SERVICE AUTHORIZATION PROCESS

All Applied Behavior Analysis (ABA) services must be prior authorized by the beneficiary's managed care organization (MCO).

If a member has primary coverage available for ABA services through another insurer, the MCO may bypass the prior authorization process and acknowledge the prior authorization granted by the primary insurer.

Prior authorization (PA) is a two-fold process. An authorization is first requested for approval to perform a functional assessment and to develop a behavior treatment plan. A second authorization is needed for approval to provide the ABA-based derived therapy services.

All PA requests must be submitted to the beneficiary's MCO. See the MCO's website for details including forms and submission instructions.

Functional Assessment and Development of the Behavior Treatment Plan

A PA request must be submitted by the ABA provider to conduct a functional assessment and to develop a behavior treatment plan (Mental Health Services Plan Development by Non-Physician). The prior authorization request must include a comprehensive diagnostic evaluation (CDE) that has been conducted by a qualified health care professional (QHCP) prescribing and/or recommending ABA services.

All CDEs completed by QHCPs will be reviewed and considered when making prior authorization decisions.

MCOs shall not deny services based solely on the age of the CDE. The MCO should deny service if no CDE exist. If the MCO requests a new CDE (either for initial or continuation of service) they shall not deny or delay available ABA services while waiting for a CDE. MCOs are responsible for arranging CDEs that are requested.

Request to Provide ABA-Based Therapy Services

A separate authorization request must be submitted by the ABA provider to request approval to provide the ABA-based therapy services to the beneficiary. This authorization request must include:

1. The CDE;

2. The behavior treatment plan;

3. The IEP; and

4. The waiver plan profile table and the schedule from the certified plan of care (POC) (if the beneficiary is in a waiver and services are being requested that will occur at the same time as waiver services).

Authorizations for ABA-derived therapy services shall be authorized for a time period not to exceed 180 days.

Reconsideration Requests

If the prior authorization request is not approved as requested, or an existing authorization needs to be adjusted, the provider may submit a request for reconsideration of the previous decision to the beneficiary's MCO (See Appendix A for contact information.).

Changing Providers

Beneficiaries have the right to change providers every 180 days unless a change is requested for good cause. If a provider change is requested based on good cause before the authorization period ends, the beneficiary, or case manager (if the beneficiary has one) must contact the MCO. (See Appendix A for contact information).

Good Cause is defined as allegation of abuse, beneficiary doesn't progress, new provider opens in area that previously lacked access, or when a dispute arises between the parent/caregiver and provider that cannot be resolved.

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