## Diagnoses & Insurance

Currently COMPANY NAME accepts children (up to age 18) diagnosed with any disability or disorder accompanied by a doctor script for “*ABA Behavior Therapy*”. At the time of this document’s creation, it is at the discretion of the insurance to accept or approve “Applied Behavior Analysis” or “Behavior Intervention services” for their insured. COMPANY NAME accepts all insurances that allow for applied behavior analysis intervention services.

## Starting Client Services

The following process is used to initiate services for clients funded by Medicaid (whose servicing agent is EQ Health Solutions); however, most insurances work in a similar fashion.

1. Client caregiver completes two documents: (1) *COMPANY NAME Client Questionnaire*, and (2) *COMPANY NAME Release of Information form*. Caregiver may complete the documents by hand and scan to Emailhandle@companybusiness.com or complete the forms electronically on the COMPANY NAME website (COMPANIES WEBSITE)
2. Once the forms are received, BILLING COMPANY works with caregivers to obtain a doctor’s script recommending “ABA Behavior Therapy.” The script must have child’s name and diagnosis, be dated from within the last year, and be signed by an MD or DO. The signature must be original, not electronic. If Providers are familiar with incoming clients, they may alert caregivers of the need for this script to expedite processing.
3. Once EQ Health Solutions approves “ABA Behavior Therapy” services for the client, BILLING COMPANY will alert the Regional Director that the client is “Ready to Be Assigned.”
	1. If a Lead Analyst ***is not*** available to take the case, the client will be placed on the “Ready to Be Assigned Waitlist.”
	2. If a Lead Analyst **is** available to take the case, BILLING COMPANY will request an authorization for an Initial Assessment from EQ Health Solutions, which will result in a 30-day window to create a Behavior Analysis Service Plan (BASP). The analyst should not move forward with the assessment/plan development until notified by BILLING COMPANY that the Initial Assessment request has been approved by EQ Health Solutions. If the client was placed on the “Ready to be Assigned Waitlist”, the Regional Director should alert BILLING COMPANY as soon as a Lead Analyst is available to take the case so that the Initial Assessment authorization may be requested.
4. The **Behavior Analysis Service Plan Initial Assessment** *(see detailed description below)* must be completed and dated within the 30-day Initial Assessment window approved by EQ Health Solutions. Its approval will authorize ongoing services hours for the client for a period ranging from 3- to 5- months (initial authorization period), at which point, the analyst must complete a BASP Reassessment to continue services (see Maintaining Client Services). The analyst may start ongoing services with the client once notified by BILLING COMPANY that the BASP Initial Assessment has been submitted and is in “pending status.” Once in “pending” status, the Provider may move forward, providing 75% of the requested hours, however, the Provider may not provide 100% of the hours until the BASP Initial Assessment is in “approved” status by EQ Health Solutions. The Provider must submit a *Diagnosing Questionnaire* (Appendix F), which lists socio-bio-psychological information about the client, with the BASP Initial Assessment (and with each subsequent BASP Reassessment). Providers should respond “ANC” on any section of this questionnaire that they feel clinically unable to evaluate.

## Maintaining Client Services

1. Providers must submit a **BASP Reassessment** (*see detailed description below*) for services to continue beyond the initial 3- to 5- month initial authorization period. The reassessment “window” is in the form of a four-week window (e.g., 2.12.18 to 3.13.18), and the Provider may complete the reassessment at any time within that window, with the last day constituting the reassessment deadline. Although the reassessment must be completed by the deadline, Providers should try to complete the BASP Reassessment midway through the window to allow sufficient time for approval, and avoid a lapse in coverage. Once the BASP Reassessment is approved, the new authorization period is considered a Concurrent Authorization by EQ Health Solutions. The analyst may resume ongoing services with the client once notified by BILLING COMPANY that the BASP Reassessment has been submitted and is in “pending status.” Once in “pending” status, the Provider may move forward, providing 75% of the requested hours, however, the Provider may not provide 100% of the hours until the BASP Reassessment is in “approved” status by EQ Health Solutions. Again, an updated *Diagnosing Interview* (Appendix F) must be submitted with the BASP Reassessment. The Provider must also submit a *Clinical Questions for Renewing Ongoing Services Questionnaire* (Appendix G), which is a synopsis of progress on goals over the prior authorization period, with the BASP Reassessment.

