Massachusetts Standard Form for Applied Behavior Analysis Services Prior Authorization Requests

EVERNORTH℠

For Behavioral Health Providers

- **To file via email (preferred) send to: ABA@Evernorth.com**
- **To file via facsimile send to:** 860.687.9230
- **To file electronically, providers in Massachusetts must register for access to the online prior authorization tool. To initiate registration, send an email to PMAC@Cigna.com and include the following information:**
    - Provider or facility name
    - Mailing address
    - Email address
    - Contact name
    - Contact telephone number

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MASSACHUSETTS STANDARD FORM FOR APPLIED BEHAVIOR ANALYSIS SERVICES PRIOR AUTHORIZATION REQUESTS

Today's Date: _____	Requested Authorization Date Range: _____ – _____ *Authorization period not to exceed 6 months. Requests must align with a provider's contract and with covered benefits of the member.*

Applied Behavior Analysis Services Require One of the Following Prior Authorization Approvals:

☐ Request for Evaluation (Complete Section 1)
☐ Request for Initial Services (Complete Sections 1 and 2)
☐ Request for Continued Services (Complete Sections 1 and 2)
☐ Amended Request for Continued Services (Complete Sections 1 and 2)

THE LICENSED APPLIED BEHAVIORAL ANALYST (LABA) RENDERING AND/OR SUPERVISING THE AUTISM SERVICES SHOULD COMPLETE THIS FORM. SUBMISSION OF THIS FORM DOES NOT GUARANTEE AUTHORIZATION OF YOUR REQUEST.

SECTION 1

MEMBER INFORMATION:

Member Name:	Member ID #:	DOB:
Sex Assigned at Birth: ☐ Male ☐ Female ☐ "X" or Intersex		
Current Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other _____		
Street Address:		
City:	State:	Zip Code:
Phone:		

PROVIDER INFORMATION:

Agency Name/NPI #:	Agency Contact Person:	
Agency Street Address:		
City:	State:	Zip Code:
LABA Professional Name:		
Provider Street Address:		
City:	State:	Zip Code:
Phone:	Fax:	
LABA NPI #:	LABA License #:	Tax ID #:

DIAGNOSIS CODE:

Definitive ICD-10 Diagnosis (F Code[s]):	
Provider Who Completed the Diagnostic Evaluation:	Date Completed:
Licensure (Select One of the Following): ☐ Licensed Physician ☐ Licensed Psychologist ☐ Other: _____	

CLINICAL INFORMATION — PLEASE SUBMIT DIAGNOSTIC REPORT WITH REQUESTS FOR INITIAL EVALUATIONS:

Please Specify the Services Your Patient Has Received in the Past Three Years:

☐ Individualized Education Program (IEP)
☐ Individualized Family Service Plan (IFSP)/Early Intervention Services
☐ Other: _____

SECTION 2

INDICATE OTHER PROVIDERS (E.G., OCCUPATIONAL, PHYSICAL, OR SPEECH THERAPIST) INVOLVED IN YOUR PATIENT'S CARE AND ANY COMMUNICATION YOU HAVE HAD WITH THOSE PROVIDERS.

PROVIDER AND SPECIALTY:	COMMUNICATION
Provider Name:	Date Last Contacted:
Specialty:	Description of Care Coordination:
Provider Name:	Date Last Contacted:
Specialty:	Description of Care Coordination:
Provider Name:	Date Last Contacted:
Specialty:	Description of Care Coordination:

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MASSACHUSETTS STANDARD FORM FOR APPLIED BEHAVIOR ANALYSIS SERVICES PRIOR AUTHORIZATION REQUESTS *(CONTINUED)*

SECTION 2 (CONTINUED)

CURRENT MEDICATIONS:

IF REQUESTING SERVICES, PLEASE DESCRIBE YOUR PATIENT'S MEDICATION PLAN. PLEASE INCLUDE MORE DETAILED INFORMATION REGARDING TREATMENT LENGTH, PATIENT RESPONSE, COMPLIANCE, AND HISTORY OF MEDICATIONS IN THE ATTACHED TREATMENT PLAN.

