Prior Approval Request Form for Behavior Modifications Interventions

For the treatment of Autism Spectrum Disorder including Applied Behavioral Analysis (ABA)

This form should be completed at a minimum of every six months. This form must be completed by the licensed psychologist, licensed applied behavioral analyst or the registered applied behavioral analyst providing and/or supervising the requested services. The parent, legal guardian or individual receiving this service must review and agree to the services documented in this request.

Please complete the form and attach the appropriate clinical documents including the initial or most recent FBA.

Return completed forms by:

- Fax: (701) 277-2971
- Mail: BCBSND
  Attn: Health Network Innovation
  4510 13th Ave. S.
  Fargo, ND 58121

Please fill out the form completely and do not state a reference to other documentation.

Patient Information	
Name	
Benefit plan number	Date of birth *(MM/DD/YYYY)*
Diagnosis and diagnosis code	
Name/credentials of individual who completed the diagnostic evaluation	
Parent/guardian name(s)	Contact number

Provider Information		
Date of services being requested	Date services began *(If services are in process)*	
Individual Supervising the ABA Services and License Registration*	NPI number	
*If the individual supervising the ABA services is a RABA, provide the name of the individual who will be supervising them		
Number of hours of skills trainer time per month		
Number of supervised sessions per month _____	Number of hours of supervision _____ per direct service hours_____	
Phone number	Fax number	
Address		
City	State	Zip
Contact person *(If additional information is needed)*	Phone Number	

For FEP Use Only

BND-23-0437261 • 4-23

Treatment Planning

Specific behavioral targets and measurements *(Please provide updated treatment plan)*

What percentage of behavioral targets were mastered in the last 3 months? _____

Please provide documentation for the family interactions, repetitive or restrictive behaviors, ADL's or IADL's and disruptive or aggressive or self-injuious behaviors

Method of data collection and analysis, such as graphs or charts

Parent/caregiver training summary of participation

Number of hours of parenting/caregiving treatment/education per week _____

Percent of direct treatment that parent/caregiver attends of the scheduled sessions _____

Number of times per week _____

Number of times per month that parenting/caregiver training occurs _____

Other *(Please explain)* _____

Updates or consultation received from member's other provider such as PT, OT, Speech, PCP,etc.

☐ Yes *(If yes, how often and when was last update)* _____

☐ No *(If yes, please provide reason)*

School

Attends _____ hours of school/preschool/early intervention program per days

Frequency of consultation with the school _____

If no consultation is occurring, why?

Attends _____ days of school/preschool/early intervention program per week

_____ Does not attend days of school/preschool/early intervention

Does not attend school/preschool during the time frame of _____ (such as summers or when school is not in session)

Barriers and/or changes to treatment plan implemented during reporting period

The following list of procedure codes is for reference only and are subject to change without notice. The inclusion of a code does not guarantee claim payment. BCBSND uses CPT®, HCPCS®, and ICD-10® manuals as well as other nationally recognized standards for coding and billing purposes, unless BCBSND has published a specific policy stating otherwise. Documentation must support all requirements for each code submitted on a claim, for example time based codes must include documentation that supports the number of minutes spent face-to-face with the provider unless otherwise specified in the manual. Documentation that does not support a submitted code will result in that claim line being denied.

Please check the codes that you are requesting services for:

Assessment

- ☐ **97151** Behavior identification assessment, administered by 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 guardian(s)/ caregiver(s) administering assessments and discussing findings and recommendations, and non face-to-face analyzing past data, scoring/interpreting.

  Number of Units requested per 6-month period: _____

- ☐ **97152** Behavior identification support 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.

  Number of Units requested per 6-month period: _____

- ☐ **0362T** Behavior identification supporting assessment, each 15 minutes of technician's time face-to-face witha patient, requiring the following components:
  - Administered by the physician or other qualified healthcare professionals who is on site;
  - With the assistance of 2 or more technicians;
  - For a patient who exhibits destructive behavior;
  - Completed in an environment that is customized to the patient's behavior.

  Number of Units requested per 6-month period: _____

NOTE: The technician would be interchangeable with skills trainer in the following codes.

Treatment

- ☐ **97153** Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face, each 15 minutes.

  Number of units requested per 6-month period: _____

- ☐ **97154** Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face, each 15 minutes.

  Number of units requested per 6-month period: _____

- ☐ **97155** Adaptive behavior treatment with protocol modification, administered by physician or other healthcare professional, which may include simultaneous direction, each 15 minutes.

  Number of units requested per 6-month period: _____

- ☐ **97156** Family adaptive behavior treatment guidance, administered by physician or other healthcare professional (with or without the patient present), face-to-face, each 15 minutes.

  Number of units requested per 6-month period: _____

- ☐ **97157** Multiple-family group adaptive behavior treatment guidance, administered by a physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, every 15 minutes.

  Number of units requested per 6-month period: _____

- ☐ **97158** Group adaptive behavior treatment with protocol modification, administered by physician or other healthcare professional, face-to-face with multiple patients, each 15 minutes.

  Number of units requested per 6-month period: _____

BND-23-0437261 • 4-23

Treatment

☐ **0373T** Adaptive behavior treatment with protocol modifications, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components:

- Administered by the physician or other qualified healthcare professionals who is on site;
- With the assistance of 2 or more technicians;
- For a patient who exhibits destructive behavior;
- Completed in an environment that is customized to the patient's behavior.

Number of units requested per 6-Month period: _____

I have reviewed and agree with the above treatment request:

Signature	Date *(MM/DD/YYYY)*

Licensed Psychologist, Licensed Applied Behavioral Analysis or the Registered Applied Behavioral Analysis

NOTE: If additional units are requested beyond what is listed during the time period please contact the Utilization Management department.

BND-23-0437261 • 4-23