# Behavior Analysis Service Plan (BASP) Development

A Behavior Analysis Service Plan (BASP) is a formal document that includes (1) an **assessment or reassessment** of the client’s behavior/skill excesses and deficits, and (2) a treatment plan with associated goals and requested service hours. Medicaid pays for a BASP Initial Assessment and each BASP Reassessment. BASPs are paid in one lump-sum distributions to the Lead Analyst on a case for all activities related to the plan construction. Given the low rates paid for the development of these plans, it is in the Providers interest to construct the plans as efficiently as possible. Contact BILLING COMPANY for more details.

## BASP INITIAL ASSESSMENT

The BASP Initial Assessment should include the components listed below. A BASP Initial Assessment template is located at the end of this document (Appendix C).

1. *Background Information*
	1. Describe biopsychosocial history, including current living situation and family composition, relevant family history, birth history, applicable legal or social service issues
	2. Provide information about the client’s school (location, classroom type, grade level, use of an aide, therapies provided, such as SLP) and therapies outside of school (e.g., aquatic)
	3. General statement of functioning in terms of communication, ambulation, personal care, and socialization
	4. Provide general description of behaviors of concern and notable skill deficits
	5. Treatment history including past services and their effectiveness
	6. Current treatments and progress (include supplements and dietary modifications)
	7. Describe client/caregiver goals
	8. Describe community resources accessed by the family (for example, support groups, social services, school-based services
	9. Describe client/caregiver goals
2. *Documents Reviewed*: brief summary of IEP, OT, PT, SLP reports to ensure non-overlapping goals in behavior plan
3. *Medical Information*:
	1. Describe medical history including diagnosis, comorbid conditions (e.g., seizures)
	2. Describe recurrent illnesses and conditions (gastrointestinal problems, chronic constipation/diarrhea, recurrent abdominal pain)
	3. Describe sleep problems
	4. Describe allergies
	5. Describe current medications (name and prescribing doctor) using a table. If no medications, write a sentence stating that there is no medication currently being taken.
4. *Functional Behavior Assessment (FBA):* to include:
	1. Target behavior definitions
	2. Target behavior baseline levels of occurrence and severity (can be identified through parent interview or direct observation, but indicate method used)
	3. Methods for assessing behavior function; to include:
		1. Indirect/interview [e.g., MAS, FAST, QBAF, CARD Indirect Functional Assessment (CIFA)
		2. Direct/observation of problem behavior; nonexperimental or experimental (e.g., ABC recording, structured descriptive assessment; SDA): Medicaid requires at least two observations of client (can be across two locations or two times)
5. *Skill Assessment*: a screening of client skill strengths and weaknesses. The Provider may request to target skill acquisition (e.g., learner readiness, adaptive behavior) if the skill target is deemed medical necessary to ameliorate. Most often, this is justified if the skill deficit is related to problem behavior including noncompliance or more severe problem behavior. The BASP template suggests a screening tool to use for early learners (e.g., Basic Language Assessment Form); however, any
6. screening tool can be used. It is possible to do a more extended skill assessment (e.g., VB-MAPP, ABLLS-R, AFLS, Autism Social Skills Profile) once ongoing hours are approved. The Provider should plan to include enough skill goals to justify ongoing hours approved. In general, the more skills goals requested, the more ongoing service hours will be approved.
7. *Preference Assessment*: identify client edible, leisure, social, and activity preferences through caregiver report or systematic preference assessment
8. *Behaviors Targeted for Decrease*: this section should identify the behaviors targeted for reduction and the strategies that will be used to decrease them. It should also include the related including baseline level, strategy for data collection, in addition to reduction and generalization criteria.
9. *Crisis plan:* a crisis plan should be included if warranted by problem behavior severity or frequency. Otherwise, Provider should indicate that no crisis plan indicated at this time.
10. *Functionally Equivalent Replacement Behaviors Targeted for Increase*: this section should identify replacement behaviors targeted for increase, with specified goals and relevant behavior-change strategies. It should also include the related problem behavior (for treatment justification), baseline level, strategy for data collection, mastery and generalization criteria.
11. *Additional Skills Targeted for Increase:* this section should identify additional skills targeted for increase, with specified goals and relevant behavior-change strategies. It should also include the related problem behavior (for treatment justification), baseline level, strategy for data collection, mastery and generalization criteria.
12. *Risk Assessment*: an analysis of risks and benefits of the proposed intervention.
13. *Caregiver involvement*: describe plan for caregiver participation in plan, including how the caregiver will be trained and how the caregiver’s implementation of the plan will be evaluated.
14. *Communication with Other Providers*: indicate communication that has occurred with other relevant professionals (e.g., doctor, psychologist, SLP.
15. *Discharge & Fading Criteria*: criteria for reducing number therapy hours based on patterns in client behavior.
16. *Summary & Recommendations*: summary of recommended services for subsequent authorization period. This summary should be presented in combination with a request for service hours distributed across provider type. See BASP Allocation of Hours section below for specific details.

