Outpatient Behavioral Health (BH) – ABA Treatment Request: Required Information for Precertification

Applies to:

Aetna plans

Innovation Health® plans

Health benefits and health insurance plans offered, underwritten and/or administered by the following:

Allina Health and Aetna Health Insurance Company (Allina Health | Aetna)

Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner|Aetna)

Sutter Health and Aetna Administrative Services LLC (Sutter Health | Aetna)

Texas Health + Aetna Health Plan Inc. and Texas Health + Aetna Health Insurance Company (Texas Health Aetna)

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GR-69017-3 (3-22)

EDI

About this form – Do not use for Maryland and Massachusetts

You can't use this form to initiate a precertification or assessment only request. To initiate a request, you have to call the number on the member's card. Or you can submit your request electronically.

Effective **March 1, 2022**, this form replaces all other Applied Behavior Health Analysis (ABA) precertification information request documents and forms.

This form will help you supply the right information with your precertification request. You don't have to use the form. But it will help us adjudicate your request more quickly.

How to fill out this form

As the patient's attending physician, you must complete all sections of the form.

You can use this form with all Aetna health plans, except Aetna's Medicare Advantage plans. You can also use this form with health plans for which Aetna provides certain management services. This includes Innovation Health Plan, Inc. and Innovation Health Insurance Company. You can't use the form with Traditional Choice/Indemnity plans.

When you're done

Once you've filled out the form, submit it and all requested supportive documentation to our Autism Care Team by:

- Confidential fax to **1-860-607-7406;** or
- Email to **BACABACases@aetna.com**; or
- Upload your information electronically on our secure provider website on the Provider Portal at **www.Availity.com**.

What happens next?

Once we receive the requested documentation, we will perform a clinical review. Then we'll make a coverage determination and let you know our decision. Your administrative reference number will be on the electronic precertification response.

How we make coverage determinations

We encourage you to review **Clinical Policy Bulletin #648: Autism Spectrum Disorders, and Applied Behavior Analysis Medical Necessity Guide**, before you complete this form. You can find the policy by visiting the website on the back of the member's ID card. The Applied Behavior Analysis Medical Necessity Guide can be found by visiting: **http://www.aetna.com/healthcare-professionals/documents-forms/applied-behavioral-analysis.pdf**

Questions?

If you have any questions about how to fill out the form or our precertification process, call us at **1-800-424-4047**.

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Fax to: **Autism Care Team** **1-860-607-7406**	Email to: **BACABACases@aetna.com**	Portal**: www.Availity.com**

Section 1 – Provide the following general information

Member name	Case reference number
Member telephone number	
Member ID	Member date of birth / /
Provider or Provider Group name	Provider or Provider Group TIN or PIN number, and Network status: ☐ Participating ☐ Non-participating TIN number: PIN number:
Provider or Provider Group full address	Provider or Provider Group phone number
Name, telephone number **and** email address of Contact person for this request	Is Voicemail confidential? ☐ Yes ☐ No
Requested start date of procedure or service / /	How long has the member received ABA services?
Current DSM-V diagnosis code(s):	Diagnosing Provider (name and credentials)

Select the CPT codes which best describe the service(s) that you will provide and enter the hours needed.

Assessment Codes

☐ 97151 _______ **Hours** per auth period
☐ 97152 _______ **Hours** per auth period
☐ 0362T _______ **Hours** per auth period

Treatment Codes

☐ 97153 ______ **Hours** per ☐ Week ☐ Month*
☐ 97154 ______ **Hours** per ☐ Week ☐ Month*
☐ 97155 ______ **Hours** per ☐ Week ☐ Month*
☐ 97156 ______ **Hours** per ☐ Week ☐ Month*
☐ 97157 ______ **Hours** per ☐ Week ☐ Month*
☐ 97158 ______ **Hours** per ☐ Week ☐ Month*
☐ 0373T ______ **Hours** per ☐ Week ☐ Month*

***Month should only be chosen when the frequency of the service occurs at less than weekly intervals**

Are any ABA hours being requested during class? ☐ Yes ☐ No
If so, how many and for which codes?

If the above requested hours are not the same as what was approved at the last review, please indicate the specific clinical rationale for the change:

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Section 2 – Provide the following member-specific information

1. Who is supervising/directing the ABA services? (name, credential/certification, and phone number)

Is Voicemail confidential? ☐ Yes ☐ No

2. Is the member receiving any additional services? ☐ Yes ☐ No If Yes, (check all that apply)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Mental Health Services ☐ Primary Care Physician ☐ Services through the school system
☐ Prescribing Physician If so, Medications: ______
☐ Other: ______

Do you collaborate with all the providers above? ☐ Yes ☐ No
If no, please explain why:

3. Check box to ensure the following essential elements are met ☐

Diagnosis of Autism Spectrum Disorder
Identifiable target behaviors that impact functioning
Parents/Guardians participate in treatment
Time-limited, individualized, measurable treatment plan
Involvement/Coordination with supplemental resources
Service providers are appropriately licensed/certified

4. The member displays impairment in the following areas (attach supporting data that demonstrates current severity level of each impairment) select all that apply:

☐ Self-injurious behavior
☐ Destructive behavior
☐ Aggressive behavior
☐ Restrictive/Repetitive behaviors
☐ Expressive/Receptive language
☐ Social/Emotional reciprocity
☐ Ability to seek/develop shared social activities
☐ Ability to recognize danger/risks
☐ Ability to advocate for self
☐ Self-Care skills impeded by symptoms of Autism

5. **Please include the following supporting documentation with your request, where applicable**

- Results of a standardized assessment (i.e. Vineland, ABAS, VB-MAPP) completed within the past 12 months. Re-evaluation of interventions and progress has been performed (every 6 months) to assess the need for ongoing ABA; **AND** a repeat validated assessment has been done every 6-12 months to demonstrate response to intervention. Include the member's IQ, if available.
- A time-limited, individualized treatment plan that has clearly defined and measured target behaviors, including baseline levels and quantifiable criteria for progress. The plan describes behavioral intervention techniques appropriate to the target behaviors, reinforcers selected, and strategies for generalization of learned skills are specified. Include baseline, interim and current data for all goals. Include the results of a functional behavior assessment and/or skills assessment, as applicable.
- Supporting data that demonstrates the level/severity of impairment justifies the number of hours requested
- Parent(s) or guardian(s) have measurable goals that work to reinforce interventions and generalize gains.
- Clearly defined, measurable, and realistic criteria for titration of hours and ultimate discharge, including an aftercare plan.
- There is involvement of, or referrals to, appropriate health care, community, or supplemental resources.
- Describe any barriers to providing this information and efforts to address those barriers.
- Any additional details to be considered for this request

Section 3 – Read this important information

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Section 4 – Sign the form. Just remember: You can't use this form to initiate a new precertification request.

Form completed by	**Title**