Nevada Medicaid and Nevada Check Up

Applied Behavior Analysis (ABA) Authorization Request

Upload this request through the Provider Web Portal. Questions? Call: (800) 525-2395

Request Date:

REQUEST TYPE:

☐ Initial Prior Authorization *For initial requests please also attach the ASD Diagnosis Certification for Requesting Initial ABA Services (FA-11F)* Start date of service: _____

☐ Continued Services ☐ Unscheduled Revision

☐ Retrospective Authorization – Date of Eligibility Decision: _____

Diagnosis must be based on qualifying results of standardized and clinically accepted diagnostic instruments for Autism Spectrum Disorder (typically those that are listed on form FA-11F), or if Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) criteria alone are used as the sole basis for diagnosis the provider must submit documentation of the specific DSM-5 criteria that were met.

NOTES:

I. Requesting Provider

Practitioner's Name:	Credentials:
Provider Group Name:	Provider Group Email:
Provider Group NPI:	Phone:

II. Servicing Provider ☐ Check if servicing provider is the same as requesting provider

Practitioner's Name:	Credentials:
Provider Group Name:	Provider Group Email:
Provider Group NPI:	Phone:

III. Recipient

Name:	DOB:
Recipient ID:	Age:
Recipient's Living Arrangements (e.g., group home, foster home, parents):	
Is the recipient in State custody? ☐ Yes ☐ No	Date recipient went into State custody:

IV. Co-Occurring Diagnoses, Current Symptoms, Relevant History

Co-occurring diagnoses:

Current symptoms and relevant history:

V. Responsible Party

Parent/Guardian Name:	Phone:
Relationship to Recipient:	

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Recipient Name:	
By signing below the parent/guardian agrees to the parent/guardian responsibilities as outlined in the Medicaid Services Manual (MSM) Chapter 3700.	
Parent/Guardian Signature:	Date:

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VI. Behavioral Targets/Behavior Disorders and Treatment Plan (List the targeted behaviors that have an impact on development,communication, interaction with peers or others in the environment or adjustment to the settings in which the recipient's functions have diminished and update the anticipated target date for mastery. For initial requests please document baseline, and for continued service requests document baseline and quantify progress or regression over the previous 90 days.) If additional space is needed to explain specific goals, please attach additional documentation in the same format as found in this section "VI" of form FA-11E. Documentation must be specific to the information requested; voluminous documentation will not be reviewed.

Target Behavior Start Date and Anticipated Date for Mastery	Baseline Level Narrative / %	Current Level	Short Term Goal	Intermediate Goal	Long Term Goal

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Target Behavior Start Date and Anticipated Date for Mastery	Baseline Level Narrative / %	Current Level	Short Term Goal	Intermediate Goal	Long Term Goal

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VII. Review of Services Provided Over the Previously Authorized Period *(Provider will report what services were provided since the last review and overall responsiveness to interventions.)*

VIII. Parent/Guardian Training and Response to Training *(Have the parent(s) (or guardians) been actively involved in training in behavioral techniques so that they can provide additional hours of intervention? Please explain.)*

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IX. Treatment Plan and Care Coordination *(Check all that apply)*

- ☐ Treatment interventions are consistent with ABA techniques
- ☐ The treatment plan and requested services are based upon the functional assessment/re-assessment
- ☐ Care coordination involving appropriate entities is occurring
- ☐ The Licensed Psychologist or BCBA is responsible for all aspects of clinical direction supervision and case management, which includes evaluation of discharge requirements

X. Describe the Recipient's Discharge Plan (*Please use separate page to describe, if needed*.)

Discharge summary must Identify:

a. The anticipated duration of the overall services;
b. Discharge criteria;
c. Required aftercare services;
d. The identified agency(ies) or Independent Provider(s) to provide the aftercare services: and
e. A plan for assisting the recipient in accessing these services**.**

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XI. ABA Services identified through an Individualized Family Service Plan (IFSP), an Individualized Educational Program (IEP), 504 Plan or Plan of Care (POC):

The recipient's IFSP, IEP, 504 Plan or POC has been reviewed and the proposed treatment in the treatment plan has
(Copies are required to be submitted with this prior authorization.)

- ☐ Yes, this recipient has an IFSP, IEP, 504 Plan or POC
- ☐ No, this recipient does not have an IFSP, IEP, 504 Plan or POC

Submitted with this authorization:

- ☐ IFSP - Date of the IFSP: _____
- ☐ IEP - Date of the IEP: _____
- ☐ 504 Plan - Date of the 504 Plan: _____
- ☐ POC - Date of the POC: _____

Provider Signature

Name of Recipient:_____ Date of Request:_____

XII. Services Requested (Providers may request review for up to 180 days which represents an authorization span of up to 6 months. The behavioral initial assessment and re-assessment do not require prior authorization). The requested services are based upon either a focused or comprehensive service delivery model. Provider is to indicate which delivery model is being utilized.

If additional space is needed to explain specific goals, please attach additional documentation in the same format as found in this section "XII" of form FA-11E. Documentation must be specific to the information requested; voluminous documentation will not be reviewed.

☐ **Focused** ☐ **Comprehensive**

	Code	Required Modifier	Code Description	Start Date and End Date (May request up to 180 days, may not exceed 180 days)	Units Per day	Days Per Week	Total Units Requested
1	97153		Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes				
2	97155		Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes				
3	0373T		Adaptive behavior treatment by protocol with modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • administered by the physician or other qualified healthcare professional 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 the patient's behavior				
4	97154		Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes				

Name of Recipient:_____ Date of Request:_____

5	97158		Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes				
6	97156		Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes				
7	97157		Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardian(s)/caregiver(s), each 15 minutes				
8	97151		Behavior identification assessment, administered by a 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 the assessment, and preparing the report/treatment plan				
9	97152		Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes				

XIII. Coverage of ABA Services

By signing below the provider ensures the following: Treatment interventions are consistent with ABA techniques; Care coordination involving appropriate entities is occurring; The Licensed Psychologist or BCBA is responsible for all aspects of clinical direction, supervision, and case management; The treatment plan and requested services are based upon the functional assessment.

Signature:	**Date:**

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.