DPHHS Logo


**Autism Treatment Services**

# EPSDT Prior Authorization & Certificate of Medical Necessity

**Initial Requests for Medicaid-HMK+ (up to age 21) and CHIP-HMK (up to age 19)**

Autism Treatment Services applications are considered on a case-by-case basis. Please complete entire form and submit all required documentation to **Fax # (406) 444-6864**. Incomplete/inaccurate applications will result in a technical denial, in which the Board Certified Behavior Analyst (BCBA) and family will be notified. A Vineland-II (or newer edition) Survey Interview adaptive assessment by state staff will be scheduled and administered with the guardian/caregiver while the member is present. The Developmental Disabilities Program team serving as experts for autism treatment services will review the form, documentation, and Vineland adaptive assessment results. The BCBA and guardian/caregiver will receive a decision from the Department. If the request is denied, the member, or his/her guardian/caregiver, will be notified and may appeal the decision.

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| REQUIRED DOCUMENTATION |
| Evaluation supporting Autism Spectrum Disorder or other related condition diagnosis and level of need  Current IEP/school evaluations (school-aged children enrolled in school)  Available Speech Therapy, Occupational Therapy, and/or Physical Therapy Assessments  Other relevant records |

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| Medicaid Participant Information | | | | | | |
| First Name: | | | Last Name: | | | |
| Medicaid-HMK+ or CHIP-HMK ID: | | | | | Birthdate: | Phone: |
| Physical Address: | | Mailing Address (if different than physical address): | | | | |
| Guardian/Caregiver Name(s) Printed: | | | | | Guardian/Caregiver Signature(s)\*: | Date Signed: |
| \*A member’s guardian/caregiver or an adult authorized in writing by the guardian/caregiver must be present and responsible for the member at all times while the member is receiving any of the autism treatment services. The member’s guardian/caregiver must agree to be instructed in implementing treatment plan interventions and must perform those interventions. | | | | | | |
| **Medicaid Provider Information (providing requested service)** | | | | | | |
| Board Certified Behavior Analyst Name: | | | | | | NPI/Provider #: |
| Date: | E-Mail | | | | Phone: | Fax: |
| I attest that the above-named member has a current diagnosis of Autism Spectrum Disorder or related condition and requires autism treatment services. I further attest that the autism treatment services being requested are evidence-based and necessary to correct or ameliorate symptoms of the stated condition. | | | | | | Signature: |
| **Requesting Provider Information** | | | | | | |
| Provider Name: | | | | | | NPI/Provider #     : |
| Contact Person: | | | Phone: | | | Fax: |
| I am the primary care provider or specialist for the above-named member. I examined this member or reviewed his/her medical record on:       I attest that the above-named member has a current diagnosis of Autism Spectrum Disorder or related condition and requires autism treatment services which are evidence-based and necessary to correct or ameliorate symptoms of the stated condition. | | | | | | Signature: |
| **Identify Requested Units for either Low Intensity OR High Intensity Level of Autism Services (Refer to Medicaid Autism Treatment Services Fee Schedule for more information on Services, CPT Codes, and Limits)** | | | | | | |
| **Low Intensity Level:**  Treatment Plan 97151 TC \_      units  Implementation Guidance 97155 TC \_      units | | | | **High Intensity Level:**  Treatment Plan 97151 \_\_      units  Implementation Guidance 97155 \_\_      units  Intensive Treatment 97153 \_      units | | |

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| Statement of Medical Necessity |

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| 1. Identify the core features the member exhibits which support the diagnosis of Autism Spectrum Disorder and will be addressed with autism treatment services. Include individualized examples of each core feature listed. |
| 2. Describe what specific goals/objectives will be addressed with autism treatment services and what interventions will be utilized to accomplish these goals and objectives. |
| 3. Provide rationale for the intensity level of services requested specific to this member. |

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| **(Department Use Only) Please do not write in area below** | | |
| Received Date: | Authorized: Y N | PA Number: |

EPSDT August 2019