Early Intensive Behavioral Intervention (EIBI) Services Pre-Authorization Request Form

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® 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 www.Availity.com 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 six (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 #: ______________________ Clinic NPI number: __________________________________ Individual provider ID/NPI number: ___________________________ Individual provider name: ___________________________________ Degree/Lic: ____________________ Provider address: ______________________________ City/state/zip: ______________________________ Supervising mental health professional name/credentials:______________________________

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

Treatment Plan

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: ______________________________________

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 BCBA or Licensed Psychologist or Physician	☐ Yes ☐ No	
A treatment plan with all of 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	☐ Yes ☐ No	

Treatment Plan			
	• 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		
	Does the treatment plan specify substantive weekly caregiver support and training?	☐ 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 and/or functional behavior assessment at least every 6 months	☐ Yes ☐ No	
Patient’s caregivers demonstrate continued commitment to participate in treatment plan	☐ Yes ☐ No	
Continued supervision of paraprofessionals by a qualified provider (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 BCBA, Psychologist, or Physician?	☐ Yes ☐ No
Does the treatment plan include a paraprofessional /Staff Supervision Schedule, with supervision conducted by a BCBA, Psychologist, or Physician?	☐ Yes ☐ No
Does the treatment plan include a Discharge Plan?	☐ Yes ☐ No

Treatment Plan

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

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

Discharge Plan

Discharge Plan - *Please note that the discharge plan must meet 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