Once completed, the BASP Initial Assessment should be saved with file name: first initial first name, period, first initial last name, period, “initial assessment”, period, date of intake (no spaces), for example, *A.S.initial assessment.3.24.18*. This file should be emailed to Emailhandle@billingcompany.com, and then “tagged” with identifiers and uploaded to the relevant client file on the COMPANY NAME Sharepoint site (see Sharepoint section below).

## Client Intake Packet

The Client Intake Packet (Appendix C) is a tool that guides Providers in collecting the information necessary for the BASP Initial Assessment. The questions may be completed via interview format or responded to directly by a client’s caregivers. The sections of the Client Intake Packet parallels the sections of the BASP Initial Assessment to make transfer of information to the plan efficient. The Client Intake Packet uses the Functional Analysis Screening Tool (FAST) to collect functional information about client target behaviors, but the Provider may substitute another indirect assessment if desired. The Client Intake Packet uses the Basic Language Assessment Form (BLAF) ® to screen for skill strength and deficits, but the Provider may substitute another screening tool if desired. Copies of COMPANY NAME mandatory consent forms, which must be completed during intake, are located at the end of the packet (see Intake Documents section below).

## BASP Reassessment

The BASP Reassessment (Template in progress) should preserve the format of the BASP Initial Assessment, and should provide an evaluation of the client’s progress on goals (and caregivers’ progress on intervention implementation) with accompanying graphed data, from the previous authorization period. Graphs should be presented with baseline data and a brief text summary, and should be displayed after each goal box, with updated status toggled (e.g., Improved). In addition, new targets and goals may be added in the Reassessment, with status toggled “New”. The Provider may request a different number or allocation of ongoing services hours in the BASP Reassessment. See BASP Allocation of Hours section below for specific details.

Once completed, the BASP Reassessment should be saved with file name: first initial first name, period, first initial last name, period, “reassessment”, period, date of intake (no spaces), for example, *A.S.reassessment.3.24.18*. This file should emailed Emailhandle@billingcompany.com and then “tagged” with identifiers and uploaded to the relevant client file on the COMPANY NAME Sharepoint site (see Sharepoint section below).

## BASP Allocation of Hours

In the Summary & Recommendations section of a BASP (Initial or Reassessment), the Provider should request a total number of service hours for the client, distributed across Provider level (e.g. BCBA, BCaBA, RBT/BSA). Providers may request up to 40 hours/week without special review by Medicaid. Service hour requests that exceed 40 hours/week require a special review from Medicaid. The number of hours requested should reflect the needs of the client, and should be based on the number/severity of targeted problem behaviors and skill deficits. In general, a higher number of problem behaviors and greater skill deficits warrant a higher number of service hours requested. The requested number should also be based on resources available; for example, if a BCaBA is not available in the area, the Provider should not request BCaBA hours.

