CardinalCare
Virginia's Medicaid Program

CLEAR FORM

VIRGINIA'S MEDICAID PROGRAM
DMAS

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Applied Behavior Analysis
(97153, 97154, 97155, 97156, 97157, 97158, 0373T)
Preservice Service Authorization Request Form

Effective Dates of Service 09/01/2025 and after.

Please be mindful of notes throughout this form providing reference to where documentation obtained during the Comprehensive Needs Assessment (CNA) are relevant and can be used for efficiency.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:	Liam	Organization Name:	Behavioral Progress Partners
Member Last Name:	O'Connell	Group NPI #:	1234567890
Medicaid #:	VAMED1234567890	LBA/LMHP NPI #:	9876543210
Member Date of Birth:	05/10/2019	Provider Tax ID #:	88-7777777
Gender:	Male	Provider Phone:	(804) 777-8888
Member Plan ID #:	CVP7890123	Provider E-Mail:	intake@behavioralprogress.com
Member Street Address:	456 Elm Street	Provider Servicing Address:	789 Oak Avenue
City, State, ZIP:	Richmond, VA 23220	City, State, ZIP:	Richmond, VA 23225
Member Phone #:	(804) 555-1234	Provider Fax:	(804) 777-8889
		Clinical Contact Name and Credentials*:	Dr. Emily Carter, LBA
Parent/Legal Guardian Name (s):	Sarah and David O'Connell	Clinical Contact Phone #:	(804) 777-8888
Parent/Legal Guardian Phone #:	(804) 555-5678	* *The individual to whom the health plan can reach out to in order to gather additional necessary clinical information.*	

Request for Approval of Services	
Retro Review Request? ◯ **Yes** ◉ **No**	
If the member is currently participating in this service, start date of service:	01/15/2025

Proposed/Requested Service Information:

From 09/01/2025 (date), To 02/28/2026 (date)

All preservice service authorization requests must include all of the following completed documentation:

1. Preservice Service Authorization Request Form
2. Provider assessment completed by the LBA, LABA or LMHP
3. Preliminary ISP including documentation of telemedicine as described in Mental Health Services Manual, Chapter IV
4. A description of the preliminary discharge plan to include referrals as service goals are met

In addition to the above requirements, all requests exceeding 20 hours (80 units) or more per week, must include the following:

1. *The schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the behavior modification plan. This schedule must be written in the "Notes" Section at the end of the form or uploaded with the service authorization form.

***Please note:** Each session must clearly be related to the successful attainment of the treatment goals. The therapeutic function of all scheduled sessions must be clearly defined regarding the number of hours requested. Schedules must be individualized. A general schedule of clinic-based activities is not sufficient to meet this requirement. Clinic-based schedules must also distinguish between time the individual spends in therapeutic interventions and time spent in recreational and non-therapeutic activities/non-reimbursable activities.

Member Full Name: Liam O'Connell Medicaid #: VAMED1234567890

CPT Code	Unit	Description	Provider qualifications	Total Daily Hours/Days Per Week	Total Weekly Hours	Total Hours: (Total Weekly hours (x) number of weeks requested	Total Units Requested (Total Hours (x) 4)	Notes
Example: 97153	per 15 min	Adaptive behavior treatment by protocol	Qualified staff	2 hours/5 days	10 hours	240 hours (24 weeks requested)	960 Units	
97153	per 15 min	Adaptive behavior treatment by protocol	Qualified staff					
97154	per 15 min	Group adaptive behavior treatment by protocol	Qualified staff					
97155	per 15 min	Adaptive behavior treatment with protocol modification	LBA/LMHP[1]/ LABA[2] May also include technician and/ or caregiver. (technician billed separately					
97156	per 15 min	Family adaptive behavior treatment guidance	LBA/LMHP[1]/ LABA[2]					
97157	per 15 min	Multiple-family group adaptive behavior treatment guidance	LBA/LMHP[1]/ LABA[2]					
97158	per 15 min	Group adaptive behavior treatment with protocol modification	LBA/LMHP[1]/LABA[2] Youth also has assigned 1:1 technician (technician not billed separately)					
0373T	per 15 min	Adaptive behavior treatment with protocol modification	Two or more technicians and LBA/LMHP[1]/LABA[2] (team rate)					

Identify all known treatment periods of Applied Behavior Analysis (or Behavior Therapy) that have been provided by any providers including the requesting provider in the past 12 months:

Provider	Dates of Service	Outcomes

Primary ICD-10 Diagnosis	F84.0
Secondary Diagnosis(es)	F80.1

Other medical/behavioral health concerns (including substance use issues, personality disorders, dementia, cognitive impairments) that could impact services? ◯ Yes ◉ No (If yes, explain below.)

SECTION I: ADMISSION CRITERIA

Individuals must meet ALL of the criteria #1-3; note that some criteria have multiple sub-criteria for consideration.

1. Specify the DSM diagnosis or provisional diagnosis corresponding with the ICD-10 diagnosis(es).

   F84.0

Describe the individual's current symptoms (including frequency, intensity and duration) and areas of functional impairment. Corresponding CNA Elements: 1, 6, 7, 12

Preliminary Treatment Goal #1: *Create a goal related to one or more of the symptoms noted above. Include when or under which conditions interventions will be provided through telemedicine, when services are scheduled to be provided in-person and if telemedicine is recommended, clinical evidence that the use of telemedicine is appropriate.*

2. Within the past 30 calendar days, the youth has demonstrated **at least two** of the following:

A. Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalic speech, impairment in receptive and/or expressive language. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.*

Liam exhibits significant communication difficulties, primarily using 2-3 word phrases and PECS for requests. He has an Expressive Language Disorder (F80.1).

