Dr. Colleen Ryan, PhD
Licensed Clinical Psychologist
Autism Spectrum Disorders Specialist

Childhood Autism Treatment Team
P.O. Box 192, 119 Mill Rd.
Palmyra WI53156
www.chattautism.com

262-370-7744 (Scheduling) **262-370-5527 (Billing)** **262-495-3005 (Fax)**

Dear Parent/Family,

Welcome! We are pleased you are interested in receiving ABA therapy services from CHATT.

Wisconsin Medicaid (ForwardHealth) requires all providers obtain various eligibility documents from families in order to apply for Prior Authorization for Behavioral Treatment services.

Please collect and make copies of all the required and any "if applicable" documents listed on the enclosed checklist and mail them to the CHATT address as follows. (Please ensure the PO Box is included, as shown below).

CHATT
P.O. Box 192, 119 Mill Rd.
Palmyra WI 53156.

Once all documents have been submitted, you can contact Dr. Ryan to schedule an office visit for skills testing as mandated by the state. CHATT will submit your documents and any test results to obtain authorization for your services.

Contact me if you have any questions at 262-370-7744 or cryan12@msn.com

Sincerely,

Colleen Ryan, PhD

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Licensed Clinical Psychologist
Clinical Director, CHATT

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262-495-8689 (Fax)

Behavior Therapy Checklist - CHATT Autism Behavioral Treatment

You as family should collect all the required and "if applicable" checklist documents below and mail them to the CHATT address as follows.

CHATT
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Required Documents

[ ] Autism-specific Diagnostic Assessment (required) –. It needs to include the diagnosis of Autism from the DSM-V with diagnosis code. This evaluation needs to be within 12 months of start of services date. See criteria from the State below on the page labeled "Diagnostic Evaluation Description"

[ ] Medical Evaluation (required) -- this is an examination by a licensed physician. It is important that your child's physical health be assessed, in addition to any family history or other medical issues. Ideally your physician should complete the attached Medical Evaluation form (see attached form labeled "Medical Evaluation" below. We include a letter you can supply your physician along with the Med Eval and Prescription forms)

- The minimal requirement is an annual PCP or Well-Child visit, but any additional evaluation is helpful.
- Physical exam required within 12 months of PA for services request; must update annually)
- Include information from member's medical provider regarding medical factors that might impact the member's participation and/or expected outcomes from behavioral treatment

[ ] Prescription (required—see attached)**:** Medical Provider's order can be a single paragraph or page from doctor, but it MUST indicate hours per week (30-40 hrs/wk) and number of months (12). Must come from a Medicaid-enrolled medical provider. We include a letter you can supply your physician, along with the Med Eval and Prescription forms).

[ ] ID Cards: (required**)** Copies of front and back of Insurance Card(s) and/or ForwardHealth Card(s).

"If-Applicable" Documents

[ ] School Schedule (required if your child is in school)

[ ] Standardized Testing include copies of any standardized testing results from school, psychological/behavioral, or medical environments that may have been done.

[ ] Current Treatment

- Any Autism, Early Childhood, Birth-to-Three, Speech/Language, or Occupational Therapy that is active/ongoing (if applicable). Includes names of relevant professionals--Psychiatrist, Nutritionist, Foster Care, etc,--for care coordination
- Current Medications (if applicable)

[ ] Previous Treatment History (if applicable) – provide dates and providers for any previous treatment. Include available treatment plans from any previous providers

[ ] Copy of Education Plan - most recent Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) or 504 Plan from school

Diagnostic Evaluation Description

Diagnostic evaluation, which includes both psychological and neuropsychological testing, is covered under the ForwardHealth mental health benefit when performed by a Medicaid-enrolled licensed physician or psychologist. A diagnostic report is required to be submitted with the PA request.

For comprehensive behavioral treatment, the diagnostic report must be dated within one year of the PA request, or for individuals continuously enrolled in a behavioral treatment program prior to the PA request, within one year of the onset of the member's current course of treatment.

