SERVICE AUTHORIZATION PROCESS

All Applied Behavior Analysis (ABA) services must be prior authorized by the Bureau of Health Services Financing (BHSF) or its designee. Recipients must select a provider of their choice based on the availability of Medicaid enrolled providers.

Prior Authorization Requests

Prior authorization 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. (See Appendix B for procedure code and description.)

All prior authorization requests must be submitted to the fiscal intermediary's Prior Authorization Unit (PAU) through the electronic prior authorization (e-PA) process via e-PA Transaction using the individual attending provider number. (See Appendix A for information about PAU and e-PA.)

NOTE: **Do not use the group provider number on the e-PA**.

Functional Assessment and Development of the Behavior Treatment Plan

A prior authorization 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.

NOTE: CDEs completed more than 18 months prior to the date of service authorization requests may require an update, progress report, or re-evaluation by a QHCP.

The authorization request will be reviewed by the PAU's ABA consultant and a decision will be made regarding the approval of the services. The decision is entered into the e-PA system and will be available for the provider to review during the following business day. A letter is also sent to the recipient, the ABA provider, and case manager (if applicable) advising of the decision.

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 recipient. This authorization request must include:

- The CDE;
- The behavior treatment plan;
- The IEP; and
- The waiver plan profile table and the schedule from the certified plan of care (if the recipient is in a waiver and services are being requested that will occur at them 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. When submitting a reconsideration request, providers should include the following:

- A copy of the prior authorization decision notice with the word "Recon" written across the top;
- The reason the reconsideration is being requested written across the bottom of the notice;
- All original documentation submitted from the original request; and
- Any additional information or documentation which supports the reconsideration request.

After the reconsideration request has been reviewed, a new notification letter with the same prior authorization number will be generated and mailed to the provider, recipient, and case manager (if the recipient has one).

Prior Authorization Liaison

The Prior Authorization Liaison (PAL) was established within the PAU to facilitate the authorization process for those Medicaid recipients who are under the age of 21 and are on the Developmental Disabilities Request for Services Registry. The PAL assists when a prior authorization request cannot be approved by the PAU because of a lack of documentation or a technical error. Before the notice of decision is issued, the PAL contacts the provider, recipient, and case manager (if the recipient has one) and informs all parties of the documentation or correction needed to prevent an unfavorable decision.

Changing Providers

Recipients 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 recipient or case manager (if the recipient has one) must contact BHSF. (See Appendix A for contact information.)