

Applied Behavior Analysis Prior Authorization Form

Clear form

Evernorth® Behavioral Health (Evernorth) requires prior authorization for the applied behavior analysis (ABA) level of care, including network exception requests.

For standard requests, ABA assessment Current Procedural Terminology (CPT®) codes (i.e., 97151, 97152, and 0362T) no longer require prior authorization. To request a network exception for an ABA assessment, please complete this form.

This prior authorization request form should be completed by the clinician who has knowledge of the patient's current clinical presentation and treatment history. *Please note: Evernorth may release the information contained in this form to the patient or their authorized representative.*

Please complete this form, attach supporting clinical documentation, and send it to ABA@Evernorth.com (preferred) or fax it to 860.687.9230. If you experience any issues with submitting your request, please call the Autism Care Coordinator team at 877.279.7603, Monday through Friday from 8:30 a.m. to 5:00 p.m. CT.

If services are approved, an authorization for ABA treatment will be written on a per month basis with CPT code 97155 and can be interchanged with ongoing treatment codes 97153–97158 and 0373T. ABA hours requested per week are multiplied by 4.33 to determine monthly averages.

Request guidelines

- + Verify the patient's coverage prior to submitting your request.
- + Complete all sections of this form as specifically and clearly as possible (typed responses are preferred).
- + Avoid omissions, generalities, and illegibility, which may result in the request being returned for completion or clarification.

Please note that Evernorth assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information. It is your responsibility to take any steps necessary to protect the email or documents prior to receipt by Evernorth.

Additional resources

- + Information about behavioral clinical criteria is available on the [Coverage Policies](#) page of Provider.Evernorth.com (scroll down to the *Supporting Behavioral Websites* section).
- + If you have questions about the [Intensive Behavioral Interventions—\(EN0499\)](#) coverage policy or medical necessity criteria, call us at **877.279.7603** to schedule a care manager discussion.
- + For information about autism resources and policies, visit our dedicated [Autism Information and Resources web page](#).
- + For a summary of the information to include for the medical necessity review, please see the [supporting clinical documentation for medical necessity criteria](#) section.

1) Type of request (select one):

- a. Initial
- b. Continued stay
- c. Reconsideration
- d. Additional units or hour increase on existing approval

2) Requested start date of new authorization: _____**3) Services being requested:**

	CPT code	Hours requested	Frequency (<i>week or month</i>)
Board Certified Behavior Analyst® (BCBA®)/supervisor hours	97155		
	97156		
	97157		
	97158		
	0373T		
Technician/Registered Behavior Technician	97153		
	97154		
Assessment (<i>network exception requests only</i>)	97151		N/A
	97152		
	0362T		

Note: The requested treatment hours should match the ABA treatment plan.

4) If BCBA/supervisor hours (CPT code 97155) are being requested, how many hours are being used for direct treatment of the patient? _____ Week Month

5) Patient information:

Patient name: _____ Patient date of birth: _____

Member ID number: _____

Current home address: _____

Is the patient their own guardian? Yes No

If no, please provide parent/guardian name and telephone number:

6) Servicing clinic information:

Name: _____

Taxpayer Identification Number (TIN): -

Servicing address: _____

7) Provider information:

Supervising provider name: _____

Credentials or license:

BCBA BCBA-D Licensed behavior analyst Licensed psychologist

Other (please specify): _____

Will the same provider be supervising the patient's entire treatment? Yes No

If no, please provide the name of the additional supervising provider and their credentials:

8) Place where services will be rendered:

Clinic Home School Community Telehealth

Other (please specify): _____

9) Contact information:

Name of contact for administrative questions or if request is approved: _____

Telephone number: _____ Fax number: _____

Email: _____

Name of contact for clinical questions or if request cannot be approved: _____

Telephone number: _____ Fax number: _____

Email: _____

10) Diagnosis:

Is the patient diagnosed with autism spectrum disorder (F84.0)? Yes No

If yes, please provide the date of the most current diagnostic evaluation: _____

Evaluator's name: _____

Evaluator's credentials or license:

Medical doctor Licensed psychologist Other (please specify): _____

Please indicate any additional diagnosis codes: _____

11) For ongoing care requests, have there been any breaks in treatment with the supervising provider since the last request? Yes No

