# Applied Behavioral Analysis (ABA) Authorization

## Member Information

First Name _____ Last Name _____

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

Phone _____ Age _____ Gender: ☐ Male ☐ Female

## Billing Provider: HSPP or PHYSICIAN

Provider Name _____ Credentials _____

Provider NPI _____ Tax ID # _____

Provider Address _____

Phone _____ Fax _____

Contact Name _____ ☐ HSPP/Psychiatrist ☐ Physician

## Supervising Provider: BCBA-D, BCBA, HSPP

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 of ABA Treatment _____

Date of most recent assessment _____

louisiana healthcare connections™

8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

1-866-595-8133
Hearing Loss: 711
Monday–Friday, 7 a.m. to 7 p.m.

LouisianaHealthConnect.com

## 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**
- **Behavioral treatment plan**
- **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 measureable 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**
- **Copy of IEP or IFSP if applicable**
- **Copy of waiver Plan Profile Table and the Schedule page from the certified plan of care**

**For subsequent treatment requests, please submit:**

- **Objective measures of *current status***
- **Objective measures of clinically significant progress (measureable 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** _____

## 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 via fax to: Louisiana Healthcare Connections**
**Behavioral Health Utilization Management Department**
**1-888-725-0101**