Autism Resource Program: 877-563-9347 Fax: 816-237-2372

For administrative questions, please contact autismadmin@lucethealth.com. For clinical questions, please contact your Autism Care Manager or the autism department at 877-563-9347.

# Treatment Request for Applied Behavior Analysis for Autism Spectrum Disorder

Please complete all parts as clearly and as specifically as possible. Illegibility may result in a delay in the authorization. Omissions and generalities could result in a peer review or denial due to lack of information.

| **Member Information** | |
|---|---|
| Member's Name: | Member ID #: |
| Date of Birth: | Age: |
| Current Diagnosis Code(s): | |
| State where member is being treated: | |
| Parent/ Guardian Name(s): | Contact Number(s): |
| Parent/ Guardian Email Address: | *Please note, if member is age 18 or above, guardianship paperwork will need to be submitted<br>Authorized Delegate Form |
| Does member attend school? ☐ Yes ☐ No | |
| Does member have an IEP? ☐ Yes ☐ No | |
| Current Medications/ Relevant Medical History: | |

| **Provider/Group Information** | |
|---|---|
| Contact Name: | Contact Phone Number: |

| | |
|---|---|
| Contact Email: | Provider Group Name: |
| Provider Group Tax ID: | Provider Group Address: |
| Behavior Analyst Name: | Behavior Analyst Individual NPI: |
| Behavior Analyst Phone: | Behavior Analyst Fax: |
| Behavior Analyst Email: | Is the Behavior Analyst in-network with local blue? ☐ Yes ☐ No |

**Authorization Information**

Requested Treatment Start Date:

Location of Services:
☐ Clinic
☐ Home
☐ School
☐ Telehealth
☐ Community
☐ Other: _____

☐ I attest that I have verified benefit coverage for these proposed places of service.
☐ I attest that I will follow the guidelines regarding concurrent billing from my local Blue
☐ I attest that I will utilize the hours requested and the hours requested reflect the member's, caregiver's, and provider's availability to participate in treatment, and have the line therapists available to provide these hours.

| Code | Hours Requested | Frequency |
|---|---|---|
| | | ☐Weekly ☐Monthly ☐Per Authorization |
| | | ☐Weekly ☐Monthly ☐Per Authorization |
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| | | ☐Weekly ☐Monthly ☐Per Authorization |

| Treatment Plan |
| --- |
| How many goals were mastered (if applicable) during authorization period?: |
| How many goals were continued/ modified during authorization period?: |
| How many goals were discontinued (if applicable) during authorization period?: |
| How many goals are new for upcoming authorization period?: |
| If applicable, please list barriers to progress and how barriers are being addressed: |
| *Please attach treatment plan including baseline data, current data, and mastery criteria for all goals. |

| Attestations |
| --- |
| ☐ I attest that treatment goals and clinical documentation are focused on active core deficits of ASD (deficits in social communication, deficits in social interaction, and restricted/ repetitive patterns of behavior/interests/activities). |
| ☐ I attest that ABA treatment is not a substitute for academic, medical or other behavioral health services |
| ☐ I attest that treatment setting and intensity (comprehensive versus focused) is appropriate for the member's clinical needs |
| ☐ I attest that all services are provided in a manner consistent with the Lucet Provider Manual, the Behavior Analysis Certification Board's Ethics Code for Behavior Analysts or relevant ethics code, generally accepted standards of care, and applicable state laws. |
| ☐ I attest that provider is accounting for generalization of skills, successful caregiver involvement or alternative plan, coordination of care, and active transition/discharge planning. This information should be individualized, measurable, and attainable. |
| ☐ I attest that member is making progress in treatment:<br>☐ Goal Mastery:<br>☐ Behavior Reduction:<br>☐ Improvement on Curriculum/Adaptive Scores:<br>☐ Community/Home Inclusion:<br>☐ Other: |
| ☐ I attest that the Lucet ABA Treatment Request Form including projected treatment outcomes, caregiver participation, transition plan, and after care plan was discussed with caregiver. |
| ☐ I attest that I have read the medical policy for this member's plan. |

☐ I attest that there are enough trained staff available to provide services for all requested hours.

Additional Relevant Information

**Future Submissions**

Did you want us to create a WebPass account for you so you can submit future requests through our online portal? ☐ Yes ☐ No

If yes, please answer the following to be used for a WebPass account:
Contact Name:
Provider Group Tax ID:
Email:

If you select yes, you will receive a time sensitive email to set up your password and an email with PowerPoint instructions on how to utilize WebPass.

| **Submission Checklist- Please contact 877-563-9347 with any questions** | |
|---|---|
| All evidence-based screening and scaling results used in determining the diagnosis must be submitted with this request as required by individual state mandate. Please refer to the Provider Manual for additional information regarding specific screenings and scales. | |
| *If you have already completed this checklist, you do not need to complete again. | |
| Did you include a complete diagnostic evaluation, including an ASD-specific standardized assessment, completed by a clinician who is licensed and qualified to make such a diagnosis confirming member has ASD <u>dated within past 5 years</u>? | ☐ Yes ☐ No<br><br>*Required for initial assessment |

| | |
|---|---|
| Did you include a Wellness Check completed by the primary care physician, including a Review of Symptoms (ROS) with a neurological component, dated within the past year? | ☐ Yes ☐ No<br><br>If no, this will need to be submitted within the first 90 days of treatment or scheduled date for appointment |
| Did you include a cognitive/ developmental evaluation dated within past 5 years? | ☐ Yes ☐ No<br><br>If no, this will need to be submitted within the first 90 days of treatment or scheduled date for appointment |
| Did you include an Adaptive Behavioral Evaluation dated within past six months? | ☐ Yes ☐ No<br><br>If no, this will need to be submitted within the first 90 days of treatment or scheduled date for appointment |
| Please note, requirements for Arkansas/ Walmart policies also require the following to be submitted within the first 90 days of treatment:<br>☐ Speech Evaluation by a licensed speech therapist<br>☐ Sensorimotor evaluation<br>☐ Hearing evaluation | |
| Please note, requirements for State of Kansas also require the following to be submitted within the first 90 days of treatment:<br>☐ Speech Evaluation by a licensed speech therapist<br>☐ Lead poisoning assessment<br>☐ Hearing evaluation | |