

**Autism Treatment Services**

# 6-Month Medical Necessity and Utilization Review

**EPSDT Reauthorization & Certificate of Medical Necessity**

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

Autism Treatment Services applications for continued services 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. 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 |
| Treatment Plan  Signed and dated by both the guardian/caregiver and BCBA  Clear and concise summary of progress towards each goal/objective  Guardian/Caregiver participation in services  Names of any Intermediate Professionals and/or Registered Behavior Technicians involved in delivering autism treatment services to the member and family under the supervision of the responsible BCBA  Vineland-II (or newer edition) Survey Interview Report scored at a 90% confidence interval  Current IEP/school evaluations (school-aged children enrolled in school)  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. | | | | |

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| **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 benefited from and requires continued autism treatment services. I continue to attest that the autism treatment services being requested are evidence-based and necessary to correct or ameliorate the symptoms of the stated condition. | | | | Signature: |
| **Identify Actual Utilization of Requested Units from Previous, Prior-Authorized 6-Month Care Span for either Low Intensity OR High Intensity Level of Services** | | | | |
| **Requested Units of Low Intensity Level Services:**  Treatment Plan 97151 TC \_     \_ units  Implementation Guidance 97155 TC      \_ units | | **Actual Utilization of Low Intensity Level Services:**  Treatment Plan 97151 TC      \_ units  Implementation Guidance 97155 TC \_     \_ units | | |
| **Requested Units of High Intensity Level Services:**  Treatment Plan 97151 \_\_     \_ units  Implementation Guidance 97155 \_     \_ units  Intensive Treatment 97153      \_\_ units | | **Actual Utilization of High Intensity Level Services:**  Treatment Plan 97151 \_     \_ units  Implementation Guidance 97155 \_     \_ units  Intensive Treatment 97153 \_     \_ units | | |
| **Identify Requested Units for either Low Intensity OR High Intensity Level of Continued 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** | | |
| 1. Explain why continued autism treatment services are necessary and what specific goals/objectives will be addressed and interventions utilized in the requested care span. | | |
| 2. Provide a review of previous goals/objectives and interventions and the progress (or lack thereof) from the previously authorized care span. Include a clinical narrative to explain progress (or lack thereof) and how services may be modified to address this. | | |
| 3. Provide rationale for the intensity level of services requested specific to this member’s current presentation. | | |
| 4. Explain any underutilization or gaps in service during the previously authorized care span. | | |
| **(Department Use Only) Please do not write in area below** | | |
| Received Date: | Authorized: Y N | PA Number: |

EPSDT August 2019