Referral for Applied Behavior Analysis

This resource is provided as a guide and courtesy only. Providers are not required to use this resource, the included checklists, sample treatment plan, or the sample treatment plan update.

As part of the Comprehensive Autism Care Demonstration, TRICARE requires a complete referral for Applied Behavior Analysis (ABA) that includes a definitive diagnosis of ASD from an approved ASD diagnosing provider (Primary Care Manager (PCM)) or specialized ASD diagnosing provider, to include a validated assessment tool and results submitted to the contractor. The DSM criteria must be documented in the DSM-5 diagnostic checklist. The complete referral must be submitted and approved prior to the commencement of ABA services.

This instruction outlines the minimum documentation criteria required for the initial and reauthorization requests for ABA services submitted to Humana Military. Providers are not required to use this form; however failure to provide necessary clinical information may result in delays, terminations of authorized care, and denials for pended claims. For complete guidance, please reference *TRICARE Operations Manual, Chapter 18, Section 4*.

Patient name: _____

DOB (mm-dd-yyyy): _____ DoD benefit #: _____

Referring provider: _____

Tax ID/NPI: _____

ASD diagnosis including symptom severity level:

_____

_____

_____

Medical/Psychological co-morbidities: _____

_____

_____

_____ Initial ASD diagnosis date: _____

Note: If the beneficiary was first diagnosed with ASD at age eight years or older a specialized ASD diagnosing provider evaluation is required.

If patient is dependent of service member, is he/she registered in Extended Care Health Option (ECHO)? ☐ Yes ☐ No

Service(s) requested:

Units	Frequency (per day/ week/month)	CPT code	Description
		97151	Includes behavior identification assessment and treatment plan, to include 1 one unit for each completed outcome measures. Outcome measures include the PDDBI, PSI/SIPA, Vineland-3 and SRS-2.

Note: Please review the *TRICARE Operations Manual* and the CPT Code crosswalk for any maximum units billed or frequency limitations.

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Clinical diagnosis: DSM-5 diagnostic checklist

Patient name: _____ DOB: _____ Sponsor ID: _____

DSM-5 criteria	Autism Spectrum Disorder		
Note: If the individual has a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or PDD-NOS, please check this box. Complete the below checklist to reclassify the previous diagnosis to Autism Spectrum Disorder.	☐		
A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (all 3 must be met):	**Present**		**Not present**
1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.	☐		☐
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.	☐		☐
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.	☐		☐
Social communication domain severity rating (check one)[see DSM-5 page 52 for severity description]): (1) Requires support (2) Substantial support (3) Very substantial support	(1) ☐	(2) ☐	(3) ☐
B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following, currently or by history:	**Present**		**Not present**
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).	☐		☐
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).	☐		☐
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).	☐		☐
4. Hyper-or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).	☐		☐
Restricted, repetitive behaviors domain severity rating (check one)[see DSM-5 page 52 for severity description]): (1) Requires support (2) Substantial support (3) Very substantial support	(1) ☐	(2) ☐	(3) ☐
	Yes		**No**
C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).	☐		☐
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.	☐		☐
E. These disturbances are not better explained by intellectual disability or global developmental delay.	☐		☐

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Clinical diagnosis: DSM-5 diagnostic checklist

DSM-5 criteria		
Autism Spectrum Disorder criteria met?	**Yes** ☐	**No** ☐
With or without intellectual impairment?	**With** ☐	**Without** ☐
With or without language impairment?	**With** ☐	**Without** ☐

Known comorbid conditions (medical/genetic/neurodevelopmental diagnosis; mental/behavioral diagnosis; other)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date of diagnosis: _____

Provider name: _____

Provider credentials:_____

Signature: _____ Date: _____

Submit form online

Civilian providers and military hospitals or clinics should submit via provider self-service at **HumanaMilitary.com** or fax to (877) 378-2316.

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