



# Request for Applied Behavior Analysis (ABA)

<b>Review Type:</b> Assessment Request <input type="checkbox"/> Initial Request <input type="checkbox"/> Continuation Request <input type="checkbox"/>		
<b>Request Date</b>		
MCO Fax:	MCO Phone:	MCO Address:

**Member Information**

<b>Member Name</b>	
<b>Member MCO ID</b>	
<b>Member DOB</b>	
<b>Member's Current Telephone</b>	
<b>Member's Parent/Guardian Name</b>	

**Provider Information**

<b>Facility/Group Name</b>		<b>Provider TIN</b>	
<b>Provider of ABA Services Name</b>		<b>Provider NPI</b>	
		<b>Provider MCO ID</b>	
<b>Facility/Group Address</b>		<b>City</b>	
		<b>Zip Code</b>	
<b>Facility/Group Phone</b>		<b>Facility Group Fax</b>	
<b>Supervisor's Name/Credentials</b>		<b>Supervisor's Phone Number</b>	
<b>Office Contact Name</b>		<b>Office Contact Phone Number</b>	

**Date of Service Requested**

(e.g. 01/01/2024 – 07/01/2024 – 26 weeks (or 6 month) date range)

<b>Start Date</b>		<b>End Date</b>	
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**Requesting CPT codes with corresponding units**

\*Units should reflect 15-minute increments, refrain from using hour increments

Code	Service Description	Modifier	Units Per Week	Units per Authorization period	Indicate if Hours are telehealth
<b>Assessment (Initial/Continuation Services)</b>					
<b>97151</b>	Behavior identification assessment	<b>HO</b> <input type="checkbox"/>			
<b>97152</b>	Behavior identification, supporting assessment	<b>HM</b> <input type="checkbox"/>			
<b>Continuation Services</b>					

<b>97153 (BA)</b>	Adaptive behavior treatment by protocol	<b>HO</b> <input type="checkbox"/>			
<b>97153 (RBT)</b>	Adaptive behavior treatment by protocol, administered by technician	<b>HM</b> <input type="checkbox"/>			
<b>97154</b>	Group adaptive behavior treatment by protocol, administered by technician	<b>HM</b> <input type="checkbox"/>			
<b>97155</b>	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional,	<b>HO</b> <input type="checkbox"/>			
<b>97156</b>	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional	<b>HO</b> <input type="checkbox"/>			
<b>97157</b>	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional	<b>HO</b> <input type="checkbox"/>			
<b>97158</b>	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional	<b>HO</b> <input type="checkbox"/>			
				<b>Total:</b>	

**Place of Service Setting**

<b>Place of Service</b>	<b>Total number of hours</b>
<b>Clinic</b>	
<b>Home</b>	
<b>Community</b>	
<b>School</b>	
<b>Telehealth</b>	
<b>Other, please specify:</b>	

**DSM-5 Diagnosis**

<b>Current Primary DSM-5 Diagnosis (include ICD-10 code)</b>	
<b>Additional DSM-5 Diagnosis (include ICD-10 code)</b>	
<b>Medical Diagnosis</b>	

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## FOR ASSESSMENT REQUESTS

Diagnosis/Diagnostic Confirmation			
<b>Who rendered the diagnosis?</b>	<b>Facility/Group Name</b>		
	<b>Provider Name and Credentials</b>		
<b>Date Diagnosis was initial rendered</b>			
<b>Was Standard Assessment used:</b>	<b>In diagnosis of ASD?</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
	<b>An established supporting diagnosis for which ABA is proven to be an effective appropriate intervention?</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
	<b>History of Traumatic Brain Injury</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
<b>Diagnostic Report Attached</b>	<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>		
<b>Doctor's Order Attached</b>	<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>		

CLINICAL FOR MEDICAL NECESSITY DETERMINATION	
<b>List all prior and current therapy/treatment; within last 12 months</b>	
<b>Describe why ABA is medically necessary (include skill deficits, communication deficits, behavior concerns)</b>	

<b>Other Medical/Behavioral Conditions</b>	
<b>Medications</b>	

Parent/Caregiver Information	
<b>Parent/Caregiver Name</b>	
<b>Relationship to Member</b>	
<b>Living arrangements</b>	
<b>Parent/Caregiver willing or able to participate</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, Please Explain:

School/Employment – Check all that Apply			
<b>Early Intervention</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not enrolled <input type="checkbox"/>	
		Not able to attend <input type="checkbox"/> Please explain:	
<b>Pre-School</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not enrolled <input type="checkbox"/>	
		Not able to attend <input type="checkbox"/> Please explain:	
<b>School</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not enrolled <input type="checkbox"/>	
		Not able to attend <input type="checkbox"/> Please explain:	
<b>Work</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not enrolled <input type="checkbox"/>	
		Not able to attend <input type="checkbox"/> Please explain:	

## FOR INITIATION OF TREATMENT/CONTINUATION OF SERVICES

Complete the Unit Guide below to demonstrate the severity of symptomology/units needed.

CLINICAL FOR MEDICAL NECESSITY DETERMINATION			
Assessment of Symptom Severity/Unit Guide			
Functional Impairment			
Communication: What is the severity of social communication deficits?	Select One	Estimated Units	Explain (Optional):
<b>Level 1/Mild (Requires Support):</b> Deficits may cause noticeable impairments including atypical or unsuccessful responses to others. Individual may have language but difficulty engaging in reciprocal conversation or remaining on topic.			
<b>Level 2/Moderate (Requires Substantial Report):</b> Clearly atypical and unsuccessful verbal and non-verbal responses. Limited ability to initiate and/or limited interest may impact ability to maintain reciprocal conversations. These are apparent even with supports in place.			
<b>Level 3/Severe (Requires Very Substantial Support):</b> Non-intelligible or atypical verbal and/or non-verbal communication methods. Rarely initiates and generally communicates only to meet needs. Inability to communicate causes severe impairments in functioning.			
Social: What is the severity of the social interaction deficits?	Select One	Estimated Units	Explain (Optional):
<b>Level 1/Mild (Requires Support):</b> Difficulty initiating social interactions. Atypical or unsuccessful responses to the social overtures of others. May have a decreased interest in social interactions.			
<b>Level 2/Moderate (Requires Substantial Support):</b> Clear social impairments apparent even with supports in place. Limited initiation of social interactions and reduced or atypical responses to the social overtures of others.			

