Applied Behavior Analysis Authorization Request

Required Documentation

Indicate below the required documentation that will be included with this Request for the specific type of Applied Behavior Analysis (ABA) authorization requested.

Required Documentation for Initial Assessment Request

- ☐ A copy of the completed diagnostic evaluation that resulted in a diagnosis of Autism Spectrum Disorder and was conducted by a Licensed Physician, Licensed Nurse Practitioner, or Licensed Psychologist.
- ☐ A copy of the referral(s) for ABA assessment and/or treatment that includes the current (within the last two years) recommendation for ABA assessment and/or treatment made by a Licensed Physician, Licensed Psychologist, or Licensed Nurse Practitioner.
- ☐ A copy of the comprehensive annual physical, or a school health examination form which includes a completed physical exam, by the Member’s Primary Care Provider and/or specialty physician that evaluated the Member’s medical, vision, hearing, genetic, developmental, and/or behavioral conditions.
- ☐ The requested number of hours planned for completion of the ABA assessment.

Required Documentation for ABA Treatment

- ☐ Initial assessment required documentation, if not previously submitted.
- ☐ A copy of the official ABA assessment, including the certification/credentials of the assessor.
- ☐ A copy of the current ABA treatment plan, that includes frequency, duration, and location of the requested ABA treatment.
- ☐ A copy of the comprehensive annual physical, or a school health examination form which includes a completed physical exam, by the member’s Primary Care Provider and/or specialty physician that evaluated the Member’s medical, vision, hearing, genetic, developmental, and/or behavioral conditions.

Applied Behavior Analysis Authorization Request

Instructions for Completing this Request

This form is based on the MVP Applied Behavior Analysis Medical Policy. Please refer to the complete policy for all indications/criteria, documentation requirements, medical necessity for continued treatment and discharge, provider requirements, and exclusions.

Complete this form for Applied Behavior Analysis (ABA) Assessment and Treatment Authorization requests, and include the request type, specific services, number of units requested per week, the total number of units requested for the authorization period, and all required documentation.

Submit this completed Authorization Request and the required documentation to MVP by email to **bhservices@mvphealthcare.com** or by fax to **1-855-853-4850**.

Request Type *(select one)*: ☐ **Initial Assessment** ☐ **Initial Treatment** ☐ **Concurrent Treatment**

Section 1: 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	Diagnosis

Section 2: Provider Information

Provider/Supervisor Name *(BCBA, LBA, LABA, Other)*	ABA Provider Type ☐ **BCBA** ☐ **State Licensed/Certified**	Certification/License No.	State

Phone No.	NPI No.	New York State MMIS No. (Medicaid/Child Health Plus)

Service Street Address	City	State	Zip Code

Email

If the Provider/Supervisor entered above is part of a Group, provide the Group information below.

Provider Group/Agency Name	**Provider Group** No.	Tax ID No.

Service Street Address	City	State	Zip Code

Phone No.	Email

Member Name | *MVP Member ID No.*

Section 3: Applied Behavior Analysis Services Requested

Requested Authorization Time Period
Start Date: ______ **End Date:** ______

Program Setting *(select all that apply)*
☐ Home ☐ Facility/Clinic ☐ School ☐ Other: ______

Service Types

☐ **Assessment and Follow-Up Assessment Service** *Each time unit equals 15 minutes.*

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.		
☐ **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 is 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.		

☐ **Direct One-to-One Applied Behavior Analysis Therapy Service** *Each time unit equals 15 minutes.*

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/qualified health care professional (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** *Each time unit equals 15 minutes.*

Service	15-Minute Units per Week	**Total** 15-Minute Units Requested
☐ **CPT 97154** Group adaptive behavior treatment by protocol by technician under the direction of physician/qualified health care professional (QHP), face-to-face with two or more patients.		
☐ **CPT 97158** Group adaptive behavior treatment with protocol modification (Social Skills Group) by physician/QHP, face-to-face with two or more patients.		

*(**Section 3** continued on page 3)*

Member Name *MVP Member ID No.*

*(**Section** 3 continued)*

☐ **Family Adaptive Behavior Treatment Guidance (Family Training) Service** *Each time unit equals 15 minutes.*

☐ **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

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** *(explain why below)*