

Service / practitioner	Behavioral health medical record documentation requirements for autism services
All services, for practitioners with a medical degree	<p>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 (February 2021).</p> <p>The providers who must follow these guidelines are:</p> <ul style="list-style-type: none"> • Physicians • Nurse practitioners • Physician assistants
<p>General guidelines: Initial outpatient evaluation for all practitioners without a medical degree</p>	<p>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.</p> <ul style="list-style-type: none"> • The following information must be kept in the medical record: <ul style="list-style-type: none"> ○ 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. If separate individuals are interviewed, include the duration for which 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 <p>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.</p>

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Applied behavior analysis therapy	<p>These requirements apply to behavior technicians, behavior tutors and licensed behavior analysts,* or LBAs.</p> <p>The tutor/technician implements instructional programs designed by the supervising LBA for a member diagnosed with autism spectrum disorder. Primary documentation will focus on implementing treatment protocols, recording data, monitoring progress and carrying out activities under the supervision of the LBA.</p> <p>Each progress note must contain legible documentation of the following:</p> <ul style="list-style-type: none"> • Name of the tutor or technician providing services and the supervising LBA responsible for the services, 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 for which each is present. <p>Documentation must show that the following occurred in session activities:</p> <ul style="list-style-type: none"> • Implementing the treatment plan designed by the LBA • Collecting and entering data to prepare reports • Describing and documenting behavior and interactions in observable and measurable terms • Assisting with individualized screenings under the supervision of the LBA • Teaching, training and skill-acquisition activities under the supervision of the LBA • Providing brief progress updates to the LBA on what is occurring during sessions <p>All progress notes must be signed by the tutor or technician and the supervising LBA, with the appropriate credentials noted.</p>

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ABA parent / guardian / caregiver training and/or socialization group treatment	<p>Documentation for each socialization group or parent / guardian / caregiver training session is required. Each note must include legible documentation of the following:</p> <ul style="list-style-type: none"> • 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 for which each is present. • Number of participants in socialization group therapy (minimum of two, maximum of eight) • Relationship of additional participants to the patient in parent/caregiver training (for example, parent, guardian, grandparent or elder sibling) <p>Documentation must include the following related to training and group activities:</p> <ul style="list-style-type: none"> • Primary focus of the socialization group or parent / guardian / caregiver training session • For socialization group therapy, a statement summarizing the current clinical status and progress of the group as a whole • Statement summarizing the behavioral interventions used in the group or training session • Nature and degree of the patient’s participation and response in the session, if the patient was present at parent/caregiver training session <p>Note: Other than the group member in whose chart the note is written, don’t mention other patients in the socialization group by name.</p> <ul style="list-style-type: none"> • Whether the member participated in the socialization group, or how the member participated in the socialization group • Signature and credentials of the treating provider (or supervising provider, as appropriate)
ABA supervision	<p>For supervision sessions of continuing care, include legible documentation of the following:</p> <ul style="list-style-type: none"> • 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 LBA) • Identification of the number of services provided and type of sessions that will be reviewed and are the basis of the current review • Review of charts, graphs or other data that form the basis of the continued treatment plan • Brief indication of the patient’s reaction to behavioral intervention — what has worked to improve function or what has not — and other observations • Results of objective screening or monitoring tools to gauge improvement • Instructions, recommendations and precautions given to technician, parents / guardians / caregivers or other significant parties • Signature and credentials of the treating provider (or supervising provider, as appropriate)

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ABA re-evaluation	<p>For subsequent re-evaluation visit for a specific problem or group of problems, the medical record must include legible documentation of the following:</p> <ul style="list-style-type: none"> • Date of the visit, along with the start and end times • Names of those present during the session. If separate individuals are interviewed, include the duration for which 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 • Updated medical history and illness with current medications, along with prescribing medical provider. Include evidence that coordination of care has taken place at least quarterly. • 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 details outlining interventions and monitoring protocols • Assignment of appropriate DSM codes • Treatment or education provided in the session • Instructions, recommendations and precautions given to the technician, parents / guardians / caregivers or other significant parties • Evaluating treatment fidelity and whether it is taking place in the manner identified • Signature and credentials of the treating provider

*Effective Jan. 7, 2020, behavior analysts must be licensed by the state of Michigan to be reimbursed by Blue Cross or BCN.