**ABA Record Audit Tool**

Provider Last Name and/or Group Name:
Reviewer Name:
Date of Review:
Patient ID:

| General Documentation Standards: | | Y | N | N/A |
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| 1. | Each client has a separate record clearly identified with name and DOB. | | | |
| 2. | Each record includes the client's address, contact information, and guardianship information. | | | |
| 3. | There is evidence of a Consent for Treatment that addresses the potential risks and benefits of treatment in the record that is signed by the client and/or legal guardian. | | | |
| 4. | If the member is their own legal guardian, appropriate release of information documents are present. | | | |
| 5. | A diagnostic report is present in the record that indicates the member has a diagnosis of Autism Spectrum Disorder, as evaluated under DSM-5 guidelines. The diagnostic report must be signed by a Physician (MD) or Clinical Psychologist (PhD or PsyD). | | | |
| 6. | As of 10/1/16- There is documentation that providers of direct service have the RBT credential (Registered Behavior Technician). | | | |
| 7. | For CA providers only- There is documentation that supervision meets the 3 tier service delivery model. | | | |
| 8. | There is documentation that at least 80% of billed supervision is spent on the direct supervision of staff. | | | |
| 9. | All assessments include all required dated signatures. | | | |

Functional Behavioral Assessment (FBA)/Initial Treatment Plan requirements

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| 1. | There is evidence of a FBA in the record and that the FBA was reviewed with the family prior to the start of treatment. | | | |
| 2. | A complete developmental, medical, and treatment history is documented. | | | |
| 3. | There is documentation of any legal issues, spiritual needs, and/or cultural variables that may impact treatment. | | | |
| 4. | A developmental assessment has been completed and documented (Vineland or ABAS) as baseline scores. | | | |
| 5. | Was the member and/or parent/legal guardian present during the assessment? | | | |
| 6. | There is evidence that the course of treatment is individualized to the client. | | | |
| 7. | The course of treatment is linked to clear, quantitative and developmentally appropriate goals/objectives with targeted timelines for achieving them. | | | |

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| 8. | Treatment Record reflects continuity and coordination of care between primary behavioral health clinician and (note all that apply under comments): Occupational Therapy, Speech Therapy, Physical Therapy, physician, therapist or school personnel. | | | |
| 8a. | Accuracy: Communication matched information in chart | | | |
| 8b. | Timeliness: Communication within 30 days of initial assessment | | | |
| 8c. | Sufficiency: Communication appropriate to condition/ treatment | | | |
| 8d. | Frequency: Occurred after initial assessment | | | |
| 8e. | Clarity: reviewer understands communication | | | |
| 9. | Depression screening- For clients age 13 and older, there is documentation that the PHQ-A was completed every 6 months or rationale as to why it wasn't completed[1] | | | |
| 10. | Current medical conditions and treatment are noted including the following information: known medical conditions, dates and providers of treatment, medications, and current therapeutic interventions and responses. | | | |
| 11. | The presence or absence of drug and/or food allergies is clearly documented. | | | |
| 12. | There are at least 2 behavior reduction goals with all of the following: | | | |
| 12a. | Detailed definition | | | |
| 12b. | Topography | | | |
| 12c. | Proposed function | | | |
| 12d. | Intervention | | | |
| 12e. | Baseline data | | | |
| 12f. | Mastery Criteria | | | |
| 13. | There are at least 2 skill acquisition goals with all of the following: | | | |
| 13a. | Detailed definition | | | |
| 13b. | Topography | | | |
| 13c. | Baseline Data | | | |
| 13d. | Mastery criteria | | | |
| 14. | There are at least 2 Caregiver Training goals with baseline and mastery criteria. Please note, attendance at staff meetings is not considered Caregiver Training (S5110). | | | |
| 15. | There is evidence that caregivers were educated about the importance of their role and trained in supporting the behavioral health treatments provided. | | | |
| 16. | There are clearly outlined discharged criteria in the FBA/Initial Treatment Plan. | | | |

[1] Member not within the specified age range; Member is non-verbal and not able to adequately participate; Member or Member's guardian requested not to participate; Other- must be specified by provider

