GENERAL
The record is accurate and clearly legible to someone other than the writer.
Each page of the record identifies the member.
All entries in the record include the responsible service provider's name.
All entries in the record include the responsible service provider's professional degree and relevant identification number, if applicable.
All entries in the record include date where appropriate.
All entries in the record include signature (including electronic signature for EMR systems in accordance with Louisiana Administration Code, Title 48, Part 1, Chapter 7 at https://www.doa.la.gov/Pages/osr/lac/books.aspx, if applicable.)
Each record includes member's address.
Each record includes employer and/or school address and telephone number, if applicable.

Each record includes preferred telephone number.
Each record includes emergency contact information.
Each record includes date of birth.
Each record includes gender.
Each record includes relationship and/or legal status, if applicable.
For members 0 to 18, documentation of guardianship is included in the record, if applicable.
Each member has a separate record.

MEMBER RIGHTS
There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the member and/or legal guardian.
The Patient Bill of Rights is either signed or refusal is documented.
There is evidence of the member being given information regarding member's rights to confidentiality.
COMPREHENSIVE DIAGNOSTIC EVALUATION
Does the CDE in the member's record match the CDE used for the approval of services?
Comprehensive Diagnostic Evaluation performed by a Qualified Health Care Professional (QHCP) as determined according to the provisions of the Louisiana Administrative Code (LAC), Title 50, Part I, Chapter 11.

TREATMENT PLAN
Evidence the licensed professional supervising treatment performed a functional assessment of the recipient utilizing the outcomes from the CDE.
Evidence the licensed professional supervising the treatment developed a behavior treatment plan.
Evidence additional assessments **should** occur every six months, if applicable.
The behavior treatment plan identifies the treatment goals to increase or decrease the targeted behaviors.
Treatment goals target a broad range of skill areas such as communication, sociability, self-care, play and leisure, motor development and/or academic.
Treatment goal *instructions* target a broad range of skill areas such as communication, sociability, self-care, play and leisure, motor development and/or academic.
Treatment goal instructions should break down the desired skills into manageable steps that can be taught from the simplest to more complex.
Treatment goal instructions must be developmentally appropriate.
Treatment goals must be developmentally appropriate.

The behavior treatment plan must be person-centered.
The behavior treatment plan must be based upon individualized goals.
The behavior treatment plan must delineate the frequency of baseline behaviors.
The behavior treatment plan must delineate the treatment development plan to address the behaviors.
The behavior treatment plan must identify long-term goals that are behaviorally defined.
The behavior treatment plan must identify intermediate goals that are behaviorally defined.

The behavior treatment plan must identify short-term goals that are behaviorally defined.
The behavior treatment plan must identify long-term objectives that are behaviorally defined.
The behavior treatment plan must identify intermediate objectives that are behaviorally defined.
The behavior treatment plan must identify short-term objectives that are behaviorally defined.
The behavior treatment plan must identify the criteria that will be used to measure achievement of behavior objectives.
The behavior treatment plan must clearly identify the schedule of services planned.

The behavior treatment plan must clearly identify the BCBA(s) responsible for delivering the services.
The behavior treatment plan must Include care coordination involving the parent(s) or caregiver(s).
The behavior treatment plan must Include care coordination involving the school, if applicable.
The behavior treatment plan must Include care coordination involving state disability programs, if applicable.
The behavior treatment plan must Include care coordination involving others as applicable.
The behavior treatment plan must include parent/caregiver training.
The behavior treatment plan must include parent/caregiver support.
The behavior treatment plan must include parent/caregiver participation.

The behavior treatment plan must identify objectives that are specific.
The behavior treatment plan must identify objectives that are measurable.
The behavior treatment plan must identify objectives that are based upon clinical observations of the outcome measurement assessment.
The behavior treatment plan must identify objectives that are tailored to the recipient.
The behavior treatment plan must ensure that interventions are consistent with ABA techniques.
The provider must address ALL of the relevant information specified in the LDH treatment plan template.

The behavior treatment plan must indicate that direct observation occurred.
The behavior treatment plan must describe what happened during the direct observation.
If there are behaviors being reported by caregiver that did not occur during assessment/observation and these behaviors are being addressed in the behavior treatment plan, indicate all situations in which these behaviors have occurred and have been documented, if applicable.
If there are behaviors being reported that did not occur and these behaviors are being addressed in the behavior treatment plan, indicate all frequencies at which these behaviors have occurred and have been documented, if applicable
If there is documentation from another source, that documentation must be attached, if applicable.
If applicable, there is any other evidence of the behaviors observed during the direct observation and that are proof of these behaviors, these must be reported on the behavior treatment plan as well.
The behavior treatment plan shall include a weekly schedule detailing the number of expected hours per week for the requested ABA services.
The behavior treatment plan shall include a weekly schedule detailing the location for the requested ABA services.
The provider shall indicate the intensity of the therapy being requested.

The provider shall indicate the frequency of the therapy being requested.
The provider shall indicate the justification for this level of service.
If technician services are being provided, supervision by a licensed behavior analyst must be a part of the treatment plan.
The licensed supervising professional must frequently review the recipient's progress using ongoing objective measurement, at a minimum of 5 percent of the total direct intervention time spent providing applied behavior analytical services per month.
The licensed supervising professional must adjust the instructions in the behavior treatment plan as needed, if applicable.
The licensed supervising professional must adjust the goals in the behavior treatment plan as needed.
The behavior treatment plan should indicate if the recipient is in a waiver which can be determined by checking the MEVS/REVS system.
DOCUMENTATION
Documentation shall accurately state the nature of the services previously provided.
Documentation shall accurately state the nature of the services currently provided.
Documentation shall accurately state the fees or charges.
Providers shall have records that demonstrate all codes were delivered to the proper client.
Providers shall have records that demonstrate all codes were billed and used properly.
Start and stop times shall be recorded for every code billed.

Start and stop times should be used following a break that is 12 minutes or longer.
Start and stop times should be used when there is a switch to a different billing code.
The daily documentation/log note shall include names of session attendees.
The daily documentation/log note shall include start time for each session.
The daily documentation/log note shall include stop time for each session.
The daily documentation/log note shall include a narrative of what happened in the session describing what programs/ interventions were run during the session
The daily documentation/log note shall include a narrative of what happened in the session describing each attendees’ responses to interventions through the session.
The daily documentation/log note shall include a narrative of what happened in the session describing each attendees’ barriers to progress
The daily documentation/log note shall include that all documentation must be individualized to each client.
CONTINUITY AND COORDINATION OF CARE
The record documents that the member was asked whether they have a PCP/APRN.
PCP/APRN's name is documented in the record, if applicable.
PCP/APRN's address is documented in the record, if applicable.
PCP/APRN's phone number is documented in the record, if applicable.

The record documents that the member was asked what other medical and/or ancillary services they are receiving.
Evidence of coordination of care between ABA services and other medical and/or ancillary services, if applicable.
PATIENT SAFETY
If there is evidence in the record of suicidal/homicidal ideation/behaviors, there is documentation that appropriate precautionary measures were taken.
If there is evidence documented in the record for Abuse or Neglect, there is documentation that appropriate protective agencies are notified immediately upon discovery.
ADVERSE INCIDENTS
For members 0 to 18, documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within 1 business day of discovery.
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency within 1 business day of discovery.
Documentation that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate.
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the health plan within 1 business day of discovery.
CULTURAL COMPETENCY

Primary language spoken by the member is documented.
Any translation needs of the member are documented, if applicable.
Language needs of the member were assessed (i.e. preferred method of communication), if applicable.
Identified language needs of the member were incorporated into treatment, if applicable.
Religious/Spiritual needs of the member were assessed.
Identified religious/spiritual needs of the member were incorporated into treatment, if applicable.
Racial needs of the member were assessed.(i.e. oppression, privilege, prejudice…etc.), if applicable.
Identified racial needs of the member were incorporated into treatment, if applicable.
Ethnic needs of the member were assessed.
Identified ethnic needs of the member were incorporated into treatment, if applicable.
Sexual health related needs were assessed, if applicable.
Identified sexual health related needs of the member were incorporated into treatment, if applicable.
DISCHARGE PLANNING
Documentation of discussion of discharge planning/linkage to next level of care.
Course of treatment (the reason(s) for treatment and the extent to which treatment goals were met) reflected in the discharge summary, when member is discharged or transitioned to a different level of care.
A discharge summary details the recipient’s progress prior to a transfer or closure, when member is discharged or transitioned to a different level of care.

Met (1)
ENTIRE record is accurate and clearly legible.
ALL pages within the record identifies the member. • This can be member name, member initials, member medical record #, member client ID #, etc.
ALL entries include responsible service provider's name. • provider= staff member responsible, not the agency or group name.
ALL entries include the responsible service provider’s professional degree, if applicable. • Professional degree can include graduate and undergraduate professional degrees such as B.A., B.S., M.S., M.A., Ph.D., AP RN, etc. • BCBA=name, BCBA, degree • Line Tech=highest credential=B.A/B.S • Line Tech without Bachelor's=No identifying degree
ALL record entries include date.
ALL record entries include signature including electronic signatures.
Record contains member’s FULL mailing address or documentation of why not • Ex. Jane Doe 123 Alphabet St, Lafayette, LA 70508. • If group home, we need the physical address. • If member is homeless, homelessness must be notated.
Record includes employer and/or school address AND telephone number OR there is documentation showing member not employed and/or not attending school. • Ex. Jane Doe is disabled and unemployed. • Ex. Johnnie Doe is not currently employed.

Record contains member's (or guardian) home and/or work telephone numbers OR it is documentation showing why no telephone number is listed for member. • Ex. Jane Doe is currently unemployed and reports having no access to a phone.
Record includes emergency contact information OR documentation why not. • Emergency contact info must include name, address, and phone number. • Ex. Jane Doe reports having no living relatives and no support system. Jane Doe refuses to provide emergency contacts.
Record includes full date of birth of member.
Record includes either biological gender or self-identified gender OR there is documentation as to why not. • Gender is whatever gender the member identifies as also included would be gender expression. • Ex. Member refused to identify as specific gender. • Ex. Member refused to disclose identified gender.
Record includes relationship and/or legal status of member OR there is documentation as to why not. • Relationship status=married, single, divorce, etc. • Legal status=minor, under custodial care of, emancipated, competent major, etc. • Ex. Member refused to disclose.
Record includes documented proof of guardianship of member from someone other than biological parents. • Can include emancipation paperwork, state custody, shared custody, etc. • If member is in the care of anyone other than their biological parent(s) we need to have proof of guardianship.
Evidence of one member per record.

Evidence of a Consent for Treatment or Informed Consent that is signed by member and/or legal guardian in the record. If not signed, documentation indicating why not.
Patient Bill of RIghts is signed by member and/or legal guardian OR documentation of refusal and/or rationale why not.
Evidence of member being given information regarding member rights to confidentiality found within the record. • This could be included in the informed consent document.
Evidence that the CDE in member's record matches CDE used for approval of services. • Reviewer will need to match what is in record with what was submitted for authorization of services.
Evidence that assessment is completed by a QHCP. A QHCP is defined as a: • Pediatric Neurologist; • Developmental Pediatrician; • Psychologist (including a Medical Psychologist); • Psychiatrist (particularly Pediatric and Child Psychiatrist); or • Licensed individual that has been approved by the recipient’s MCO medical director as meeting the requirements of a QHCP when: o The individual’s scope of practice includes differential diagnosis of Autism o Spectrum Disorder and comorbid disorders for the age and/or cognitive level of the recipient; and o The individual has at least two years of experience providing such diagnostic assessments and treatments.

Providers should go to Appendix D in the ABA manual. There are detai within manual, their plan of care MUST address all information specifie Treatment Plan may be found within the actual assessment. Typical pr assessment into report to determine goal/objective for member includ
Evidence the licensed professional supervising treatment performed a functional assessment of the recipient utilizing the outcomes from the CDE.
Evidence the licensed professional supervising treatment developed the behavior treatment plan.
If applicable, there is evidence of additional assessments occurring every six months.
The behavior treatment plan identifies the treatment goals to increase or decrease the targeted behaviors.
Evidence of treatment goals targeting a broad range of skills areas. • Focused Behavioral Intervention may only be geared towards ONE skill area versus broad range. • Should be stated in prescription therapy hours and assessment, 15 hours or less.
Evidence of treatment goals *INSTRUCTIONS* targeting a broad range of skills areas. • Focused Behavioral Intervention may only be geared towards ONE skill area versus broad range. • Should be stated in prescription therapy hours and assessment, 15 hours or less.
Evidence of treatment goal instructions breaking down the desired skills into manageable steps, taught from simplest to more complex.
Evidence that treatment goal instructions are developmentally appropriate.
Evidence that treatment goals are developmentally appropriate.

Evidence of the behavior treatment plan being person-centered. • Centered around the person with goals of what will be done. • We are looking for more than just a generic treatment plan and/or copy/paste across all members being served at one agency.
Evidence of the behavior treatment plan has individualized goals. • Individualization of goals/objectives/interventions. • We are looking for more than just a generic treatment plan and/or copy/paste across all members being served at one agency.
The behavior treatment plan delineates the frequency of baseline behaviors. • Could be found on visual graph within the plan that would outline baseline behaviors reported during assessment.
The behavior treatment plan delineates the treatment development plan to address the behaviors. • Goals within plan would specifically address challenging behaviors such as Johnny will decrease daily episodes of aggression by % with instructions on how.
Evidence of behaviorally defined long-term goals within the behavior treatment plan. • Be aware that goals may not be clearly identified as “long-term goals” within treatment plans. Look for GOALS.
Evidence of behaviorally defined intermediate goals within the behavior treatment plan. • Be aware that intermediate and short-term goals are not clearly defined in the manual and may not be clearly identified within the treatment plan. Providers will not be penalized for not having these delineated from over-arching goals.

Evidence of behaviorally defined short-term goals within the behavior treatment plan. • Be aware that intermediate and short-term objectives are not clearly defined in the manual and may not be clearly identified within the treatment plan. Providers will not be penalized for not having these delineated from over-arching objectives.
Evidence of behaviorally defined long-term objectives within the behavior treatment plan. • Be aware that objectives may not be clearly identified as “long-term objectives” within treatment plans. Look for Objectives.
Evidence of behaviorally defined intermediate objectives within the behavior treatment plan. • Be aware that intermediate and short-term objectives are not clearly defined in the manual and may not be clearly identified within the treatment plan. Providers will not be penalized for not having these delineated from over-arching objectives.
Evidence of behaviorally defined short-term objectives within the behavior treatment plan. • Be aware that intermediate and short-term objectives are not clearly defined in the manual and may not be clearly identified within the treatment plan. Providers will not be penalized for not having these delineated from over-arching objectives.
Evidence that the behavior treatment plan includes identified criteria that will be used to measure achievement of behavior objectives. • Criteria specifically stated such as aggression will decrease by 50%. • Can be found within verbiage of goal.
Evidence that the behavior treatment plan clearly identifies the schedule of services planned. • Daily schedule: prescribed hours, ratio of line therapies to supervision, etc. • A planned schedule needs to be laid out clearly within the plan.

Criteria
Evidence that the behavior treatment plan clearly identifies the BCBA responsible for delivering the services. • The behavior treatment plan is developed by the BCBA; the behavioral technicians would not be referenced by name within the plan.
Evidence that the behavior treatment plan includes care coordination involving the parent(s) or caregiver(s). • Talking with parent/caregiver such as recommendation of other services, etc.
The behavior treatment plan Includes care coordination involving the school, if applicable.
The behavior treatment plan includes care coordination involving state disability programs, if applicable • We want to see that the provider checked on whether member is in a state disability program or not.
The behavior treatment plan Includes care coordination involving others as applicable. • Others=Medical and Ancillary Services such as PT, ST, OT, PCP, APRN, etc.
The behavior treatment plan includes parent/caregiver training. • Training is defined as teaching someone a skill. • Training is specifically prescribed within treatment plan and goals to address parent behavior. • Training can also be found in parent graphs within some treatment plans.
The behavior treatment plan includes parent/caregiver support. • Support is giving feedback regarding progress made towards mastery of the skill taught. • Documentation pertaining to feedback given to parent/caregiver related to training goals • Ex. support in form of redirection when parent attempting to potty train, etc.
The behavior treatment plan includes evidence of parent/caregiver participation such as signature on treatment plan by parent/caregiver.

The behavior treatment plan identifies objectives that are specific.
The behavior treatment plan identifies objectives that are measurable.
The behavior treatment plan identifies objectives that are based upon clinical observations of the outcome measurement assessment. • Ex. Narratives and/or graphs will describe how individuals performed on the outcome measurement assessment. Those results will be used to build goals/objectives and identify how data will be collected.
The behavior treatment plan identifies objectives that are tailored to the recipient.
Evidence that the behavior treatment plan interventions are consistent with ABA techniques. • The Professional and Ethical Compliance Code for Behavioral Analysts https://www.bacb.com/wp-content/uploads/2020/05/BACB-Compliance-Code-english_190318.pdf
Evidence that ALL of the relevant information specified in the LDH treatment plan template is addressed. • Section 4, Appendix D of manual https://www.lamedicaid.com/provweb1/providermanuals/manuals/ABA/ABA.pdf

The behavior treatment plan indicates that direct observation occurred.
The behavior treatment plan describes what happened during direct observation.
If applicable, there is indication that behaviors reported by parents/caregivers are documented and being addressed in the behavior treatment plan despite no observation by Provider of these behaviors. Provider did not observe behavior during assessment/observation. • Ex. Member's caregiver shared with Provider that Member engages in self-injurious behaviors. During the assessment, Provider does not observe self-injurious behaviors. Provider still includes self-injurious behaviors within the treatment plan to decrease reported behavior.
If applicable, there is indication that if behaviors are reported by parents/caregivers, the frequency of these behaviors are documented and being addressed.
If applicable, there is evidence of documentation from another source attached to the record such as an IEP, CDE, etc.
If applicable, there is evidence of reported behaviors observed during the direct observation be included on treatment plan. • Ex. Parent reports aggressive behaviors displayed by member. Provider conducts direct observation of member which confirms aggression. Aggressive behaviors is included on tx plan to target.
Evidence that there is a weekly schedule detailing the number of expected hours per week for requested ABA services. • Member is expected to be in the center for X amount of hours per week.
Evidence that the weekly schedule details the location for requested ABA services.
There is indication of intensity of the therapy being requested.

There is indication of the frequency of therapy being requested.
There is evidence of the justification for this level of service.
If technician services are being provided, there is evidence of supervision by a licensed behavior analyst within the treatment plan.
There is evidence that ongoing objective measurements is being conducted. • At minimum 5% per month of the total direct intervention time provided to child should be time spent in supervision, we expect time spent in supervision to be geared towards progress measurement in addition to supervisor session. • Supervision note would capture this.
If applicable, there is evidence of the licensed supervising professional adjusting instructions within the treatment plan as needed.
If applicable, there is evidence of the licensed supervising professional adjusting the goals in the behavior treatment plan as needed.
The behavior treatment plan indicates if the recipient is in a waiver. • We want to ensure the waiver was checked by provider.
Evidence that the documentation accurately states the nature of the services previously provided. • Can be found within the initial assessment.
Evidence that the documentation accurately states the nature of the services currently provided.
Evidence that the documentation accurately states the fees or charges.
Evidence that member record demonstrates all codes were delivered to the proper client.
Evidence that member record demonstrates all codes were billed and used properly.
Evidence that start AND stop times are recorded for every code billed.

Evidence that start AND stop times are used following a break that is 12 minutes or longer.
Evidence that start AND stop times are used when there is a switch to a different billing code.
Evidence that the daily documentation/log note includes names of session attendees.
Evidence that the daily documentation/log note includes start time for each session.
Evidence that the daily documentation/log note includes stop time for each session.
Evidence that the daily documentation/log note includes a narrative of what happened in the session describing what programs/ interventions were run during the session (If BCBA provides the services, the narrative is expected; If RLT provides service then data recorded is sufficient to count for narrative).
Evidence that the daily documentation/log note includes a narrative of what happened in the session describing each attendees' responses to interventions through the session (If BCBA provides the services, the narrative is expected; If RLT provides service then data recorded is sufficient to count for narrative).
Evidence that the daily documentation/log note includes a narrative of what happened in the session describing each attendees' barriers to progress (If BCBA provides the services, the narrative is expected; If RLT provides service then data recorded is sufficient to count for narrative).
Evidence that the daily documentation/log note includes documentation that is individualized to each client.
The record documents that the member was asked whether they have a PCP/APRN.
PCP/APRN's name is documented in the record, if applicable.
PCP/APRN's address is documented in the record, if applicable.
PCP/APRN's phone number is documented in the record, if applicable.

