

# Applied Behavior Analysis Authorization Request



## Instructions for Completing the Request

Complete this form for Applied Behavior Analysis (ABA) Assessment and Treatment Authorization requests. Include the request type (assessment or treatment), the specific services, the number of units requested per week, and the total number of units requested for the authorization period.

**Include the required documentation below for the type of authorization specific to this Request. Please add a “check” for each item included.**

### Initial Assessment Request Required Documentation

- A copy of the comprehensive evaluation that resulted in the Autism Spectrum Disorder Diagnosis, conducted by a Licensed Psychologist or Licensed Physician
  - Referral(s) for ABA Assessment or Treatment that includes the current recommendation made by a physician, psychologist, psychiatric nurse practitioner, pediatric nurse, or physician assistant
  - Supplemental Documentation, to the extent applicable:
    - For a member with cognitive delays, a Cognitive Assessment including Full Scale IQ
    - For a member with significant speech delays, a copy of the most recent speech evaluation related to their current functional status by a Speech and Language Pathologist
    - For a member with significant sensory and/or motor delays that impacts behavior, a copy of the most recent evaluation related to their current functional status from their Occupational Therapist and/ or Physical Therapist
  - A copy of the comprehensive annual physical by the member’s Primary Care Provider (PCP) and/or specialty physician
  - Supporting documentation that co-occurring conditions are being addressed by appropriate providers, *where applicable*
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### ABA Treatment Required Documentation

- Initial Assessment Request Required Documentation (if not previously submitted)
- A copy of the official ABA Assessment, including the certification/credentials of the assessor
- A copy of the ABA treatment plan, to include frequency, duration, and location of the requested ABA treatment
- Documentation of specific parent/caregiver training procedures
- Documentation of coordination of care that addresses crisis plan, transition planning, and discharge planning

**Submit this completed Request and required documentation to MVP.**

Email [bhservices@mvphealthcare.com](mailto:bhservices@mvphealthcare.com)

Fax **1-855-853-4850**

*This form is based on the MVP Medical Policy: Applied Behavior Analysis.*

# Applied Behavior Analysis Authorization Request



<b>Requested Authorization</b>		<b>Request Type</b>		
Start Date	End Date	<input type="checkbox"/> Initial Assessment	<input type="checkbox"/> Initial Treatment	<input type="checkbox"/> Concurrent Treatment

## Section 1: MVP Member Information

Member Name		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:		Date of Birth
Phone No.	MVP Member ID No.	Plan Type		
City of Residence	State	Zip Code	Diagnosis	

## Section 2: Provider Information

Provider/Supervisor Name <i>(BCBA, LBA, LABA, Other)</i>		ABA Provider Type <input type="checkbox"/> BCBA <input type="checkbox"/> State Licensed/Certified		Certification/License No.	State
NPI No.	Phone No.	Email			
Service Street Address			City	State	Zip Code

**If the individual above is part of a Group, provide the Group information below.**

Provider Group/Agency Name		Provider Group ID No. <i>(if known)</i>	Tax ID No.
Phone No.	Provider Group Email		
Service Street Address		City	State   Zip Code

## Section 3: Applied Behavior Analysis Services Requested

**Program Setting** *(select all that apply)*

Home  Facility/Clinic  School  Other: \_\_\_\_\_

**Service Types** *Each time unit equals 15 minutes.*

**Assessment and Follow-Up Assessment Service**

Conducted by physician or other qualified health care professional (QHP). Behavior identification assessment, administration of tests, detailed behavioral history, observation, caretaker interview, interpretation, discussion of findings, recommendations, preparation of report, development of treatment plan. Assessment of strengths and weaknesses of skill areas across skill domains (e.g., VB-MAPP, ABLLS-R, Functional Behavior Assessment, Functional Analysis) and follow-up assessments.

<input type="checkbox"/> <b>CPT 97151</b> Behavior identification assessment (initial or reassessment) administered by a physician/QHP. Up to 32 units maximum for initial assessment, up to 12 units maximum for reassessment.	15-Minute Units per Week	Total 15-Minute Units Requested
<input type="checkbox"/> <b>CPT 97152</b> Behavior identification supporting assessment administered by technician under direction of physician/QHP, face-to-face with patient. Units are in 15-minute increments. Clinical justification required.	15-Minute Units per Week	Total 15-Minute Units Requested
<input type="checkbox"/> <b>CPT 0362T (Not covered for New York State Medicaid Managed Care Plans)</b> Behavior identification supporting assessment for severe behaviors administered by a physician/QHP who is on-site, with the assistance of two or more technicians, for a patient who exhibits destructive behavior, completed in an environment that is customized to a patient's behavior. Clinical justification required.	15-Minute Units per Week	Total 15-Minute Units Requested

MVP Member Name	MVP Member ID No.
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**Service Types continued**

*Each time unit equals 15 minutes.*

**Direct One-to-One Applied Behavior Analysis Therapy Service**

<input type="checkbox"/> <b>CPT 97153</b> Adaptive behavior treatment by protocol administered by technician under the direction of physician/QHP, receiving one hour of supervision for every 5–10 hours of direct treatment.	15-Minute Units per Week	<b>Total 15-Minute Units Requested</b>
<input type="checkbox"/> <b>CPT 97155</b> Adaptive behavior treatment with protocol modification, administered by physician/QHP. May be used for Direction of Technician (Supervision) face-to-face with one patient.	15-Minute Units per Week	<b>Total 15-Minute Units Requested</b>
<input type="checkbox"/> <b>CPT 0373T (Not covered for New York State Medicaid Managed Care Plans)</b> Adaptive behavior treatment with protocol modification implemented by physician/QHP who is on-site with the assistance of two or more technicians for severe maladaptive behaviors. Clinical justification required.	15-Minute Units per Week	<b>Total 15-Minute Units Requested</b>

**Group Adaptive Behavior Treatment Service**

<input type="checkbox"/> <b>CPT 97154 (Not covered for New York State Medicaid Managed Care Plans)</b> Group adaptive behavior treatment by protocol by technician under the direction of physician/QHP, face-to-face with two or more patients.	15-Minute Units per Week	<b>Total 15-Minute Units Requested</b>
<input type="checkbox"/> <b>CPT 97158</b> Group adaptive behavior treatment with protocol modification (Social Skills Group) by physician/QHP, face-to-face with two or more patients.	15-Minute Units per Week	<b>Total 15-Minute Units Requested</b>

**Family Adaptive Behavior Treatment Guidance (Family Training) Service**

<input type="checkbox"/> <b>CPT 97156</b> With individual family	15-Minute Units per Week	<b>Total 15-Minute Units Requested</b>
<input type="checkbox"/> <b>CPT 97157 (Not covered for New York State Medicaid Managed Care Plans)</b> With multiple family group.	15-Minute Units per Week	<b>Total 15-Minute Units Requested</b>

**Section 4: Additional Treatment and Coordination of Care**

**Additional Services the Member is Receiving** *(select all that apply)*

- Speech Therapy    
  Physical Therapy    
  Occupational Therapy    
  Behavioral Health Services    
  Primary Care  
 Member is not receiving any additional services    
 Other: \_\_\_\_\_

Collaboration with treating providers for the services listed above is complete. The data obtained is used to inform ABA goals and treatment plan.  Yes    No

If **No**, please explain why.

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