




Provider Guide to the
Early Intervention Program

Including benefit coverage for applied behavior analysis (ABA), habilitative-rehabilitative and related services.

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 GOVERNMENT OF THE
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Table of Contents

Executive Summary	3
Autism Spectrum Disorder (ASD) and Applied Behavior Analysis (ABA) Therapy	4
What is ASD?	4
What is ABA Therapy?	4
Issues for Consideration	5
Certification in ABA Therapy	6
ABA Therapy in the Treatment of ASD	6
Identifying ABA Therapy	7
Essential Practice Elements of ABA Therapy	7
Treatment Models	8
Habilitative and Rehabilitative Services	10
Early Intervention Services (members ages 0 – 4)	12
Strong Start Program: Intake Procedures	12
Prior Authorization and Implementation of the IFSP Process	12
Reauthorization and Concurrent Reviews	14
Denials	15
Treatment Delivery Settings	15
Age at Initiation of Services	15
Incorporating ABA Therapy with Other Forms of Treatment	15
Assessment, Treatment Plan Formulation and Measurement of Progress	16
The Assessment Process	16
Treatment Plan Requirements (Intensive/Non-Intensive)	16
Authorization Types	17
Types of Services	17
Treatment Intensity and Duration	17
Working with Caregivers and Other Professionals	18
Parents, Caregivers and Family Members	18
Parent and Caregiver Training	18
Examples of Behavioral Targets	18

Program Components _____	18
Coordination with Other Health Professionals _____	19
Treatment Discontinuation, Discharge and Transition Planning _____	19
Transition/Discharge _____	19
Treatment Discontinuation _____	19
Contracting and Credentialing Process _____	20
Contracting and Credentialing Process _____	20
Credentialing and Contracting Requirements _____	20
Network Participation Qualification Criteria for ABA Therapy Services, Developmental Therapy (Special Instruction) and Habilitative Service Providers _____	21
ABA, Habilitative and Rehabilitative Provider Billing and Reimbursement _____	22
Member Eligibility _____	22
CMS Health Insurance Form (CMS-1500) _____	22
Examples of Typical ABA Therapy CPT Codes _____	23
Appendix A — Sample Treatment Plan _____	24
Appendix B — Sample Quarterly Progress Report _____	30
Appendix C —Bibliography _____	39

Executive Summary

Welcome to the AmeriHealth Caritas District of Columbia (“AmeriHealth Caritas DC”) Provider Guide to the Early Intervention Program (EIP). This guide is intended to inform providers regarding the application of applied behavior analysis (ABA) therapy and other services in the treatment of AmeriHealth Caritas DC members with autism spectrum disorder (ASD), developmental delays and disabilities. This guide also provides valuable information on habilitative and rehabilitative services, both as stand-alone treatments and as treatments integrated into an ABA program.

To determine coverage for the services described in this guide, AmeriHealth Caritas DC will apply medically necessary criteria to authorization and referral requests; AmeriHealth Caritas DC will also conduct reviews on a prospective, concurrent and/or retrospective basis.

AmeriHealth Caritas DC defines “medically necessary” as services, equipment or pharmaceutical supplies that:

- A physician or other treating health provider, exercising prudent clinical judgment, would provide or order the service for a patient for the purpose of evaluating, diagnosing or treating illness, injury, disease, physical or mental health conditions, or their symptoms, and the provision of the service is:
 - In accordance with generally accepted standards of medical practice;
 - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury, disease, or physical or mental health condition; and

Not primarily for the convenience of the individual or treating physician, or other treating healthcare providers, and more cost effective than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results with respect to the diagnosis or treatment of that individual’s illness, injury, disease or physical or mental health condition. The information contained in this guide is based on best practice guidelines from nationally recognized specialty organizations, professional standards of care and expert clinical opinions.

By applying these highly workable ABA methodologies, AmeriHealth Caritas DC offers an efficient and cost-effective approach to developing, maintaining and/or restoring full functionality to members who have an ASD or who are developmentally delayed or disabled.

ABA therapy is a specialized behavioral health treatment with numerous clinical and delivery components. Components include:

- Behavioral analyst training and credentialing.
- Authorization of services.
- Management of benefits.
- A treatment methodology for ASD which includes:
 - A treatment mechanism.
 - An initial assessment and formulation of treatment goals, along with documentation of measureable progress.
 - Clinical procedures.
 - Dosage and duration of treatment.
 - Supervision.

