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 autism services

For Blue Cross commercial and BCN commercial

Service / practitioner	Behavioral health medical record documentation requirements for autism 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 (February 2021)**. 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. 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 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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Applied behavior analysis therapy	These requirements apply to behavior technicians, behavior tutors and licensed behavior analysts,* or LBAs. 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. Each progress note must contain legible documentation of the following: • 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. Documentation must show that the following occurred in session activities: • 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 All progress notes must be signed by the tutor or technician and the supervising LBA, with the appropriate credentials noted.

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ABA parent / guardian / caregiver training and/or socialization group treatment	Documentation for each socialization group or parent / guardian / 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 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) Documentation must include the following related to training and group activities: • 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 Note: Other than the group member in whose chart the note is written, don't mention 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 treating provider (or supervising provider, as appropriate)
ABA supervision	For supervision sessions of continuing care, include legible documentation of the following: • 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	For subsequent re-evaluation visit for a specific problem or group of problems, the medical record must include legible documentation of the following: • 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-5 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.