Summit COMMUNITY CARE

https://provider.summitcommunitycare.com

Applied Behavioral Analysis (ABA) Authorization Request

Please submit this form electronically (our preferred method) at **https://apps.availity.com**. If you prefer to fax, submit to **844-442-8014**.

Identifying data			
Member name:			
Medicaid ID:		Date of birth:	
Address:			
City, state:		ZIP code:	

Provider information					
Provider/facility name:					
Tax ID:		Phone:		Fax:	
Provider address:					
City, state:		ZIP code:			
Provider NPI:					
Name of other behavioral health providers:					

PCP information					
PCP name:				PCP NPI:	
PCP tax ID:		Phone:		Fax:	
PCP address:					
City, state:		ZIP code:			

DSM-V diagnoses

Medications		
Current medications (indicate changes since last report):	**Dosage:**	**Frequency:**

Assessment and treatment

- For initial assessment requests, please attach the interdisciplinary reports confirming Autism diagnosis.
- The *Treatment Plan* should be dated within 30 days of start date.
- **Please ensure the following has been included in your request:**
  - Current behavioral support plan and treatment plan including symptoms and behaviors requiring treatment, skills to be addressed, baseline measures, and current progress
  - Description of desired outcomes/alleviation of problems and/or symptoms in specific, behavioral, and measurable terms including updated evaluation of functioning via standardized tools at least every two years
  - List of any other services member is receiving (e.g., PT, OT, ST, school, BH) and coordination of care with other providers
  - Schedule of treatment (hours per day/week)
  - Documentation of parental involvement and measurable parent goals
  - Measurable client specific discharge criteria and transition plan

Baseline level of behaviors
Treatment goals
Behavior reduction plan **Provider must state baseline frequency duration, latency, and intensity of problem behaviors**
Functional assessment/analysis results
Behavior plan goals
Behavior improvement plan
Parent/guardian training and support goals
Justification for ABA therapy hours requested **(Provide specific information used to determine the need for ABA therapy at hours requested)**
Predominant location where services will take place
☐ Home ☐ Clinic ☐ School ☐ Other (if other, please specify)
Objective outcome criteria by which goal achievement is measured
Discharge/transition plan

Requested service authorization
Authorization is a two-fold process. A prior authorization (PA) is first requested for approval to perform a functional assessment and to develop a behavior treatment plan. A second PA is needed for approval to provide the ABA-based derived therapy services. Providers may request review for up to 180 days, which represents an authorization span of six months. The requested services are based upon either a focused or comprehensive service delivery model. The provider is to indicate which delivery model is being used. **Please submit all appropriate clinical information, provider contact information, and any other required documents with this form to support your request.**

Code	Modifier	Code description	Start date	End date	Hours requested per week	Units requested per week	Total units requested
97151		Behavior identification assessment administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardians/caregivers administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan					
97152		Behavior identification — supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minutes					
97153		Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes					
97154		Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15 minutes					
97155		Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes					

Code	Modifier	Code description	Start date	End date	Hours requested per week	Units requested per week	Total units requested
97156		Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardians/caregivers, each 15 minutes					
97157		Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes					
97158		Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients, each 15 minutes					

Note: Psychological/neuropsychological testing requests require a separate form.

Treatment plan coordination
I have requested permission from the patient/patient's parent or guardian to release information to the PCP. ☐ Yes ☐ No
If not, give rationale:
Treatment plan was discussed with and agreed upon by the patient/patient's parent or guardian. ☐ Yes ☐ No
If not, give rationale:

Provider signature:	
Date:	