

Autism Spectrum Disorder Services Prior Authorization Form

- For Tufts Health Plan Commercial products (including Tufts Health Freedom Plan), fax to 617.673.0314
- For Tufts Health RITogether, fax to 857.304.6404
- For Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans (ACPPs) and Tufts Health Direct, fax to 888.977.0776

Today's date: ___ / ___ / ___ Date range of requested sessions: ___ / ___ / ___ to ___ / ___ / ___

You may request services for 6-month timeframe

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 Direct, Tufts Health RITogether and Tufts Health Together – MassHealth MCO Plan and ACPPs)
 - 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. Tufts Health Plan will not approve the request if completed by a non-BCBA provider. Submission of this form does not guarantee authorization of your request.

Member Information:

Member Name: _____ Member ID #: _____ DOB: ___/___/___
 Member Address: _____ Phone: _____
 City: _____ State: _____ ZIP: _____

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: _____

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

Code	Description 1 unit = 15 minutes, 4 units = 1 hour Please do <i>not</i> request units per week, instead request units per authorization period	# of UNITS requested over 6-month time period
97151	Behavior identification assessment, administered by physician or other qualified healthcare 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 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. Please provide clinical rationale for 0362T and 0373T in a <u>separate attachment</u>.		

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

Code	Description 1 unit = 15 minutes, 4 units = 1 hour (except H2019) Please do <i>not</i> request units per week, instead request units per authorization period	# 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.

ABA Codes for Tufts Health RITogether Check here if you are the secondary provider requesting authorization (you must bill the XP modifier)

Code	Description Please do <i>not</i> request units per week, instead request units per authorization period	# of UNITS requested over 6-month time period
H2014	Treatment consultation – occupational, physical, speech and language therapists (15-minute unit)	
H2014 HO	Treatment Consultation (Master Level Clinician) (15-minute unit)	
H2014 HP	Treatment Consultation (Doctoral Level Clinician) (15-minute unit)	
H0046	Lead Therapy (30-minute unit)	
H0046 HO	Clinical Supervision – Home Based or Treatment Support Worker (Master Level Clinician) (30-minute unit)	
H0046 HP	Clinical Supervision – Home Based or Treatment Support Worker (Doctoral Level Clinician) (30-minute unit)	
S9446	Patient Education – Social Skills Group (30-minute unit)	
T1013	Sign language or oral interpreter services, (up to 8 hours per month, 4 for supervision and 4 for parent training, not to be used with direct service) (15-minute unit)	
T1016	Treatment Consultation (15-minute unit)	
T1024	Home Based Therapy-Specialized treatment/treatment support (30-minute unit)	

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
-

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: _____ _____ Specialty: Primary Care Provider	Date last contacted: _____ Description of care coordination:
Provider Name: _____ _____ Specialty: Behavioral Health Provider	Date: _____ Description of care coordination:
Provider Name: _____ _____ Specialty: School based services	Date: _____ Description of care coordination:
Provider Name: _____ _____ Specialty: Occupational Therapist Please specify: _____	Date: _____ 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

Signature of treating BCBA professional: _____

Date ___ / ___ / ___