BlueCross BlueShield
Federal Employee Program

Prior Authorization Request Form	*Applied Behavioral Analysis (ABA)*
Standard Fax Number: 1 (855) 895-3504	**Urgent Fax Number:** 1 (844) 244-0226

Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for medical requests and requests for medications covered under the medical benefit. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Notice: The Federal Employee Program has a 15 Calendar Day turn-around time on all Standard Prior Authorization Requests according to the Blue Cross Blue Shield Service Benefit Plan. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

☐ **New Standard Request** ☐ **New Urgent Request**

Important For Urgent Requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. ***If there is no MD signature present the request will be processed as a Standard request.***

MD Signature REQUIRED For Urgent Requests Only:

☐ **Modification Or** ☐ **Extension Requests Complete the Section Below:**

Date Last Authorized:	Previous Authorization Number:
MD/NP/PA justification for modification or extension:	

Patient Information:

First Name:	Last Name:
Date of Birth:	ID Number:
Address:	

Referring/Prescribing Provider:

Name:			NPI:	
Street Address + Suite #:			Email address:	
City:	State:	Zip:	Phone:	Fax:
Type of Provider: ☐ PCP ☐ Specialist Type:			Contact Name and Phone Number:	

Servicing/Billing: Provider/Vendor/Lab *If same as Referring/Prescribing Provider Check Here* ☐

Name:			NPI:	
Street Address + Suite #:			Email address:	
City:	State:	Zip:	Phone:	Fax:

Specialist Type:	Contact Name and Phone Number:

If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:

Group Name:		NPI:
Street Address + Suite #:		
City:	State:	Zip:

Billing Facility (If Applicable):

Facility Name:	NPI:
Street Address + Suite #:	

City:	State:	Zip:	Phone:	Fax:

Contact Name and Phone Number:

Anticipated Date of Service:	**If Lab, Draw Date:**

Place of Service: (Check One Box Only or If typing replace box with an "X"):

☐ Office	☐ Home	☐ On Campus OP Hosp
☐ Acute Rehab	☐ Hospice	☐ PHP
☐ Ambulance- Air or Water	☐ Independent Clinic	☐ RTC – Psychiatric
☐ Ambulance-Land	☐ Independent Laboratory	☐ RTC – SUD
☐ Ambulatory Surgical Center	☐ Inpatient Hospital	☐ Skilled Nursing Facility
☐ Assisted Living Facility	☐ Intermediate Care Facility	☐ Telehealth
☐ Birthing Center	☐ IOP	☐ Urgent Care Facility
☐ Custodial Care Facility	☐ IP Psychiatric Facility	☐ Other - Please Specify:
☐ End Stage Renal Disease TX	☐ Nursing Facility	
☐ Group Home	☐ Off Campus OP Hosp	

Please enter all codes requested; unlisted codes must have a description.
Please include the quantity for each code requested and if applicable, left, right or bilateral designations.

ICD-10 Code(s):

CPT/HCPC Code(s):

For questions: Call FEP Authorization Requests Phone Number: 1 (800) 633-4581

Please provide the following documentation

Date ABA services began *(Please include initial start of ABA services after initial DX of Autism):*

Name of assessment tool utilized to determine the above DSM-5 diagnosis and date of Dx:

Location of current services: ☐Home ☐Office ☐Community ☐School ☐Other:

Is this member currently enrolled in school with an IEP? ☐Yes☐No *If "No" please provide rationale why there is no IEP in place. Also, include what the family's plan is to have the member enrolled in school/ IEP.*

Criteria to Initiate Care*

Please attach the following information to this request

- An established and current (within 24 months) DSM-5 diagnosis of Autism Spectrum Disorder using validated assessment AND the scores from the tools utilized to make that diagnosis or ABA therapy within the past 90 days.
- Developmental assessment has been completed within the last 12 months using validated assessment tools (e.g. Vineland, ABAS). Data must be included that demonstrates the standard deviation for each skill area.
- A current care plan that reflects:
  - The caregiver's level of participation in the proposed plan of care
  - Specific, quantifiable goals that relate to developmental deficits or behaviors that pose a significant risk of harm to the recipient or others
  - Objective, observable, and quantifiable metrics that are or will be utilized to measure change toward the specific goal behaviors
  - Collaboration of Care: Documentation that adjunctive treatments (e.g., psychotherapy, social skills training, medication services, educational services, PT, OT, SLP) have been considered for inclusion in the treatment plan, with the rationale for exclusion
  - Discharge Criteria and Transition Plan- Note: It is imperative that a realistic exit criterion is established. Please factor in all the facets above when creating the transition plan/exit criteria versus non-specific or unrealistic future expectations.

Criteria for Continued Care*

Follow-up documentation should include:

- Date that ABA therapy was initiated. What services have been provided and at what intensity (hours of service per week)?
- Updated documentation that reflects progress toward goals utilizing objective, observable, and quantifiable metrics.
- Developmental assessment has been completed within the last 6 months using validated assessment tools (e.g. Vineland, ABAS). Data must be included that demonstrates the standard deviation for each skill area and results must reflect that the eligible recipient still cannot participate at an age appropriate level because of the presence of behavioral excess and/or the absence of functional skills.

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Criteria for Continued Care*

Follow-up documentation should include:

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- Documentation that the recipient's caregivers demonstrate continued commitment to participation in the recipient's treatment plan and demonstrate the ability to apply those skills.
- Documentation that the behavior issues are not exacerbated by the treatment process.
- Documentation that the recipient has the required cognitive capacity to benefit from the care.
- Collaboration of Care: Documentation that adjunctive treatments (e.g., psychotherapy, social skills training, medication services, educational services, PT, OT, SLP) have been considered for inclusion in the treatment plan, with the rationale for exclusion
- Discharge Criteria and Transition Plan- Note: It is imperative that a realistic exit criterion is established. Please factor in all the facets above when creating the transition plan/exit criteria versus non-specific or unrealistic future expectations.

*Current/Proposed Service Schedule

Time	Day	Location	ABA Goals / Skills Addressed	People Involved to Address Goal

View our Medical Policy online at https://www.fepblue.org/legal/policies-guidelines