mercy care | mercy care advantage HMO SNP
Phone: 602-263-3000 or 800-624-3879
Fax: 800-217-9345

Applied Behavior Analysis (ABA) Prior Authorization Request Form

Date of Request: _____ ***Total Number of Pages:*** _____

MEMBER INFORMATION

Member Name: _____ Member ID: _____

Date of Birth: _____ Age: _____ Guardian: _____ Phone #: _____

Diagnosis Code(s)/Description(s): _____ HB 2442 (Jacob's Law) ☐

Other Insurance (if applicable) Name/Policy Number: _____ Phone #: _____

REQUESTING GROUP AND INDIVIDUAL PROVIDER INFORMATION

Group ABA Provider Name *(Company):* _____

NPI #: _____ TIN # _____

Address: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Individual ABA Provider Name: _____ NPI #: _____

Phone #: _____ Fax #: _____ Email: _____

Credentials: BCBA ☐ BCBA-D ☐ LBA (Arizona) ☐

**It is the Group Provider's responsibility to ensure the Individual Provider is:*
(a) an active Arizona Licensed Behavior Analyst
(b) directly responsible for all LBA-level aspects of case management

Behavioral Health Home Provider Name: _____

Contact Person: _____ Phone #: _____

CURRENT REQUEST FOR SERVICES: CPT CODES/UNITS

Treatment Request: Initial ☐ Concurrent ☐

Treatment Model: Focused ☐ Comprehensive ☐

Dates of Service: Start Date- _____ End Date- _____ *(ABA authorizations may only be issued up to 6 months at a time)*

CPT Code	Service Description	Frequency: Hours	/ Time Interval (wk/mo)	TOTAL UNITS
97151 *(Non-Par only)*	**Assessment/Reassessment**		Auth Period	
97152 *(Non-Par only)*	**Supporting assessment**		Auth Period	
97153	**1:1 Therapy**			
97154	**Group Therapy**			
97155	**Direct Case Supervision**			
97156	**Individual Parent/Caregiver Training**			
97157	**Multiple Family Caregiver Training**			
97158	**Group Therapy**			

*** As of 7/1/2023, 0362T and 0373T are no longer AHCCCS covered services

TREATMENT PLAN COMPONENTS

Please check **ALL** boxes to attest that each component is *current* and included in the attached Treatment Plan:

☐ Member Biopsychosocial Information (i.e.- age, family, diagnosis info, medical hx, hx of behavior issues school info, SDOH concerns)	☐ Instructional techniques; Behavior Interventions; Treatment Protocols for all goals
☐ Comprehensive Skill Assessment / Functional Assessment (conducted in last 30 days); Details/Findings/Progress Comparisons	☐ Maintenance and Generalization Plan
☐ Rationale for Services: Narrative summary of current clinical presentation; Functional Impairments across skills/behavior domains	☐ Care Coordination
☐ Goals- Acquisition, Behavior Reduction and Parent Training	☐ Titration Plan and Discharge Criteria; progress made
☐ Operational definitions of each behavior/goal/skill	☐ Projected Therapy Schedule, Setting, Modality
☐ Data collection procedures; baseline & progress performance levels	☐ Name, credentials, and signature of supervising LBA

Please provide explanation for any missing information

ASSESSMENT INFORMATION

** LBAs are required to conduct formal assessments at the onset of services AND every 6 months for reauthorization*

Page numbers of Treatment Plan where assessment information is located: Pages_____

Details of most recent assessment:
Date(s)/Time(s) of session(s): _____ _____ _____

Participants: _____ Place(s) of Service: _____

Method(s): Direct ☐ Indirect ☐ Progress (if concurrent): Choose Item

Name(s) of Standardized Assessment tool(s): _____

Treatment Plan Goals are based on assessment results and individualized to member's current clinical presentation: Yes ☐ No ☐

ASSESSMENT OF FUNCTIONAL IMPAIRMENT/SYMPTOM SEVERITY

Based on current assessment results and clinical presentation, rate the severity of Functional Impairment across each skill/behavior (Please provide objective explanation of symptom presentation in attached clinical)

Symptom Severity per Skill/Behavior Domain	*None*	*Mild*	*Moderate*	*Severe*
Maladaptive Behavior: i.e., aggression, self-injury, property destruction, elopement, restrictive/repetitive behaviors, and interests; abnormal, inflexible, or intense preoccupations	☐	☐	☐	☐
Language/Communication: i.e., problems with expressive or receptive language, poor understanding, or use of non- verbal communications, stereotyped or repetitive language	☐	☐	☐	☐
Social Interaction: i.e., lack of social, emotional reciprocity, failure to initiate/seek/develop share social interests or activities; deficits may range from basic joint attention skills to complex executive functioning issues	☐	☐	☐	☐
Self-Care/ Adaptive Skills: i.e., difficulty recognizing danger/risks, or advocating for self; problems with grooming/eating/toileting skills; problems with organization sustained attention, adjusting to changing environments	☐	☐	☐	☐

Proposed Weekly ABA Therapy Schedule

(Time of day)	Monday	Tuesday	Wednesday	Thursday	Friday
Direct Therapy					
Supervision					
Parent Training					

Place(s) of Service: Home ☐ Community ☐ Clinic ☐ School ☐ Weekend Schedule, if applicable : _____

Modality: In-Person ☐ Telehealth (TH) ☐

List appx % of TH services, per CPT code _____

***Note: Please answer below fields as reflected in the attached supporting clinical documentation.**

Coordination of Care/ Schedule Considerations

1. Does member receive any other therapeutic services besides ABA ? Choose Item If yes, please include description & schedule.

2. Is member in school? Choose Item If yes, please include class type, accommodations, and schedule.

3. Is there coordination of care with other providers? Choose Item If yes, please detail provider coordination.

Service Intensity / Duration / Adjustments

Length of time member has been in ABA services: Choose Item

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

Has there been any adjustment to requested service hours since last authorization? Choose Item

Progress (for Concurrent Requests)

Please rate the member's overall progress towards treatment goals over the last authorization period in each area:

1. Skill Acquisition Goals: Choose Item
2. Behavior Reduction Goals: Choose Item
3. Parent Training Goals: Choose Item
4. Titration/Discharge Goals: Choose Item

Please explain any barriers to treatment or plan modifications for any areas the member is not making steady progress in the attached clinical and/or in the area below.

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

_____ _____

Signature Date

_____

Printed Name and Title

*To review full AHCCCS Medical Policy Manual 320-S, go to: Arizona Policy Manual

* This document will guide, not replace, a comprehensive review of the attached clinical. Determinations will be based on the full Treatment Plan / Progress Note.