

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

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

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.			

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

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			

11.	There are at least 2 Caregiver Training goals with all of the following: <i>Please note, attendance at staff meetings is not considered Caregiver Training (S5110).</i>			
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

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: <ul style="list-style-type: none"> • Observation • Instruction • Modeling • Performance-based feedback to front-line treatment providers and parents on the fidelity of delivery • Data collection for the purpose of inter-observer agreement on patients' response to treatment • Collecting baseline data with reliability on new targets/ objectives as patients master current targets 			
3b.	Indirect case supervision: <ul style="list-style-type: none"> • Development of individualized patient response forms • Development of token economic stimuli • Development of behavioral contracts or stimulus generalization materials • Summarizing, reviewing and analyzing data 			

Discharge of Client

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.			