Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Behavioral health medical record documentation requirements for applied behavior analysis services

For Blue Cross PPO (commercial), Blue Cross Medicare Plus Blue℠ PPO, Blue Care Network HMO℠ (commercial) and BCN Advantage℠ members

Service / practitioner	Behavioral health medical record documentation requirements for ABA services
All services, for practitioners with a medical degree	Providers with a medical degree must follow the medical record documentation guidelines published by the Centers for Medicaid & Medicare Services in the Medical Learning Network guide **ICN 006764 (August 2016)**. The providers who must follow these guidelines are: • Physicians • Nurse practitioners • Physician assistants
General guidelines: Initial outpatient evaluation for all practitioners without a medical degree	For the initial outpatient visit for a specific problem or group of problems, the medical record must include legible documentation of the items listed here. • The following information must be kept in the medical record: ○ Date of birth / calculated age ○ Gender ○ Home address ○ Home / work telephone numbers ○ Contact name and relationship ○ Employer or school ○ Marital or legal status ○ Emergency contact information ○ Appropriate consent forms / guardianship information ○ Active problem list ○ List of current medications (periodically reconciled with or by prescribing provider) ○ Michigan Automated Prescription System queries as indicated or required by state law • Date of the initial visit • Start and stop times • Names of those present during the session and if separate individuals are interviewed, including the duration each is present • Presenting problems and precipitating factors • Complete mental status examination • Results of the relevant diagnostic testing available, including results completed with interpretation and screening tools when available • Past psychiatric and substance use disorder history, including inpatient or outpatient treatment • Medical history and current medications along with prescribing medical provider, including evidence of coordination of care • Psychosocial history including, as appropriate, the case developmental and family history • Objectively stated treatment plan and rationale with as much detail as possible outlining interventions and monitoring protocols • Assignment of appropriate DSM codes • Treatment or education provided in the session • Instructions, recommendations and precautions given to the patient or other significant parties • Signature and credentials of the treating provider Note: If the initial visit is provided by a psychiatrist, a medical history — including all prescriptions, over-the-counter medications, and holistic and “natural” supplements — must be documented.

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ABA line therapy	Each ABA therapy session for the day can be summarized in one comprehensive progress note for that day with attached "process notes" outlining the individual therapy interval being documented in either a graphic form or brief notation. Use of graphic progress charting is strongly encouraged. Each progress note must contain legible documentation of the following: • Name of the person providing services and the direct supervisor responsible for the services provided, with credentials • Date of the session along with start and end times • Names of those present during the session. If separate individuals are interviewed, include the duration each is present. • Patient's current clinical status as evidenced by the patient's signs and symptoms at the time of each session. For example, progress notes might refer to continuation or resolution of specific behaviors, abnormalities identified on mental status examination, psychomotor retardation or agitation interfering with activities of daily living, decreased or increased anxiety. • Statement summarizing the relationship between signs and symptoms and the primary focus of the therapy session, such as specific behaviors and the therapeutic intervention used to extinguish those behaviors and subsequent modification of the interventions based on benefit (A,B,C documentation), and what would be the next intervention for each specific behavior being treated that day • Statement summarizing the clinical intervention used in the therapy session • Statement summarizing the patient's degree of progress toward the treatment goals, including the use of objective tools to monitor progress. This must refer to behavior changes and progress in reducing symptoms. • Reference to progress in the treatment plan and discharge plan developed at the start of therapy Progress notes may reflect different types or stages of therapy. For example, initial sessions may focus on evaluation, while final sessions may focus on termination and plans for self-care. Progress in longer-term therapy may evolve over several sessions, rather than being obvious from session to session. Regardless of whether the therapy is long term or short term, progress notes must show dynamic, goal-oriented therapy designed to treat an active issue / behavior. The notes must include thoughtful reflection on the treatment plan at the following intervals: • With crisis intervention or short-term therapy, after every session with the patient • With patients undergoing long-term therapy, at least after every third session For longer-term therapy, each session note must show that the clinician is: • Actively directing treatment • Regularly assessing progress • Appropriately adjusting the treatment plan All progress notes must be signed by the tutor and the supervising clinician, with the appropriate credentials noted.

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ABA parental training or socialization group treatment	A progress note for each socialization group or parent / caregiver training session is required. Each note must include legible documentation of the following: • Date of the session along with start and end times • Names of those present during the session. If separate individuals are interviewed, include the duration each is present. • Number of participants in socialization group therapy (minimum of two, maximum of 8) • Relationship of additional participants to the patient in parent caregiver training (for example, parent, guardian, grandparent or elder sibling) • Primary focus of the socialization group session • Statement summarizing the clinical intervention used in the therapy session and the results, both positive or negative • Nature and degree of the patient's participation and response in the session if the patient was present at parent/caregiver training session • For socialization group therapy, a statement summarizing the current clinical status and progress of the group as a whole Note: Other than the group member in whose chart the note is written, there should be no mention of other patients in the socialization group by name. • Whether the member participated in the socialization group, or how the member participated in the socialization group • Signature and credentials of the tutor and the supervising treating provider
ABA supervision	For supervision sessions of continuing care, legible documentation of the following must be included: • Date of the supervision session along with start and end times • Names of those present during the session and the relationship of the individuals (for example, a tutor and the supervising board-certified behavior analyst) • Identification of the service provided number and type of sessions that will be reviewed and are the basis of the current review • Updated medical history or new intercurrent illnesses and current medications (and changes in medications) along with prescribing medical provider. Include evidence that coordination of care has taken placed at least quarterly. • Clinical findings with review of graphical or other data that form the basis of the progress or lack thereof during the review interval • Brief indication of the patient's reaction to therapeutic intervention — what has worked to improve function or what has not • Objectively stated treatment plan and rationale, if changed from the last review, including which interventions will be kept in the treatment plan and which will not, along with new interventions and their planned outcome. This is to allow progress to be measured. • Results of objective screening or monitoring tools to gauge improvement • Instructions, recommendations and precautions given to other significant parties • Signature and credentials of the tutor and supervising treating provider

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ABA re-evaluation	For subsequent revaluation visit for a specific problem or group of problems, the medical record must include legible documentation of the following: • Date of the visit • Start and end times • Names of those present during the session. If separate individuals are interviewed, include the duration each is present. • Presenting problems • Techniques that have been utilized up to this time to extinguish the behaviors, and their level of success • Focused mental status examination • Results of relevant diagnostic testing, graphic reports and monitoring tools, when available • Medical history and illness currently and current medications along with prescribing medical provider and evidence of coordination of care • Psychosocial history if any changes during the interval — either positive or negative — that could affect the member • Objectively stated treatment plan including modification and rationale, with as much detail as possible outlining interventions and monitoring protocols • Assignment of appropriate DSM-5 codes • Treatment or education provided in the session • Instructions, recommendations and precautions given to the patient or to other significant parties • Signature and credentials of the treating provider