CLEAR FORM

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Applied Behavior Analysis
(97153, 97154, 97155, 97156, 97157, 97158, 0373T)
Concurrent Service Authorization Request Form

Effective Dates of Service 09/01/2025 and after.

Please be mindful of notes throughout this form providing reference to where documentation obtained during the Comprehensive Needs Assessment (CNA) are relevant and can be used for efficiency.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		LBA/LMHP NPI #:	
Member Date of Birth:		Provider Tax ID #:	
Gender:		Provider Phone:	
Member Plan ID #:		Provider E-Mail:	
Member Street Address:		Provider Servicing Address:	
City, State, ZIP:		City, State, ZIP:	
Member Phone #:		Provider Fax:	
		Clinical Contact Name and Credentials*:	
Parent/Legal Guardian Name (s):		Clinical Contact Phone #:	
Parent/Legal Guardian Phone #:		* *The individual to whom the health plan can reach out to in order to gather additional necessary clinical information.*	

Request for Approval of Services	
Retro Review Request? ◯ **Yes** ◯ **No**	
If the member is currently participating in this service, start date of service:	

Proposed/Requested Service Information:

From _____ (date), To _____ (date)

All concurrent service authorization requests must include all of the following completed documentation:

1. Concurrent Service Authorization Request Form
2. All items required in all sections of this form

In addition to the above requirements, all requests exceeding 20 hours (80 units) or more per week, must include the following

1. *The schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the behavior modification plan. This schedule must be written in the "Sechedule" Section at the end of the form or uploaded with the service authorization form.

***Please note:** Each session must clearly be related to the successful attainment of the treatment goals. The therapeutic function of all scheduled sessions must be clearly defined regarding the number of hours requested. Schedules must be individualized. A general schedule of clinic-based activities is not sufficient to meet this requirement. Clinic-based schedules must also distinguish between time the individual spends in therapeutic interventions and time spent in recreational and non-therapeutic activities/non-reimbursable activities.

Member Full Name: Medicaid #:

CPT Code	Unit	Description	Provider qualifications	Total Daily Hours/Days Per Week	Total Weekly Hours	Total Hours: (Total Weekly hours (x) number of weeks requested	Total Units Requested (Total Hours (x) 4)	Notes
Example: 97153	per 15 min	Adaptive behavior treatment by protocol	Qualified staff	2 hours/5 days	10 hours	240 hours (24 weeks requested)	960 Units	
97153	per 15 min	Adaptive behavior treatment by protocol	Qualified staff					
97154	per 15 min	Group adaptive behavior treatment by protocol	Qualified staff					
97155	per 15 min	Adaptive behavior treatment with protocol modification	LBA/LMHP[1]/ LABA[2] May also include technician and/ or caregiver. (technician billed separately					
97156	per 15 min	Family adaptive behavior treatment guidance	LBA/LMHP[1]/ LABA[2]					
97157	per 15 min	Multiple-family group adaptive behavior treatment guidance	LBA/LMHP[1]/ LABA[2]					
97158	per 15 min	Group adaptive behavior treatment with protocol modification	LBA/LMHP[1]/LABA[2] Youth also has assigned 1:1 technician (technician not billed separately)					
0373T	per 15 min	Adaptive behavior treatment with protocol modification	Two or more technicians and LBA/LMHP[1]/LABA[2] (team rate)					

Medication Update			
Name of Medication	Dose	Frequency	For any changes, note if: New, Ended or Changed in dose/frequency from last authorization

SECTION I: CARE COORDINATION

Please list all medical/behavioral services or community interventions/supports the individual has participated in since the last Authorization, as well as any changes:

Name of Service/Support	Provider Contact Info	Frequency	*For any changes, note if:* New, Ended or Changed in frequency/intensity from last authorization

Describe Care Coordination activities with these other services/supports since the last authorization.

SECTION II: TREATMENT PROGRESS

Along with this document, please include the following:

1. Original Comprehensive Needs Assessment (CNA), and an addendum to the CNA (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery,
2. Updated Individual Service Plan (ISP) that reflects the current goals and interventions,
3. A summary of youth's treatment progress that contains the following:
   - Graphical presentation of progress on each goal and objective in the ISP;
   - Overview of family involvement during service period with regards to the youth's ISP to include: who has been involved; progress made: and continuing needs of family goals/training to include reasons the youth and parent/caregiver need continued ABA;
   - A summary of progress towards generalization of adaptive functioning in multiple settings to include assessing for maintenance of the skills acquired and updating the ISP as needed to test for generalization of skills in multiple environments;
   - Progress toward the anticipated date of discharge from services including any plan to gradually reduce services and consultative actions as planned to include identifying lower levels of care, natural supports care coordination needs.