There is documentation that member was asked what other medical and/or ancillary services are being received such as OT, ST, PT, etc.
If applicable, there is evidence of coordination of care between ABA service provider and other medical and/or ancillary services.
If the member was placed on a watch for harmful behavior, documentation of the appropriate precautionary measures occurred such as removal of sharp items, notifying caregiver/911, etc.
There is documentation that appropriate protective agencies were notified within 24 hours, if applicable. • The LA Children's Code Article 610 (https://codes.findlaw.com/la/childrens-code/la-ch-code-tit-vi-art-610.html) • www.dcfs.la.gov/abuse
Reporting Form (https://ldh.la.gov/index.cfm/page/2454)
For members 0 to 18, documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within 1 business day of discovery.
Documentation within the record that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency within 1 business day of discovery. • Current AI reporting form includes ANEE: Abuse, Neglect, Extortion, Exploitation, and Death.
Documentation within the record that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate.
Documentation within the record that adverse incidents listed on the adverse incident reporting form were reported to the health plan within 1 business day of discovery. • Current AI reporting form includes ANEE: Abuse, Neglect, Extortion, Exploitation, and Death.

Primary language spoken by the member is documented.
Any translation needs of the member are documented, if applicable.
Language needs of the member were assessed OR documentation that member declined to identify.
Identified language needs of the member were incorporated into treatment, if applicable.
Religious/Spiritual needs of the member were assessed OR documentation that member declined to identify.
Identified religious/spiritual needs of the member were incorporated into treatment, if applicable.
Racial needs of the member were assessed OR documentation that member declined to identify.
Identified racial needs of the member were incorporated into treatment, OR documentation that member declined.
Ethnic needs of the member were assessed OR documentation that member declined to identify.
Identified ethnic needs of the member were incorporated into treatment, OR documentation that member declined to identify.
Sexual health related needs were assessed OR documentation that member declined to identify.
Identified sexual health related needs of the member were incorporated into treatment OR documentation that member declined to identify.
Documentation of discussion of discharge planning/linkage to next level of care.
Course of treatment reflected in the discharge summary, when member is discharged or transitioned to a different level of care.
The discharge summary details the recipient's progress prior to a transfer or closure.

Not Met (0)
ENTIRE record is NOT accurate or clearly legible.
Not all of the pages within the record identifies the member.
Not all entries include responsible service provider's name.
Not all entries include responsible service provider's professional degree, if applicable.
Not all record entries include date.
Not all record entries include signature.
Record does NOT contain member's FULL mailing address and NO documentation of why not. • Ex. Jane Doe Lafayette, LA 70508
Record includes only employer and/or school address without telephone or vice versa.

Record does NOT contain telephone number. No documentation, why not.
Record does NOT include emergency contact information. No documentation why not.
Record does not include full date of birth.
Record does NOT include gender whether biological or self-identified. No documentation as to why not.
Record does NOT include relationship and/or legal status. No documentation as to why not.
Record does NOT include documented proof of guardianship.
Evidence of multiple members' information being kept in one record.

No signature found in record to consent for treatment or informed consent. No documentation why not.
No signed patient bill of rights found in record. No documentation why bill of rights is not signed.
NO evidence of member being given information regarding member's right to confidentiality found within the record.

NO evidence that the CDE in member's records matches CDE used for approval of services.
Evidence that assessment is NOT completed by an QHCP.

led instructions to filling out the treatment plan and the te
ed within the Medicaid State Plan for ABA and most recent
ocess includes record review, complete assessment with Jo
ling behavior reduction and skill acquisition goals. Behavior

NO Evidence the licensed professional supervising treatment performed a functional assessment of the recipient utilizing the outcomes from the CDE.
NO Evidence the licensed professional supervising treatment developed the behavior treatment plan.
No Not Met until manual verbiage is changed.
The behavior treatment plan does NOT identify the treatment goals to increase or decrease the targeted behaviors.
NO evidence of treatment goals targeting broad range of skills areas.
NO evidence of treatment goals targeting broad range of skills areas.
NO evidence of treatment goal instructions breaking down the desired skills into manageable steps, taught from simplest to more complex.
NO evidence that treatment goal instructions are developmentally appropriate.
NO evidence that treatment goals are developmentally appropriate.

