Request for Applied Behavior Analysis (ABA)

Review Type: Assessment Request ☐ Initial Request ☐ Continuation Request ☐		
Request Date		
MCO Fax:	MCO Phone:	MCO Address:

Member Information

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

Provider Information

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

Date of Service Requested

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

Start Date		**End Date**	

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
Assessment (Initial/Continuation Services)					
97151	Behavior identification assessment	**HO** ☐			

Medicaid coverage provided by Wellpoint Tennessee, Inc.

We comply with the applicable federal and state civil rights laws, rules, and regulations and do not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call 833-731-2154. Information about the civil rights laws can be found at tn.gov/tenncare/members-applicants/civil-rights-compliance.html.

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97152	Behavior identification, supporting assessment	**HM** ☐			
Continuation Services					
97153 (BA)	Adaptive behavior treatment by protocol	**HO** ☐			
97153 (RBT)	Adaptive behavior treatment by protocol, administered by technician	**HM** ☐			
97154	Group adaptive behavior treatment by protocol, administered by technician	**HM** ☐			
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional,	**HO** ☐			
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional	**HO** ☐			
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional	**HO** ☐			
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional	**HO** ☐			
				Total:	

Place of Service Setting

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

DSM-5 Diagnosis

Current Primary DSM-5 Diagnosis (include ICD-10 code)	

Additional DSM-5 Diagnosis (include ICD-10 code)	
Medical Diagnosis	

FOR ASSESSMENT REQUESTS

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

CLINICAL FOR MEDICAL NECESSITY DETERMINATION	
List all prior and current therapy/treatment; within last 12 months	

Describe why ABA is medically necessary (include skill deficits, communication deficits, behavior concerns)	
Other Medical/Behavioral Conditions	
Medications	

Parent/Caregiver Information	
Parent/Caregiver Name	
Relationship to Member	
Living arrangements	
Parent/Caregiver willing or able to participate	**Yes ☐ No ☐** **If No, Please Explain:**

School/Employment – Check all that Apply		
Early Intervention	**Yes ☐ No ☐**	**Full Time ☐ Part Time ☐ Not enrolled ☐** **Not able to attend ☐** **Please explain:**
Pre-School	**Yes ☐ No ☐**	**Full Time ☐ Part Time ☐ Not enrolled ☐** **Not able to attend ☐** **Please explain:**
School	**Yes ☐ No ☐**	**Full Time ☐ Part Time ☐ Not enrolled ☐**

		Not able to attend ☐ **Please explain:**
Work	**Yes ☐ No ☐**	**Full Time ☐ Part Time ☐ Not enrolled ☐**
		Not able to attend ☐ **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):**
Level 1/Mild (Requires Support): 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.			
Level 2/Moderate (Requires Substantial Report): 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.			

Level 3/Severe (Requires Very Substantial Support): 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):**
Level 1/Mild (Requires Support): Difficulty initiating social interactions. Atypical or unsuccessful responses to the social overtures of others. May have a decreased interest in social interactions.			
Level 2/Moderate (Requires Substantial Support): 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.			
Level 3/Severe (Requires Very Substantial Support): 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.			
Behavior: **What is the severity of behavior difficulties deficits?** *(e.g., restricted, and repetitive behaviors)* **What is the severity of maladaptive behaviors?** *(e.g., aggression, self-injurious behavior)*	**Select One**	**Estimated Units**	**Explain (Optional):**
Level 1/Mild (Requires support): 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.			
Level 2/Moderate (Requires Substantial Support): 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.			
Level 3/Severe (Requires Very Substantial Support): 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.			

Adaptive: What is the severity of adaptive deficits?	Select One	Estimated Units	Explain (Optional):
Level 1/Mild (Requires Support): Difficulty recognizing danger/risks, or advocating for self; problems with grooming/eating/toileting skills			
Level 2/Moderate (Requires Substantial Support): Difficulty recognizing danger/risks, or advocating for self; problems with grooming/eating/toileting skills			
Level 3/Severe (Requires Very Substantial Support): Difficulty recognizing danger/risks, or advocating for self; problems with grooming/eating/toileting skills			

Other Domain: (if applicable/not included above)	Explanation
List Domain	
Indicate Severity: Check one	**Mild:** ☐ **Moderate:** ☐ **Severe:** ☐
What is the main skill deficit in this area?	
How has the member progressed in this area, if applicable?	
What are the target mastery skills for this area?	
Member Participation	**Yes** ☐ **No** ☐ **Describe participation**

Caregiver Participation	**Yes ☐ No ☐** **Describe participation**
Has measurable progress been made toward goals and are they documented in the member's ABA therapy treatment plan?	**Yes ☐ No ☐** **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 ☐ No ☐** **If No, Please Explain:**
List Standardized Assessments used to validate progress and include scores	**Name of Assessment:** **Date Assessed:** **Score:**
How long has the member been receiving this intensity, i.e. hours per week, of services?	
Provide length of time member has been receiving ABA services.	
• **Have there been any breaks in service? If yes, please explain.**	
Hours per week of other therapeutic activities • **speech therapy** • **occupational therapy** • **physical therapy** • **outpatient counseling** • **medication management** • **and home-based services other than ABA, etc.**	
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.	**Documents Attached: Yes ☐ No ☐**
	Low ☐ Moderate ☐ High ☐ Proficient ☐

How would you rate caregivers regarding their proficiency with ABA techniques and working with the individual?	**How many hours of parent training (97156) are provided? _____ Hours**
Please provide number of hours used; number of hours approved for last auth period to complete below formula. **Percentage of Authorization Units Utilized formula: (Hours Utilized divided by Hours Approved multiplied by 100)** **If under 90% utilized, please explain.** ***Note: These figures are in reference to 97153/direct care, per week***	**Hours Utilized _____ /Hours Approved _____** **= _____** **x 100 = _____**
Clinical Justification for increase in hours of service ***Specify barriers/rationale for this change**	
Attach fading plan	**Documents Attached: Yes ☐ No ☐**

_____

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: