

# Applied Behavior Analysis Authorization Request



## Instructions for Completing the Request

Complete this form for both Initial and Concurrent Applied Behavior Analysis (ABA) Authorization Requests. Include the service requested, the specific treatment, the number of requested units, and the units per month.

### **Include the required documentation below for the type of authorization specific to this Request.**

#### **Initial Assessment Request Required Documentation**

- A copy of the completed evaluation with the Autism Spectrum Disorder (ASD) diagnosis completed by a licensed Physician or Psychologist.
- A copy of the written recommendation for ABA made by a licensed physician or psychologist.

#### **Initial Treatment Request Required Documentation**

- A copy of the current Individualized Education Program (IEP) and Committee on Special Education (CSE) evaluation, and/or Early Intervention Plan (EIP) Information. If not available, provide:
  - A copy of a completed full scale IQ report; and
  - An explanation as to why an IEP, CSE evaluation, or EIP is not available or completed, and;
  - Copies of completed PT, OT, speech, and cognitive testing/evaluations.
- Current schooling, including number of hours attending per week.
- Documented history, if any, of previous ABA treatment.
- Treatment plan, including reports and progress notes.
- Goals of treatment
- Active collaboration with member's PCP and date of last physical.
- For hearing, vision, or seizure disorders, documentation of active collaboration with treating provider/specialist.
- For sensorimotor delays, a copy of the documented evaluation and active collaboration with OT and PT.
- For other behavior health diagnoses, documentation of active collaboration with therapist/psychiatrist.

#### **Concurrent Treatment Request Required Documentation**

- Any missing documentation from Initial Treatment Request.
- Changes to schooling (if any).
- Updated treatment plan, including reports and progress notes.
- Updated goals of treatment.
- Continued documentation of active collaboration with PCP and other treating providers.

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

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

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

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

## Section 2: Provider Information

Provider/Supervisor Name <i>(BCBA, LBA, LABA, Other)</i>		ABA Provider Type		Certification/License No.	State
		<input type="checkbox"/> BCBA <input type="checkbox"/> State Licensed/Certified			
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 <i>(select all that apply)</i> <input type="checkbox"/> Home <input type="checkbox"/> Facility/Clinic <input type="checkbox"/> School <input type="checkbox"/> Other: _____	Hours Per Week of ABA Services Requested
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### Service Types *Each time unit equals 15 minutes.*

<input type="checkbox"/> <b>Assessment and Follow-Up Assessment Service</b>	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</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.

**Service Types continued***Each time unit equals 15 minutes.* **Treatment Planning Service** **HCPCS H0032**

Treatment planning.

15-Minute Units  
per Week**Total 15-Minute  
Units Requested** **Direct One-to-One Applied Behavior Analysis Therapy Service** **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.

15-Minute Units  
per Week**Total 15-Minute  
Units Requested** **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.

15-Minute Units  
per Week**Total 15-Minute  
Units Requested** **CPT 0373T**

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**Total 15-Minute  
Units Requested** **Group Adaptive Behavior Treatment Service** **CPT 97154**

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**Total 15-Minute  
Units Requested** **CPT 97158**

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**Total 15-Minute  
Units Requested** **Family Adaptive Behavior Treatment Guidance (Family Training) Service** **CPT 97156**

With individual family

15-Minute Units  
per Week**Total 15-Minute  
Units Requested** **CPT 97157**

With multiple family group.

15-Minute Units  
per Week**Total 15-Minute  
Units Requested****Submit this completed Request and required documentation to MVP.**Email [bhservices@mvphealthcare.com](mailto:bhservices@mvphealthcare.com)Fax **1-855-853-4850**