Applied Behavioral Analysis (ABA) Authorization

Member Information

First Name _____ Last Name _____

Member Medicaid ID # _____ Date of Birth (mm/dd/yyyy) _____

Phone _____ Age _____ Gender: ☐ Male ☐ Female

Billing Provider: Qualified Health Care Professional (QHCP) or PHYSICIAN

Provider Name _____ Credentials _____

Provider NPI _____ Tax ID # _____

Provider Address _____

Phone _____ Fax _____

Contact Name _____ ☐ QHCP/Psychiatrist ☐ Physician

Supervising Provider: BCBA-D, BCBA, QHCP

Provider Name _____ Credentials _____

Provider NPI _____ Tax ID # _____

Group/Facility Name _____

Address _____

Phone _____ Fax _____

Diagnostic and Treatment Information

Primary Diagnosis (Required) _____

Secondary Diagnosis _____

Prior Treatment Relative to Diagnosis _____

Standardized Tools Used for Diagnosis _____

Diagnosis Date _____ Member in School? ☐ Yes ☐ No

Does member have an IEP or 504 plan? ☐ Yes ☐ No

Receiving early intervention services? ☐ Yes ☐ No Describe other services received in addition to the ABA requested, including but not limited to PT, OT, ST or mental health services:

_____

Is this an initial authorization request? ☐ Yes ☐ No Date span of previous ABA Treatment _____

Date of most recent assessment _____

louisiana healthcare connections™

P.O. Box 84180
Baton Rouge, LA 70884
1-866-595-8133 (TTY: 711)
Monday–Friday, 7 a.m. to 7 p.m.
FAX: 1-844-720-2029
LouisianaHealthConnect.com

BRO-DP-ABA
FORM-0822

Additional Information

Please submit the information noted below with all treatment requests. If documentation is not received, the request will be reviewed based on information available at the time of review.

CURRENT PRESENTATION/SYMPTOMS	MILD	MODERATE	SEVERE
Safety risk to self/others:	☐	☐	☐
Aggression:	☐	☐	☐
Disruptive behavior:	☐	☐	☐
Destruction of property: Mood	☐	☐	☐
issues:	☐	☐	☐
Other: _____	☐	☐	☐

ADDITIONAL CLINICAL DESCRIPTION

For initial assessment, please submit comprehensive diagnostic information including standardized measures and referral from diagnosing provider for ABA services to include estimated duration of care.

For initial treatment plan, please submit:

- **CDE treatment plan**
- **Behavioral treatment plan**
- **Copy of IEP or IFSP if applicable**
- **Copy of waiver Plan Profile Table and the Schedule page from the certified plan of care**
- **Objective testing showing significant behavioral deficit**
- **Description of coordination of services with other providers (school, PT, OT, ST)**
- **Proposed treatment schedule including the provider type who will render services**
- **Proposed functional and measurable treatment goals with expected timeframes which target identified behavior deficits**
- **Proposed plan for parent involvement and training and parent's goals for outcomes**
- **Any medical conditions that will impact outcomes of treatment**

For subsequent treatment requests, please submit:

- **Objective measures of *current status***
- **Objective measures of clinically significant progress (measurable and functional improvement) toward each stated treatment goal**
- **Updated plan for treatment including updated goals and timeline for achievement**
- **Any necessary changes to the treatment plan**
- **Developmental testing which should have occurred within the first two months of treatment**

PLEASE NOTE: *Information older than 30 days will be considered outdated and will not be accepted for review.*

Authorization Information

Start Date _____ **End Date** _____

Please note: A service authorization period shall not exceed 180 days for ABA services.

Billing Codes

Codes	Description	Unit Interval	Number of Units Requested (ex. 4 units = 1 hour)
97151	Behavior identification assessment, administered by a physician or other qualified healthcare professional	15 min	
97152	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional	15 min	
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional	15 min	
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional	15 min	
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional	15 min	
97156	Family adaptive behavior treatment guidance, administered by physical or other qualified healthcare professional	15 min	
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present)	15 min	
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional	15 min	
0362T	Behavior identification supporting assessment, administered by the physician or other	15 min	
0373T	Adaptive behavior treatment with protocol modification, administered by the physician or other	15 min	

***Modifiers should be used in billing to reflect the credentials of staff delivering services and allow for proper claims payment.

By signing below, I attest that all professionals and paraprofessionals rendering service(s) under the proposed treatment plan have the appropriate training and education required to render service(s).

_____ _____

Rendering Provider Signature **Date**

Please submit form and other supporting clinical information via our preferred method of the online portal:
https://louisianahealthconnect.com/providers/login.html
or
Via fax @ 1-844-720-2029
to
Louisiana Healthcare Connections
Applied Behavioral Analysis Department