Applied Behavior Analysis Prior Authorization Form

Instructions:

As the requesting provider, you are required to complete all sections of this form and include supporting clinical documentation. Please submit it along with all required supporting documentation to the Autism Case Management team via fax.

Confidential Fax: 1-215-238-2500

If you need assistance submitting your request, please contact the Autism Case Management team at 1-800-688-1911, Monday through Friday from 8:00 a.m. to 6:00 p.m. ET.

Important considerations:

- Providers are encouraged to verify benefits and eligibility, as ABA benefits and authorization requirements are determined by (and vary based on) the specific benefit plan. Routine verification of insurance information is recommended to prevent disruption of services.
- Providers are encouraged to submit requests at least 2 weeks prior to the start of services and ensure that the start dates and hours / units are accurate to avoid claims/ billing issues.
- The form should be completed by a provider knowledgeable about the patient's clinical presentation and treatment history.
- Typed responses are preferred. If it is handwritten, please use blue or black ink.
- Ensure that start dates and hours match those in the treatment plan.
- If referencing the treatment plan, indicate the page number.
- Approval is based on medical necessity.
- For a summary of information to include for the medical necessity review, please see "Supporting clinical documentation for medical necessity" on page 5.

Next Steps

Once we receive your submission, our team will conduct a clinical review. An authorization decision will be made, and you will be notified of the outcome. The authorization response will include your reference number.

Coverage Determination Process

Our decisions are based on InterQual Criteria and plan-specific criteria to ensure appropriate care and coverage. Consult the Provider Manual for more information.

Applied Behavior Analysis Prior Authorization Form

SECTION A — Request type

Please indicate the type of request you are seeking authorization for.

Assessment request	Initial ABA request
Continued stay request	Additional units or hour increase on existing approval
Continuation of Care	
Requested start date of new authorization ______________	

SECTION B — Provider information

Group/Facility name		Provider fax #
Provider full address		Provider phone #
Provider TIN #	NPI #	Provider network status
Contact for this request (provide name, phone # and address)		
Email address		

SECTION C — Member information

Member name: (last, first, middle initial)	Member ID
Address	DOB
Member/Caregiver contact information	
Name/Relationship to member	Phone #
Email address	
Is the member diagnosed with Autism Spectrum Disorder? Yes No	

If yes, please include the following:

Date of most current diagnostic evaluation: ______________

Type of assessment completed: ______________

Evaluator's name and credentials: ______________

SECTION A — Member information (continued)

Please list any other relevant diagnosis and their diagnostic codes:

SECTION D — Standardized assessments

Please indicate which adaptive behavior assessments were administered in making the initial diagnosis of ASD, or indicate page numbers in the treatment plan where this information can be found:

Name of Assessment	Current Score	Previous Score	Baseline Score	Date

If additional assessments were used, please include the assessment, dates of administration, and scores (e.g. Skills based assessments - VBMAPP and/or Adaptive Behavior Assessments - Vineland-3):

Current requested treatment start date ____________

Place of Service (POS) - please separate hours requested in the school setting.

Clinic Home School Community

Other (please specify)

CPT code	Service	Hours/Amount	Units	Frequency
97151	Behavior identification assessment			(Per authorization)
97153	Adaptive behavior treatment by protocol			Week Month
97155	Adaptive behavior treatment with protocol modification			Week Month
97156	Family adaptive behavior treatment guidance			Week Month
97157	Multiple-family group adaptive behavior treatment guidance			Week Month
97154	Group adaptive behavior treatment by protocol			Week Month
97158	Group adaptive behavior treatment with protocol modification			Week Month

SECTION B — Standardized assessments (continued)

The following services (2:1) must be provided in a setting that is customized to the member's behavior with a physician or other qualified health care professional on site and immediately accessible to the technicians.

CPT code	Service	Hours/Amount	Units	Frequency
0362T	Behavior identification supporting assessment			Week Month
0373T	Adaptive behavior treatment with protocol modification			Week Month

SECTION E — Supervising provider information

Supervising provider name

Tax Identification Number (TIN)

Is the provider above supervising all ABA treatment?

Yes No

If No, list all others providing supervision:

Supervising provider credentials

BCBA BCBA-D LBS Licensed Psychologist

Other (please specify)

Declaration and Signature

X

Supervisor's signature

/ /

Date (mm/dd/yy)

Supporting clinical documentation for medical necessity

Does the member have an established and current documented diagnosis of ASD consistent with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision (DSM-5-TR) criteria, using validated autism assessment tools (e.g., Autism Diagnostic Observation Schedule (ADOS); Autism Diagnostic Interview (ADI-R); Parent Evaluation Developmental Stages (PEDS), or Brigance Diagnostic Inventory of Early Development II)?

With this request, did you include:

1. Diagnostic Evaluation

   Was a complete diagnostic evaluation conducted by a Qualified Health Practitioner (QHP)?
   (e.g., MD, DO, PhD, PsyD, PMHNP)

   Family Practice
   Pediatrics
   Developmental Pediatrics
   Pediatric Neurology
   Psychiatry
   Psychologist
   Psychiatric Mental Health Nurse Practitioner

2. Validated Assessment Tools

   Did you include assessment tools specific to the member's individual developmental and skill needs that were utilized during the initial assessment to determine severity, progress towards treatment goals and appropriateness of care?

   ADOS / ADOS-2
   ADI-R
   PEDS
   Brigance Inventory
   M-CHAT
   CARS-2
   ASRS
   ASQ
   STAT
   RITA-T
   SCQ
   Other: ______________________________

3. Coordination of Care

   Is there documentation of coordination with other health care providers, necessary to ensure collaboration, consistency and support outcomes.
   (e.g., OT, PT, Speech, schools, daycare, pediatrician, psychiatrist)

4. Treatment Plan Documentation

Is a treatment plan included in the record?
Does the treatment plan include:

- Significant history
- Diagnosis of ASD and rationale for requiring services
- Any related professional provider's orders
- The goals for the services, which must be:
  - Specific and measurable
  - Individualized
  - Updated on a frequent basis
  - Based on the individual's progress
  - To improve function and/or behavior significantly
  - To prevent loss of attained skill or function and/or produce socially significant improvement in human behavior (reduce interfering behaviors)
- Type, amount, duration, and frequency of services
- Direct observation, measurement, and functional analysis of the relations between environment and behavior
- Interventions such as, but not limited to, physical, occupational, speech therapy(ies), ABA and/or other related structured behavioral services that are consistent with current techniques and standards
- Any contraindications to a course of services
- Clear expectations for progress using evidence-based measurement
- When appropriate, a summary of past services and the results that were achieved
- Parent(s)' and/or caregiver(s)' awareness and understanding of the diagnoses, prognoses, and goals of services
- Caregiver training and participation: It is recommended that there are at least two goals targeting caregiver training to provide an objective measure of their inclusion in the treatment planning process.
- Generalization and maintenance should be included as part of the initial treatment plan development. It is expected that skills acquired occur in functional contexts across people, places, and time to be considered truly mastered.
- Titration & Discharge Planning: Criteria for mastery of skills proposed should be included for each goal. An estimated length of service should also be presented based on the goals identified and treatment plan.
- Reasonable expectation, based on the individual's clinical history, that withdrawal of treatment will result in the decompensation or the recurrence of signs and symptoms
- Signature of the treating licensed professional provider (e.g., MD/DO, licensed psychologist)