Is your patient receiving medications? ☐ Yes ☐ No	If yes, by whom?
If yes, please list current medications and dosages:	

CLINICAL PRESENTATION:

Please identify which of the core areas of the ASD diagnosis will be targeted and expanded upon in the attached Treatment Plan:

☐ Communication Deficits ☐ Social Deficits ☐ Maladaptive Behaviors ☐ Repetitive/Restricted Behaviors

Please indicate the severity level of Autism Spectrum Disorder per the DSM-V diagnostic criteria (Level 3 "Requiring very substantial support," Level 2 "Requiring substantial support," and Level 1 "Requiring support"), in addition to any specifiers:

☐ Severity Level: _____

☐ With or Without Accompanying Intellectual Impairment: _____

☐ With or Without Accompanying Language Impairment: _____

☐ Associated with Another Neurodevelopmental, Mental, or Behavioral Disorder: _____

☐ With Catatonia

☐ Associated with a Known Medical or Genetic Condition or Environmental Factor: _____

ASSESSMENT TOOL(S):

Please identify which assessment tool or tools were used to measure progress and address all core areas of autism spectrum disorder, as well as the date(s) completed: _____

Date:

ADDITIONAL INFORMATION:

Additional Information:

Signature of Treating LABA Professional:

Date:

ABA AUTHORIZATION CODE REQUEST CHART

Please fill out EITHER # of units requested per week, OR # of units per authorization period, per individual health plan policy. Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this section. Requests must align with a provider's contract and with covered benefits of the member.

CODE	DESCRIPTION 1 Unit = 15 Minutes, 4 Units = 1 Hour	# OF UNITS REQUESTED PER WEEK (HOURS PER WEEK)	# OF UNITS FOR AUTHORIZATION PERIOD	PLANNED SERVICE LOCATION (EX. HOME, OFFICE, COMMUNITY, ETC.)
97151	Behavior Identification Assessment, Administered by a Physician or Other Qualified Health Care Professional (15-Minute Unit)			
97152	Behavior Identification—Supporting Assessment by a Technician (15-Minute Unit)			
97153	Adaptive Behavior Treatment by Technician (15-Minute Unit)			
97154	Group Adaptive Behavior Treatment Protocol Technician (15-Minute Unit)			
97155	Adaptive Behavior Treatment with Protocol, Administered by a Physician or Other Qualified Health Care Professional (15-Minute Unit)			
97156	Family Adaptive Behavior Treatment Guidance, Administered by a Physician or Other Qualified Health Care Professional (15-Minute Unit)			
97157	Multiple-Family Group Adaptive Behavior Treatment Guidance, Administered by a Physician or Other Qualified Health Care Professional (15-Minute Unit)			

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ABA AUTHORIZATION CODE REQUEST CHART *(CONTINUED)* **Please fill out EITHER # of units requested per week, OR # of units per authorization period, per individual health plan policy. Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this section. Requests must align with a provider's contract and with covered benefits of the member.*				
CODE	**DESCRIPTION** **1 Unit = 15 Minutes, 4 Units = 1 Hour**	**# OF UNITS REQUESTED PER WEEK (HOURS PER WEEK)**	**# OF UNITS FOR AUTHORIZATION PERIOD**	**PLANNED SERVICE LOCATION (EX. HOME, OFFICE, COMMUNITY, ETC.)**
97158	Group Adaptive Behavior with Protocol, Administered by a Physician or Other Qualified Health Care Professional (15-Minute Unit)			
*0362T	Behavior Identification Supporting Assessment, Administered by a Physician or Other Qualified Health Professional, 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 the Patient's Behavior (15-Minute Unit)			
*0373T	Adaptive Behavior Treatment with Protocol Modification, Administered by a Physician or Other Qualified Health Professional, 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 the Patient's Behavior (15-Minute Unit)			

T codes are used for patients who need two clinicians to provide services.* ***Please provide clinical rationale for 0362T and 0373T in a separate attachment or in the attached treatment plan.*

ADDENDUM 1

CHECKLIST OF CRITICAL FEATURES OF THE TREATMENT PLAN

This document represents a list of critical features of a treatment plan. Not all components are required. Please check which components of the treatment plan will be included in the supplemental materials.

