Early Intensive Behavioral Intervention (EIBI) Services Prior authorization Request Form

BlueCross BlueShield Minnesota

Type of review: ☐ Initial ☐ Concurrent

All components of the diagnostic assessment for autism spectrum disorders AND psychological testing, as described in the Blue Cross and Blue Shield of Minnesota Medical Policy X-43, must be completed before EIBI services can be approved. Providing complete information will help expedite this review. Please send a copy of the most recent assessment and testing results with interpretations with this form.

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers are required to use the Availity Essentials® Provider Portal to submit pre-service prior authorization requests. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross**. Please complete the clinical sections on this form and attach it to your request at **Availity.com/essentials** to ensure a timely review.

Providers outside of Minnesota or without electronic access can fax this form and complete clinical records to support the request to (651) 662-0854.

Member Information

Member ID: _____ Date of birth: _____

Member name: _____

Member address: _____

City/state/ZIP: _____

Member phone: _____

Please answer the following questions if the patient is age 6 or above:

School attended in the past (check one): ☐ No ☐ Part-time ☐ Full-time

- If part-time or full-time, dates: _____ hours per day: _____

School attending currently (check one): ☐ No ☐ Part-time ☐ Full-time

- If part-time or full-time, hours per day: _____

Indicate coordination plan with educational system: _____

Provider Information

Contact person: _____

Phone: _____ Fax: _____

Clinic name: _____Clinic ID number: _____

Clinic NPI number: _____

Individual provider ID/NPI number: _____

Individual provider name: _____ Degree/Lic: _____

Provider address: _____

City/state/ZIP: _____

Supervising mental health professional name/credentials: _____

List all diagnosis and ICD-10 codes: _____

List ALL medications and dosages: _____

Is the member medication compliant? ☐ Yes ☐ No

List all supplements (vitamins, herbals, etc.): _____

Date ABA therapy started under any provider: _____

Date ABA therapy started with current provider: _____ Number of sessions to date: _____

Date range for authorization request: _____ through _____

Requested number of hours per week: _____ Estimated length of treatment: _____

Parent/guardian authorizes treatment: ☐ Yes ☐ No

Parent education and support services available: _____

Treatment Plan

Service Codes with Description	Specify Hours per Week	Units	From Date	To Date

As stated in Medical Policy X-43 for initial requests, please include:

Component	Included? Yes or No	Date of Assessment
Diagnostic assessment within the past 12 months with assessments by independent licensed psychologist or physician, that includes:	☐ Yes ☐ No	
• Assessment of symptoms of autism spectrum disorder (e.g., ADOS; ADI-R)	☐ Yes ☐ No	
Adaptive Behavior Assessment (e.g., Vineland Adaptive Behavior Scales, Adaptive Behavior Assessment System)	☐ Yes ☐ No	
Medical evaluation including neurologic exam	☐ Yes ☐ No	
Functional Behavioral Assessment within the past 12 months completed by Board-Certified Behavior Analyst (BCBA) or licensed psychologist or physician	☐ Yes ☐ No	

Treatment Plan (continued)		
A treatment plan with all the following elements: • Identification and detailed description of targeted behaviors • Detailed description of treatment modalities and interventions for each targeted behavior • Specific, quantifiable goals that related to deficits or behaviors that pose a significant risk of harm to the patient or others • Objective, observable and quantifiable metrics utilized to measure change toward the specific goal behaviors • Documentation of adjunctive treatments (e.g., occupational therapy, speech therapy, social skills training, medication services) • Plan for communication and coordination with other providers and agencies • Total number of days per week and hours per day of direct services to the patient and caregivers	☐ Yes ☐ No	
Does the treatment plan specify substantive weekly caregiver support with included parent training goals?	☐ Yes ☐ No	
As stated in Medical Policy X-43 for concurrent requests, please include:		
Component	Included? Yes or No	Date of Assessment
Does the patient show improvement from baseline in targeted skill deficits and behaviors identified in the approved treatment plan using validated assessments of adaptive functioning (e.g., Vineland, ABAS)?	☐ Yes ☐ No	
Assessment of adaptive functioning (example: Vineland-3) to be completed every 6 months for comprehensive treatment plan of 25-40 hours per week, and every 12 months for 10-25 hours per week.	☐ Yes ☐ No	
Patient's caregivers demonstrate continued commitment to participate in treatment plan and is measured by included parent training goals.	☐ Yes ☐ No	
Continued supervision of paraprofessionals by a qualified provider (Board-Certified Behavior Analyst (BCBA), licensed psychologist or physician)	☐ Yes ☐ No	
As stated in the Medical Policy X-43, please include:		
Does the treatment plan include parent training conducted by a Board-Certified Behavior Analyst (BCBA), psychologist, or physician?	☐ Yes ☐ No	
Does the treatment plan include a paraprofessional /staff supervision schedule, with supervision conducted by a Board-Certified Behavior Analyst (BCBA), psychologist, or physician?	☐ Yes ☐ No	
Does the treatment plan include a discharge plan?	☐ Yes ☐ No	

Treatment Plan (continued)

Behavior Reduction Goals - Please note that your graphs must meet Behavior Analyst Certification Board (BACB) guidelines for graphing, as detailed in section C-10 of the Behavior Analyst Certification Board (BACB): BCBA/BCaBA Task List (5th edition).

Please attach a graph for each behavior reduction goal, listing one behavior per graph. Display the per-session, weekly or monthly data.

Discharge Plan

Discharge plan - Please note that the discharge plan must meet Behavior Analyst Certification Board (BACB) guidelines for discharge, as detailed in Section 8: Discharge, Transition Planning, and Continuity of Care in Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers.

Please indicate the discharge plan for this member:

Signatures

Clinical supervisor / credentials	Date
Lead behavior therapist/credentials	Date
Parent/guardian signature	Date

Case Management

Case Management services are available to assist the provider/member with discharge planning, family support, etc. Please contact our Behavioral Health Case Management Department at (877) 887-0873 to get connected to a case manager.

☐ **Yes**, I am interested in a case manager reaching out to assist.

Contact Name: _____Phone: _____

☐ **No**, I am not interested at this time.