BlueCross BlueShield of Texas

Applied Behavior Analysis (ABA)

Managed Care/Concurrent Review – Page 1

For any questions, call BCBSTX at 800-528-7264 or BCBSTX FEP at 800-528-7264. Fax Forms to 877-361-7646.

Instructions: For the **Managed Care/Concurrent Request (MCCR)** for ABA Services, submit only completed pages #1-3, & a Member Treatment Schedule.

FEP Members Only: Submit **MCCR** forms #1-3, Member Training Schedule, Provider Baseline and Skills Assessment Instruments, & Comprehensive Treatment Plan.

PATIENT INFO

Patient Name:	Date of Birth: ____ /____ /_____	Today's Request Date: ____ /____ /_____
Subscriber Name:	Subscriber ID#:	Group #:
Patient resides in what state?	Services conducted in same state? ☐ Yes ☐ No ☐ If no, what state?	

AUTHORIZATION/COMMUNICATION SENT TO

Facility/Provider Name:		Facility/Provider NPI#:	
Street Address:	City:	State:	Zip Code:
Telephone #:	Fax #:	Email Address:	Office Contact:

PROVIDER TREATMENT REQUEST

DX Code or Description: Primary _____ Secondary _____ For ASD DX: ☐ Level 1 ☐ Level 2 ☐ Level 3

BCBS Expectation: Diagnostic Assessment is conducted within 24-36 months of this request. Please include any new diagnostic assessment with these forms.

Treatment Request Start Date ____ / ____ / _____ | Requested Service Intensity: ☐ Focused ☐ Comprehensive

Total Requested Hours Per Week _____ ((Note: 0359t assessment code (for full clinical assessment) will be authorized every 6 months.))

Provider Request Service Hours	t codes	0360t	0361t	0364t	0365t	0366t	0367t	0368t	0369t	0370t	0371t	0372t	Total
	Hrs/wk												

Add'l Code(s) Request and Reason:

Medical History

Sleeping Issues? ☐ Yes ☐ No If yes, please describe:

Eating Issues Related to ASD? ☐ Yes ☐ No If yes, please describe:

Meds? ☐ Yes ☐ No If yes, prescribed by:

Please list (medications/dosages):

PARENTAL INVOLVEMENT

How many hours/week is the parent/caregiver expected to participate in training sessions? _____/ week.

Is the caregiver participating in expected training sessions and meeting their goals? ☐ Yes ☐ No

Are the parents/caregivers utilizing skills from training sessions with their family member outside of therapy? ☐ Yes ☐ No

Supports Outside ABA Treatment

Member accessing other program services? ☐ School Based ☐ Educational ☐ NA ☐ Other: _____

Member has IEP, ISP, or ARD in place? ☐ Yes ☐ No If no, why not? _____

Is this member accessing other therapeutic services? ☐ Physical Thrpy ☐ Occupational Thrpy ☐ Speech Thrpy ☐ NA

Is there coordination of care with other medical or BH providers? Those are: _____

Is the family accessing community supports? Which ones:_____

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Managed Care/Concurrent Review – Page 2

Patient Name:	Date of Birth: ____ /____ /_____	Today's Request Date: ___/____/_____

BASELINE & ASSESSMENT INFO

Current Assessment Completed: __ / __ / ____	Conducted by (name):	License/Cert:

Assessment Participants: ☐ Patient Only ☐ Parents/Caregivers ☐ Patient, Parents/Caregivers

Current Assessment Instrument:	Current/This TX 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 instrument such as the VB Mapp, ABLLS, and the Vineland. Also, please attach standardized measurement scoring summaries if the member has been in treatment prior to this request. If changing instruments for reasons such as age or skills measured, please note the current/new assessment and previous assessment above.

DEVELOPMENTAL FUNCTIONING ASSESSMENT

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 Score Date__/__/___	3rd Test Score Date__/__/___	4th Test Score Date__/__/___	5th Test Score Date__/__/___	__th (Latest) Score Date__/__/___	Current % of this Domain

CURRENT MALADAPTIVE BEHAVIORS

(1) Behavior: _____ Freq _____ per ☐ day or ☐ week

(2) Behavior: _____ Freq _____ per ☐ day or ☐ week

(3) Behavior: _____ Freq _____ per ☐ day or ☐ week

(4) Behavior: _____ Freq _____ per ☐ day or ☐ week

(5) Other significant behaviors: _____ Freq _____ per ☐ day or ☐ week

Coordination of Care – Please list the BH or medical providers you are coordinating care for this member, or the reason why this is not occurring:

Requirement: Attach Member's Weekly Therapy and School Schedule Documentation

Note: BCBSTX only authorizes actual ABA service time. The ABA benefit will not cover: 1) ABA when simultaneously involved in other activities such as school time, other therapeutic supports, naptime, meals, breaks, etc.; 2) services that appear to be shadowing in nature; and 3) services to be provided by the school.

Approved ABA services in any setting must be consistent with services they would receive in a clinic setting. BCBSTX does not cover duplicate services.

1. **Please provide the member's schedule for ABA treatment, school (if school-age), other therapeutic supports (OT, ST, PT).**
2. **The IEP, ISP, or ARD may be requested to confirm services provided by the school.**
3. **If you have an existing member schedule with the information/elements noted in Member Schedule Form, you may submit that. If not, please use Schedule Form.**

Managed Care/Concurrent Review – Page 3

Patient Name:	Date of Birth: ____ /____ /_____	Today's Request Date: ____ /____ /_____

CONCURRENT TREATMENT PLAN

Goal:	Measurable Goals	Expected Goal Achievement (%)
1		_____ %
2		_____ %
3		_____ %
4		_____ %
5		_____ %

TREATMENT FADE/DISCHARGE PLAN

Member's Fade Plan: Member will step down from current hrs/week _____ to _____ hrs/week, on date ___ / ___ / _____ or within these # of _____ months. If the attainment of an assessment score is instrumental in a fading/discharge activity and plan, please include below. The member will have accomplished the following to start a fade plan to discharge:

Parent/Caregiver in agreement? ☐ Yes ☐ No Other referrals/supports recommended at time of fading or discharge:

My signature confirms that I am providing/supervising the requested ABA services:

ABA Supervisor Signature: _____ Date: ____ / ____ / _____

ABA Supervisor Printed Name: _____ Clinic Name: ____ / ____ / _____