<p><b>Level 3/Severe (Requires Very Substantial Support):</b> Very limited initiation of social interactions and minimal responses to the social overtures of others. Engages in social interactions only to get needs met and may respond only to very direct approaches.</p>			
<p><b>Behavior:</b>  <b>What is the severity of behavior difficulties deficits?</b> (e.g., restricted, and repetitive behaviors)  <b>What is the severity of maladaptive behaviors?</b> (e.g., aggression, self-injurious behavior)</p>	<b>Select One</b>	<b>Estimated Units</b>	<b>Explain (Optional):</b>
<p><b>Level 1/Mild (Requires support):</b> Inflexibility interferes with functioning in one or more contexts. May experience difficulties switching between activities. Problems with organization and planning may impact independence. Little interference to daily life.</p>			
<p><b>Level 2/Moderate (Requires Substantial Support):</b> Inflexibility of behavior. Difficulties coping with change and/or shifting focus or action. Restricted and/or repetitive behaviors are obvious to the casual observer. Any of these can interfere with functioning in a variety of contexts.</p>			
<p><b>Level 3/Severe (Requires Very Substantial Support):</b> Inflexibility, extreme difficulty coping with change, inability to shift focus and/or action. Maladaptive, restrictive, and/or repetitive behaviors cause great distress and marked interference in all contexts.</p>			
<p><b>Adaptive: What is the severity of adaptive deficits?</b></p>	<b>Select One</b>	<b>Estimated Units</b>	<b>Explain (Optional):</b>
<p><b>Level 1/Mild (Requires Support):</b> Difficulty recognizing danger/risks, or advocating for self; problems with grooming/eating/toileting skills</p>			
<p><b>Level 2/Moderate (Requires Substantial Support):</b> Difficulty recognizing danger/risks, or advocating for self; problems with grooming/eating/toileting skills</p>			
<p><b>Level 3/Severe (Requires Very Substantial Support):</b> Difficulty recognizing danger/risks, or advocating for self; problems with grooming/eating/toileting skills</p>			
<p><b>Other Domain:</b> (if applicable/not included above)</p>	<b>Explanation</b>		

List Domain	
Indicate Severity: Check one	Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/> Severe: <input type="checkbox"/>
What is main skill deficit in this area?	
How has the member progressed in this area, if applicable?	
What is the target mastery skills for this area?	
Member Participation	Yes <input type="checkbox"/> No <input type="checkbox"/> Describe participation
Caregiver Participation	Yes <input type="checkbox"/> No <input type="checkbox"/> Describe participation
Has measurable progress been made toward goals and are they documented in the member's ABA therapy treatment plan?	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, Please Explain:
If this request is for a continuation of ABA therapy already begun, can progress be maintained if ABA therapy is reduced or discontinued?	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, Please Explain:
List Standardized Assessments used to validate progress and include scores	Name of Assessment: Date Assessed: Score:

<p>How long has the member been receiving this intensity, i.e. hours per week, of services?</p>	
<p>Provide length of time member has been receiving ABA services.</p>	
<ul style="list-style-type: none"> <li>• Have there been any breaks in service? If yes, please explain.</li> </ul>	
<p>Hours per week of other therapeutic activities</p> <ul style="list-style-type: none"> <li>• speech therapy</li> <li>• occupational therapy</li> <li>• physical therapy</li> <li>• outpatient counseling</li> <li>• medication management</li> <li>• and home-based services other than ABA, etc.</li> </ul>	
<p>Attach cumulative graphs/charts of baseline data and current progress; current behavioral support plan and treatment plan including symptoms and behaviors requiring treatment, skills to be addressed, baseline measures and current progress, and schedule of services. Ensure attachment includes description of goals achieved within the authorization period and any barriers to treatment.</p>	<p>Documents Attached: Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>How would you rate caregivers regarding their proficiency with ABA techniques and working with the individual?</p>	<p>Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> Proficient <input type="checkbox"/></p>
<p>Please provide number of hours used; number of hours approved for last auth period to complete below formula.</p> <p>Percentage of Authorization Units Utilized formula: (Hours Utilized divided by Hours Approved multiplied by 100)</p> <p>If under 90% utilized, please explain. <i>Note: These figures are in reference to 97153/direct care, per week</i></p>	<p>How many hours of parent training (97156) are provided? _____ Hours</p> <p>Hours Utilized _____ /Hours Approved _____</p> <p>= _____</p> <p>x 100 = _____</p>
<p>Clinical Justification for increase in hours of service *Specify barriers/rationale for this change</p>	
<p>Attach fading plan</p>	<p>Documents Attached: Yes <input type="checkbox"/> No <input type="checkbox"/></p>



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\_\_\_\_\_  
Provider's Signature

This may be the signature of the person completing the form; however, it should note that is on behalf of the current treating provider. Or the actual recommending current treating provider may sign.

\_\_\_\_\_  
Print Provider's Name

\_\_\_\_\_  
Date

Please note that an authorization is not a guarantee of payment; coverage is subject to all terms and conditions of the member's benefit plan. I hereby attest that all the information can be in the member's medical record, and is true/accurate to the best of my knowledge: