

Applied Behavior Analysis (ABA) documentation requirements for initial and continued treatment plans



Initial treatment plan

Background information/demographics

- Member's name
- Member's ID
- Birthdate
- Intake date at current provider
- Author of current treatment plan
- Date current plan was written (dates any previous updates were made to the plan)
- Plan must be written or updated within 60 days of sending in for re-authorization.

Biopsychosocial history

- Relevant medical information/other diagnoses
- Current medications/allergies
- Family current concerns and barriers/interview
- Autism spectrum disorder (ASD) diagnosis date
- Provider that made the diagnosis/assessment
- Communication/developmental history
- Educational history/ current schedule if applicable/ individualized educational program if applicable
- ABA therapy history/schedule of current therapy
- Schedule of any other therapies
- Coordination of care occurring

Assessments

- Comprehensive/developmental assessments
- Functional behavior assessment
- Dates they were conducted and by who
- Legible charts/graphs

Individualized treatment goals

(based on assessment, there should be enough goals considering the intensity of behaviors and the requested units)

- All goals should be specific, observable, measurable, include baseline measurements and progress over time with data.
- Operationally defined behaviors
- Behavior baselines
- Behavior reduction goals
- Skill acquisition goals (should be appropriate for ABA and based on comprehensive/developmental assessment and have baseline measurements)
- Plan for generalization
- Caregiver goals
- Transition and discharge plan

ABA therapy recommendations

- Units/hours
- Clinical rationale

Disclaimer: This information should be used to assist with providing essential contents of a treatment plan for Applied Behavior Analysis (ABA) therapy. This document does not replace any state, Milliman Care Guidelines (MCG) or Molina Healthcare specific guidelines, policy or procedure.

Continued treatment plan

Treatment plan should include the same components of an initial treatment plan above and the provider should ensure it contains:

Updated treatment goals

- Updated comprehensive/developmental assessments
 - Progress/status of goals
- Progress for all goals, from at least the previous month, should be noted with data.
- Target behaviors and behavior support plan if applicable
 - Operational and behavioral definitions of the target behavior excesses and deficits
 - Updated graphs for the previous authorization
 - Prevention (antecedent) strategies, replacement behaviors and consequence strategies
- Updated progress on caregiver goals
- Barriers to progress if lack of progress demonstrated with data, low number of goals mastered across the treatment period.