(●) Yes ( ) No

Preliminary Treatment Goal #2A: *Create a goal related to the difficulties with communication. Include when or under which conditions interventions will be provided through telemedicine, when services are scheduled to be provided in-person and if telemedicine is recommended, clinical evidence that the use of telemedicine is appropriate.*

Increase verbal requests and responses to simple instructions

B. Severe impairment in social interaction /social reasoning /social reciprocity/ and interpersonal relatedness. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.*

Socially, he struggles with joint attention and engaging in reciprocal play with peers.

(●) Yes ( ) No

Preliminary Treatment Goal #2B: *Create a goal related to the difficulties in social interaction, reasoning, reciprocity and interpersonal relatedness. Include when or under which conditions interventions will be provided through telemedicine, when services are scheduled to be provided in-person and if telemedicine is recommended, clinical evidence that the use of telemedicine is appropriate.*

Engage in reciprocal play with a peer for 5 minutes (in-person, clinic/home)

C. Frequent intense behavioral outbursts that are self-injurious or aggressive towards others. *Describe any repeated occurrences of behaviors that are endangering to self or others, are difficult to control, cause distress, or negatively affect the youth's health.*

Liam exhibits significant communication difficulties, primarily using 2-3 word phrases and PECS for requests, which directly contributes to frequent tantrums. These outbursts occur 4-5 times daily, lasting 10-15 minutes, often triggered by demands or removal of preferred items. They impact his participation in preschool and family activities.

(●) Yes ( ) No

Preliminary Treatment Goal #2C: *Create a goal related to the difficulties with intensive behavioral outburst. Include when or under which conditions interventions will be provided through telemedicine, when services are scheduled to be provided in-person and if telemedicine is recommended, clinical evidence that the use of telemedicine is appropriate.*

Reduce frequency of tantrums by 50%

D. Disruptive, obsessive, repetitive, or ritualized behaviors. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.*

Frequent tantrums (4-5 times daily, lasting 10-15 minutes), often triggered by demands or removal of preferred items. These impact participation in preschool and family activities. Also displays repetitive hand flapping when excited or overstimulated.

(●) Yes ( ) No

Preliminary Treatment Goal #2D: *Create a goal related to the difficulties with disruptive, obsessive, repetitive or ritualized behaviors.* Include when or under which conditions interventions will be provided through telemedicine, when services are scheduled to be provided in-person and if telemedicine is recommended, clinical evidence that the use of telemedicine is appropriate.

Engage in appropriate leisure activities without self-stimulatory behavior.

E. Difficulty with sensory integration. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.*

He also displays repetitive hand flapping when excited or overstimulated and shows over-responsivity to loud noises and certain textures.

(●) Yes ( ) No

Preliminary Treatment Goal #2E: *Create a goal related to the difficulties with sensory integration. Include when or under which conditions interventions will be provided through telemedicine, when services are scheduled to be provided in-person and if telemedicine is recommended, clinical evidence that the use of telemedicine is appropriate.*

Tolerate unexpected loud noises and novel textures with minimal distress.

3. Please provide information on the identity and relationship of any identified family member(s)/caregiver(s) available to participate in ABA services with the youth.

Sarah O'Connell (Parent), David O'Connell (Parent)

Section V: RECOVERY & DISCHARGE PLANNING

Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge should begin at the first contact with the individual. Recovery planning should include discussion about how the individual and service providers will know that the member has achieved sufficient progress to move to a lower, less intensive level of care or into full recovery with a maintenance plan.

What would progress/recovery look like for this individual?

Meaningful progress for Liam includes a 50% reduction in tantrum frequency through increased functional communication (verbal or PECS). Progress will also be demonstrated by his ability to engage in reciprocal play with a peer for 5 minutes, engage in appropriate leisure activities without self-stimulatory behavior, and tolerate unexpected loud noises and novel textures with minimal distress. Readiness for discharge will be indicated by his ability to transition to a mainstream kindergarten setting with minimal support.

What barriers to progress/recovery can the individual, their natural supports, and/or the service provider identify?

Inconsistent strategy implementation at home and limited community resources for peer interaction.

What types of outreach, additional formal services or natural supports, or resources will be necessary to reach progress/recovery?

Outreach will focus on community playgroups and respite care.

At this time, what is the vision for the level of care this individual may need at discharge from this service?

Transition to mainstream kindergarten with minimal support.

What is the best estimate of the discharge date for this individual? 02/28/2026

By my signature (below), I am attesting that 1) an LMHP, LMHP-R, LMHP-S, LMHP-RP or LABA has reviewed the individual's psychiatric history and completed the appropriate assessment or addendum; and 2) that this assessment indicates that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on the following date: 08/15/2025

Signature (actual or electronic) of LMHP (Or R/S/RP or LABA): _____

Printed Name of LMHP (Or R/S/RP or LABA): Dr. Emily Carter

Credentials: LBA

Date: 08/15/2025

Schedule (20 Hours or more)

Notes