- Delivery based on tiered service.
- Caregiver and medical professional involvement.
- Aftercare (discharge, planning for transition and continuity of care).

Autism Spectrum Disorder (ASD) and Applied Behavior Analysis (ABA) Therapy

What is ASD?

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) of the current American Psychiatric Association, ASD is characterized by varying degrees of difficulty in social, verbal and nonverbal communication and by the presence of restricted repetitive patterns of behavior and restricted interests. In short, no two individuals, both diagnosed with ASD, share the same manifestations of the disorder. On the other hand, individuals and their families recognize an ASD diagnosis as a severe disorder which for many will require appropriate medical treatment and/or behavioral treatment in order to achieve independent functionality.

What is ABA Therapy?

AmeriHealth Caritas DC providers should begin ABA therapy by evaluating an individual's past and current environment in conjunction with organic variables, like genetics, and ongoing physiological variables. ABA therapy then uses observation, measurement and functional analysis to identify changes in environmental events through specialized assessment methods, and incorporates these into a treatment plan. In order to change the environment in which the individual diagnosed with ASD is experiencing the world, ABA therapy uses Antecedents (events occurring prior to the behavior in question), Behavior (the manner in which the individual responds) and Consequences (events that happen to the individual subsequent to the behavior) to focus on behavioral difficulties. Then, ABA therapy changes in that environment are implemented, with the goal of significant improvement in human social behavior.

ABA therapy has become a standard of care in the treatment of ASD because it has, in many cases, successfully remediated the core deficits of ASD and helped individuals develop and restore their abilities and functionality in hundreds of documented peer-reviewed studies over the past 50 years.¹

¹ Lovaas, O. I. (1987). Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology*, 55, 3-9.

McEachin, J. J., Smith, T., & Lovaas, O. I. (1993). Long-term outcome for children with autism who received early intensive behavioral treatment. *American Journal on Mental Retardation*, 97, 359-372.

Green, G., Brennan, L. C., & Fein, D. (2002). Intensive behavioral treatment for a toddler at high risk for autism. *Behavior Modification*, 26, 69-102.

Hanley, G. P., Iwata, B. A., & McCord, B. E. (2003). Functional analysis of problem behavior: A review. *Journal of Applied Behavior Analysis*, 36, 147-185.

Cohen, H., Amerine-Dickens, M., & Smith, T. (2006). Early intensive behavioral treatment: Replication of the UCLA model in a community setting. *Developmental and Behavioral Pediatrics*, 27, S145-S155.

Wong, C., Odom, S.L., Hume, K., Cox, A. W., Fettig, A., Kucharczyk, S. et al. (2013). Evidence-based practices for children, youth, and young adults with autism spectrum disorder. Chapel Hill, NC: The University of North Carolina, Frank Porter Graham Child Development Institute, Autism Evidence-Based Practice Review Group.

Issues for Consideration

This guide provides ABA therapy information based on best clinical practices which are supported by established research findings. However, the most significant feature of ABA therapy is a customized treatment plan; this is an integral component of successful treatment for those diagnosed with ASD.

The approach presented in this guide is not intended to lessen the frequency, quality or accessibility of services available through ABA therapy.

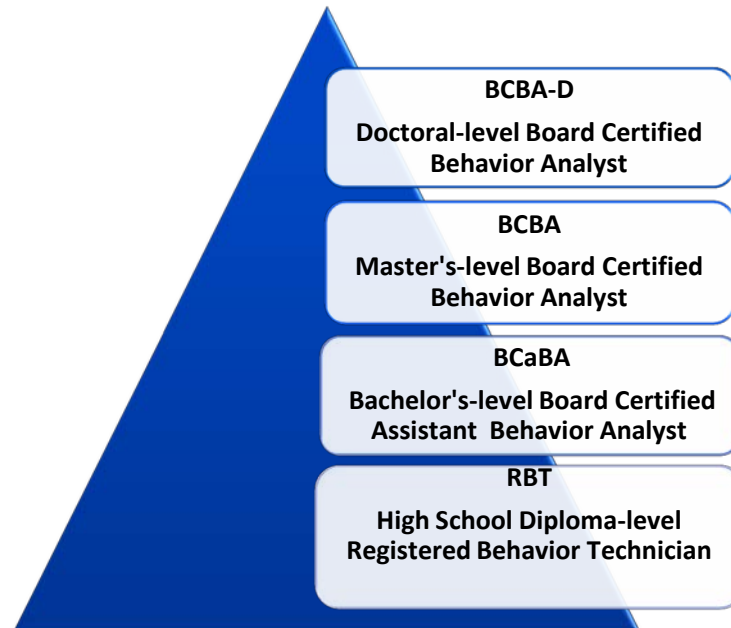
ABA therapy must not be limited to precise situations or specific environments, but consigned to surroundings that take advantage of customized client treatment outcomes.