If yes, please provide the date of the last treatment: _____

12) List which standardized assessments will be or have been administered or indicate page numbers in the treatment plan where this information can be found:

Name of assessment	Date completed

13) For out-of-network providers, is this a network exception request? Yes No

If yes, please describe why any clinical treatment specialties are clinically relevant for this patient and would be uniquely available from this provider as opposed to a clinician in the Evernorth network:

Name of contact to negotiate rates if request is approved: _____

Telephone number: _____ Fax number: _____

Email: _____

If no, please indicate whether the patient is aware they are using out-of-network benefits: Yes No

Supporting clinical documentation for medical necessity criteria

Below is a summary of the supporting clinical documentation to include for the medical necessity review.

Please note this list is not all-inclusive. Full details of the medical necessity criteria are available in the [Intensive Behavioral Interventions—\(EN0499\) coverage policy](#).

Standardized ABA assessments

- + Include a fully completed ABA assessment, with all clinical domains assessed, that is readministered at least once every year.
- + Include the ABA assessment's date of completion and indicate the respondent and form or version used. For initial requests, the ABA assessment should be completed within 60 days of the requested start date.
- + If the ABA assessment uses a grid or towers and there are bubbles, complete the applicable bubbles to indicate when a given domain was fully assessed (e.g., all bubbles should be filled in when a milestone is not met or there is a score of zero). If the bubbles cannot be filled in, add a comment that clarifies when a domain was fully assessed.
- + Refer to page 3 of the [coverage policy](#) for additional information.

Treatment across settings

- + Include a clear description of how direct treatment time will be used in each setting where ABA treatment occurs. This should include the following details for each individual setting:
 - Proximity of staff that are providing direct treatment.
 - The nature of intervention and description of active treatment provided.
 - Hours per week or month of treatment provided in each setting.
 - Frequency of learning opportunities provided in each setting that are related to the treatment plan goals.
 - Description of how the learning opportunities are presented.
 - A clinical rationale to support interventions for each setting where treatment occurs.
 - Goal data and progress updates for each setting where treatment occurs.
 - Parent training and caregiver goals for all relevant stakeholders where treatment occurs.
- + Refer to page 4, page 5, and the “Glossary of Terms” section of the [coverage policy](#) for additional information.

Treatment plan goals for autism core deficit

- + Clearly demonstrate how the treatment plan goals relate to the core deficits of autism: social communication, social interaction, and restrictive, repetitive, or stereotyped patterns of behavior.
- + Refer to page 5 of the [coverage policy](#) for additional information.

Goals and data

- + Ensure treatment goal data are quantitative rather than anecdotal in nature.
- + Include baseline, interim, and current goal data, with dates recorded, to demonstrate progress over time.
- + Include clear and measurable mastery criteria for each treatment plan goal to illustrate when a goal has been met. The reported data should align with the mastery criteria.
- + Be familiar with the elements of a clearly defined and measurable goal:¹
 - Context or condition in which the behavior(s) will occur (e.g., when shown an item or object in the environment and asked, “What is it?”).
 - Clear definition of the behavior(s) to be targeted and measured (e.g., independently tacts object[s]).
 - Method of measuring the targeted behavior(s) and degree of independence for mastery criteria (e.g., correct responding in 80 percent of opportunities across three consecutive sessions for 20 objects).
- + Refer to page 8 and the “Glossary of Terms” section of the [coverage policy](#) for additional information.

Additional hours requested for existing authorization

- + Include the clinical rationale for the requested increase of treatment intensity, such as new goals, behaviors, assessment updates, or other pertinent details.
- + Refer to page 7 of the [coverage policy](#) for additional information.

Barriers to progress

- + Include the clinical rationale for pattern and plan to address barriers if there is limited progress or regression on treatment goals.
- + Refer to page 7 and page 16 of the [coverage policy](#) for additional information.

Break in treatment

- + Provide updated quantifiable baseline data, with dates, and a new, fully completed standardized assessment if a break in treatment of 60 days or longer occurs.
- + Refer to page 7 of the [coverage policy](#) for additional information.

1. Turner, K. (2022). Functional Behavior Assessment (Rev. ed). Congella Academic Publishing.

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