Quality of Documentation Definitions Tool
Applied Behavior Analysis (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 instances. Programs that are compliant in less than 85% of the charts reviewed will be required to develop a Corrective Action Plan (CAP) in conjunction with the Optum Maryland, Maryland Medicaid, MDH, or any other auditing agency.***
1. Has the participant or parent/guardian, with the consent of the participant, consented to treatment? *COMAR 10.09.36.03 A (7)* *COMAR 10.58.16.14 A* **YES / NO**	**Y =** There is documentation that the participant or parent/legal guardian has given consent to treatment. In instances when obtaining consent is not possible, the program shall document the reasons why the participant cannot give written consent; verify the participant's verbal consent; and document periodic attempts to obtain written consent. **Additionally**, in the instance where a legal guardian has been appointed, the OMHC has received appropriate documentation (court orders and custody agreements regarding healthcare decision-making, or a letter from the agency naming a specific person to make healthcare decisions, if an agency such as DSS has custody). **N =** There is no documentation that consent was obtained; or the above required elements are not present in the record.	85% of all medical records reviewed contain the required documentation.
2. Does the medical record contain a prescription for ABA service? *COMAR 10.09.28.03 B (7)* **YES / NO**	**Y =** The medical record contains a prescription for ABA service, ordered by a qualified health care professional, that is: • Written on a prescription pad; • Documented in a completed *Physician Confirmation of Autism Spectrum Disorder Diagnosis* form with supporting documents; **OR** • Contained in the *Comprehensive Diagnostic Evaluation* (CDE). **N =** The record does not contain a prescription for ABA service in any of the above-listed ways; or the prescription for ABA service was not ordered by a qualified health care professional.	85% of all medical records reviewed contain the required documentation.

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3. Does the medical record contain a complete *Comprehensive Diagnostic Evaluation* (CDE)?
COMAR 10.09.28.01 B (9)
COMAR 10.09.28.03 B (6)
 	
YES / NO
	Y = The medical record contains a *Comprehensive Diagnostic Evaluation* (CDE) that is:
	• Performed by a qualified health care professional with the help of validated instruments;
	• Completed within the last 3 years;
	• Includes the following:
	  ○ 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; **AND**
	  ○ A recommendation outlining the need for ABA services that was **written within the last 6 months**
	
	OR, the record contains:
	
	• 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, and complete *Comprehensive Diagnostic Evaluation* (CDE) or a *Clinical Review for Autism Spectrum Disorder and Applied Behavior Analysis* form meeting the above-required elements.
		85% of all medical records reviewed contain the required documentation.

4. Does the medical record contain an individualized and comprehensive ABA assessment?
COMAR 10.09.28.01 B (31)
COMAR 10.09.28.03 B (8)
COMAR 10.09.28.04 B (1)
 	
YES / NO
	Y = The medical record contains an ABA assessment that:
	• Was performed in person with the participant and the participant's parent or caregiver;
	• Was performed by a psychologist, licensed BCBA-D, or licensed BCBA;
	• Addresses the behavioral needs; and 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**
	• Development of a treatment plan.
		85% of all medical records reviewed contain the required documentation.

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	N = The medical record does not contain an individualized and comprehensive ABA assessment; **OR** the assessment does not contain all above-required elements.	

5. Does the medical record contain a reassessment every 180 days or sooner, depending on the authorization span?
COMAR 10.09.28.04 B (8)
 	
YES / NO
	Y = The medical record contains a reassessment that:
	• Was performed in person with a participant and a participant's parent or caregiver;
	• Was completed by a psychologist, BCBA-D or BCBA;
	• Was completed every 180 days or sooner, depending on the authorization span; **AND**
	• Includes the following:
	  ○ Progress toward each behavior goal;
	  ○ A revision of the treatment plan based on progress; **AND**
	  ○ A recommendation for continued medically necessary ABA services;
	
	N = The medical record contains reassessment(s) that are not comprehensive, per the above-listed requirements above; and/or the record is missing reassessment(s).
	
	N/A = A reassessment is not due for the participant; therefore, it would not be present in the record.
		85% of all medical records reviewed contain the required documentation.

6. Does the medical record contain the required documentation of each service delivered? *COMAR 10.09.28.04 F* **YES / NO**	**Y =** The medical record contains documentation of each service delivered, which, at a minimum, includes: • Location; • Start time and end time; • 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, and date and time of participation; **AND** • A legible signature, along with the printed or typed name and appropriate title, of the individual providing care. **N =** The medical record contains documentation that does not include all above-required elements; or documentation is missing from the record.	85% of all medical records reviewed contain the required documentation.

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7. Does the medical record contain documentation of direct supervision, or direct and remote supervision of the BCaBA or RBT? *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* **YES / NO**	**Y =** The medical record contains documentation of direct supervision, or direct and remote supervision, of the BCaBA or RBT. **Additionally**, if doing remote supervision, approval from the Department is present in the record. **N =** The medical record does not contain documentation of direct supervision, or direct and remote supervision of the BCaBA or RBT; and/or approval from the department is missing, if remote supervision is provided.	85% of all medical records reviewed contain the required documentation.
8. Is the supervision ongoing and equal to at least ten percent (10%) of the number of hours of direct ABA treatment? *COMAR 10.09.28.04 (B) (10) (b)* **YES / NO**	**Y =** The medical record contains documentation that supervision is ongoing and equal to at least ten percent (10%) of the number of hours of direct ABA treatment. **N =** The medical record does not contain documentation that supervision is ongoing and equal to at least ten percent (10%) of the number of hours of direct ABA treatment; or the supervision does not equal to at least ten percent (10%) of the number of hours of direct ABA treatment.	85% of all medical records reviewed contain the required documentation.
9. Is at least twenty-five percent (25%) of the supervision performed in person? *COMAR 10.09.28.04 (B) (10) (b)* **YES / NO**	**Y =** The medical record contains documentation that at least twenty-five percent (25%) of the supervision is performed in person. **N =** The medical record does not contain documentation that at least twenty-five percent (25%) of the supervision is performed in person; or documentation does not support that at least twenty-five percent (25%) of the supervision is performed in person.	85% of all medical records reviewed contain the required documentation.