This guide offers guidance regarding ABA therapy treatment only; additional behavioral health treatment techniques are not addressed.

Certification in ABA Therapy

The Behavior Analyst Certification Board (BACB) is a nonprofit 501(c) (3) corporation established to provide professional credentialing of qualified individuals. The BACB applies uniform content, standards and criteria in its credentialing process. The BACB credentials and recognizes practitioners at four levels:

- Doctoral-level Board Certified Behavioral Analyst (BCBA-D).
- Master’s-level Board Certified Behavior Analyst (BCBA).
- Bachelor’s-level Board Certified Assistant Behavior Analyst® (BCaBA).
- High School Diploma Registered Behavior Technician (RBT).



The National Commission for Certifying Agencies (NCCA), the accreditation arm of the Institute for Credentialing Excellence, has accredited the BCBA, BCaBA and the Registered Behavior Technician (RBT) programs.

Professionals credentialed at the BCBA-D and BCBA levels are called Behavior Analysts. Under current certification criteria and local regulation, professionals credentialed as BCaBAs must practice under the supervision of a Behavior Analyst. Those with the RBT designation must practice under the close, ongoing supervision of a Behavior Analyst or “designated RBT supervisor”.

ABA Therapy in the Treatment of ASD

ABA therapy is a behavioral, psychological approach that uses the theory of behaviorism to modify human behaviors as part of a learning or treatment process. ABA therapy professionals use treatment interventions based on the principles of learning (to include operant and respondent learning) that resulted from experimental psychological research to: a) systematically change behavior in various settings, b) decrease maladaptive behaviors, c) augment adaptive behaviors, d) teach new skills, and e) show that the interventions used are the cause of observable improvements in behavior. Therefore, behavior analysts focus on the objective and reliable

measurement of observable behavior within applicable settings such as home, school and community. Functionally assessing the relationship between a targeted behavior and the environment is a key component of ABA therapy. ABA therapy research ranges from behavioral intervention methods to basic research, which involves investigating the rules by which humans adapt and maintain behavior.

Identifying ABA Therapy

AmeriHealth Caritas DC provides coverage for evidence-based treatment interventions founded on the principles of ABA therapy in a well-designed ABA program, and includes in its network those practitioners who are qualified to provide ABA treatment services.

ABA therapy

ABA therapy programs are essentially comprised of two main treatment components — a behavior modification component and a teaching component. When an individual is being taught new skills and behaviors, the teaching component is used. The behavior modification component is used to reduce inappropriate behaviors. In order to address inappropriate behaviors, a functional assessment is performed to identify the reason for the behavior. The results are used to develop a plan to extinguish or reduce the frequency of the behaviors.

ABA therapy has important characteristics apparent throughout treatment:

- 1) An objective analysis of the individual's condition by observing the relationship of the environment to the individual's behavior, as reflected through detailed data collection.
- 2) Importance given to understanding the context of the behavior and its value to the individual and the environment.
- 3) Application of the principles and procedures of behavior analysis in a manner that is in concert with the health and wellbeing of the individual.
- 4) ABA therapy treatment plans lay emphasis on producing treatment outcomes that are socially relevant and meaningful for the child.

