Applied Behavior Analysis
Retrospective Review Cover Form

Instructions

Please complete all required fields and include supporting clinical documents for requested dates of service. If this is an initial assessment authorization request, please include comprehensive diagnostic evaluation.

- This form is to be used for post-service requests only
- Requests for new service should be submitted using the prior authorization request process by signing in to the Provider Express secure portal using your One Healthcare ID: www.identity.onehealthcareid.com
- For assistance with dates/scheduling, please call the behavioral health number on the back of member's card to speak with a representative from the national Applied Behavior Analysis (ABA) team

The information provided will be protected in accordance with HIPAA requirements and other applicable confidentiality regulations.

Submission fax numbers

Fax completed form and required documentation to **1-855-312-1470.**

Need assistance?

Please call the appeals department at **1-866-556-8166**

Mailing address:
National Appeals Team
Attn: Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512

Information required for submission

Please complete all applicable fields and include necessary backup documentation with your submission.

Provider information

Provider Facility/Group Name:

Provider TIN:

Provider Servicing Street Address:

Provider City, State, Zip:

Provider Phone #:

Provider Fax #:

Designated Case Supervisor Name and Credentials:

Member information

Member First Name:

Member Last Name:

Member DOB:

Member Address:

Member ID #:

Exact Dates of Service*:

**please omit current/future dates of service which should be managed through the pre-service clinical review process. If unsure of dates to be requested or you need to review current/future dates, please call the behavioral health number on the back of member's card and request to speak with the National ABA team.*

Please ensure the following is included in the supporting clinical documents for review per the ABA Supplemental Clinical Criteria or state-specific Clinical Criteria. Please complete this section:

Current Primary DSM-5 Diagnosis and Code Number:

Who made the diagnosis?

Date diagnosis was given:

Was the diagnosis a result of a Comprehensive Diagnostic Evaluation (CDE):

Other Medical or Mental Health Diagnoses:

Medications:

Location of services:

School setting details

Is member in school? Yes ☐ No ☐

If yes, what type of school:

Hours per week member is in school:

Who requested services in the school (did the school/provider request services)?

Did the school confirm that the provider can provide services in this setting? Yes ☐ No ☐

What services were/are recommended in the IEP?

Is there a mention of ABA in service recommendation? Yes ☐ No ☐

What services were rendered during school (staff training, shadow, 1:1 aide, pull-out, ABA, etc.)?

School setting details, con't.

What is the breakdown of hours at each location?

How many hours were allocated to school personal training 97156?

What goals were addressed with school personnel to support generalization of the treatment plan during this time?

What ABA goals were/are being worked on in the school that are tied to core deficit of autism?

How were/are the ABA goals being generalized across environments, such as home or center?

What is the titration plan to fade school services, if they were/are in public or private school instead of an ABA school?

Other services provided:

Hours per week of other therapeutic activities outside of school (i.e., speech, occupational therapy, OP counseling):

Is there coordination of care with other providers? Yes ☐ No ☐

If yes, please include coordination of care supporting clinical documents

Number of years member has been receiving ABA services:

How long has the member been receiving services at this intensity?

What is the severity of social deficit?

What is the severity of behavior deficits?

What is the severity of destructive, maladaptive behaviors?

What is the severity of communication deficit?

Are caregivers involved in treatment?

Please provide details about caregiver involvement (separate training sessions, shadowing in sessions, etc.):

How many hours per week are the caregivers involved in either sessions or caregiver training?

How would you rate caregivers regarding their proficiency with ABA techniques and working with the individual?

Explain why services were delivered without prior authorization, if applicable

Attestation

I hereby certify and attest that all the information provided as part of this retroactive authorization request is true and accurate.

Name:

Title:

Signature:

Date:

Please list ONLY the total units already rendered (with clinical documentation) for claim payment submission.

		Total # units (not a range)
97151 per 15 min	Behavior identification assessment, administered by a physician or other qualified health care 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.	
97152 per 15 min	Behavior identification supporting assessment, administered by one technician under direction of a physician or other qualified health care professional, face-to-face with the patient.	
0362T per 15 min	• Behavior identification supporting assessment, 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.	
97153 per 15 min	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with the patient.	
97154 per 15 min	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 the patient.	
97155 per 15 min	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient.	
97156 per 15 min	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s).	
97157 per 15 min	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 guardians/caregivers.	
97158 per 15 min	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients.	
0373T per 15 min	Adaptive behavior treatment with protocol modification, each 15 minutes of technician 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.	