Service hours (for Medicaid and most funding sources) are requested in terms of units (or quarter hours) per week, with 1 service hour equal to 4 units (or quarter hours). For example, a request for 40 service hours per week equates to 160 units (or quarter hours) per week. This is further divided up by Provider level (BCBA/BCaBA, RBT/BSA), and may be divided even further by location (home/school/community).

Medicaid identifiers are H2019 (BCBA/Lead Analyst), H2012 (BCaBA), and (H2014) Behavior Technician (RBT or BSA). The Provider should also attempt to present how service hours will be distributed across the day using a table. An hour allocation example is presented below, and in the BASP Initial Assessment Template (Appendix C). Please note that requests above 160 Units (40 hours) are approvable with a special services approval from Medicaid. Please contact your regional director for a special services request to ensure it is completed correctly.

*In the* ***example*** *below, we are requesting a total of* ***144 units*** *(36 hours) per week; divided up into* ***16 units*** *(4 hours) of H2019: BCBA/Lead Analyst,* ***32 units*** *(8 hours) of H2012: BCaBA, and* ***96 units*** *(24 hours) of* H2014: *Behavior Technician, per week.* ***THIS IS AN EXAMPLE ONLY.*** *Make yours match the client’s needs*

|  |  |  |  |
| --- | --- | --- | --- |
| **HCPCS** | **Description of Services** | **# Units / Quarter Hours Requested per Week** | **Service Location** |
| H2019 | Behavior Analysis Lead Analyst | 16 units | Home/ School / Community |
| H2014 | Behavior Analysis- Technician | 96 units | Home / School  |
| H2012 | Behavior Analysis- Assistant Behavior Analyst | 32 units | Home / School |

**EXAMPLE ONLY - Weekly Breakdown of Requested Hours**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Monday | Tuesday | Wednesday | Thursday | Friday |
| Time/Location | 10:00-2:30 p.m.School | 10:00-2:30 p.m.School | 10:00-2:30 p.m.School | 10:00-2:30 p.m.School | 10:00-2:30 p.m.School |
| Activity | * Behavior Reduction Program
* Communication Training
* Skill Program
* Caregiver Training
 | * Behavior Reduction Program
* Communication Training
* Skill Program
* Caregiver Training
 | * Behavior Reduction Program
* Communication Training
* Skill Program
* Caregiver Training
 | * Behavior Reduction Program
* Communication Training
* Skill Program
* Caregiver Training
 | * Behavior Reduction Program
* Communication Training
* Skill Program
* Caregiver Training
 |
| Time/Location | 4:00 to 6:00 p.m.Home | 4:00 to 6:00 p.m.Home | 4:00 to 6:00 p.m.Home | 4:00 to 6:00 p.m.Home | 4:00 to 6:00 p.m.Home |
| Activity | * Adaptive behavior (e.g. dressing/

toileting)* Caregiver Training
 | * Adaptive behavior (e.g. dressing/

toileting)* Caregiver Training
 | * Adaptive behavior (e.g. dressing/

toileting)* Caregiver Training
 | * Adaptive behavior (e.g. dressing/

toileting)* Caregiver Training
 | * Adaptive behavior (e.g. dressing/

toileting)* Caregiver Training
 |

|  |  |
| --- | --- |
|  | Saturday |
| Time/Location | 12 p.m. to 3:30 p.m.Community |
| Activity | * Social Skills Training
* Safety Training
* Caregiver Training (home)
 |

***Cases involving Severe Behavior Disorders***: for cases that involve severe problem behavior (e.g., high frequency or intensity aggression, SIB, property destruction), the Provider should request ***concurrent services*** from a higher-credentialed individual (e.g., BCBA or BCaBA) and technician until problem behavior has reached a specific reduction goal. Depending on the client, the Provider can request the total hours overlapping or a portion of hours overlapping (i.e., to work on specific goals) as in the examples below. The request should be **bolded** in the BASP to ensure that the request is visible to the funding agent. In addition, the Provider should request that 50% of parent training occur without the client present.

