QUALITY OF DOCUMENTATION **ABA**	**GUIDELINES FOR SCORING INDIVIDUAL RECORDS** **Y = Meets Standard N = Does Not Meet Standard** **N/A = Not Applicable**	**GUIDELINES FOR DETERMINING PROGRAM COMPLIANCE WITH STANDARDS** ***Programs are expected to strive to achieve all quality of documentation standards in 100% of the instances. Programs that are compliant in less than 75% of the charts reviewed will be required to develop a Program Improvement Plan (PIP) in conjunction with the Beacon and Maryland Medicaid***
1. Has the participant consented for treatment or with the consent of the participant, a parent or guardian has consented for treatment?	**Y =** Consent for services is documented by signature of the consumer or, when applicable, legal guardian. In instances when this is not possible, the program shall document the reasons why the individual cannot give written consent; verify the individual's verbal consent; and document periodic attempts to obtain written consent. **N =** Consent for treatment is not present in the chart **OR** there is a consent form signed by an individual as the consumer's guardian, but there is no documentation to support this individual's ability to sign as legal guardian.	75% of all medical records reviewed have documented consent for services.
2. Does the medical record contain a prescription for ABA service either written on a prescription pad; or a completed Physician Confirmation of Autism Spectrum Disorder Diagnosis form with supporting documents; or contained in the Comprehensive Diagnostic Evaluation (CDE) ordered by a qualified health care professional? COMAR 10.09.28.03 B (7)	**Y =** Prescription for ABA service either written on a prescription pad; **OR** a completed Physician Confirmation of Autism Spectrum Disorder Diagnosis form with supporting documents; **OR** contained in the Comprehensive Diagnostic Evaluation (CDE) ordered by a qualified health care professional. **N =** There is not a Prescription for ABA service either written on a prescription pad; **OR** a completed Physician Confirmation of Autism Spectrum Disorder Diagnosis form with supporting documents; **OR** contained in the Comprehensive Diagnostic Evaluation (CDE) ordered by a qualified health care professional.	75% of all medical records reviewed have the prescription for ABA service either written on a prescription pad; or a completed Physician Confirmation of Autism Spectrum Disorder Diagnosis form with supporting documents; or contained in the Comprehensive Diagnostic Evaluation (CDE) ordered by a qualified health care professional.

3. Does the medical record contain a current Comprehensive Diagnostic Evaluation (CDE) with the required elements, completed within the last 3 years and a recommendation outlining the need for ABA services written within the last 6 months; or a Clinical Review for Autism Spectrum Disorder and Applied Behavior Analysis form completed by a qualified health care professional? COMAR 10.09.28.01 B (9) COMAR 10.09.28.03 B (6) Beacon Provider Alert Comprehensive Diagnostic Evaluation (CDE) Guidelines to Access the Applied Behavior Analysis (ABA) Benefit, May 5, 2017	**Y =** The medical record contains a current Comprehensive Diagnostic Evaluation (CDE) with a parent/caregiver interview, direct observations of the participant outlining behaviors consistent with ASD per DSM-V criteria, a description of developmental and psychosocial history of the participant, documentation of current functioning across major domains of development, a statement identifying presenting diagnosis; completed within the last 3 years; and a recommendation outlining the need for ABA services written within the last 6 months; **OR** a Clinical Review for Autism Spectrum Disorder and Applied Behavior Analysis form completed by a qualified health care professional. **N =** The medical record does not contain a current Comprehensive Diagnostic Evaluation (CDE) with a parent/caregiver interview, direct observations of the participant outlining behaviors consistent with ASD per DSM-V criteria, a description of developmental and psychosocial history of the participant, documentation of current functioning across major domains of development, a statement identifying presenting diagnosis; completed within the last 3 years; and a recommendation outlining the need for ABA services written within the last 6 months; **OR** the CDE is missing a required element; **OR** a Clinical Review for Autism Spectrum Disorder and Applied Behavior Analysis form completed by a qualified health care professional.	75% of all medical records reviewed contain a current Comprehensive Diagnostic Evaluation (CDE) **OR** a Clinical Review for Autism Spectrum Disorder and Applied Behavior Analysis form completed by a qualified health care professional.
4. Does the medical record contain a comprehensive ABA assessment performed in person with the participant and the participant's parent or caregiver by a psychologist, licensed BCBA-D, or licensed BCBA which addresses the behavioral needs; includes an interview, direct observation, record review, data collection, analysis, assessment of the participant's current level of functioning, skills deficits, and maladaptive behaviors using validated instruments; and develops a treatment plan? COMAR 10.09.28.04 B (1)	**Y =** The medical record contains a comprehensive ABA assessment performed in person with the participant and the participant's parent or caregiver by a psychologist, licensed BCBA-D, or licensed BCBA which addresses the behavioral needs; includes an interview, direct observation, record review, data collection, analysis, assessment of the participant's current level of functioning, skills deficits, and maladaptive behaviors using validated instruments; and develops a treatment plan. **N =** The medical record does not contain a comprehensive ABA assessment performed in person with the participant and the participant's parent or caregiver by a psychologist, licensed BCBA-D, or licensed BCBA which addresses the behavioral needs; includes an interview, direct observation, record review, data collection, analysis, assessment of the participant's current level of functioning, skills deficits, and maladaptive behaviors using validated instruments; and develops a treatment plan; **OR** the assessment is completed by someone not authorized; **OR** the assessment is missing a required element.	75% of all medical records reviewed have a comprehensive ABA assessment performed in person with the participant and the participant's parent or caregiver by a psychologist, licensed BCBA-D, or licensed BCBA which addresses the behavioral needs; includes an interview, direct observation, record review, data collection, analysis, assessment of the participant's current level of functioning, skills deficits, and maladaptive behaviors using validated instruments; and develops a treatment plan

