

Applied Behavioral Analysis (ABA) Authorization



Member Information

Today's Date (mm/dd/yyyy) _____ Member Medicaid # _____

First Name _____ Last Name _____

Gender: Male Female Age _____ Date of Birth (mm/dd/yyyy) _____

Is there a primary payor? Yes No

Member Address _____

City _____ State _____ Zip Code _____

Legal Guardian Name _____ Member or Guardian Phone Number _____

Board Certified Behavioral Analyst (BCBA) and BCBA Information

Provider Name _____ Credentials _____

Provider NPI _____ Tax ID # _____

Provider Address _____

Phone _____ Fax _____

Contact Name _____ QHCP/Psychiatrist Physician

Group/Facility Provider: BCBA-D, BCBA, QHCP

Provider Name _____ Credentials _____

Provider NPI _____ Tax ID # _____

Address _____

Phone _____ Fax _____

Diagnostic and Treatment Information

ICD-10 and DSM DX Code (required) _____

Secondary Diagnosis _____

Prior ABA Treatment _____

Last Authorization # (date span) _____

Diagnosis Date _____

Member in School? Brick & Mortar Home School No Services being provided in the school? Yes No

If yes do you have the IEP? Yes No If yes please provide the month and year of last update:

If services are being rendered in school and you selected no, please explain why:

Diagnostic and Treatment Information (cont'd)

Does member have an IEP or 504 plan? Yes No

Receiving early intervention services? Yes No Describe other services received in addition to the ABA requested, including but not limited to PT, OT, ST or mental health services:

Type of Request: Assessment Only? Initial treatment? Continuation of treatment?

Date of most recent assessment _____

Additional Information

Please submit the information noted below with all treatment requests. If documentation is not received, the request will be reviewed based on information available at the time of review.

CURRENT PRESENTATION/SYMPTOMS	MILD	MODERATE	SEVERE
Safety risk to self/others:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggression:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disruptive behavior:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Destruction of property:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood issues:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For initial assessment, please submit comprehensive diagnostic information including standardized measures and referral from diagnosing provider for ABA services to include estimated duration of care.

- Prior authorization form
- CDE
- Prescription for ABA ordered by a QHCP if ABA is not recommended in CDE

For initial treatment request, please submit:

- CDE
- Behavioral treatment plan including measureable treatment goals and parent training
- Proposed treatment schedule including the provider type who will render services
- Proposed functional and measurable treatment goals with expected timeframes which target identified behavior deficits
- Dated copy of IEP or IFSP, if applicable
- Copy of waiver Plan Profile Table and the Schedule page from the certified plan of care, if applicable
- Objective testing showing significant behavioral deficit
- Description of coordination of services with other providers (school, PT, OT, ST)
- Any medical conditions that will impact outcomes of treatment
- Individualized measurable titration plan
- Individualized measurable discharge plan
- Schedule of services planned, including location, and the individual providers responsible for delivering the services, and Functional Behavioral Assessment (Please advise the assessment tool utilized and include baseline data graph and progress);

For subsequent treatment requests, please submit:

- Objective measures of clinically significant progress (measurable and functional improvement) toward each stated treatment goal**
- Updated plan for treatment including updated goals and timeline for achievement**
- Any necessary changes to the treatment plan**
- Is there coordination of care with other providers? If yes please include coordination of care in attached supporting clinical documents**
- Include progress or lack-of with any previous treatment interventions**
- Dated copy of IEP or IFSP, if applicable**
- Individualized measurable titration plan**
- Individualized measurable discharge plan**
- Schedule of services planned, including location, and the individual providers responsible for delivering the services, and Functional Behavioral Assessment (Please advise the assessment tool utilized and include baseline data graph and progress);**

Authorization Information

Start Date _____ End Date _____

Please note: A service authorization period shall not exceed 180 days for ABA services.

Billing Codes

Codes	Description	Unit Interval	Weekly # of Units Requested	Total # of Units Requested
97151	Behavior identification assessment, administered by a physician or other qualified healthcare professional	15 min		
97152	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional	15 min		
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional	15 min		
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional	15 min		
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional	15 min		
97156	Family adaptive behavior treatment guidance, administered by physical or other qualified healthcare professional	15 min		
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present)	15 min		
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional	15 min		
0362T	Behavior identification supporting assessment, administered by the physician or other	15 min		
0373T	Adaptive behavior treatment with protocol modification, administered by the physician or other	15 min		

***Modifiers should be used in billing to reflect the credentials of staff delivering services and allow for proper claims payment.

By signing below, I attest that all professionals and paraprofessionals rendering service(s) under the proposed treatment plan have the appropriate training and education required to render service(s).

Rendering Provider Signature

Date