Request for Applied Behavior Analysis (ABA) reassessment

Overview

This resource is provided as a guide and courtesy only. Providers are not required to use this resource, included checklists, sample Treatment Plan (TP) or the sample update. This document outlines essential information for the initial ABA assessment and TP for beneficiaries receiving ABA for the treatment of Autism Spectrum Disorder (ASD) under the Autism Care Demonstration (ACD). Providers are not required to use this guidance. However, failure to provide necessary clinical information may result in delays, terminations of authorized care, and denied claims.

TRICARE Operations Manual, Chapter 18, Section 4 provides policy information and detailed guidance on how Humana Military will operate ABA services under the ACD.

Relevant information

ABA reassessments and TP updates must be submitted to Humana Military for review prior to the expiration of each six month authorization period (as early as 60 days in advance). Any delay in submission may delay/terminate continued authorization for ABA services. Only one ABA supervisor is authorized to design, monitor, and supervise ABA services for each beneficiary at a time. Behavior Technicians (BTs) may not conduct ABA assessments or establish TPs.

Elements of the assessment include:

- Observing the beneficiary one-on-one in person, face-to-face
- Obtaining current and past behavioral functioning history, to include functional behavior analysis and behavior intervention plan, if appropriate
- Reviewing previous assessments and health records
- Conducting interviews with parents/caregivers to further identify and define deficiencies
- Administering assessment tools
- Interpreting assessment results
- Developing the TP and designing the instructions for the supervised assistant behavior analysts and BTs
- Discussing findings and recommendations with parents/caregivers

ABA assessment/TP checklist

- ☐ Beneficiary name
- ☐ DoD Benefits Number (DBN) or SSN
- ☐ Beneficiary Date of Birth (DOB)
- ☐ Name of the referring provider
- ☐ Year of the initial ASD diagnosis
- ☐ ASD-diagnosing/referring provider's ASD diagnosis
- ☐ Level of symptom severity
- ☐ Any comorbid disorders
- ☐ Prescribed medications
- ☐ Number of hours enrolled in school
- ☐ Duration of time receiving ABA services
- ☐ Number of hours receiving other support services
- ☐ Family history
- ☐ Date initial assessment/TP
- ☐ Date/Time current assessment/TP update completed
- ☐ ABA provider conducting assessment
- ☐ Assessment results
- ☐ PDDBI Parent Form Domain/Composite Score Summary
- ☐ Progress toward short and long-term treatment goals
- ☐ Evaluation of progress on each treatment target (i.e., Met, Not Met, Discontinued)
- ☐ Family member/caregiver engagement and implementation of the ABA TP at home
- ☐ Recommended number of weekly hours of ABA
- ☐ Parent/Caregiver and ABA supervisor signatures

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Continuation of ABA services request form

Beneficiary name: _____ Age: _____

Date of Birth: _____ DoD Benefit Number (DBN): _____

Requesting provider: _____ ☐ BCBA ☐ BCBA-D ☐ Other: _____

Tax ID/NPI: _____ Telephone number: _____

Clinic: _____ Referring provider: _____

ASD diagnosis and any co-morbid disorders (include ASD-diagnosing/referring provider's diagnosis according to DSM-5 criteria):

Diagnostic code	Level of symptom severity/support required	Diagnosing provider/title	Date of diagnosis

Date of initial ABA assessment/TP:_____

Prescribed medications (include current and past medications, dosage, purpose, duration, outcomes and prescribing physician):

Family medical/psychological history:

Condition	Relationship to beneficiary	Date of diagnosis

Summarize current living situation (specify where the beneficiary lives and with whom, trauma/stressors, etc.):

Number of hours enrolled in school: _____ Age-appropriate grade level: _____ Current grade level: _____

Note: Please attach Individual Education Plan (IEP) if participating in special education and/or requesting services in school setting.

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Currently receiving ABA services: ☐ Yes ☐ No If yes, date when ABA services began: _____

History of ABA services (include current number of weekly hours, location/setting and servicing provider's credentials):

Services received from other providers (PT, OT, SLT, etc.), as well as any special education services:

Service	Hours/Week	Location/Setting	Describe efforts to collaborate with this provider

Date/Time of current assessment: _____ Evaluator/Title: _____

Outcome measures completed: ☐ Vineland-3 ☐ SRS-2 ☐ PDDBI ☐ PSI/SIPA

Procedure/Instrument/Data source	Date completed

Date of outcome measures evaluation: _____

Please attach full publisher print report or hand-scored protocol and summary score sheet(s).

Summary - Evaluation of findings for all domains (language, development, social communication and adaptive behavior skills):

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Review of progress/changes/additions/revisions – In descriptive terms, document progress toward achieving the outcomes and/or the changes/additions/revisions made to any part of the ABA TP.

Note: Either graphic representation of ABA TP progress or an objective measurement tool consistent with the baseline assessment must be used to display progress toward short/long-term treatment goals. Documentation should note interventions that were ineffective and required modification of the TP.

Treatment goal: _____

Start date: _____ Anticipated completion date: _____ ☐ Met ☐ No change ☐ Making progress

Discussion: ☐ Continue ☐ Discontinue ☐ Modify

Treatment goal: _____

Start date: _____ Anticipated completion date: _____ ☐ Met ☐ No change ☐ Making progress

Discussion: ☐ Continue ☐ Discontinue ☐ Modify

Treatment goal: _____

Start date: _____ Anticipated completion date: _____ ☐ Met ☐ No change ☐ Making progress

Discussion: ☐ Continue ☐ Discontinue ☐ Modify

Review of family member/caregiver engagement and implementation of the ABA TP at home (include reasons for lack of/inability for parental involvement, if appropriate):

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Note: Treatment may vary in terms of intensity and duration, the complexity and range of treatment goals, and the extent of direct treatment provided. Many variables, including the number, complexity, and intensity of behavioral targets and the beneficiary's own response to treatment help determine which model is most appropriate.

ABA supervisor recommendations: ☐ Focused treatment ☐ Comprehensive treatment ☐ Total weekly hours of ABA: _____

☐ Sole delivery model ☐ Tiered delivery model

Day of week	Time span	Location	BCBA/BT/Assistant	ABA focus during this time span
Monday	_____ to _____			
	_____ to _____			
	_____ to _____			
Tuesday	_____ to _____			
	_____ to _____			
	_____ to _____			
Wednesday	_____ to _____			
	_____ to _____			
	_____ to _____			
Thursday	_____ to _____			
	_____ to _____			
	_____ to _____			
Friday	_____ to _____			
	_____ to _____			
	_____ to _____			
Saturday	_____ to _____			
	_____ to _____			
	_____ to _____			
Sunday	_____ to _____			
	_____ to _____			
	_____ to _____			

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Service	Code(s)	Units	Frequency (per day/week/month)
Behavior identification assessment and treatment plan	97151		
Adaptive behavior treatment by protocol (per 15 minutes)	97153		
Adaptive behavior treatment by protocol modification (per 15 minutes)	97155		
Family adaptive behavior treatment guidance (per 15 minutes)	97156		
Multiple-family group Adaptive Behavior Treatment Guidance (per 15 minutes)	97157		
Group adaptive behavior treatment by protocol modification (per 15 minutes)	97158		
Medical team conference	99366/ 99368		

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

If recommended units/hours differ from what will be rendered, please provide an explanation:

If requesting services beyond the service threshold, please provide rationale for request:

Parent/Caregiver name: _____

Parent/Caregiver signature: _____ Date: _____

ABA supervisor name: _____

ABA supervisor signature: _____ Date: _____

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