Essential Practice Elements of ABA Therapy

The following characteristics are evident in all phases of assessment, diagnosis and treatment:

- 1) Specific levels of baseline behavior must be defined when developing treatment goals.
- 2) Treatment should be directed at establishing small units or behavior targets which build up toward larger and more significant changes in functioning.
- 3) In order to ascertain progress toward treatment goals, detailed data collection on behavioral targets must be recorded. It must be measurable and obtained as a result of direct observational data analysis.
- 4) Functional Behavior Assessment (FBA) — There must be an understanding of the function of the undesirable behaviors is critical because most problem behaviors serve a purpose and are reinforced by their consequences. Examples of such are to gain attention, to avoid an undesirable request or situation, and/or to engage in a particular activity or obtain a particular object.
- 5) Behavior Intervention Plan (BIP) — A BIP is developed using information gathered from the FBA. The BIP outlines a plan for decreasing the frequency of the behavior.
- 6) The treatment environment must be maintained in such a way as to minimize problematic behaviors.

- 7) A carefully designed, individualized and detailed behavior analytic treatment should be constructed, including evidence-based behavior analytic treatment methods.
- 8) Frequent direct assessment, analysis and adjustments should be made to the treatment plan based on the individual's progress. This should be determined by observable and measurable data analysis.
- 9) Treatment protocols should be implemented frequently in various environments until the individual can function in a variety of situations.
- 10) Family members are a key component of the program and should be provided support and training in order to promote and maintain improvements in behavior. They should be involved in all decisions pertaining to programming for the child.
- 11) The ABA therapy should be designed and monitored by a Board Certified Behavior Analyst or Licensed Behavioral Health Clinician who ensures the strategies are being appropriately implemented.

Treatment Models

ABA therapy may vary in terms of length of time and intensity. The individual's level of functioning and number of behavioral targets, among other variables, dictate the most appropriate treatment model. Generally, these variables can be categorized into one of two treatment models: focused ABA therapy or comprehensive ABA therapy.

Focused ABA therapy — Non-intensive behavior therapy (no age limit)

Focused ABA therapy involves treatment that addresses a limited number of behavioral targets. There are no age or cognitive level limitations with this treatment model. This treatment model may be appropriate for children whose behavior threatens the safety of themselves or others. It may also be used when their behaviors impede them from participating in community life or remaining in a less-restrictive environment, or when there is an absence of developmentally appropriate adaptive or social skills, such as toileting, feeding or dressing.

Focused ABA therapy can range from 10 – 25 hours per week of direct therapy, and can be part of a step-down or discharge plan from a comprehensive ABA therapy program.

Comprehensive ABA therapy — Intensive behavior Therapy (encouraged for ages 3 and under)

Comprehensive ABA therapy involves multiple behavior targets across all developmental domains affected by the individual's ASD. These programs generally range from 26 – 40 hours of direct treatment per week. It may begin with 1:1 staffing. When appropriate, the inclusion of small groups as part of the treatment may be introduced gradually.

Intensive early treatment is a form of comprehensive ABA therapy. The goal is to bring the individual's level of functioning equal to typically developing peers. Behavior targets are drawn from multiple domains of functioning, including cognitive, communicative, social and emotional. Treatment is intensive and initially provided in structured therapy sessions. When the individual is able to benefit from a less structured and more naturalistic treatment approach, then such approaches are utilized. An important component of this treatment model is training and participation of the parent or caregiver.

Research studies suggest that children 3 years or younger with an ASD diagnosis have better outcomes when they receive when they receive 25-30 hours per week of intensive early treatment of ABA therapy, and it is not uncommon for children in this age group to receive 30 hours of treatment.

AmeriHealth Caritas DC's Early Intervention Services (EIS) program uses both the comprehensive and focused ABA therapy models in the treatment of ASDs, developmental delays and disabilities. The health plan works with providers to determine the best treatment plan for the child.

ABA therapy components

ABA therapy usually focuses on the following areas:

- Cognitive functioning.
- Pre-academic skills.
- Safety skills.
- Social skills.
- Play and leisure skills.
- Community integration.
- Vocational skills.
- Coping and tolerance skills.
- Adaptive and self-help skills.
- Language and communication.
- Attending and social referencing.
- Reduction of interfering or inappropriate behaviors.

