Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavioral Analysis (ABA) Services

Instructions: Submit this certification with **initial requests** for ABA services along with pages 2-5.
Do not submit this page with requests for continued service.

Request Date:	
Recipient Name:	Recipient DOB:

Practitioner Certification Ordering ABA Services: *Practitioner must be a Physician, Physician's Assistant, Advanced Practice Registered Nurse (APRN), Psychologist, Ph.D. or a Board Certified BCBA acting within their scope of practice.*

A Practitioner acting within their scope of practice as defined by State law certifies the following:

1. This individual is between 0 and 21 years of age and has an established diagnosis of ASD or other related condition for which ABA is recognized as medically necessary.

2. ABA services are required to develop, maintain or restore to the maximum extent practical the functions of the individual for whom they are requested.

3. The individual exhibits excesses and/or deficits of behavior that significantly impedes access to age appropriate home or community activities.

4. There is a reasonable expectation that the individual will improve, or maintain function to the maximum extent practical with ABA services.

5. Please identify the diagnostic tool utilized to establish the ASD diagnosis as well as qualifying score. Please check the appropriate box below and enter the individual's score for the diagnostic tool used:

☐ Autism Diagnostic Observation Schedule (ADOS) Score: _____
Subscales Scores: _____

☐ Childhood Autism Rating Scale (CARS) Score: _____
Subscales Scores: _____

☐ Gilliam Autism Rating Scale (GARS-2) Score: _____

Please indicate the subscales presenting concern observed on the rating sheets:

_____

Name of Practitioner: _____

Credentials: _____

Signature: _____

Date of Diagnosis: _____

Applied Behavior Analysis (ABA) Authorization Request

Recipient Name:	Recipient DOB:

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, and 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

Applied Behavior Analysis (ABA) Authorization Request

Recipient Name:	Recipient DOB:

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.)*

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/re-assessment
- ☐ Care coordination involving appropriate entities is occurring
- ☐ The Licensed Psychologist or 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, but have been formulated and coordinated with these.

☐ Yes ☐ No ☐ N/A

Recipient Name:	Recipient DOB:

X. Services Requested *(Providers may request review for up to 180 days which represents an authorization span of up to 6 months. The behavioral initial assessment and re-assessment 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	0364T		Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time				
2	0365T		Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time				
3	0368T		Adaptive behavior treatment with protocol modification administered by physician or the qualified health care professional with one patient; first 30 minutes of face-to-face time				
4	0369T		Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time				
5	0373T		Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient				
6	0374T		Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time, face-to-face with patient				

Recipient Name:				Recipient DOB:			
7	0366T		Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time				
8	0367T		Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time				
9	0372T		Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients				
10	0370T		Family adaptive behavior treatment guidance, administered by physician or other licensed qualified health care professional (without the patient present)				
11	S5110		Family adaptive behavior treatment guidance administered by physician or other licensed qualified health care professional with patient present				
12	S5110	HQ	Group Family Adaptive Behavior Treatment guidance administered by physician or other licensed qualified healthcare professional with patient present				

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, and 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.