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 laboratories 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. MSA-2081 must be completed by the treating clinician and submitted to MDHHS by the billing (laboratory) provider.

The completed MSA-2081 from the treating/ordering clinician must document all 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.
- Treating clinician signature. Alternatively, a signed laboratory order or requisition or signed medical documentation supporting the clinician's intent to order the test will satisfy the MSA-2081's signature requirement.

Supporting medical documentation relevant to the requested test from the beneficiary's treating/ordering clinician will be required if the MSA-2081 is incomplete or contains insufficient clinical justification. Medical necessity letters submitted as clinical documentation must be beneficiary specific and created and signed by the treating/ordering clinician. Generic statements, letters, or order/requisition forms created by a laboratory will not be accepted as a substitute for required clinical documentation or completion of the MSA-2081.

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	Instructions
Box 1	MDHHS Use Only
Box 2	Enter the Laboratory or Billing Provider's name. For rWGS requests, the Hospital should be reported as the Billing Provider.
Box 3	Enter the Laboratory or Billing Provider's 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 33	Treating clinician signature. Alternatively, a signed laboratory order, requisition or signed medical documentation supporting the clinician's intent to order the test will satisfy the signature requirement.

Form Submission

This form and 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 – Health Services

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 – Health Services, 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/BILLING PROVIDER NAME	3. NPI NUMBER	4. PHONE NUMBER ( ) -
5. LABORATORY/BILLING PROVIDER 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. ORDERING PROVIDER'S PHONE NUMBER ( ) -

17. ORDERING PROVIDER'S FAX NUMBER ( ) -	18. ORDERING PROVIDER'S CONTACT PERSON NAME 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					

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

26. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE REQUESTED TESTS:

27. DISEASE/CONDITION/GENE MUTATION BEING TESTED FOR:

28. BENEFICIARY'S SYMPTOMS, CLINICAL FINDINGS, PREVIOUS TEST RESULTS, ALL PREVIOUSLY TRIED TREATMENTS, 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. NAME OF LABORATORY REPRESENTATIVE SUBMITTING FORM	32. PHONE ( ) -

33. ORDERING 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.

ORDERING PROVIDER'S PRINTED NAME AND SIGNATURE: DATE / /

ALNERATIVELY A SIGNED LABORATORY ORDER OR REQUISITION OR SIGNED MEDICAL DOCUMENTATION SUPPORTING THE CLINICIAN'S INTENT TO ORDER THE TEST WILL SATISFY THE SIGNATURE REQUIREMENT.

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 ON THE BASIS OF RACE, NATIONAL ORIGIN, COLOR, SEX, DISABILITY, RELIGION, AGE, HEIGHT, WEIGHT, FAMILIAL STATUS, PARTISAN CONSIDERATIONS, OR GENETIC INFORMATION. SEX-BASED DISCRIMINATION INCLUDES, BUT IS NOT LIMITED TO, DISCRIMINATION BASED ON SEXUAL ORIENTATION, GENDER IDENTITY, GENDER EXPRESSION, SEX CHARACTERISTICS, AND PREGNANCY.