1. Example 1 (**All Service Hours Concurrent** Request):

*Because client exhibits high frequency, high severity aggression at school,* ***we are requesting concurrent therapy services*** *to be provided by the BCBA (or BCaBA) and Behavior Technician* ***during all service hours (i.e., 30) each week******at school*** *until aggression meets the reduction goal of 1 occurrence or less during session for four consecutive weeks.*

1. Example 2 (**Portion of Service Hours Concurrent** Request):

*Because client exhibits high frequency, high severity aggression during hygiene routines at home,* ***we are requesting concurrent therapy services*** *to be provided by the BCBA (or BCaBA) and Behavior Technician* ***for 5 hours each week at home*** *until aggression meets the reduction goal of 1 occurrence or less during session for four consecutive weeks.*

## Intake Documents (Consent Forms)

During the first meeting, the Provider should have the client’s caregiver sign all COMPANY NAME intake documents, including consent forms, which are located at the end of the Intake Packet (Appendix B). The documents include: *(a) Behavior Analyst Service Expectations, (b) Behavior Assistant Service Expectations, (c) Informed Consent for Treatment, (d) Release of Information form, (e) Abuse/Neglect Policy, (f) First Aid Release, (g) Client Bill of Rights, (h) Title VI letter, (i) Title VI (j) Receipt Signature form, (k) Steps for Submitting Grievance form, Grievance Report form*. All forms should be signed by the caregiver and Lead Analyst on the case, with the exception of the *Behavior Assistant Service Expectations*. This form should be signed by the caregiver and Behavior Technician assigned to the client’s case, with one copy reserved for each Behavior Technician. Once signed, the consent forms should be scanned in the order listed above into a single PDF file, with file name: first initial first name, period, first initial last name, period, “consents”, period, date of intake (no spaces), for example, “A.S.consents.3.24.18”. This file should be emailed to Emailhandle@billingcompany.com, and then “tagged” with identifiers and uploaded to the relevant client file on the COMPANY NAME Sharepoint site (see Sharepoint section below).

## Behavior Plan Crisis Procedures & Restrictive Procedures

If data represent that more restrictive procedures are required for target behavior reduction (for the safety of the client and or others in the nearby environment; ensure that all Providers and the Caregiver(s) or Legal Guardian(s) are trained and certified in a specific restrictive procedure. Prior to the use of restrictive procedures, the Provider should obtain the approval of the caregiver and the Regional Director. The Regional Director should ensure that all records of certificates of Provider trainings are maintained for liability purposes.

## Discharge Summary

Once a client is discharged from services, the Provider should write a discharge summary (see example in Appendix E). The discharge summary should be a (brief) summary of client target behavior, goals, and progress on goals, during treatment (with relevant graphs). In addition the Provider should present the reason for discharge. Once completed, the discharge summary should be saved with file name: first initial first name, period, first initial last name, period, “discharge summary”, period, date of intake (no spaces), for example, “A.S. discharge summary.3.24.18”. This file should be emailed to Emailhandle@billingcompany.com , and then “tagged” with identifiers and uploaded to the relevant client file on the COMPANY NAME Sharepoint site (see Sharepoint section below).

## Daily Progress Notes

Most funding sources require the Provider to write a daily progress notes for each session conducted, which will be uploaded for each session through the BILLING COMPANY Platform. Daily progress notes should provide a synopsis of behavioral service provided during the session, including (1) a brief description of client & the therapeutic setting (2) the specific programs trained and behavior-change observed (client & caregiver), and (3) caregiver reported concerns/Significant events impacting treatment.

See the examples for each section below:

1. Brief description of client & therapeutic setting.

*The BA/RBT conducted session with Client at his residence, with his mother present, at a previously agreed upon time. Client appeared healthy and happy, as evidenced by his frequent smiling and playful interactions with the RBT. No medical or safety issues arose during the session.*

* Must always include observable behavior that led to client’s hypothesized emotional state
* Must always document if safety/medical concerns present
1. Brief description of specific programs trained (client & caregiver) and behavior-change observed.

