BlueCross BlueShield of Texas

Applied Behavior Analysis

# Clinical Service Request Form



**Check one: ☐ Initial Request ☐ Concurrent Request**

**Submit forms at least two weeks before requested start date.**
**For any questions, call Blue Cross and Blue Shield of Texas at 800-851-7498 or BCBSTX Federal Employee Program® at 800-779-4602. Fax forms to 877-361-7646.**

1) **For the Initial Treatment Request**
   Submit: Completed Clinical Service Request Form (pages 1-5), Diagnostic Evaluation Report, Provider Baseline and Skills Assessment Instruments and Comprehensive Treatment Plan (additional information may be requested by a clinician once the case is reviewed)
2) **For the Concurrent Treatment Request**
   Submit: Completed Clinical Service Request Form (pages 1-5), Skills Re-Assessment Report and Comprehensive Treatment Plan (additional information may be requested by a clinician once the case is reviewed)

## PATIENT INFO

**Patient Name** _____ **Patient Date of Birth** _____ **Today's Date** _____

**Subscriber Name** _____ **Subscriber ID** _____ **Group** _____

**Patient resides in what state?** _____

## DIAGNOSTIC PRACTITIONER INFO

**Diagnostic Practitioner Name** _____ **NPI** _____

**Diagnostic Practitioner Type, if PCP:** ☐ Family Practice ☐ Internal Medicine ☐ Pediatrics

**Diagnostic Practitioner Type, if Specialized ASD-Diagnosing Provider:** ☐ Developmental Behavioral Pediatrics ☐ Neurodevelopmental Pediatrics ☐ Child Neurology ☐ Adult or Child Psychiatry ☐ Licensed Clinical Psychology ☐ Other (specify) _____

**Primary Diagnosis Code** _____ **Secondary Diagnosis Code** _____

*Current diagnostic required not older than 36 months.*

**Initial Evaluation Date** _____ **Most Recent Evaluation Date** _____

## PROVIDER INFO

**Rendering Qualified Healthcare Provider (QHP)* Name** _____

**Fill in the Rendering QHP who is directly providing treatment.*

**NPI** _____ **Email** _____

**Telephone** *(please provide a number with confidential voicemail)* _____ **ext** _____

**Master's/PhD level clinician/state-recognized professional credential or certification** _____

**State** _____ **License/Cert#** _____

**Clinic Practice Name** _____

**NPI** _____ **Fax** _____

**Clinic Practice Rendering Provider Address** _____ **City** _____ **State** _____ **Zip Code** _____

**Practice Contact Name** _____ **Telephone** _____ **ext** _____

**Admin Billing Office Address** _____

## CERTIFICATION OF DX & TREATMENT EXPECTATION

**I, ☐ Diagnostic Practitioner or ☐ ABA Services Supervisor** (having confirmed with the diagnostician), am recommending ABA services and certify there is a reasonable expectation that this member can actively participate and demonstrates the capacity to learn and develop generalized skills to assist in his/her independence and functional improvements.

| | |
|---|---|
| **Line Therapist Requirements** | **Requirements for line staff providing 1:1 therapy:** 1) 18+ years of age; 2) High school diploma or GED; 3) criminal background check prior to active employment; 4) via practice expense, completed training of ASD and behavioral related subjects/evidence based techniques (40 hours) and 5) have on-going supervisory oversight by the BCBA or ABA treatment supervisor for a minimum of 5% of hours directly worked with members. |
| **ABA Supervisor Requirements** | **As the ABA Supervisor (above), I attest** that I follow outlined guidelines for supervision by the BACB and have an active license in the state where this member's services are rendered. ☐ Yes ☐ No |





A B A

Patient Name _____ Patient Date of Birth _____

## CERTIFICATION OF PROVIDER QUALIFICATIONS

**By signing and returning this form to Blue Cross and Blue Shield of Texas, I hereby certify:** (1) credentials/license as noted above; (2) the line therapists for whom I, or an outpatient mental health agency or clinic, will bill meet the qualifications set forth above; (3) if staff changes at any time, new staff must meet the same qualifications; (4) time spent meeting the training requirements are not billable to BCBSTX or members of BCBSTX and (5) BCBSTX may, in its discretion, review its claim history or request supporting information in order to verify the accuracy of this certification.

I accept the length of stay (days or units) deemed medically necessary by the initial clinical reviewer, based on the clinical information provided and the Health Plan's established medical necessity criteria. I understand that if the initial clinical reviewer is unable to approve the full requested length of stay or service, I may request a subsequent review by a peer clinical reviewer. Yes☐ No☐

**Rendering QHP Signature** _____ **Date** _____

**Rendering QHP Printed Name** _____ **Practice Name** _____

## PROVIDER TREATMENT REQUEST

**Current Request Start Date** _____ **Requested Service Intensity:** ☐ Focused ☐ Comprehensive

**Total Requested Hours Per Week** _____

*(Note: Re-assessment package, for full clinical assessment, will be authorized every 6 months based on state plan)*

### ABA Procedure Code Request

| **Codes** | **97151** Assessment **QHP** | **97152** Assessment, **Tech** | **97153** Direct Treatment, **Tech** or **QHP** | **97155** Protocol Modification & Supervision of Tech **QHP** | **97154** Group Treatment, **Tech** or **QHP** | **97158** Group Protocol Modification **QHP** | **97156** Family Treatment, **QHP** | **97157** Multi Family Treatment, **QHP** |
|---|---|---|---|---|---|---|---|---|
| **Units per 15 minutes** | | | | | | | | |

Additional Code(s) Request and Reason

***ABA services require prior authorization. This form can be submitted up to 60 days prior to the treatment request start date. For forms submitted after the requested start date, claims should be submitted through your normal process and you will receive instructions on how to proceed.***

