TUFTS Health Plan

# Autism Spectrum Disorder Services Prior Authorization Form

- For Tufts Health Together (MCO Plan and Accountable Care Partnership Plans) and Tufts Health Direct, fax to 888.977.0776
- For Tufts Health Plan Commercial Products and Tufts Health Freedom Plan Products, fax to: 617.673.0314

Today's date: ___ / ___ / ___

Date range of requested sessions: ___ / ___ /___ to ___ / ___ /___

(For Tufts Health Together (MCO Plan and Accountable Care Partnership Plans) and Tufts Health Direct, you may request services for 6-month time frames. For Tufts Health Plan Commercial Products and Tufts Health Freedom Plan Products, you may request services for 3-month time frames)

**Autism spectrum disorder (autism) services require one of the following prior authorization approvals:**

☐ Request for Initial Evaluation: Submit pages 1-3 with copies of the following:

- Individualized Education Program (IEP) (specific to Tufts Health Together (MCO Plan and Accountable Care Partnership Plans) and Tufts Health Direct)
- Comprehensive diagnostic evaluation completed by a neurologist, pediatrician, psychiatrist, psychologist, or other licensed physician experienced in autism treatment

☐ Request for Continued Services: Submit pages 1 – 7

The Board-Certified Behavioral Analyst (BCBA) rendering and/or supervising the autism services should complete this form. We will not approve the request if completed by a non-BCBA provider. Submission of this form does not guarantee authorization of your request.

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**Member Information:**

Member Name: _____ Member ID #: _____ DOB: ___/___/___

Member Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

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**Provider Information**:

Agency Name: _____ NPI #: _____

BCBA NPI #: _____ BCBA License #: _____

Name of BCBA professional who will perform/supervise services: _____

Provider Address: _____

City: _____ State: _____ ZIP: _____

Tax ID #: _____ Phone: _____ Fax: _____

How many times have you seen this patient? _____ Date of most recent contact: ___/ ___/ ___

Estimated duration of ABA Services (Planned time from initiation to completion), in months: _____

Name and Phone number of person to contact with questions and/or authorization decision information:

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**Requested Services**:
**ABA Codes for Commercial Products (See page 3 for Together and Direct Codes)**

| Code | Description | # of units requested over 3-month time period |
|---|---|---|
| 97151 | Behavior identification assessment, administered by physician or other qualified healthcare professional (15-minute unit) | |
| 91752 | 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 physician or other qualified healthcare professional (15-minute unit) | |
| 97156 | Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professionals (15-minute unit) | |
| 97157 | Multiple – family group adaptive behavior treatment guidance administered by physician or other qualified healthcare professional (15-minute unit) | |
| 97158 | Group adaptive behavior with protocol administered by physician or other qualified healthcare professional (15-minute unit) | |
| *0362T | Behavior identification supporting assessment, each 15 minutes of technician time face to face with a patient, 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, each 15 minutes of technician time face to face with a patient, 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.<br>**Please provide clinical rationale for 0362T and 0373T in a separate attachment.** | | |

**ABA Codes for Tufts Health Direct and Tufts Health Together (see page 2 for Commercial Codes)**

| Code | Description | # of units requested over 6-month time period |
|---|---|---|
| H0031 | Mental health assessment by nonphysician; assessment and treatment planning by a BCBA (15-minute increment) | |
| H0032 | Mental health service plan development by nonphysician; direct supervision of a paraprofessional by a BCBA (15-minute unit) | |
| H2012 | Behavioral health day treatment, per hour; direct service by a BCBA (1-hour unit) | |
| H2019 | Therapeutic behavioral services, per 15 minutes; paraprofessional direct service supervised by a BCBA (15-minute unit) | |
| 97156 | Family adaptive behavior treatment guidance, administered by a licensed professional (with or without mbr present, face-to-face with guardian(s)/caregiver(s) (15-minute unit) | |

**Note:** For Tufts Health Together members, use the modifier U2. For Tufts Health Direct members, use the modifier UF.

**Definitive ICD10 Diagnosis (F Code):**

**Clinical Information**: Please specify the services your patient has already received.

- ☐ Individualized Education Program (IEP)
- ☐ Individualized Service Plan (ISP)
- ☐ Early intervention services
- ☐ Comprehensive diagnostic evaluation Date Completed: ___/ ___/ ___

  Provider who completed the diagnostic evaluation: _____

  Licensure (select one of the following):

  - ☐ Neurologist/Pediatric neurologist
  - ☐ Developmental pediatrician
  - ☐ Psychiatrist
  - ☐ Psychologist
  - ☐ Other licensed physician experienced in the diagnosis and treatment of autism

TUFTS Health Plan

**For Requests for Continued Services:**

Please list the providers, including yourself, from whom your patient has received autism services.

| Autism services provider | Start date | End date (if applicable) |
|---|---|---|
| | ___ / ___ / ___ | ___ / ___ / ___ |
| | ___ / ___ / ___ | ___ / ___ / ___ |
| | ___ / ___ / ___ | ___ / ___ / ___ |

Is your patient receiving any special services at school or in the community? ☐ Yes ☐ No

If yes, which ones?

_____

_____

_____

_____

_____

ABA treatment should include parent/guardian development of behavior management skills that support effective generalization of the member in-session training. Describe parent/guardian participation.

_____

_____

_____

_____

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:** _____<br>_____<br><br>**Specialty:** Primary Care Provider | **Date last contacted:** _____<br>**Description of care coordination:** |
| **Provider Name:** _____<br>_____<br><br>**Specialty:** Behavioral Health Provider | **Date:** _____<br>**Description of care coordination:** |
| **Provider Name:** _____<br>_____<br><br>**Specialty:** School based services | **Date:** _____<br>**Description of care coordination:** |
| **Provider Name:** _____<br>_____<br><br>**Specialty:** Occupational Therapist<br>Please specify: _____ | **Date:** _____<br>**Description of care coordination:** |
| **Provider Name:** _____<br>_____<br><br>**Specialty:** Speech Therapist<br>Please specify: _____ | **Date:** _____<br>**Description of care coordination:** |
| **Provider Name:** _____<br>_____<br><br>**Specialty:** Other | **Date:** _____<br>**Description of care coordination:** |

**Current medications**: If requesting continued services, please describe your patient's medication plan.

Has your patient received a medication consultation? ☐ Yes ☐ No

If yes, by whom? _____

Is your patient receiving medications? ☐ Yes ☐ No

If yes, please list the medications below.

| Medication | Dosage | Treatment length and patient response | Prescribing Provider |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Treatment Goals:** If requesting continued services, please identify behaviors you are working with your patient to change. Please attach additional pages if needed. You may attach treatment plan in lieu of this page as long as it contains all of the below information.

| Behavior (identify if it is targeted for increase or reduction) | Date behavior identified | Goal | Current level of functioning | Target completion date |
|---|---|---|---|---|
| | | | | |
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| | | | | |
| | | | | |

Signature of treating BCBA professional: _____

Date ___ / ___ / ___