*Client’s “vocal manding (requesting) program” was conducted. He engaged in 80% unprompted requests for iPad, 50% unprompted mands for book, and 30% unprompted mands for mother’s attention. Client’s “gross motor imitation” and “one-step instruction” programs were conducted. On the first cold probe of the day, the client engaged in correct responding for 60% of the 5 imitation targets and 80% of the five one-step instruction targets. One of the imitation targets was mastered. Client’s toileting program was conducted. Client engaged in appropriate voiding (urination) on 2 of 5 opportunities, and had one accident. Client’s dressing program was conducted. The client correctly completed 80% of a 10-step task analysis.*

*Client engaged in 5 occurrences of high-intensity aggression, 10 occurrences of tantrum (average duration: 10 seconds), and 20 occurrences of property destruction. The BA/RBT followed protocols for problem behavior outlined in Client’s BASP.*

*Client’s mother, was trained to implement the interventions for Client’s problem behavior using verbal instruction, modeling, rehearsal, and feedback. The clients parent correctly executed 85% of the intervention components. Fidelity checks on her implementation will be conducted in upcoming sessions.*

* Document other notable events, such as preference assessment or skill assessment updates performed, the development of a task analysis, etc.
* If a new behavior arises that warrants data collection, try to document the antecedents/consequences for the behavior that you observed.
1. Caregiver reported concerns/Significant events impacting treatment.

*Client’s mother reported that Client’s behavior escalated over the previous week, and that client’s aggression resulted in minor injury (e.g., bruise on arm) to clients younger sister on August 1, 2017. In addition, his mother reported that Client’s SLE has only been sleeping approximately 3 hours each night. The Client is scheduled to undergo a tonsillectomy and will be unavailable for therapy for at least one week.*

* Potential documentation may include caregiver’s positive or negative appraisals of therapeutic targets/outcomes
* Potential documentation may include changes in medication or diet, hospital stays, changes to routine, the introduction of a new therapy (e.g., speech & language therapy), etc.

**Additional Tips:**

* Always refer to yourself in the third-person (The RBT, BA met with; engaged in….)
* Report only objective (factual) information in progress notes; **do** **not** include subjective appraisals of client, caregivers, or their environment (e.g., she doesn’t spend enough time with her son; she should not have given him caffeinated soda).
* If there is a serious event, such as a Baker Act or an injury, the BA/RBT must fill out an incident report in compliance with the COMPANY NAME Policies & Procedures Manual (see P & P Manual for more information).
* Always stick to the target behavior/goals outlines in the BASP. If you have any suggestions or thoughts on making changes, please discuss those changes with the Lead Analyst on the case.
* When in doubt, consult your Lead Analyst

## Locations for Services

Providers may provide services in any location, as long as the setting is relevant to treatment. For example, a Provider may provide therapy in the school if skill deficits are present or problem behavior occurs in the school setting. A Provider may provide services in the community if the behavioral issues occur in the community setting (e.g., elopement, greetings, appropriate walking in stores). Additional information about COMPANY NAME’s own recommendations is provided in the table below.

|  |  |  |  |
| --- | --- | --- | --- |
| In the Home/ Residence | In the Community | In the School | Summer Camps or Day Cares |
| Services can occur in all sections of the home within means of target behavior reduction and skill acquisition programs, this is at the discretion of the COMPANY NAME staff member**Times when it a caregiver should be present -** Bathing, brushing teeth, cooking, etc.  | **Times when it is optional for caregiver to be present** - grocery stores, restaurants, public libraries, events such as Autism Speaks, public parks, camps**Times when it a caregiver should be present** - Speech therapy, Occupational therapy, Doctor’s office, Dentist Office,  | **Times when it is optional for teacher to be present-** the earning of reinforcers with COMPANY NAME staff outside of the classroom; one on one ABA pull out sessions outside of the classroom; community outing or field trip **Times a teacher should be present** – restrooms (unless toilet training specifically as a target behavior), within the classroom, activities within the hallways such as transitioning between classes, etc. cafeteria, gym, car waiting area, auditorium, etc.  | Follows the same restrictions as “In the School” setting |