Submit to: Utilization Management Department
Fax: **1-833-544-1828**

# APPLIED BEHAVIOR SUPPORT (ABS) OUTPATIENT TREATMENT REQUEST FORM

Please print clearly and fill out entire form even if the information is documented in attachments.
Incomplete or illegible forms will be returned or delay processing.

## MEMBER INFORMATION

Date: _____
Member Name: _____ Gender: ☐ Female ☐ Male ☐ not identified
Medicaid ID#: _____ Phone Number: _____
Date of Birth: _____ Age: _____
Additional insurance: ☐ yes ☐ no Additional insurance name/policy #:_____

## BILLING PROVIDER INFORMATION

Provider Name: _____ Group/Facility Name:_____
Provider NPI: _____ Group/Facility Address: _____
Provider Tax ID: _____ Phone Number: _____
Provider Phone: _____ Fax Number: _____

## DIAGNOSTIC AND TREATMENT INFORMATION

Primary Diagnosis: _____Date of diagnosis: _____Diagnosing Provider/Doctor_____
Standardized Tool Used for Autism Diagnosis

| Test: | Initial Test Date and Score: | Test: | Initial Test Date and Score: |
|---|---|---|---|
| ☐ ADI-R | _____ | ☐ GARS | _____ |
| ☐ ADOS | _____ | ☐ Other_____ | _____ |
| ☐ CARS-2 | _____ | | |

Additional Diagnosis: ☐ yes ☐ no if yes, diagnosis, dates and diagnosing provider: _____
Any medical conditions that will impact outcomes of treatment: ☐ yes ☐ no If yes, list:
_____
Medication: ☐ yes ☐ no
If yes, list: _____

Prior and Current Treatment Related to Primary Diagnosis:

| **Intervention** | **Past service Start/end dates, or no if not applicable** | **Current service start date, or No if not applicable** | **Additional information, description, related service** | **Schedule of services** |
|---|---|---|---|---|
| IFSP (include related services) | | | | |
| IEP (include related services) | | | | |
| 504 Plan | | | | |
| ABA | | | | |

| | | | | |
|---|---|---|---|---|
| OT private | | | | |
| PT private | | | | |
| **Intervention** | **Past service Start/end dates, or no if not applicable** | **Current service start date, or No if not applicable** | **Additional information, description, related service** | **Schedule of services** |
| SP/L therapy private | | | | |
| General education | | | | |
| Homeopathic therapy | | | | |

## BASELINE AND ASSESSMENT INFORMATION

Date Current Assessment Completed ____/ ____ / ____Conducted by (name) _____License/Cert _____
Assessment Participants: □ Patient Only □ Parents/Caregivers Only □ Patient and Parents/Caregivers
Please select at least one (1) instrument that will be utilized for the member's entire treatment episode so progress can effectively be measured. Choose a recognized instrument such as the VB MAPP, ABLLS, AFLS, PEAK, or the Vineland.

| Name of Assessment | Current Test Date | Current Score | Previous Test Date | Previous Test Score |
|---|---|---|---|---|
| | | | | |
| Name of Assessment | Current Test Date | Current Score | Previous Test Date | Previous Test Score |
| | | | | |

**Also, please attach standardized measurement scoring summaries if the member has been in treatment prior to this request.**

## CURRENT DISRUPTIVE BEHAVIORS

(1) Behavior_____ Freq _____ per □ hour □ day or □ week
(2) Behavior_____ Freq _____ per □ hour □ day or □ week
(3) Behavior_____ Freq _____ per □ hour □ day or □ week
(4) Behavior_____ Freq _____ per □ hour □ day or □ week

## CURRENT COMMUNICATION AND SOCIAL SKILLS STATUS

□ Vocal: How Many Mands_____ Describe communication: _____
□ Non-Vocal: Device Used_____ Describe communication:
_____

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Describe Social Skills (family relationships, interaction with adults and peers, what does play look like? _____
_____

## AUTHORIZATION REQUEST

Please note that retrospective dates will not be processed. Please submit retrospective date requests to: **1-866-714-7991.**

Start Date: _____End Date: _____Is the request: ☐ Focused ☐ Comprehensive ☐ Initial ☐ Concurrent
For Concurrent Requests: What is the fulfillment rate? (on average how many hours a week are services rendered versus authorized for the request? What factors impact the units used, including member/family illness, transportation barriers, etc.):
_____

| **Codes (market specific allowable codes)** | **Description per time (15 minutes) Market specific (for example, IA)** | **Frequency: How often seen (per week/month)** | **Total units requested per authorization time frame** |
|---|---|---|---|
| 97151 | Behavior identification assessment | | |
| 97152 | Behavior identification supporting assessment | | |
| 0362T | Behavior identification supporting assessment (client and 2 or more techs, QHP on site) | | |
| 97153 | Adaptive behavior treatment by protocol | | |
| 0373T | Adaptive behavior treatment with protocol modification (client and 2 or more techs, QHP on site) | | |
| 97154 | Group adaptive behavior treatment by protocol | | |
| 97155 | Adaptive behavior treatment with protocol modification | | |
| 97156 | Family adaptive behavior treatment guidance | | |
| 97157 | Multiple Family group adaptive behavior treatment | | |
| 97158 | Group adaptive behavior treatment with protocol modification | | |

## ADDITIONAL INFORMATION REQUIREMENTS

Please submit the information noted below with all treatment requests. If documentation is not received, the requests will be reviewed based on the information available at the time of the review.

**For initial treatment requests:**

- ☐ Physician Order and referral within one year of request
  - Physician NPI
  - Member name and DOB
  - Member Primary Diagnosis
  - Physician's treatment recommendation
  - Ordering Physician Signature and date
- ☐ Comprehensive Diagnostic Evaluation (CDE) and assessments
- ☐ Proposed treatment schedule, including related therapy and naps.

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- ☐ Proposed functional and measurable treatment goals with expected time frames for achievement of the goals
- ☐ Proposed plan for parent/caregiver involvement and performance-based parent goals and baseline
- ☐ Functional Behavior Assessment/ and BIP/BATP

**For subsequent treatment request:**

- ☐ Updated assessment information
- ☐ Any developmental testing which should have occurred within the first two months of treatment.
- ☐ Summary of member status, e.g., changes in medication, social, progress to date, schedule
- ☐ Objective measures of current status and clinically significant progress towards each stated treatment goal
- ☐ Performance based parent/caregiver goal progress and updated goals
- ☐ Timeline for achievement of goals
- ☐ Updated ABA FBA/FA and BIP
- ☐ If there is an increase or decrease in hours requested, include a description explaining why the hours are being modified

## AUTHORIZATION SIGNATURES

Rendering Provider Signature: _____ Date: _____

By signing above, I attest that I am actively participating in the treatment plan and coordinating services for the member. I attest that all professionals and paraprofessionals rendering service under the proposed treatment plan have the appropriate training and education required to render services.