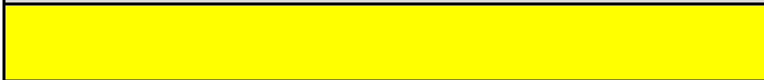
NO evidence of the behavior treatment plan being person-centered. Evidence of goals being copy/paste, very generic, not specific to member, etc.
NO evidence that the behavior treatment plan has individualized goals. Evidence of goals being copy/paste, very generic, not individualized for member, etc.
The behavior treatment plan does NOT delineate the frequency of baseline behaviors.
The behavior treatment plan does NOT delineate the treatment development plan to address the behaviors.
NO evidence of behaviorally defined long-term ***goals*** within the behavior treatment plan.
No Not Met until manual changes.

No Not Met until manual changes.
NO evidence of behaviorally defined long-term objectives within the behavior treatment plan.
No Not Met until manual changes.
No Not Met until manual changes.
NO evidence that the behavior treatment plan includes identified criteria that will be used to measure achievement of behavior objectives.
NO evidence that the behavior treatment plan clearly identifies the schedule of services planned.

NO evidence that the behavior treatment plan clearly identifies the BCBA responsible for delivering the services.
NO evidence that the behavior treatment plan includes care coordination involving the parent(s) or caregiver(s).
The behavior treatment plan does not include care coordination involving the school, if applicable.
The behavior treatment plan does not Include care coordination involving state disability programs, if applicable. No evidence that Provider checked on whether member is in state disability program or not.
The behavior treatment plan does not Include care coordination involving others as applicable.
The behavior treatment plan does not include parent/caregiver training.
The behavior treatment plan does not include parent/caregiver support.
The behavior treatment plan does not include parent/caregiver participation.

The behavior treatment plan does not identify objectives that are specific.
The behavior treatment plan does NOT identify objectives that are measurable.
The behavior treatment plan does NOT identify objectives that are based upon clinical observations of the outcome measurement assessment.
The behavior treatment plan does NOT identify objectives that are tailored to the recipient.
NO evidence that the behavior treatment plan interventions are consistent with ABA techniques.
NO evidence that ALL of the relevant information specified in the LDH treatment plan template is addressed.

The behavior treatment plan does NOT indicate that direct observation occurred.
The behavior treatment does NOT describe what happened during direct observation.
If applicable, there is NO indication that if reported by parents/caregivers, behaviors are documented and being addressed.
If applicable, there is no indication that if reported by parents/caregivers, the frequency of these behaviors are documented and being addressed.
If applicable, there is NO evidence of documentation from another source attached to the record.
If applicable, there is NO evidence of reported behaviors observed during the direct observation be included on treatment plan.
NO evidence of weekly schedule detailing the number of expected hours per week for requested ABA services.
NO evidence of weekly schedule detailing the location for requested ABA services.
There is NO indication of intensity of the therapy being requested.

There is no evidence of frequency of therapy being requested.
There is NO evidence of justification for this level of service.
If technician services are being provided, there is NO evidence of supervision by a licensed behavior analyst within the treatment plan.
There is NO evidence that ongoing objective measurements is being conducted.
If applicable, there is NO evidence of the licensed supervising professional adjusting instructions within the treatment plan as needed.
If applicable, there is NO evidence of the licensed supervising professional adjusting the goals in the behavior treatment plan as needed.
The behavior treatment plan does NOT indicate if the recipient is in a waiver.

NO evidence that the documentation accurately states the nature of the services previously provided.
NO evidence that the documentation accurately states the nature of the services currently provided.
NO evidence that the documentation accurately states fees or charges.
NO evidence that member record demonstrates all codes were delivered to the proper client.
NO evidence that member record demonstrates all codes were billed and used properly.
NO evidence that start AND stop times are recorded for every code billed.

No Not Met until manual changes.
No Not Met until manual changes.
NO evidence that the daily documentation/log note includes names of session attendees.
NO evidence that the daily documentation/log note includes start time for each session.
NO evidence that the daily documentation/log note includes stop time for each session.
NO evidence that the daily documentation/log note includes a narrative of what happened in the session describing what programs/ interventions were run during the session.
NO evidence that the daily documentation/log note includes a narrative of what happened in the session describing each attendees' responses to interventions through the session.
Evidence that the daily documentation/log note includes a narrative of what happened in the session describing each attendees' barriers to progress.
NO evidence that the daily documentation/log note includes documentation that is individualized to each client.
The record does not documents that the member was asked whether they have a PCP/APRN
PCP/APRN's name is not documented in the record, if applicable.
PCP/APRN's address is not documented in the record, if applicable.
PCP/APRN's phone number is not documented in the record, if applicable.

