OKLAHOMA
Health Care Authority

APPLIED BEHAVIOR ANALYSIS (ABA)

EXTENSION PRIOR AUTHORIZATION REQUEST

(This form must be filled out completely or your request will be considered as incomplete, will receive a technical denial, and will require resubmission)

Request type:	Extension
Date of request:	

Provider Name:	Provider ID w/service Loc:

Treating BCBA email address:	BCBA phone number:
Name of BCBA:	Member ID:
Primary clinic email address:	Primary clinic phone number:
Member name:	Member age and DOB:
Date of comprehensive diagnostic evaluation/assessment/provider:	Custodial agency (i.e., DHS, OJA, N/A):
(***Comprehensive diagnostic evaluation/ assessment must be completed prior to start of services and copy included with the initial request)***	Custody status (temporary, permanent, no involvement with state custody):

Will ABA treatment service be provided in-person via telehealth or hybrid by the BCBA?	How often will the BCBA provide services via telehealth? How often will the BCBA provide services 1:1 to the member and for what duration of time?
How often will the treating BCBA provide 1:1 in person supervision of the treating RBT(s) or BCaBA(s) (cpt code 97155) for this member and for what duration of time?	How often will the treating BCBA provide 1:1 telehealth supervision of the treating RBT(s) or BCaBA(s) (cpt code 97155) for this member and for what duration of time?
Please identify the RBT(s) and/or BCaBA(s) that worked or working with the member through the authorization period. (Note: OHCA understands this may change through the authorization period.)	

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Estimated duration of ABA services based on current deficits/maladaptive behaviors (planned time from initiation of care to completion, in months:

Requested Start Date:	Requested End Date (date cannot exceed 6 months per authorization period)	Hours requested per week for each CPT code:	Frequency requested (i.e., high, moderate, targeted, maintenance):

DSM-5 diagnoses with accompanying specifiers (e.g., 299.00 autism spectrum disorder). The primary diagnosis must be ASD-related.

Diagnoses:
Primary Diagnosis Code:
Diagnosis Description:
Diagnosis Code:
Diagnosis Description:

Does the member have a primary insurance? If so, please identify the primary insurance information. Does the primary insurance cover ABA? If so, please provide prior authorization letter of hours approved or showing ABA is not a covered benefit?
Is member transitioning back from a managed care entity (i.e., Aetna, Humana, Oklahoma Complete Health)? If so, please attach a copy of the prior authorization letter showing dates and hours of previous approval.

Is member transitioning back from a managed care entity (i.e., Aetna, Humana, Oklahoma Complete Health)? If so, please attach a copy of the prior authorization letter showing dates and hours of previous approval.
List the guardian's name and relationship to member including their address and phone number. If DHS/OJA involvement, list caseworker contact info including email address.
Has the frequency of the targeted behaviors diminished since the last review? If not, what modifications have been made to the treatment plan and treatment environment to address behaviors. (i.e., an increase in parent training, specific modifications to the behavior support plan, etc.)?
Has there been a change in staff since the last review period? How has this contributed to any change in atypical or maladaptive behaviors?

Has the member started any additional services since the last review period (i.e., OT, PT, Speech, BH outpatient counseling, school-based services via an IEP, etc.)? If so, please list them below, including the days and times.
What medications is the member on? Has the member, started any new medications? Please list below.
Is this prior authorization request for school-based services? (Note: ABA is not reimbursable by Medicaid in a school setting and is only approved on a time limited basis when a member is transitioning from clinic back to school or from an inpatient stay.)
If member attends school, what days and times? What days and times does member attend ABA treatment?

Targeted Behaviors for Reduction

Have additional deficits, atypical or maladaptive behaviors been identified within the last review period that will be added to the treatment plan?
Describe how the ABA treatment specifically improved the member's deficits, atypical or disruptive behaviors over the last review period (e.g., improvements in communication, following directives, disruptive behaviors, pica, self-injury, intentional property destruction, etc.).

Parent Training

How many parent trainings were scheduled for this review period? How many trainings did the parent/legal guardian attend this review period? If the parent/legal guardian missed any parent training, please give the detailed reason(s) why. Include dates offered to make up for parent training.
Is the parent/legal guardian meeting their goals? If not, what is being done to further assist them?
If parent/legal guardian was unable to attend 85% of sessions, please explain why? What efforts have been made to work with the parent/legal?

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Current FBA completed:	Conducted by (name):	License:
Current Assessment instrument:	**Current/This Episode Test Date:**	**Current Score:**
Previous Assessment Instrument:	**Previous Test Date:**	**Previous Test Score:**

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 instruments such as VBMAPP, ABLLS, or the Vineland. (Please include summary below, full attachment is not necessary)

Developmental Functioning Assessments

List assessment domain(s) below (i.e., communication, social skills, sensory, etc.) and test score/history to the right.	1st Test Score Date:	2nd Test Date:	3rd Test Date:	4th Test Date:	5thTest Date:	6th Test Date:	Current % of the Domain

Describe the member's progress made during the last review period, regarding treatment goals. Please attach a copy of the updated treatment plan, FBA, and behavior support plan if applicable, and any additional assessments to support medical necessity criteria.

Treatment Fade/Discharge Plan: Please identify when member will step down from current hours? Identify what realistic goals the member will need to accomplish over this extension period to start a fade plan to discharge.