Treatment Plan for Service Authorization:

- ☐ **Reason for Referral**
- ☐ **Brief Background Information**
- ☐ **Demographics (Name, Age, Gender, Diagnosis) Living Situation**
  - a. Home/School/Work Information
  - b. Cultural Considerations for Individual and/or Family
- ☐ **Clinical Interview**
  - a. Information Gathering on Problem Behaviors, including Developing Operational Definitions of Primary Area of Concern and Information Regarding Possible Function of Behavior
- ☐ **Review of Recent Assessments/Reports (File Review)**
  - a. Any Recent Functional Behavior Assessment, Cognitive Testing, and/or Progress Reports
- ☐ **Assessment Procedures and Results**
  - a. Brief Description of Assessments, including their Purpose
    - • INDIRECT ASSESSMENTS:
      - i. Provide Summary of Findings for Each Assessment (Graphs, Tables, or Grids)
    - • DIRECT ASSESSMENTS:
      - ii. Provide Summary of Findings for Each Assessment (Graphs, Tables, or Grids)
  - b. Target Behaviors are Operationally Defined, including Baseline Levels
- ☐ **Treatment Plan (Focused ABA)**
  - a. Treatment Setting (Home/Community/Clinic/Other)
  - b. Operational Definition for Each Behavior and Goal
  - c. Specify Behavior Management (that is, Behavior Reduction and/or Acquisition) Procedures:
    - • Antecedent-Based Interventions
    - • Consequence-Based Interventions
  - d. Describe Data Collection Procedures
  - e. Proposed Goals and Objectives†
  - f. Supervision Plan
  - g. Level of Risk of Harm (i.e., Current Risk of or Present Suicidal Ideation, Harm Toward Self or Others, etc.)
  - h. Barriers to Treatment (Note Any Breaks in Services Throughout the Last Authorization Period and Any Barriers to the Individual's Progress with Treatment)

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MASSACHUSETTS STANDARD FORM FOR APPLIED BEHAVIOR ANALYSIS SERVICES PRIOR AUTHORIZATION REQUESTS *(CONTINUED)*

CHECKLIST OF CRITICAL FEATURES OF THE TREATMENT PLAN *(CONTINUED)*

☐ **Treatment Plan (Skill Acquisition—Comprehensive ABA)**
- a. Treatment Setting (Home/Community/Clinic/Other)
- b. Instructional Methods to be Used
- c. Operational Definition for Each Skill
- d. Describe Data Collection Procedures
- e. Proposed Goals and Objectives†
- f. Supervision Plan

☐ **Parent/Caregiver Training**
- a. Specify Parent Training Procedures
- b. Describe Data Collection Procedures
- c. Proposed Goals and Objectives†

☐ **Number of Hours Requested**
- a. Number of Hours Needed for Each Service (and Setting if Applicable)
- b. Clinical Summary that Justifies Hours and Setting Requested
- c. Billing Codes Requested (For Example, CPT, HCPCS)

☐ **Coordination of Care**

☐ **Transition Plan**

☐ **Discharge Plan**

☐ **Crisis Plan**

†Proposed Goals and Objectives — Each Goal and Objective Should Include:

a. Current Level (Baseline)
b . Behavior Parent/Caregiver Is Expected to Demonstrate, including Condition Under which it Must Be Demonstrated and Mastery Criteria (the Objective or Goal)
c. Date of Introduction
d . Estimated Date of Mastery
e. Data on Progress
f. Plan for Generalization
g. Indication of Whether Goal Has Been Met, Is Progressing, or Is Regressing (include Explanations as Appropriate)
h. Plan for Supervision

**Source: "Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers" 2020 pp.23-24, CASP (The Council of Autism Service Providers) https://assets-002.noviams.com/novi-file-uploads/casp/pdfs-and-documents/ASD_Guidelines/ABA-ASD-Practice-Guidelines.pdf*

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