## ABA TREATMENT HISTORY

**Initial/First Date of ABA Services from current provider/facility** _____

**Has this member had ABA services with any other provider?** ☐ No ☐ Yes When was the initial date? _____

**Intensity of these services:** ☐ Focused ☐ Comprehensive Avg. # of hours/week _____

**Continuous ABA services since start?** ☐ Yes ☐ No If break from services, when and why?

| **Medical History** | **Sleep Issues Related to ASD?** ☐ Yes ☐ No If yes, please describe<br>**Eating Issues Related to ASD?** ☐ Yes ☐ No If yes, please describe |
|---|---|

**Is the patient taking medication?** ☐ Yes ☐ No

If yes, prescribed by _____ Professional Licensure/Credential _____

Current Medications (Dosages)

Patient Name _____ Patient Date of Birth _____

## BASELINE & ASSESSMENT INFO

**Date Current Assessment Completed** _____ **Conducted by (name)** _____ **License/Cert** _____
*Assessment must be within the last 30 days.*

**Assessment Participants:** ☐ Patient Only ☐ Parents/Caregivers ☐ Patient and Parents/Caregivers

**Please select one (1) instrument that will be utilized for the member's entire treatment episode so progress can effectively be measured. Choose a recognized instrument such as the VB MAPP, ABLLS, AFLS, ABAS or the Vineland. Also, please attach standardized measurement scoring summaries if the member has been in treatment prior to this request.**

| Name of Assessment Instrument | Current Test Date | Current Score | Previous Test Date | Previous Test Score |
|---|---|---|---|---|
| | | | | |
| **Name of Assessment Instrument** | **Current Test Date** | **Current Score** | **Previous Test Date** | **Previous Test Score** |
| | | | | |

## CURRENT MALADAPTIVE BEHAVIORS

(1) **Behavior** _____ **Freq** _____ per ☐ hour ☐ session ☐ day or ☐ week

(2) **Behavior** _____ **Freq** _____ per ☐ hour ☐ session ☐ day or ☐ week

(3) **Behavior** _____ **Freq** _____ per ☐ hour ☐ session ☐ day or ☐ week

(4) **Behavior** _____ **Freq** _____ per ☐ hour ☐ session ☐ day or ☐ week

## MEMBER TREATMENT PLAN

| **Member Skill Acquisition Goals**<br>(focusing on the development of spontaneous social communications, adaptive skills and appropriate behaviors) | **Enter Total Number** |
|---|---|
| New goals | |
| Goals carried over from previous authorization period | |
| Goals on hold | |
| Goals mastered during the previous authorization period | |
| Other (describe): | |

A B A

Patient Name _____ Patient Date of Birth _____

## PARENT INVOLVEMENT

The parent/caregiver is expected to participate in training sessions _____ hours per week.

| | Intro Date | Baseline (%) | Measurable Parent Training Goals | Current Progress/Data (%) | Expected Mastery Date |
|---|---|---|---|---|---|
| **1** | | | | | |
| **2** | | | | | |
| **3** | | | | | |

## TREATMENT FADE/ TRANSITION/ DISCHARGE PLAN

**Member's Fade Plan:** Member will step down from current _____ hrs/week to _____ hrs/week, on date _____ or within _____ months.

Measurable Fade Plan with Criteria

**Discharge Plan with Objective and Measurable Criteria**

Other referrals/supports recommended at time of discharge

**Parent/Caregiver in agreement?** ☐ Yes ☐ No

Patient Name _____ Patient Date of Birth _____

| Member ABA Schedule | | | |
|---|---|---|---|
| **Day of Week** | **Time Span** | **Location** | **Lunch / Breaks** |
| **Monday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ | ☐ Office/Clinic ☐ Home<br>☐ Community/ Daycare ☐ School<br>☐ Other_____ | |
| **Tuesday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ | ☐ Office/Clinic ☐ Home<br>☐ Community/ Daycare ☐ School<br>☐ Other_____ | |
| **Wednesday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ | ☐ Office/Clinic ☐ Home<br>☐ Community/ Daycare ☐ School<br>☐ Other_____ | |
| **Thursday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ | ☐ Office/Clinic ☐ Home<br>☐ Community/ Daycare ☐ School<br>☐ Other_____ | |
| **Friday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ | ☐ Office/Clinic ☐ Home<br>☐ Community/ Daycare ☐ School<br>☐ Other_____ | |
| **Saturday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ | ☐ Office/Clinic ☐ Home<br>☐ Community/ Daycare ☐ School<br>☐ Other_____ | |
| **Sunday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ | ☐ Office/Clinic ☐ Home<br>☐ Community/ Daycare ☐ School<br>☐ Other_____ | |

| Member School and Other Therapy Schedule | |
|---|---|
| **Day of Week** | **Time Span** |
| **Monday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ |
| **Tuesday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ |
| **Wednesday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ |
| **Thursday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ |
| **Friday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ |
| **Saturday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ |
| **Sunday** | Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____<br>Time ___:_____ to ___:_____ |

| **Supports Outside ABA Treatment** | |
|---|---|
| | **Member accessing other school program?** ☐ Public ☐ Private ☐ Home ☐ Other (Specify) _____<br>**Member has IEP, ISP, 504 or ARD in place?** ☐ Yes ☐ No If no, why not?<br><br>**Is this member accessing other therapeutic services?** ☐ Physical Therapy ☐ Occupational ☐ Speech ☐ NA<br>**Is there coordination of care with other medical or BH providers?** ☐ Yes ☐ No; Those are _____ |

Please submit any relevant clinical information to support the services rendered at a location other than office or home. Add this information to the first page of the attached clinical documentation.

A B A