Intensive behavior therapy services include assessment, treatment planning and behavioral interventions for AmeriHealth Caritas DC members with ASDs. Trained providers conduct these services. Typically, a patient diagnosed with an ASD is treated in an outpatient setting. However, more intensive treatment may be provided in an acute care setting or with a provider as needed, and when the provider and parent(s) establish reasonable, objective and measurable treatment goals.

Habilitative and Rehabilitative Services

Other services may be used in the treatment of ASD:

- **Speech therapy** is an important adjunct to an ABA therapy program. It addresses the social communication deficits found in children with ASD. Speech and language therapy goals can be worked on in a 1:1 setting. Ideally in an ABA therapy program, the speech language therapist will collaborate with the BCBA, OT, PT, assistants and parents on techniques for addressing the individual speech and language goals of the child throughout the therapeutic sessions. Speech and language goals should be recorded and updated on a weekly basis.
- **Occupational therapy** improves sensory integration problems in children with ASD. It is also used to teach adaptive daily living skills that involve fine motor movements. Treatment goals are developed from conducting occupational therapy assessments to address fine motor, gross motor and self-help skills, as well as individualized sensory processing difficulties.
- **Physical therapy** is similar to occupational therapy in that treatment goals are developed to improve the child's daily living activities. It also improves gross motor skills, such as sitting, walking and coordination. In addition to improving gross motor skills, physical therapy addresses sensory integration difficulties.

For each of these other service areas, the child's comprehensive treatment plan and specific, measureable goals should be reviewed, adjusted and updated on a quarterly basis.

Providers of habilitative and rehabilitative services must meet the treatment plan requirements of ABA therapy providers, including submission of quarterly progress reports for each applicable quarter during which services were rendered (e.g., 3, 6, 9 and 12 month quarterly progress reports). Please see appendix C for an example of a quarterly progress report.

Reports must include the following:

- Documentation that the patient's medical record:
 - Includes notes tied to quarterly progress reports/goals.
 - Includes signed quarterly progress reports which were reviewed with parent/guardian.
 - Demonstrates treatment competencies and coordination of care.
- Completion of all elements on the quarterly progress report.

- Objectives that reflect needed intensity and/or modification to ensure developmental progress.

Early Intervention Services (members ages 0 – 4)

The Individuals with Disabilities Education Act (IDEA) provides states with federal grants to institute early intervention programs. Any child from birth to age four with a developmental delay or physical or mental condition that is likely to result in a developmental delay is eligible to receive early intervention services through these programs. The services should address the child's individual needs.

The Individualized Family Service Plan (IFSP) provides the mechanism for planning and documenting the early intervention services required for a child with a disability and her/his family. The IFSP is based on a comprehensive evaluation of the child. It describes the child's current levels of functioning and the anticipated goals. It should also list the specific services that will be provided to the child and family.

Early Intervention (EI) services are aimed at minimizing the impact of disabilities on the development of the child. Services for the child may include, but are not limited to, speech and language instruction, occupational therapy, physical therapy, ABA therapy and psychological evaluation. Services for families may include training to reinforce the affected child's new skills and counseling to help the family adapt.

Strong Start Program: Intake Procedures

The District of Columbia's Early Intervention Program (DCEIP) — "Strong Start" — is for families with children under age four who have concerns about their child's development. The program provides a system of coordinated services for children under age four with developmental delays. Strong Start is overseen by the Office of the State Superintendent of Education (OSSE) and is the sole entry point into the system for families and their children to receive EI services.

In order for a member to receive AmeriHealth Caritas DC benefit coverage of ABA therapy or any other services under the EI services program, they must first be found eligible for EI services through the DC Early Intervention Program [DCEIP].

Prior Authorization and Implementation of the IFSP Process

In order to receive ABA therapy and other services, members, providers and agencies must adhere to AmeriHealth Caritas DC's prior authorization process described below:

- 1) Health plan members with concerns about the development of their children are referred to AmeriHealth Caritas DC by DCEIP for an evaluation and assessment to determine eligibility for EI services through the Strong Start program (DCEIP). Eligibility is determined via evaluations, assessments and clinical opinions.
- 2) AmeriHealth Caritas DC schedules an evaluation within 10 days of receipt of the referral.
- 3) Upon completion of the evaluation and assessment, AmeriHealth Caritas DC submits its findings to DCEIP within two working days.
- 4) Once the child is found eligible for EI services, an IFSP meeting is set up by DCEIP to develop an IFSP to provide services that meet the individual needs of the child. The evaluations and assessments in conjunction with other information are used in the development of an IFSP. The evaluations, assessments, and IFSP are entered into the OCTO database system by DCEIP. The IFSP should also be sent to AmeriHealth Caritas DC via secure fax or email.
- 5) The IFSP meeting is comprised of a multidisciplinary team and the parent or guardian. An AmeriHealth Caritas DC representative, such as a case manager or behavioral health clinician, should attend the IFSP meeting.