ForwardHealth requires documentation of the following elements in the diagnostic report:

- Detailed interview regarding developmental, medical, family, educational, and intervention history.
- Use of a diagnostic tool that is validated in peer-reviewed clinical literature and appropriate for the condition being evaluated, and which is administered according to protocol (e.g., for autism spectrum disorders [ASD], the Autism Diagnostic Observation Schedule-2 [ADOS-2], Autism Diagnostic Interview-Revised [ADI-R], and Childhood Autism Rating Scale [CARS-2] are examples of validated tools appropriate for diagnosing autism).
- Direct observation of the member, including written descriptions of clinical observations.
- Direct probing of the member to assess specific skills, including descriptions of findings.
- Review of relevant records (e.g., medical, Birth to 3, school, outside therapies).
- Consultation with other professionals, for members with comorbid medical or mental health conditions that may contribute to the presenting symptoms.
- Discussion of additional symptoms, possible or actual co-morbid conditions, and differential diagnosis.

If documentation in the member's medical record indicates potential or actual co-morbid conditions that could impact behavioral treatment, and that are not adequately clarified in the diagnostic report, ForwardHealth may request an independent diagnostic evaluation.

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Dear Physician/MD,

Completion and return of the following documents--labeled Medical Evaluation and Prescription—(or similar ones with equivalent information), are required by Wisconsin Medicaid (ForwardHealth) to process future prior authorization for ABA therapy services for your patient.

We would greatly appreciate it if you could complete the information requested on these two pages and fax to CHATT, 262-495-3005, or mail to CHATT, PO Box 192, 119 Mill Rd., Palmyra WI 53156.

Please forgive the imposition; this is a ForwardHealth/Medicaid requirement, and not our own.

Thanks!

Colleen Ryan, PhD
Clinical Director,
Childhood Autism Treatment Team

BEHAVIORAL HEALTH PRESCRIPTION - R_X

Date:_____

Patient:_____

Address:_____

_____

Service Order:

35-40 hours per week intensive ABA Therapy for autism, 4 weeks/month, for 12 months.

Optional Comment_____

Optional Comment _____

Provider Signature_____

Printed Name:_____

Provider NPI (or Medicaid ID):_____

Organization:_____

Address:_____

_____

Phone_____

MEDICAL EVALUATION (Provide details about the medical provider's examination and evaluation of the member's physical health.)

Name — Member

Date of Birth — Member	Date of Most Recent Exam

Name — Provider

Provider's National Provider Identifier

Hearing and Vision		*Complete Only for Abnormal Findings*	
		Follow-up Test Date	**Results or Comments**
Audiology Screen	❑ Within Normal Limits ❑ Outside Normal Limits		
Vision Screen	❑ Within Normal Limits ❑ Outside Normal Limits		

Genetic Testing	**Reason**	**Details About Normal Findings**
Genetic Testing (e.g., chromosomal microarray, Fragile X)	❑ Completed — No Abnormalities ❑ Completed — Abnormalities Noted ❑ Not Completed — No Concerns ❑ Not Completed — Other Reason	

Medical Issue	**Findings**	*Complete Only When Concerns Are Noted*		
		Follow-up Test Date	**Medication Trials?**	**Results or Comments**
Seizure Disorder	❑ No Concerns ❑ Concerns Noted			
Attention Problems	❑ No Concerns ❑ Concerns Noted			
Sleep Concerns	❑ No Concerns ❑ Concerns Noted			
Digestion Problems	❑ No Concerns ❑ Concerns Noted			
Elimination Problems	❑ No Concerns ❑ Concerns Noted			
Nutrition Concerns	❑ No Concerns ❑ Concerns Noted			
Depression Concerns	❑ No Concerns ❑ Concerns Noted			
Other Concerns	List Area of Concern			

Does member regularly take prescription medications? ❑ Yes ❑ No

If yes, provide a current medication list, with the date of the last medication check.

SIGNATURE — Medical Provider

Name — Medical Provider (Print)	Date Signed