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 should fax this form along with clinical support records to 701-277-2971.

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_____	
Phone number	Fax number	
Address		
City	State	Zip

For FEP Use Only

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Provider Information

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)*

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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.

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