**DEPARTMENT OF SOCIAL SERVICES**
DIVISION OF MEDICAL SERVICES
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PIERRE, SD 57501-2291
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DSS
Strong Families - South Dakota's Foundation and Our Future

# APPLIED BEHAVIOR ANALYSIS THERAPY PRIOR AUTHORIZATION REQUEST FORM

Form must be ***submitted with medical records*** to support services.

| | | |
|---|---|---|
| **Date:** | **Select ABA Service Category:** | |
| **RECIPIENT INFORMATION** | | |
| **Medicaid ID (9 digits):** | **Date of Birth:** | **Sex:** ☐ M ☐ F |
| **Last Name:** | **First Name:** | |
| **ABA THERAPY PROVIDER INFORMATION** | | |
| **ABA Therapy Provider Name:** | | |
| **ABA Provider NPI:** | **ABA Provider Taxonomy:** | |
| **ABA Provider Address:** | | |
| **Point of Contact Name and Title:** | | |
| **Fax:** | **Phone:** | |
| *NOTE: The determination notice will be sent to the listed point of contact.* | | |

| |
|---|
| **APPLIED BEHAVIOR ANALYSIS THERAPY ASSESSMENT** |
| *This section must be completed for the ABA Therapy Provider to perform an ABA Assessment for services.* |
| **Diagnosing Physician Name:** |
| **Diagnosing Physician NPI:** **Taxonomy:** |
| **Date of Diagnosis:** |
| **Name of Evidence-Based Evaluation Diagnosis Instrument(s):** (Attach a copy to this request) |
| **Autism Spectrum Disorder (ASD) Diagnosis:** |

## APPLIED BEHAVIOR ANALYSIS CARE PLAN AND DIRECT SERVICES

*This section must be completed for the initial provision of ABA care plan and direct therapy services. This section should be completed for each 6 month re-authorization of services.*

**Name of Standardized ABA Assessment(s) used by ABA Therapy Provider:** (Attach assessment results to this request)

## CARE PLAN

**Date of Care Plan:**

☐ **I certify that an individualized care plan has been completed and attached for the recipient on this form. The care plan contains the following information:**

- Description of target ASD behavior(s) and goal behavior(s);
- Measurable behavior treatment goal(s);
- Method or treatment protocol intended to decrease target ASD behavior(s) and implement goal behavior(s);
- Criteria to be used for objective assessment of progress towards behavior Treatment goals; and
- Frequency of assessment of criteria towards progress of behavior treatment goals.

**Anticipated Duration of Services:**

**Discharge Plan:** (if services expected to end in the next 6 months)

## DIRECT SERVICES

| CPT Code | Service | Unit Measure | Planned Units | | |
|---|---|---|---|---|---|
| | | | Week | Month | 6 Months |
| 0364T 0365T | Adaptive behavior treatment by protocol. | 30 min. | | | |
| 0366T 0367T | Group adaptive behavior treatment by protocol | 30 min. | | | |
| 0368T 0369T | Adaptive behavior treatment w/ protocol modification | 30 min. | | | |
| 0370T | Family adaptive behavior treatment guidance | Encounter | | | |
| 0371T | Group family adaptive behavior treatment guidance | Encounter | | | |
| 0372T | Group adaptive behavior treatment social skills group | Encounter | | | |

## RE-AUTHORIZATION OF ABA DIRECT SERVICES

**INDICATE RECIPIENT'S PROGRESS TOWARDS BEHAVIOR GOALS:_____%____**
Attach evidence of progress during pervious 6 month period if not included in the care plan.

**INDICATE ANY PROPOSED TREATMENT INTERVENTIONS OR MODIFICATIONS:** If no modifications are being made to the care plan, please include justification for continued care plan services.

**OTHER COMMENTS RELATED TO RECIPIENT CARE:**

☐ I certify that the information given in this form is a true and accurate medical indication for the procedure(s) required. There is no other equally effective treatment available which is more conservative or substantially less costly (ARSD 67:16:01:06.02). All other treatment to correct this problem has been exhausted.

**PROVIDER NAME:** _____

**PROVIDER SIGNATURE:**_____ **DATE:** _____

REMEMBER TO ATTACH ANY SUPPLEMENTAL MATERIALS/ATTACHMENTS TO THIS FORM BEFORE SUBMITTING TO SOUTH DAKOTA MEDICAID.