ASURIS
NORTHWEST HEALTH

Behavioral Health Utilization Management

Applied Behavioral Analysis (ABA)
Initial Request Form

Please fully complete all sections. Once finished you may fax this form and supporting clinical documents via email: FAXBHRepository@asuris.com or Fax: (888) 496-1540.

Member information		
Member Name:		Member ID:
Date of birth:	Age:	Gender: ☐ M ☐ F

Ordering physician	
Physician name:	NPI:
Address:	
Phone #:	Fax #:

Agency Information		
Agency name:		
Tax ID:	NPI:	
Address:		
Phone #:	Fax #:	
Contact person: (if different than BCBA)	Phone #:	Fax #:

BCBA or rendering provider information. ☐ Same as Agency above	
Provider name:	
Tax ID:	NPI:
Address:	
Phone #:	Fax #:

ABA Request

Request for:

☐ ABA Assessment: [pre-authorization only required for Federal Employee Program (FEP)]

☐ Initial Treatment Request (Prior Authorization)

Expedited request Yes ☐ No ☐

Defined as: when the member or his/her provider believes that waiting for a decision within the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy.

Explanation required:

Note: There is very little evidence to support the efficacy of ABA for people 13 years and older. If you are requesting ABA for someone 13 or older, please provide additional justification for this (e.g., severe risk of injury to self or others related to ASD or self-injurious stereotypical movement disorder).

Presenting Problem & Background:

Requirements:

☐ Was member diagnosed with Autism Spectrum Disorder by a licensed provider experienced in the diagnosis and treatment of Autism using a standardized assessment tool?

Provider name / license: _____.

Diagnosis Code: _____. Date of Diagnosis: _____.

Assessment tool used: ☐ ADOS. ☐ CARS. ☐ STAT. ☐ CSBS. ☐ ADI-R. ☐ Other: _____.

Date of Assessment: _____. Score: _____.

Additional comments:

☐ Please describe the symptoms and behaviors that are impairing the member's functioning in the following areas reflecting safety risk:

Communication:

Social and/or behavioral functioning:

☐ Was ABA therapy recommended or prescribed by a licensed provider experienced in the diagnosis and treatment of Autism?

Provider name / license: _____.

Date of Recommendation _____.

Documentation:

NOTE: For FEP policies, clinical notes must be included with request to demonstrate that medical necessity criteria are met.

Please include a completed Individualized Treatment Plan (ITP) with your request that includes:

1. A detailed description of specific behaviors targeted for therapy. Targeted behaviors must be those which prevent the member from participating in age-appropriate home or community activities and/or are presenting a safety risk to self or others; and
2. For each targeted behavior, an objective baseline measurement using standardized instruments that include frequency, intensity, and duration; and
3. A detailed description of treatment interventions and techniques specific to each of the targeted behaviors, including the frequency and duration of treatment for each intervention which is designed to improve the member's ability to participate in age-appropriate home or community activities and/or reduce the safety risk to self or others; and
4. Where there was a prior course of ABA therapy, documentation will specify the anticipated benefit of an additional course of treatment; and
5. A description of training and participation of family (parents, legal guardians and/or active caretakers as appropriate) in setting baseline and demonstrating progress toward treatment goals that directly support member's ITP; and
6. Clinical justification for the number of days per week and hours per day of direct ABA services provided to the member and the family, and the hours per week of direct face-to-face supervision of the treatment being delivered and observation of the child in their natural setting; and
7. Individualized and measurable discharge and/or transition criteria.

Request Details

Authorization start date: _____.

- Please note that the below CPT codes are the Asuris approved CPT codes for ABA services.
- Authorizations are for 6 months (26 weeks).
- Please list requested units for 6 months. Each unit is for 15 minutes.
  Example: Services for 97153 are provided for 10 hours per week. This would total 40 units per week and 1040 units per 6 months (26 weeks).
- Place of Service (i.e.: home, school, specify other setting).

  School is not an approved/eligible POS for Federal Employee Program (FEP) policies.

Adaptive Behavior Treatment	Units: 15 min=unit	CPT Code	Timeframe: 6 Months	Place of Service
Behavioral Identification Assessment		97151		
Observational Behavioral Follow-Up Assessment		97152		
Adaptive Behavior Treatment by Protocol		97153		
Group Adaptive Behavior Treatment w/ protocol		97154		
Adaptive Behavior Treatment w/Protocol Modification		97155		
Family Adaptive Behavior Treatment Guidance		97156		
Multiple-Family Group Adaptive Behavior Treatment Guidance		97157		
Adaptive Behavior Treatment Social Skills Group		97158		
Exposure Behavioral Follow-Up Assessment		0362T		
Exposure Adaptive Behavioral Treatment w/Protocol Modification (first 60min)		0373T		

Provider name (print):	License information:
Provider signature:	Date: