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*

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

This form is based on the MVP Medical Policy: Applied Behavior Analysis for Autism Spectrum Disorder

Applied Behavior Analysis Authorization Request

Requested Authorization
Start Date **End Date**

Request Type
☐ Initial Assessment ☐ Initial Treatment ☐ Concurrent Treatment

Section 1: MVP Member Information

Member Name	Gender ☐ Male ☐ Female ☐ Other:	Date of Birth

Phone No. ( )	MVP Member ID No.	Plan Type

City of Residence	State	Zip Code

Section 2: Provider Information

Provider/Supervisor Name *(BCBA, LBA, LABA, Other)*	ABA Provider Type ☐ BCBA ☐ 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. *(if known)*	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.

Service	15-Minute Units per Week	**Total** 15-Minute Units Requested
☐ **CPT 97151** 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.		
☐ **CPT 97152** 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.		
☐ **CPT 0362T** ***(Not covered for New York State Medicaid Managed Care Plans)*** 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.		

MVP Member Name	**MVP Member ID No.**

***Service Types** continued*

Each time unit equals 15 minutes.

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

Service	15-Minute Units per Week	**Total** 15-Minute Units Requested
☐ **CPT 97153** 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.		
☐ **CPT 97155** Adaptive behavior treatment with protocol modification, administered by physician/QHP. May be used for Direction of Technician (Supervision) face-to-face with one patient.		
☐ **CPT 0373T** ***(Not covered for New York State Medicaid Managed Care Plans)*** 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.		

☐ Group Adaptive Behavior Treatment Service

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

☐ Family Adaptive Behavior Treatment Guidance (Family Training) Service

Service	15-Minute Units per Week	**Total** 15-Minute Units Requested
☐ **CPT 97156** With individual family		
☐ **CPT 97157** ***(Not covered for New York State Medicaid Managed Care Plans)*** With multiple family group.		

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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