western sky community care™
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Behavioral Health
Applied Behavior Analysis (ABA)
Clinical Review Form ABA

Specialty Care Provider Prior Authorization

(Address all areas. An incomplete form may result in a delay of your request.)

Submit completed form and MCO cover sheet by email or fax.

Date Form Completed:

INITIAL ◯ CONCURRENT ◯

Agency/Provider Information

Name Agency:

National Provider ID:

Address/Service Location:

Facility/Program Contact:
(Name)

Phone: Fax: Email:

Requested Dates of Service:

Requested Number of Service Units:
(use table provided)

Start Date of services:

Scheduled date of CDE:

Completed date of CDE and ISP:

Date of Stage 2 Assessment:

Indicate what forms are attached

Documentation of the diagnosis of autism (attach referral form) ◯

CDE or Targeted Evaluation ◯

ISP ◯

Stage 2 assessment results and treatment plan ◯

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Additional forms or assessments:

STAGE 3: Planning & Treatment

Level of Care Requested:
(include Billing Code)

Provide complete information on the codes, modifiers to be used, total units, and hours requested.

Billing Codes	1st Modifier	2nd Modifier	3rd Modifier	Total Units (U) Requested	Indicate Total Hours/per week or month

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Additional forms or assessments:

STAGE 3: Planning & Treatment

Level of Care Requested:
(include Billing Code)

Provide information on the location and approximate time services will occur.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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Member Information

Member Name:
(First/Last)

Member ID or SSN: Member DOB: Member Age:

Name of Legal Guardian:

Guardian Address: Phone:

Member currently lives with:
(homeless, parents/siblings)

Status of DD Waiver APPLICATION ◯ WAITLIST ◯ APPROVED ◯

Have you had contact with the member's MCO care coordinator? YES ◯ NO ◯

Who is the care coordinator's
point of contact at your agency?

Email: Phone:

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Reason for Requested Specialty Care Services

Identify specialty care areas that are not currently/adequately addressed by the behavioral analytic practitioner. Specialty areas currently recognized, but not limited to, are aggression, self-injury, sleep dysregulation, and feeding disorders (see Medical Assistance Program Manual Supplement 16-08 for operational definitions of behaviors associated with these areas). There may be additional specialty areas identified that have the potential to provide significant improvement for the client and their family.

- Provide specific and detailed information describing the behavior to include frequency, intensity, and duration of behaviors.
- Address any potential for harm to self or others (if relevant).
- Documentation of disruption of quality of life for the eligible recipient and their family (if relevant).
- Document previous ABA services.

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Client History

EVALUATION AND DSM DIAGNOSES

Current DSM Diagnosis:
(Include all diagnoses and DSM-V ICD-10-CM codes)

FOR MEMBERS WITH ESTABLISHED ASD OR ARE LESS THAN 3 YEARS OF AGE AND ARE SUSPECTED OF HAVING ASD
Provide the following information

Date of ASD diagnosis: **By whom:**

Evaluation tool(s) utilized:

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Supports

Complete with available information. If information is not available, explain how and when in-formation will be gathered.

Describe natural and care giver supports available to member to participate in ABA services.

Explain expectations of parent/guardian participation in Assessment, Treatment Planning, and Therapy Sessions.

Identify barriers and how barriers will be addressed?
(Planned or predicted.) See Appendix A for examples.

How is the Treatment Plan being implemented into the home?

Describe environment where member receives services.

How will Language/Spiritual/Cultural Factors affect treatment engagement?
(Note: Incorporate language/spiritual/cultural factors into treatment plans and goals.)

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List any additional supports the member or family is currently receiving

Complete with available information. If information is not available, explain how and when in-formation will be gathered.

BH treatment services
(type, provider, frequency)

Personal Care services
(type, provider, frequency)

Speech, Physical, or Occupational therapies
(type, provider, frequency)

Other

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Goals and Areas of Functioning

For examples see Appendix B

1. GOALS:
   (type, provider, frequency)

2. Areas of functioning expected to improve by next review:

3. Parent Goals

4. Is there a safety plan in place?
   Please attach if relevant.

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Discharge Plan Information

ABA services should have an estimated end date.

Current estimated length of service.
Include an end date.

Explain the specific behaviors needed for the member to be discharged from services

Identify barriers to successful discharge
(See Appendix A for examples)

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Current Medications

(List all MH/SA and Medical)

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

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Current Medications

(List all MH/SA and Medical)

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

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(List all MH/SA and Medical)

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

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Current Medications

(List all MH/SA and Medical)

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

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Current Medications

(List all MH/SA and Medical)

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

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Additional Comments/Notes:

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Appendix A | Reference Only

TREATMENT BARRIERS AND CONSIDERATIONS

Identifying potential treatment barriers and considerations not covered in the Prior Authorization form will assist ABA providers and Care Coordinators in planning for successful delivery of services.

Family

- Family involvement/support
- Family dynamics (e.g., divorce or family conflicts)
- Health issues: Member
- Health issues: Family

Environment

- Environment safety concerns
- Environment is not therapeutically beneficial to lead to positive treatment outcomes

Family Schedules

- Member's schedule conflicts with treatment schedule
- Family's schedule conflicts with treatment schedule

Behavior

- High-risk behavior(s) that interfere with home or out-patient treatment

Financial

- Insurance costs
- Treatment
- Supplies

Transportation

Language

Cultural Considerations

Other

- Respite Care
- Caregiver/Family training
- Parent Support group
- Family counseling
- Financial Assistance
- Higher level of care

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Appendix B | Reference Only

EXAMPLES OF GOALS AND FUNCTIONING

EXAMPLE OF A GOAL

Problem Behavior: Class of behavior - Tantrum

Operational Definition: Ella will scream, cry, grab at objects, and refuse to speak, shut down, drop to the floor, and hit her brother with an open and or closed hand.

Baseline: 2x per day per parent report; 3x per 2-hour observation.

Function: Attention /Access to preferred items/Escape

Context/setting: 1-home

Ultimate Goal: Ella will not engage in tantrum behavior, no more than 1x per week during non- therapeutic and therapeutic sessions for 3 consecutive months.

Short Term Goal: Ella will not engage in tantrum behavior during therapeutic sessions, no more than 1x per week for 3 consecutive months.

EXAMPLE OF FUNCTIONING EXPECTED TO IMPROVE

History of behavior: Parent report Ella has engaged in tantrum behavior for multiple years.

PROACTIVE/ANTECEDENT TACTICS:

Priming: Ella will be primed about what the reinforces will be and what behaviors are required to earn tokens to cash in on those reinforcers

Differential Reinforcement of Other Behavior: Ella will earn tokens for not engaging in elopement behavior

Differential Reinforcement of Alternative behavior: Ella will earn tokens for practicing alternative behaviors to gain access to her needs (use mands)

REACTIVE/CONSEQUENCE STRATEGIES:

Extinction (access and escape): Ella will be returned to the allowed area/proximity and will not be allowed to access any items via inappropriate behavior

Replacement Behaviors: Proactively teaching coping strategies, such as taking a break, deep breathes.