BlueCross BlueShield of North Carolina

BlueCross BlueShield Federal Employee Program

Fax: 866-987-4159

Applied Behavioral Analysis/Adaptive Behavioral Treatment for Autism Spectrum Disorder (ABA/ABT)

AUTHORIZATION REQUEST

Submission of this form is only a request for services and does not guarantee approval. Incomplete forms may delay processing. All NC Providers must provide their 5-digit Blue Cross Blue Shield of North Carolina (Blue Cross NC) provider ID# below.

Date of Request	Patient Name	Patient Blue Cross NC ID Number	Patient Date of Birth
FEP Member Benefit Type	☐ **Standard/Basic Option** ☐ **FEP Blue Focus* (200 hours benefit limit per year)**		

Requesting/Ordering Provider Information		**Servicing Provider or Facility Location (for services to be performed outside of the provider's office)**	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, Tax ID # or NPI**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #		**Fax #**	

Current DX – Please list ICD-10 codes(s), Diagnosis Name, Specifier (if applicable)

ICD-10 Code _____ DX Name _____ Specifier _____
ICD-10 Code _____ DX Name _____ Specifier _____
ICD-10 Code _____ DX Name _____ Specifier _____

Authorization Request type (check One)	☐ **Initial Treatment Request** ☐ **Extension of Treatment Request.** **Please provide previous reference/authorization approval #:** _____		
Place of Service	☐ **Office** ☐ **Home** ☐ **Other:** _____ Please note: Blue Cross North Carolina will not reimburse for ABT delivered in the school setting. Daycare constitutes an extension of the home setting.		
Requested Treatment Start Date		**Anticipated End Date**	
CPT (Procedure Code) and #	☐ **97151 # Units/Hours** _____ ☐ **97154 # Units/Hours** _____ ☐ **97157 #Units/Hours** _____ ☐ **97152 # Units/Hours** _____ ☐ **97155 # Units/Hours** _____ ☐ **97158 #Units/Hours** _____ ☐ **97153 # Units/Hours** _____ ☐ **97156 # Units/Hours** _____		

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Initial Assessment - to be completed for Initial Treatment Requests Only (please check all that apply)

☐ **All assessments pertaining to diagnosis, functional behavior, and skills have been completed by a qualified treating health care professional whose scope of practice includes treatment of autism spectrum disorder.**

For each domain, please provide the name of the assessment tool used for evaluation, the tool's average score and Standard Deviation limits, and the patient's score.

Domain	Name of assessment tool used for evaluation	Assessment tool average score and standard deviation limits	Patient's score
Diagnosis for autism spectrum disorder			
Severity of autism symptoms			
Functional behavioral assessment			

Describe how the symptoms of autism spectrum disorder impact the member's function at school, home, and/or community environments: _____

_____

_____

_____

Describe symptoms related to autism spectrum disorder that pose harm to the member and/or others: _____

_____

_____

_____

Does the treating health care professional expect that the individual's behavior and skills will improve to a clinically meaningful extent, in at least two settings (i.e. home, community, school, etc.) with ABT provided by, or supervised by, a licensed ABT provider? ☐ Yes ☐ No

List the settings where improvement is expected as a result of ABT provided by, or supervised by, a licensed ABA provider? _____

_____

Do the recipient's caregivers commit to participate in the goals of the treatment plan? …… …….. ☐ Yes ☐ No

Is the recipient medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital level of care? …….. ☐ Yes ☐ No

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Does the treatment plan have elements of behaviorally specific, quantifiable goals, that relate to developmental deficits or behaviors that are important for successful participation in everyday activities, such as home, school or the community or pose significant risk of harm to the recipient or others? …….. ☐ Yes ☐ No

Please provide information on number of ABT service hours per day and location of services.

Location	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
H = Home O = Office C=Community							
How many hours?							

Treatment Plan (to be completed with initial and extension requests):

List/Describe the following:

Behaviorally specific, quantifiable goals, that relate to developmental deficits or behaviors that are important for successful participation in everyday activities, such as home, school or the community or pose a significant risk of harm to the recipient or others: _____

_____

_____

_____

Objective, observable and quantifiable metrics are utilized to measure change toward the specific goal behaviors: _____

_____

_____

_____

Documentation that adjunctive treatments (e.g., psychotherapy, group social skills training, medication services, educational services) have been considered for inclusion in the treatment plan, with the rationale for exclusion: _____

_____

_____

_____

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Continued Care – for EXTENSION of Services ONLY:

Please describe improvements from baseline in skill deficits and problematic behaviors using objective, observable and quantifiable metrics:

Skill deficit and/or problematic behavior	Name of assessment tool used for evaluation	Assessment tool average score and standard deviation limits	Patient's baseline score	Patient's follow-up score after ABT.

Describe how the symptoms of autism spectrum disorder impact the member's function at school, home, and/or community environments: _____

_____

_____

_____

Describe symptoms related to autism spectrum disorder that pose harm to the member and/or others: _____

_____

_____

_____

Do the recipient's caregivers demonstrate continued commitment to participation in the recipient's treatment plan and demonstrate the ability to apply those skills in naturalized settings? …….. ☐ **Yes** ☐ **No**

Can the gains that have made toward development norms and behavioral goals be maintained if care is reduced? ……..... ☐ **Yes** ☐ **No**

Are behavioral issues exacerbated by the treatment process? …….. ☐ **Yes** ☐ **No**

Does the recipient maintain the required cognitive capacity to benefit from the care provided and to retain and generalize treatment gains? ……. ☐ **Yes** ☐ **No**

What is the frequency of evaluation and documentation of gains made toward behavioral goals?

_____

_____

_____

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By signing below, I certify that I have appropriate authority to request prior authorization and certification for the item(s) indicated on this request and that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in the patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available. Finally, I certify that I've completed this form in its entirety and I understand that an incomplete form may delay processing.

Signature: _____ Date: _____

Fax this form with required documentation to Blue Cross NC Federal Employee Program Behavioral Health @ 866-987-4159.

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