PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

CLEAR FORM

VIRGINIA'S MEDICAID PROGRAM DMAS

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Applied Behavior Analysis (97155, Et al.)
INITIAL Service Authorization Request Form

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. ***For all requests exceeding 20 hours (80 units) or more per week, please submit with (or write in note section) the service authorization request the schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the behavioral modification plan.***

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 Address:	
City, State, ZIP:		City, State, ZIP:	
Member Phone #:		Provider Fax:	
		Clinical Contact Name and Credentials*:	
Parent/Legal Guardian Name (s):		Phone #	
Parent/Legal Guardian Phone #:		* *The individual to whom the MCO 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), for a total of _____ units of service.

Plan to provide _____ hours of service per week.*

***For all requests exceeding 20 hours (80 units) or more per week, submit the schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the behavioral modification plan.**

Identify all known treatment periods of Applied Behavior Analysis (or Behavior Therapy) that have been provided by any providers including the requesting provider in the past 12 months:

Provider	Dates of Service/Intervention	Outcomes

Primary ICD-10 Diagnosis	
Secondary Diagnosis(es)	

Other medical/behavioral health concerns (including substance use issues, personality disorders, dementia, cognitive impairments) that could impact services? ☐ Yes ☐ No (If yes, explain below.)

SECTION I: ADMISSION CRITERIA

Individuals must meet ALL of the criteria #1-3; note that some criteria have multiple sub-criteria for consideration.

1. Specify the DSM diagnosis or provisional diagnosis corresponding with the ICD-10 diagnosis(es).

Describe the individual's current symptoms (including frequency, intensity and duration) and areas of functional impairment. Corresponding CNA Elements: 1, 6, 7, 12

Preliminary Treatment Goal #1: *Create a goal related to one or more of the symptoms noted above.*

2. Within the past 30 calendar days, the youth has demonstrated **at least two** of the following:	
A. Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalic speech, impairment in receptive and/or expressive language. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.*	☐ Yes ☐ No
Preliminary Treatment Goal #2A: *Create a goal related to the difficulties with communication.*	
B. Severe impairment in social interaction /social reasoning /social reciprocity/ and interpersonal relatedness. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.*	☐ Yes ☐ No
Preliminary Treatment Goal #2B: *Create a goal related to the difficulties in social interaction, reasoning, reciprocity and interpersonal relatedness.*	

C. Frequent intense behavioral outbursts that are self-injurious or aggressive towards others. *Describe any repeated occurrences of behaviors that are endangering to self or others, are difficult to control, cause distress, or negatively affect the youth's health.*	☐ Yes ☐ No
Preliminary Treatment Goal #2C: *Create a goal related to the difficulties with intensive behavioral outburst.*	
D. Disruptive, obsessive, repetitive, or ritualized behaviors. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.*	☐ Yes ☐ No
Preliminary Treatment Goal #2D: *Create a goal related to the difficulties with disruptive, obsessive, repetitive or ritualized behaviors.*	

E. Difficulty with sensory integration. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.*	☐ Yes ☐ No
Preliminary Treatment Goal #2E: *Create a goal related to the difficulties with sensory integration.*	

3. Please provide information on the identity and relationship of any identified family member(s)/caregiver(s) available to participate in ABA services with the youth.

Section V: RECOVERY & DISCHARGE PLANNING

Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge 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 member has achieved sufficient progress to move to a lower, less intensive level of care or into full recovery with a maintenance plan.

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: _____

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 #:

Notes