As a reminder, this ISP should include the following information:

- **Treatment goals** designed with the individual that are person-centered, recovery-oriented, and trauma-informed.
  - Service providers should write these goals in collaboration with the individual and thus the goals should use words that are understandable and meaningful to the individual.
  - Treatment goals should leverage individual strengths and should address barriers to participation in care.
  - If the individual has experienced trauma, the provider should assure that interventions reflect and address the impacts of those experiences.
- **Objective Measures** for each treatment goal to monitor and demonstrate progress.
  - The metrics used for these objectives should be meaningful and relatively easy to track.
  - Avoid use of percentages unless that percent completion is obvious and easily computed.

- Objectives should include frequency counts of observable behaviors and severity ratings of behavior if these ratings have established anchors on a scale to support accuracy (e.g. 0 = not observed/experienced in the last week, 5 = observed/experienced nearly all day, every day this week). Frequency ratings can indicate severity, but not in all cases and so measuring both how often problem behaviors are happening as well as how severe or impairing they are allows for optimal tracking of progress.
- Description of how this objective will be measured (e.g. how often will they be measured and by whom, how will the tracking be logged and where)
- Standardized, evidence-based assessments (or composite scales) are acceptable so long as they reflect the goal being measured. (E.g. Goal is related to reduction of depression symptoms and then measured by the Personal Health Questionniare-9 (PHQ-9)).

- **Interventions** that seek to address the needs for services and support progress towards specific goals.
  - Providers should describe interventions in terms of the activities involved, the skills these activities promote/develop, and any necessary adaptations to standard intervention that will be necessary for this individual's culture, identity, or personal preferences.
  - Interventions should seek to achieve or maintain stability in the least restrictive environment possible. Thus, if a provider conducts an intervention in a more restrictive than natural environment (e.g. clinic), part of the intervention should be to translate the use of skills to the least restrictive environment (e.g. community).
  - If more than one provider type is involved in the delivery of the service, the provider should list interventions specific to the scope of each relevant provider type in addressing the treatment goal and measuring progress.
- **Dosage of Intervention**
  - Treatment plan should include a description of the frequency in terms of days/hours the providers will deliver the interventions.
- **Treatment Progress**
  - Providers should describe progress in terms of the identified goals and objectives.
  - Providers should describe any alterations in goals or whether new goals have been established and why.
  - Goals and measurement may change over time as the provider's understanding of the problem evolves and/or as the individual may disclose new information or exhibit new behaviors that impact goals.
  - Continued stay authorization requires explanation of how the plan is evolving and how it will support recovery for the individual.
- **Resources and Strengths**
  - The treatment plan should include individual strengths, preferences, and resources that the individual identifies as relevant to their recovery.
- **Barriers**
  - The treatment plan should include a list of ongoing or evolving barriers to treatment, additional resources that would support the individual in overcoming these barriers, and a plan for how to address them.

Section III: RECOVERY & DISCHARGE PLANNING

Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge from services should begin at the first contact with the individual. Recovery planning should include discussion about how the individual and service providers will know that the individual has made sufficient progress to move to a lower, less intensive level of care or into full recovery with a maintenance plan. ***These responses should reflect any updated understanding of the recovery and discharge plan since the last review.***

What would progress/recovery look like for this individual?

What barriers to progress/recovery can the individual, their natural supports, and/or the service provider identify?

What types of outreach, additional formal services or natural supports, or resources will be necessary to reach progress/recovery?

At this time, what is the vision for the level of care this individual may need at discharge from this service?

What is the best estimate of the discharge date for this individual?

By my signature (below), I am attesting that 1) an LMHP, LMHP-R, LMHP-S, LMHP-RP or LABA has reviewed the individual's psychiatric history and completed the appropriate assessment or addendum; and 2) that this assessment indicates that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on the following date(s): _____

Signature (actual or electronic) of LMHP (Or R/S/RP or LABA): _____

Printed Name of LMHP (Or R/S/RP or LABA): _____

Credentials: _____

Date: _____

Member Full Name: Medicaid #:

Schedule (20 Hours or more)

Notes