Prior Approval Request Form for Behavior Modifications Interventions

For the treatment of Autism Spectrum Disorder including Applied Behavioral Analysis (ABA)

This form should be completed at a minimum of every six months. This form must be completed by the licensed psychologist, licensed applied behavioral analyst or the registered applied behavioral analyst providing and/or supervising the requested services. The parent, legal guardian or individual receiving this service must review and agree to the services documented in this request.

Instructions: All fields in this form are required unless otherwise indicated (optional / applicable). If not completed in full, expect a delay in response

Effective Jan. 1, 2025, Blue Cross Blue Shield of North Dakota (BCBSND) providers must use the Availity Essential Provider Portal. **Faxes and phone calls for preservice precertification requests will no longer be accepted** unless BCBSND gives approval due to system issues.

Providers outside of North Dakota without electronic access:

- fax this form along with clinical support records to 701-277-2971
- for an urgent request, utilize the urgent fax line at 701-277-2138. When using the urgent fax line, you must write "urgent" on the case itself, so the Utilization Management (UM) team knows to prioritize.

"Urgent" definition: The absence of treatment could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function. "Urgent" can also mean in the opinion of the health care provider, with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is subject in this case.

Questions? Call BCBSND UM at 800-952-8462. If providers are unable to use Availity to submit photos or for member submitted requests, please mail request and/or photos to:

BCBSND
Attn: Utilization Management
4510 13th Ave S
Fargo, ND 58121

Patient Information	
Name	
Benefit plan number	Date of birth *(MM/DD/YYYY)*
Diagnosis and diagnosis code	
Name/credentials of individual who completed the diagnostic evaluation	
Parent/guardian name(s)	Contact number

Provider Information	
Date of services being requested	Date services began *(If services are in process)*
Individual Supervising the ABA Services and License Registration*	NPI number
*If the individual supervising the ABA services is a RABA, provide the name of the individual who will be supervising them	
Number of hours of skills trainer time per month	
Number of supervised sessions per month ________	Number of hours of supervision _______ per direct service hours_______

For FEP Use Only

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Provider Information

Phone number	Fax number

Address

City	State	Zip

Contact person *(If additional information is needed)*	Phone Number

Treatment Planning

Specific behavioral targets and measurements *(Please provide updated treatment plan)*

What percentage of behavioral targets were mastered in the last 3 months? ___________________________

Please provide documentation for the family interactions, repetitive or restrictive behaviors, ADL's or IADL's and disruptive or aggressive or self-injuious behaviors

Method of data collection and analysis, such as graphs or charts

Parent/caregiver training summary of participation

Number of hours of parenting/caregiving treatment/education per week ___________________________

Percent of direct treatment that parent/caregiver attends of the scheduled sessions ___________________________

Number of times per week ___________________________

Number of times per month that parenting/caregiver training occurs ___________________________

Other *(Please explain)* ___________________________

Updates or consultation received from member's other provider such as PT, OT, Speech, PCP,etc.

☐ Yes *(If yes, how often and when was last update)* ___________________________

☐ No *(If yes, please provide reason)*

Treatment Planning

School

Attends __________ hours of school/preschool/early intervention program per days

Frequency of consultation with the school __________

If no consultation is occurring, why?

Attends __________ days of school/preschool/early intervention program per week

__________ Does not attend days of school/preschool/early intervention

Does not attend school/preschool during the time frame of _______________ (such as summers or when school is not in session)

Barriers and/or changes to treatment plan implemented during reporting period

The following list of procedure codes is for reference only and are subject to change without notice. The inclusion of a code does not guarantee claim payment. BCBSND uses CPT®, HCPCS®, and ICD-10® manuals as well as other nationally recognized standards for coding and billing purposes, unless BCBSND has published a specific policy stating otherwise. Documentation must support all requirements for each code submitted on a claim, for example time based codes must include documentation that supports the number of minutes spent face-to-face with the provider unless otherwise specified in the manual. Documentation that does not support a submitted code will result in that claim line being denied.

Please check the codes that you are requesting services for:

Assessment

☐ **97151** Behavior identification assessment, administered by physician or other qualified healthcare 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.

Number of Units requested per 6-month period: ______________________

☐ **97152** Behavior identification support assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minutes.

Number of Units requested per 6-month period: ______________________

☐ **0362T** Behavior identification supporting assessment, each 15 minutes of technician's time face-to-face witha patient, requiring the following components:

- Administered by the physician or other qualified healthcare professionals who is on site;
- With the assistance of 2 or more technicians;
- For a patient who exhibits destructive behavior;
- Completed in an environment that is customized to the patient's behavior.

Number of Units requested per 6-month period: ______________________

NOTE: The technician would be interchangeable with skills trainer in the following codes.

Treatment
☐ **97153** Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face, each 15 minutes. Number of units requested per 6-month period: ______________________
☐ **97154** Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face, each 15 minutes. Number of units requested per 6-month period: ______________________
☐ **97155** Adaptive behavior treatment with protocol modification, administered by physician or other healthcare professional, which may include simultaneous direction, each 15 minutes. Number of units requested per 6-month period: ______________________
☐ **97156** Family adaptive behavior treatment guidance, administered by physician or other healthcare professional (with or without the patient present), face-to-face, each 15 minutes. Number of units requested per 6-month period: ______________________
☐ **97157** Multiple-family group adaptive behavior treatment guidance, administered by a physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, every 15 minutes. Number of units requested per 6-month period: ______________________
☐ **97158** Group adaptive behavior treatment with protocol modification, administered by physician or other healthcare professional, face-to-face with multiple patients, each 15 minutes. Number of units requested per 6-month period: ______________________
☐ **0373T** Adaptive behavior treatment with protocol modifications, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: ▪ Administered by the physician or other qualified healthcare professionals who is on site; ▪ With the assistance of 2 or more technicians; ▪ For a patient who exhibits destructive behavior; ▪ Completed in an environment that is customized to the patient's behavior. Number of units requested per 6-Month period: ______________________

I have reviewed and agree with the above treatment request:

Signature	Date *(MM/DD/YYYY)*

Licensed Psychologist, Licensed Applied Behavioral Analysis or the Registered Applied Behavioral Analysis

NOTE: If additional units are requested beyond what is listed during the time period please contact the Utilization Management department.