.
- Other related testing or clinical findings of the beneficiary or family member relevant to the requested test.
- How the test results will be utilized to significantly alter the medical management or treatment of the disease.

For complete information on coverage, documentation, claims completion, and reimbursement, refer to the following documents:

- Laboratory Chapter of the MDHHS Medicaid Provider Manual.
- Billing & Reimbursement for Professionals chapter of the MDHHS Medicaid Provider Manual.
- Laboratory databases on the MDHHS website:
  www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

The MSA-2081 must be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 2	Enter the laboratory name.
Box 3	Enter the laboratory NPI number.
Box 19	Enter the date of service. This should be the date the specimen was collected.
Box 21	Enter a complete description of the laboratory test requested.
Box 22	Enter the HCPCS/CPT Procedure Code.
Box 26	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description) necessitating the requested test.
Box 29	The definitive treatment or action plan should be specific to the beneficiary.
Box 30	List other insurance coverage available for services requested and additional remarks pertinent to the request.
Box 31	Must be completed for all requests.

Form Submission

This form and required documentation must be submitted electronically utilizing the CHAMPS Prior Authorization Request List page. Providers unable to submit electronically may submit the form and documentation via fax or mail to:

MDHHS - Medical Services Administration
Program Review Division
P.O. Box 30170, Lansing, Michigan 48909

Fax Number: (517) 335-0075

Providers may check the status of an authorization request on the CHAMPS Prior Authorization Request List page or by contacting the MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276.**

Michigan Department of Health and Human Services

GENETIC AND MOLECULAR LABORATORY TEST AUTHORIZATION REQUEST

1. AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

This completed form and clinical records included with the form must document the following:

- Beneficiary-specific medical indication(s) for the requested test.
- Beneficiary's signs and symptoms, relevant family history, and other testing or clinical findings of the beneficiary or family member relevant to the requested test.
- How the test results will be utilized to significantly alter the medical management or treatment of the condition/disease.

2. LABORATORY NAME	3. NPI NUMBER	4. PHONE NUMBER ( ) -
5. LABORATORY ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		6. FAX NUMBER ( ) -

7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	8. SEX ☐ M ☐ F	9. BIRTH DATE / /	10. BENEFICIARY ID NUMBER
11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)			

12. ORDERING PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)	13. NPI NUMBER	14. ORDERING PROVIDER SPECIALTY/TAXONOMY
15. ORDERING PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		16. PHONE NUMBER ( ) -

17. FAX NUMBER ( ) -	18. CONTACT PERSON AND PHONE ( ) -	19. DATE OF SERVICE/SPECIMEN COLLECTION DATE / /

20. LINE NO.	21. TEST NAME	22. PROCEDURE CODE	23. MODIFIER	24. QUANTITY	25. CHARGE
01					
02					
03					
04					

26. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE REQUESTED TESTS:	27. DISEASE/CONDITION/GENE MUTATION BEING TESTED FOR:

BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL): BENEFICIARY ID NUMBER:

28. BENEFICIARY'S SYMPTOMS, CLINICAL FINDINGS, PREVIOUS TEST RESULTS, FAMILY HISTORY, AND/OR ETHNIC BACKGROUND THAT SUPPORTS THE NEED FOR THIS GENETIC TEST. ATTACH SUPPORTING CLINICAL DOCUMENTATION AS NEEDED:

29. WILL THE TEST RESULTS CHANGE THE BENEFICIARY'S TREATMENT (FREQUENCY, INTENSITY, OR TYPE OF SURVEILLANCE OF THE DISEASE/CONDITION) OR ESTABLISH A DIAGNOSIS? IF YES, DESCRIBE:

DIAGNOSIS: ☐ NO ☐ YES, DESCRIBE:

GUIDING SURVEILLANCE: ☐ NO ☐ YES, DESCRIBE:

MEDICAL INTERVENTION: ☐ NO ☐ YES, DESCRIBE:

MEDICATION MANAGEMENT: ☐ NO ☐ YES, DESCRIBE:

OTHER: ☐ NO ☐ YES, DESCRIBE:

30. OTHER RELEVANT INFORMATION RELATED TO THE TESTING BEING REQUESTED OR ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE ON THE DATE OF SERVICE:

31. PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PROVIDER OR LABORATORY REPRESENTATIVE'S PRINTED NAME AND SIGNATURE: DATE / /

MDHHS USE ONLY

32. REVIEW ACTION AND CONSULTANT REMARKS ☐ SEE CHAMPS

☐ APPROVED ☐ RETURN

☐ DENIED ☐ NO ACTION ☐ APPROVED AS AMENDED

CONSULTANT SIGNATURE DATE

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary but is required if payment from applicable programs is sought.

THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS) DOES NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, RELIGION, AGE, NATIONAL ORIGIN, COLOR, HEIGHT, WEIGHT, MARITAL STATUS, GENETIC INFORMATION, SEX, SEXUAL ORIENTATION, GENDER IDENTITY OR EXPRESSION, POLITICAL BELIEFS, OR DISABILITY.