CONCURRENT AUTHORIZATION FOR ABA/BEHAVIORAL SERVICES

Member Name: _____

Member ID#: _____ Date of Birth: _____

Requesting Provider: _____

Phone Number: _____ NPI #: _____

Provider Address: _____

Date of Initial Evaluation:			
Services Requested:			
CPT		Hours Per Week:	
CPT		Hours Per Week:	
CPT		Hours Per Week:	
CPT		Hours Per Week:	
CPT		Hours Per Week:	

INDICATIONS FOR CONTINUED TREATMENT:	
Treatment Initiated in last 5 months	☐ Yes ☐ No
A) At least 80% of behavioral targets achieved/expected to be achieved by goal date	☐ Yes ☐ No
1) Parent/Caregiver Training attendance at least 80% of planned parent sessions	☐ Yes ☐ No
B) 50% to 79% of behavioral targets achieved/expected to be achieved by goal date & treatment plan revised for unattained targets	☐ Yes ☐ No
1) Increased time/frequency working on targets	☐ Yes ☐ No
2) Change in treatment techniques	☐ Yes ☐ No
3) Increased parent/caregiver Training	☐ Yes ☐ No
4) Identification & resolution of barriers to treatment effectiveness	☐ Yes ☐ No
5) Goals reconsidered	☐ Yes ☐ No
a) Goals modified/removed	☐ Yes ☐ No
b) Parents/Caregivers agree to changes	☐ Yes ☐ No

INDICATIONS FOR CONTINUED TREATMENT (continued):	
C) 25-49% of behavioral targets achieved/expected to be achieved by goal date	☐ Yes ☐ No
Co-occurring disorder newly identified & treatment plan revised	☐ Yes ☐ No
1) Intellectual disability	☐ Yes ☐ No
2) Anxiety disorder	☐ Yes ☐ No
3) Mood disorder	☐ Yes ☐ No
4) Psychotic disorder	☐ Yes ☐ No
D) Family/Provider scheduling difficulties	☐ Yes ☐ No
1) Resulted in inadequate treatment intensity	☐ Yes ☐ No
2) Have now been resolved	☐ Yes ☐ No
E) Achieved greater than 50% of behavioral targets for last 3 months	☐ Yes ☐ No
Has some verbal expression	☐ Yes ☐ No
1) Functioning	☐ Yes ☐ No
Treatment initiated w/in last 12 months	☐ Yes ☐ No
Treatment initiated over 12 months ago	☐ Yes ☐ No
a) Patient able to communicate requests nonverbally/verbally	☐ Yes ☐ No
b) Patient able to follow one-step directions	☐ Yes ☐ No
2) Progress from baseline demonstrated on repeated assessments	☐ Yes ☐ No
a) Structured parent/caregiver interview	☐ Yes ☐ No
b) Direct behavioral observation	☐ Yes ☐ No
c) Checklist/Rating Scale for Symptoms of ASD	☐ Yes ☐ No
d) Expressive/Receptive Language Measure	☐ Yes ☐ No
e) Measure of cognitive function	☐ Yes ☐ No

PARENT CAREGIVER TRAINING	
A) Occurring greater than one time/week	☐ Yes ☐ No
B) Occurring greater than one time x/ 3 weeks and parent/caregiver attendance is at least 80% of planned sessions	☐ Yes ☐ No
Coordination with other service providers	
A) Behavior analyst has updated information from other treatment providers/school within the last 12 months	☐ Yes ☐ No
B) Patient not receiving other therapeutic services	☐ Yes ☐ No
Treatment duration	
A) ABA initialed w/I last 36 months	☐ Yes ☐ No
B) ABA initialed over 36 months ago and less than 20 hrs/wk of ABA planned	☐ Yes ☐ No

TREATMENT PLAN	
Current Targets Address Safety/Functioning	☐ Yes ☐ No
A) Communication/Language	☐ Yes ☐ No
B) Social/Family Interaction	☐ Yes ☐ No

REPETITIVE/RESTRICTIVE BEHAVIORS	
A) Behavior interferes with functioning/relationships	☐ Yes ☐ No
B) Potential to harm self/others	☐ Yes ☐ No
C) ADLs/ADOLs	☐ Yes ☐ No
D) Disruptive/Aggressive/Self-injurious Behavior	☐ Yes ☐ No

PROVIDER QUALIFICATIONS	
Case supervised by state-licensed BCBC/BCBA-D	☐ Yes ☐ No
Planned supervision of case	
1) Greater than 4 supervision sessions/month	☐ Yes ☐ No
2) Greater than 1 hour of supervision per 15th hour of direct treatment	☐ Yes ☐ No
Direct/Video-based supervision planned	
1) Greater than 1 time in two weeks	☐ Yes ☐ No
2) Greater than 1 hour per 30 hours of direct treatment	☐ Yes ☐ No
Direct treatment providers:	
A) All direct treatment providers are credentialed for independent practice of ABA	☐ Yes ☐ No
1) BCBA/BCBA-D	☐ Yes ☐ No
2) Licensed behavior analyst by state statute	☐ Yes ☐ No

SERVICES:
Treatment Intensity
Select one of the following
☐ 1) Attends full days of school/preschool/EI & up to 15 hours/week of direct ABA treatment
☐ 2) Attends half days of school/preschool/EI & up to 25 hours/week of direct ABA treatment
☐ 3) Not enrolled in school/preschool
☐ 4) Less than 6 years of age
☐ 5) Up to 30 hours/week of direct ABA treatment
Select one of the following
☐ 1) Up to 2 hours of supervision per 10th hour of direct treatment
☐ 2) Up to 3 hours/week of parent/caregiver training
☐ 3) Up to 12 hours per year of consultation with other providers/agencies/school personnel

TREATMENT PLAN	
*Plan must be child-centered, strength-based, family focused, community-based, multisystem, and culturally-competent. Parental training must be involved so they can provide additional hours of intervention. Complete this page or attach treatment plan.	
Goal 1:	
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
Goal 2:	
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
Goal 3:	
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:

IF APPLICABLE, WAS THE PLAN SUBMITTED AND APPROVED BY THE HUMAN RIGHTS COMMITTEE?
☐ Yes ☐ No

Signature: _____

Date: _____

REVIEWED 08/23/2018