There is NO documentation that member was asked what other medical and/or ancillary services are being received.
If applicable, there is NO evidence of coordination of care between ABA service provider and other medical and/or ancillary services.
If the member was placed on a watch for harmful behavior, there was no documentation of the appropriate precautionary measures occurred.
There is no documentation that appropriate protective agencies were notified within 24 hours, if applicable.
For members 0 to 18, no documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within 1 business day of discovery.
No documentation that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency within 1 business day of discovery.
No documentation that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate.
No documentation that adverse incidents listed on the adverse incident reporting form were reported to the health plan within 1 business day of discovery.

Primary language spoken by the member is not documented. No documentation why not.
Any translation needs of the member are not documented, when applicable. No documentation why not.
Language needs of the member were not assessed. No documentation why not.
Identified language needs of the member were not incorporated into treatment, if applicable. No documentation why not.
Religious/Spiritual needs of the member were not assessed. No documentation why not.
Identified religious/spiritual needs of the member were not incorporated into treatment, if applicable. No documentation why not.
Racial needs of the member were not assessed. No documentation why not.
Identified racial needs of the member were not incorporated into treatment, if applicable. No documentation why not.
Ethnic needs of the member were not assessed. No documentation why not.
Identified ethnic needs of the member were not incorporated into treatment, if applicable. No documentation why not.
Sexual health related needs were not assessed. No documentation why not.
Identified sexual health related needs of the member were not incorporated into treatment, if applicable. No documentation why not.
No documentation of discussion of discharge planning/linkage to next level of care.
Course of treatment not reflected in the discharge summary, when member is discharged or transitioned to a different level of care.
There is no discharge summary that details the recipient’s progress prior to a transfer or closure.

N/A
No N/A
No N/A
No N/A
No N/A
No N/A
No N/A
No N/A
mbr is between age 0-kindergarden age.

No N/A
No N/A
No N/A
No N/A
No N/A
If member is over age of 18 OR if no proof of guardianship required (biological parents)
No N/A

No N/A

No N/A

No N/A

No N/A

No N/A

emplate. If provider chooses not to use specific template version of the ABA Provider Manual. ohn Doe w/ parent feedback, compile info with ral Treatment Plan is the ABA assessment/plan.
No N/A
No N/A
If no evidence of additional assessments until manual verbiage is changed.
No N/A
No N/A
No N/A
No N/A
No N/A
No N/A

No N/A
No N/A
No N/A
No N/A
No N/A
N/A if not clearly identified; give point if it is there.

N/A if not clearly identified; give point if it is there.
No N/A
N/A if not clearly identified; give point if it is there.
N/A if not clearly identified; give point if it is there.
No N/A
No N/A

No N/A
No N/A
No N/A
No N/A
No evidence that care coordination was required.
No N/A
No N/A
No N/A

No N/A
No N/A
No N/A
No N/A
No N/A
No N/A

No N/A
No N/A
If it not applicable
If it not applicable
if not applicable.
if not applicable.
No N/A
No N/A
No N/A

No N/A
No N/A
No N/A
No N/A
if not applicable.
if not applicable.
No N/A
No N/A
No N/A
No N/A
No N/A
No N/A
No N/A

N/A if start and stop times are not identified following a break that is 12 minutes or longer until manual changes.
N/A if start and stop times are not identified when switching to a different billing until manual changes.
No N/A
no N/A
No N/A
No N/A
No N/A
No N/A
No N/A
No N/A
if not applicable.
if not applicable.
if not applicable.

No N/A
if not applicable.
No evidence of member requiring precautionary measures.
No evidence of Abuse or Neglect.
Member is over the age of 18. Incident involved the guardian. Member had no reportable adverse incident.
Member had no adverse incidents.
Member had no adverse incidents. Incident did not involve direct care staff.
Member had no adverse incidents.

No N/A
No translation needs were identified.
No N/A
No language needs were identified.
No N/A
No identified religious/spiritual needs.
No N/A
No identified racial needs.
No N/A
No identified ethnics needs.
No N/A
No identified sexual health related needs.
No N/A
Member has not been discharged.
Member has not been discharged.