Treatment Plan requirements

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| 1. | There is evidence that an updated treatment plan was reviewed with the family at least every 6 months. | | | |
| 2. | A complete developmental, medical, and treatment history is documented. | | | |
| 3. | There is documentation of any legal issues, spiritual needs, and/or cultural variables that may impact treatment. | | | |
| 4. | An updated developmental assessment has been completed; baseline and current scores are documented (Vineland or ABAS) at least every 6 months. | | | |
| 5. | Treatment Record reflects continuity and coordination of care between primary behavioral health clinician and (note all that apply under comments): Occupational Therapy, Speech Therapy, Physical Therapy, physician, therapist or school personnel. | | | |
| 5a. | Accuracy: Communication matched information in chart | | | |
| 5b. | Timeliness: Communication within 30 days of initial assessment | | | |
| 5c. | Sufficiency: Communication appropriate to condition/ treatment | | | |
| 5d. | Frequency: Occurred after initial assessment | | | |
| 5e. | Frequency: Occurred after change in treatment | | | |
| 5f. | Frequency: Occurred after termination of treatment | | | |
| 5g. | Clarity: reviewer understands communication | | | |
| 6. | Depression screening- For clients age 13 and older, there is documentation that the PHQ-A was completed every 6 months or documented rationale as to why it wasn't completed[1] | | | |
| 7. | Current medical conditions and treatment are noted including the following information: | | | |
| 7a. | Known medical conditions | | | |
| 7b. | Dates and providers of treatment | | | |
| 7c. | Medications | | | |
| 7d. | Current therapeutic interventions and responses | | | |
| 8. | The presence or absence of drug and/or food allergies is clearly documented. | | | |
| 9. | There are at least 2 behavior reduction goals with all of the following: | | | |
| 9a. | Detailed definition | | | |
| 9b. | Topography | | | |
| 9c. | Proposed function | | | |
| 9d. | Intervention | | | |
| 9e. | Baseline data | | | |
| 9f. | Mastery criteria | | | |
| 9g. | Current frequency or graph of progress | | | |
| 10. | There are at least 2 skill acquisition goals with all of the following: | | | |
| 10a. | Detailed definition | | | |
| 10b. | Topography | | | |
| 10c. | Baseline data | | | |
| 10d. | Mastery criteria | | | |
| 10e. | Current progress | | | |

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| 11. | There are at least 2 Caregiver Training goals with all of the following: *Please note, attendance at staff meetings is not considered Caregiver Training (S5110).* | | | |
| 11a. | Baseline | | | |
| 11b. | Mastery criteria | | | |
| 11c. | Current progress | | | |
| 12. | There is evidence that if the member is not making progress on behavior reduction or skill acquisition goals, that the intervention has been changed for that goal. | | | |
| 13. | Evidence that required data was collected in order to adequately track treatment progress | | | |
| 14. | There are clearly outlined discharged criteria in the treatment plan. | | | |

Service Delivery Notes

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| 1. | There is a separate entry in the record for each service billed that is legible to someone other than the writer. | | | |
| 2. | Each record documents the following information for each visit: | | | |
| 2a. | Start and end times | | | |
| 2b. | Who is present during the visit | | | |
| 2c. | Who performed the visit (provider's name, provider's credential/license and signature) | | | |
| 2d. | Behaviors tracked during the visit (including any monitoring/ data collection of targeted risk behaviors) | | | |
| 2e. | Clinical note on the recipient's behavior | | | |
| 2f. | Visit setting | | | |
| 2g. | Any communication with guardians/ caregivers | | | |
| 3. | Where applicable, case supervision standards are followed: | | | |
| 3a. | Direct case supervision:<br>• Observation<br>• Instruction<br>• Modeling<br>• Performance-based feedback to front-line treatment providers and parents on the fidelity of delivery<br>• Data collection for the purpose of inter-observer agreement on patients' response to treatment<br>• Collecting baseline data with reliability on new targets/ objectives as patients master current targets | | | |
| 3b. | Indirect case supervision:<br>• Development of individualized patient response forms<br>• Development of token economic stimuli<br>• Development of behavioral contracts or stimulus generalization materials<br>• Summarizing, reviewing and analyzing data | | | |

Discharge of Client

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| 1. | If the client was transferred to another ABA agency, there is documentation of a discharge summary (consisting of: goal status and discharge plan that was also made available to the parent/caregiver). | | | |
| 2. | If the client was discharged, there is documentation that appropriate referrals for ongoing behavioral health services were given to the member and/or family. | | | |
| 3. | A discharge plan is present in the record that summarized the reason for discharge from treatment, the progress/mastery of treatment goals, and an aftercare plan. | | | |
| 4. | All clinical records are completed within 30 days following discharge. | | | |