Applied Behavior Analysis Retrospective Review Cover Form

Please complete this form and fax to 1-855-312-1470 along with:

- ***Supporting clinical documents for requested dates of service***
- ***Member's Comprehensive Diagnostic Evaluation.***

Information provided will be protected in accordance with HIPAA requirements and other applicable confidentiality regulations.

Once submitted if you have any follow up questions regarding your submission, please contact Appeals Department at 1-866-556-8166.

(Note: Text fields will expand as needed. You may copy and paste into fields.)

Provider Facility/Group Name: Click or tap here to enter text.
Provider TIN: Click or tap here to enter text.
Provider Servicing Address: Click or tap here to enter text.
Provider City, State, Zip: Click or tap here to enter text.
Provider Phone #: Click or tap here to enter text.
Provider Fax #: Click or tap here to enter text.
Designated Case Supervisor Name and Credentials: Click or tap here to enter text.

Member First Name: Click or tap here to enter text.
Member Last Name: Click or tap here to enter text.
Member DOB: Click or tap here to enter text.
Member Address: Click or tap here to enter text.
Member ID #: Click or tap here to enter text.
Exact Dates of Service (Please do not include current/future dates of service. These should be handled via ongoing clinical review process)*:* Click or tap here to enter text.

(This is a post service request. Current/future dates of service should be handled via the prior authorization process. If unsure of dates to be requested or you need to review current/future dates, please call the behavioral health number on the back of member's card and request to speak with the National ABA team).

Explain why services were delivered without prior authorization: Click or tap here to enter text.

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U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California

Please list ONLY the total units already rendered, supported by clinical documentation, and that will be submitted for claims payment		
97151 per 15 min	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.	Click or tap here to enter text. Units total
97152 per 15 min	Behavior identification supporting assessment, administered by one technician under direction of a physician or other qualified health care professional, face-to-face with the patient.	Click or tap here to enter text. Units total
0362T per 15 min	• Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • administered by the physician or other qualified healthcare professional who is on site, • with the assistance of two or more technicians, • for a patient who exhibits destructive behavior, • completed in an environment that is customized to the patient's behavior.	Click or tap here to enter text. Units total
97153 per 15 min	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with the patient.	Click or tap here to enter text. Units total
97154 per 15 min	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with the patient.	Click or tap here to enter text. Units total
97155 per 15 min	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient.	Click or tap here to enter text. Units total

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Please list ONLY the total units already rendered, supported by clinical documentation, and that will be submitted for claims payment		
97156 per 15 min	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s).	Click or tap here to enter text. Units total
97157 per 15 minutes	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers.	Click or tap here to enter text. Units total
97158 per 15 min	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients.	Click or tap here to enter text. Units total
0373T per 15 min	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • administered by the physician or other qualified healthcare professional who is on site, • with the assistance of two or more technicians, • for a patient who exhibits destructive behavior, • completed in an environment that is customized, to the patient's behavior.	Click or tap here to enter text. Units total

Note: Please ensure the following is included in member's attached supporting clinical documents for review per the ABA Supplemental Clinical Criteria. Please complete the section below.

Current Primary DSM-5 Diagnosis and Code Number: Click or tap here to enter text.

Who gave the diagnosis? Click or tap here to enter text.

Date diagnosis was given: Click or tap here to enter text.

Was the diagnosis a result of a Comprehensive Diagnostic Evaluation (CDE): Choose an item.

Other Medical or Mental Health Diagnosis: Click or tap here to enter text.

Medications: Click or tap here to enter text.

Location of services: Choose an item.

Is member in school? Choose an item.

If yes, what type of school is member in: Choose an item.

Hours per week member is in school: Click or tap here to enter text.

For the dates requested, if services were rendered in the school setting for members in kindergarten and above, please answer the following questions:

1. *What services are recommended in the IEP? Is there a mention of ABA?* Click or tap here to enter text.
2. *What type of school is the child in?* Click or tap here to enter text.
3. *What services were rendered during the school time, i.e., staff training, shadow, 1:1 aide, pull out ABA services, etc.?* Click or tap here to enter text.
4. *What is the breakdown of codes and units at each location, i.e., home, school, after school hours, daycare?* Click or tap here to enter text.

5. *Are ABA goals being worked on in the school tied to the core deficits of social, communication and behavior?* Click or tap here to enter text.
6. *Are the goals appropriately coordinated with home services?* Click or tap here to enter text.
7. *What is the titration plan to fade out of the school and who will the skills be transferred to in the school setting?* Click or tap here to enter text.
8. *Who requested services in the school (parent, school, etc.)?* Click or tap here to enter text.
9. *Is the goal of providing services in school to help the child function in an education environment?* Click or tap here to enter text.
10. *How are the services in school affecting the home/community/center-based services?* Click or tap here to enter text.

Other services child receives: Click or tap here to enter text.

Hours per week of other therapeutic activities outside of school (i.e., speech, occupational therapy, OP counseling): Click or tap here to enter text.

Is there coordination of care with other providers? If yes, please include coordination of care in attached supporting clinical documents: Choose an item.

Length of time in years member has been in ABA services: Click or tap here to enter text.

How long has the member been receiving services at this intensity of services: Click or tap here to enter text.

Proposed Start Date of Authorization/Notification: Click or tap here to enter text.

What is the severity of communication deficit? Choose an item.

What is the severity of social deficit? Choose an item.

What is the severity of behavior deficits? Choose an item.

What is the severity of destructive, maladaptive behaviors? Choose an item.

Are caregivers involved in treatment? Choose an item.

Please give a brief description of caregiver involvement, i.e., separate training sessions, shadowing in sessions, etc. Click or tap here to enter text.

How many hours per week are the caregivers involved in either sessions or caregiver training? Choose an item.

How would you rate caregivers regarding their proficiency with ABA techniques and working with the individual? Choose an item.

I hereby certify and attest that all the information provided as part of this retro authorization request is true and accurate:

Click or tap here to enter text. _____ Click or tap here to enter text. _____

Signature Date

Click or tap here to enter text. _____

Printed Name and Title