5. Does the medical record contain an individualized, Beacon approved treatment plan(s) for ABA services developed by a licensed psychologist, licensed BCBA-D or licensed BCBA for the audit review period? COMAR 10.09.28.01 B (31) COMAR 10.09.28.03 B (8)	**Y =** The medical record contains an individualized, Beacon approved treatment plan(s) for ABA services developed by a licensed psychologist, licensed BCBA-D or licensed BCBA for the audit review period. **N =** The medical record does not contain an individualized, Beacon approved treatment plan(s) for ABA services developed by a licensed psychologist, licensed BCBA-D or licensed BCBA for the audit review period; **OR** the treatment plan is missing from the record for the audit review period.	75% of all medical records reviewed have an individualized, Beacon approved treatment plan(s) for ABA services developed by a licensed psychologist, licensed BCBA-D or licensed BCBA for the audit review period.
6. Does the medical record contain reassessment(s) which evaluates progress toward each behavior goal, a revision of the treatment plan based on progress, and a recommendation for continued medically necessary ABA services; completed in person with a participant and a participant's parent or caregiver every 180 days or sooner depending on the authorization span by a psychologist, BCBA-D or BCBA? COMAR 10.09.28.04 B (8)	**Y =** The medical record contains reassessment(s) which evaluates progress toward each behavior goal, a revision of the treatment plan based on progress, and a recommendation for continued medically necessary ABA services; completed in person with a participant and a participant's parent or caregiver every 180 days or sooner depending on the authorization span by a psychologist, BCBA-D or BCBA. **N =** The medical record does not contain reassessment(s) which evaluates progress toward each behavior goal, a revision of the treatment plan based on progress, and a recommendation for continued medically necessary ABA services; completed in person with a participant and a participant's parent or caregiver every 180 days or sooner depending on the authorization span by a psychologist, BCBA-D or BCBA; **OR** the reassessment(s) are missing an element; **OR** the reassessments are completed by someone not authorized.	75% of all medical records reviewed have reassessment(s) which evaluates progress toward each behavior goal, a revision of the treatment plan based on progress, and a recommendation for continued medically necessary ABA services; completed in person with a participant and a participant's parent or caregiver every 180 days or sooner depending on the authorization span by a psychologist, BCBA-D or BCBA
7. Does the medical record contain documentation of each service delivered, which at a minimum, includes: location, start/end times; a description of the service provided, including reference to the treatment plan; description of the participant's parent or caregiver's participation, including the parent or the caregiver's name and relationship to the participant, date and time of participation; and a legible signature, along with the printed or typed name of the individual providing care, with the appropriate title? COMAR 10.09.28.04 F	**Y =** The medical record contains documentation of each service delivered, which at a minimum, includes: location, start/end times; a description of the service provided, including reference to the treatment plan; description of the participant's parent or caregiver's participation, including the parent or the caregiver's name and relationship to the participant, date and time of participation; and a legible signature, along with the printed or typed name of the individual providing care, with the appropriate title. **N =** The medical record does not contain documentation of each service delivered, which at a minimum, includes: location, start/end times; a description of the service provided, including reference to the treatment plan; description of the participant's parent or caregiver's participation, including the parent or the caregiver's name and relationship to the participant, date and time of participation; and a legible signature, along with the printed or typed name of the individual providing care, with the appropriate title; **OR** the documentation is missing an element.	75% of all medical records reviewed contain documentation of each service delivered, which at a minimum, includes: location, start/end times; a description of the service provided, including reference to the treatment plan; description of the participant's parent or caregiver's participation, including the parent or the caregiver's name and relationship to the participant, date and time of participation; and a legible signature, along with the printed or typed name of the individual providing care, with the appropriate title .

8. Does the medical record contain documentation of direct supervision or direct and remote supervision of the BCaBA RBT, or BT? Does the provider have approval from the Department for remote supervision? COMAR 10.09.28.01 B (13) & (34) COMAR 10.09.28.02 H (3) & I (5) COMAR 10.09.28.04 B (10) COMAR 10.09.28.05 F	**Y =** The medical record contains documentation of direct supervision or direct and remote supervision of the BCaBA RBT, or BT; if remote supervision, approval from the department is present. **N =** The medical record does not contain documentation of direct supervision or direct and remote supervision of the BCaBA RBT, or BT; **OR** if remote supervision, approval from the department is not present.	75% of all medical records reviewed have documented direct supervision or direct and remote supervision of the BCaBA RBT, or BT; if remote supervision, approval from the department is present.
9. Is the supervision ongoing, equal to at least 10 percent (10%) of the amount of hours of direct ABA treatment? COMAR 10.09.28.04 (10) (b)	**Y =** The medical record contains documentation that supervision is ongoing and equal to at least 10 percent (10%) of the amount of hours of direct ABA treatment. **N =** The medical record does not contain documentation that supervision is ongoing and equal to at least 10 percent (10%) of the amount of hours of direct ABA treatment; **OR** the supervision does not equal to at least 10 percent (10%) of the amount of hours of direct ABA treatment.	75% of all medical records reviewed have documentation that supervision is ongoing and equal to at least 10 percent (10%) of the amount of hours of direct ABA treatment.
10. Is at least 25 percent (25%) of the supervision performed in person? COMAR 10.09.28.04 (10) (c)	**Y =** The medical record contains documentation that at least 25 percent (25%) of the supervision is performed in person. **N =** The medical record does not contain documentation that at least 25 percent (25%) of the supervision is performed in person; **OR** the supervision documented is less than the required 25%; **OR** no supervision has been documented.	75% of all medical records reviewed have documented that at least 25 percent (25%) of the supervision is performed in person.