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IA Health Link – Autism Services and Autism Support Program (ASP)
Applied Behavior Analysis (ABA) authorization request

Fax request to: 1-866-877-5229 Questions? Call: 1-800-454-3730

Request date:	Recipient name:	Recipient Medicaid ID:
Request type: ☐ Initial prior authorization ☐Continued service ☐ Unscheduled revision ☐Reconsideration ☐Retrospective authorization – date of services: _____		**For ASP program, include information year of service:** Not applicable ☐ Initial service year ☐ Second service year ☐ **Diagnosis (List):** _____ _____ _____ **Diagnosis date:** _____ **Diagnosing practitioner/license:** _____

I. Requesting provider		
Practitioner's name:		Credentials:
Provider group name:		Provider group email:
Provider group NPI:	Phone:	Fax:
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:	Fax:
III. Recipient		
Name:		Date of birth:
Recipient ID:		Age:
Recipient's living arrangements (e.g., parents, group home, foster home):		
IV. Standardized outcome tool or LPHA's assessment result:		
V. Responsible party		
Parent/guardian name:		Phone:
Relationship to recipient:		
Signature:		Date:

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V. 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. For continued service requests, document baseline and quantify progress or regression over the previous 90 days.)*

Target behavior start date and anticipated date for mastery	Baseline level	Current level	Short-term goal	Intermediate goal	Long-term goal

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VI. 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.) Section requires a copy of the implementing provider's implementation plan.*

VII. 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.)*

VIII. 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/reassessment care coordination involving appropriate entities is occurring.
☐ The licensed psychologist or board certified behavioral analysis (BCBA) is responsible for all aspects of clinical direction supervision and case management and this includes evaluation of discharge requirements.

IX. ABA services may not be duplicative of services under an Individualized Family Service Plan (IFSP) or an Individualized Educational Program (IEP).

The recipient's IFSP or IEP has been reviewed, and the proposed treatment and treatment plan are not duplicative. ☐ Yes ☐ No ☐ N/A

An implementation plan must include the following demographic information: • The member's name • The member's address • The member's date of birth • The member's Medicaid state identification number • The behavioral health intervention services provider's name • The date the plan was developed and revised

The plan must include the diagnosis and treatment order from the licensed practitioner of the healing arts, including scope, amount and duration of services.

Applied Behavior Analysis (ABA) authorization request (cont).

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X. Services requested *(Providers may request review for up to 180 days which represents an authorization span of up to six months. The behavioral initial assessment and reassessment 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.)*

Focused **Comprehensive**

	Code	Required modifier	Code description	Start date and end date (may request up to 180 days, may not exceed 180 days)	Number of units requested per 30 day time frame	Total number of days requested	Total units requested
1	G9012	HO/HP	Case oversight and management of treatment team by licensed mental health professional or certified BCBA, per 15 minutes				
2	H0031	HO/HP	Functional behavioral assessment, per hour				
3	H2014	HO/HP/HN	Skill development				

4	H2019	HO/HP/HN	Direct applied behavioral analysis, services by a paraprofessional or board certified behavioral analysis (BCBA) provider, per 15 minutes				
5	S5108	HO/HP/HN	Home care training, client; per 15 minutes				
6	S5110	HO/HP/HN	Home care training, family; per 15 minutes				
7	H0032	HO/HP	Functional behavioral assessment, per 15 minutes				

XI. 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.