

Regional Monitoring of Autism Benefit – Applied Behavioral Analysis Consumer Specific Standards

PROVIDER SITE:	DATE OF REVIEW: <i>Click or tap to enter a date.</i>
NAMES OF REVIEWERS:	DATE REPORT SENT TO PROVIDER: <i>Click or tap to enter a date.</i>
CORRECTIVE ACTION REQUIRED: <input type="checkbox"/> Yes <input type="checkbox"/> No	CORRECTIVE ACTION DUE DATE: <i>Click or tap to enter a date.</i>
CORRECTIVE ACTION ACCEPTED: <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE CORRECTIVE ACTION ACCEPTED: <i>Click or tap to enter a date.</i>

	Standard	Source	Evidence may include	Score	Evidence Found, Notes, Comments
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AUTISM BENEFIT/APPLIED BEHAVIORAL ANALYSIS (Desk Review)					
1.1	Beneficiaries IPOS addresses the needs. A. As part of the IPOS, there is a comprehensive individualized ABA behavioral plan of care that includes specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals for improvement. B. The IPOS must address risk factors identified for the child and family, specify how the risk factor may be minimized and describe the backup plan for each identified risk.	Medicaid Provider Manual MHSA Section 18	Policy & Procedure Consumer Chart	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
1.2	Beneficiaries services and supports are provided as specified in the IPOS, including: A. Amount B. Scope C. Duration	Medicaid Provider Manual MHSA Section 18	Policy/Procedure Consumer Chart; Assessment; Progress Notes; Adjudicated claims	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
1.3	Beneficiaries BHT authorization was completed by Utilization Management (UM) staff who are free from conflict of interest as evidenced by documentation that the staff does not provide any other service to that beneficiary.	Medicaid Provider Manual MHSA Section 18	Policy/Procedure Consumer Chart	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
1.4	Beneficiaries ongoing determination of level of service (every six months) has evidence of measurable and ongoing	Medicaid Provider Manual MHSA Section	Policy/Procedure	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)	

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	improvement in targeted behaviors as demonstrated with ABLLS-R or VB-MAPP or other appropriate documentation of analysis (i.e. graphs, assessment reports, records of service, progress reports, etc.).	18; DCH Site Review Protocol for Autism Beneficiaries; Contract SOW III.h	Consumer Chart; Assessments (within 6 mos. from last assessment)	<input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
1.5	Beneficiaries whose average hours of ABA services during a quarter were within the suggested range for the intensity of service plus or minus a variance of 25%.	Medicaid Provider Manual MHSA Section 18; Regional Procedure – Autism Benefit Compliance Monitoring	Policy/Procedure Consumer Chart; Assessment; Progress Notes; Adjudicated claims	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
1.6	Observation Ratio: Number of Hours of ABA observation during a quarter are \geq to 10% of the total service provided.	MSA 1559 Policy SOW III.b.	Policy/Procedure; Claims data; progress notes; supervision to demonstrate 1 hour to every 10 hrs.	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
			TOTAL SCORE/%:	Points	%
Findings:					
Strength:					
Recommendations (does not require corrective action):					
Corrective Action Plan (PROVIDER COMPLETES):					
Reviewer Response:					

	Standard	Source	Evidence may include	Score	Evidence Found, Notes, Comments
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Documentation/Reporting Requirements (desk review)					
2.1	Transportation Logs include name of transporter and if ABA services were provided during transport. If ABA services are provided by BT, the name of the BT and name of transporter is included.	Contract; Statement of Work III.a	Transportation logs	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
2.2	Supervision Logs indicate date, duration, and content of supervision; supervision name and signature; staff name, client name	Contract; Statement of Work III.b	Supervision logs	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
2.3	Family Training Progress Notes include date, content, duration, and signature of family member receiving training and staff providing training.	Contract; Statement of Work III.c	Progress notes; date stamp end time after session end-time	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
2.4	Social Skills Group Progress Notes indicate date, content, and duration of session, signature of BHT supervisors	Contract; Statement of Work III.d	Progress notes; date stamp end time after session end-time	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
2.5	Group adaptive behavior progress note includes date, content, duration of session, and signature of technician providing the service.	Contract; Statement of Work III.e	Progress notes; date stamp end time after session end-time	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
2.6	Telepractice services are pre-authorized in the IPOS and with MDHHS prior to service being rendered.	Contract; Statement of Work III.f	Active telepractice case reports (WSA); cross-reference with GT modifier	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	
2.7	ABA exposure adaptive treatment – double staffing notes include dated, duration of session, and signature of both rendering providers.	Contract; Statement of Work III.g	Progress notes; assessment indicates need for intensive	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0) <input type="checkbox"/> Partial (1) <input type="checkbox"/> NA	

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			service; evidence of Behavior Treatment Review by BTC		
			TOTAL SCORE/%:	Points	%
Findings:					
Strength:					
Recommendations (does not require corrective action):					
Corrective Action Plan (PROVIDER COMPLETES):					
Reviewer Response:					