- 6) Following the IFSP meeting, the IFSP Service Coordinator enters the IFSP into the OCTO database system.
- 7) If a child requires ABA therapy and/or other services through his or her IFSP plan, the IFSP Service Coordinator must refer the child to AmeriHealth Caritas DC's Early Intervention services program. The referral notification must be entered into the OCTO database system.
- 8) Once a referral is received, AmeriHealth Caritas DC Early Intervention services Case Management division will review all referrals to make a determination on appropriate health plan coverage and services.
- 9) All services must be prior authorized by AmeriHealth Caritas DC before services are rendered.
- 10) Prior authorization requests for children with IFSPs should be submitted via the OCTO database system. For children without IFSPs, prior authorization requests should be made via fax to 1-202-408-1031 or 1-877-759-6216.
- 11) If the services requested from the referral notification are covered by AmeriHealth Caritas DC, the Case Management division will locate and assign an in-network ABA, habilitative or rehabilitative service provider to the health plan member within twenty-five days of receipt of the referral notification.
- 12) The assigned service provider must enter a treatment plan and all relevant clinical documentation into the OCTO system and forward such information to AmeriHealth Caritas DC's Case Management division. The provider is responsible for ensuring AmeriHealth Caritas DC has received relevant documentation to commence the prior authorization process. ABA, habilitative or rehabilitative providers must not render services prior to receiving authorization from AmeriHealth Caritas DC.
- 13) AmeriHealth Caritas DC begins the prior authorization process after receiving all pertinent documentation from the ABA, habilitative or rehabilitative provider. The initial authorization is for a three month period.
- 14) Initial treatment requests must include evidence of an autism spectrum disorder (ASD) diagnosis, developmental delay or disability; relevant clinical documentation; and a treatment plan.
- 15) If a member requires ABA therapy or other services in an inpatient treatment or acute care facility, the provider is required to seek prior authorization for the inpatient service.
- 16) Once services have been authorized, AmeriHealth Caritas DC's Case Management division will fax or email the authorization notification to the provider and will also call to ensure receipt of the authorization.
- 17) AmeriHealth Caritas DC Case Management will enter the authorization into the OCTO database system.
- 18) AmeriHealth Caritas DC notifies the parent or guardian of authorization and provides them the name of the assigned provider. The parent or guardian is also told to expect a call from the provider to set a date for the evaluation.
- 19) Services provided to a member prior to authorization by AmeriHealth Caritas DC are subject to a retrospective review process.
- 20) The OCTO system notifies AmeriHealth Caritas DC of all updated evaluations and assessments.

Reauthorization and Concurrent Reviews

In order to receive reauthorization of Early Intervention services, providers must adhere to AmeriHealth Caritas DC's reauthorization process described below:

- 1) Providers must contact AmeriHealth Caritas DC's Case Management division to request reauthorization of services. Reauthorization requests for children with IFSPs should be submitted via the OCTO database system. For children without IFSPs, requests should be made via fax to 1-202-408-1031 or 1-877-759-6216.
- 2) Reauthorization of services is subject to a concurrent review process.
- 3) Reauthorizations are for three months at a time. However, AmeriHealth Caritas DC reserves the right to adjust the length of the authorization period.
- 4) Concurrent reviews are not restricted to a request for reauthorization of services. Concurrent reviews may be conducted at any time during an authorized period of service delivery, should AmeriHealth Caritas DC deem it necessary.
- 5) Requests for reauthorization must include a treatment update with a graphic display of progress (via email, fax and the OCTO database system). The treatment update should include, but is not limited to, the following:
 - Mastered behavior targets.
 - Continuous behavior targets.
 - Goals (both new and baseline goals).
 - Psychological updates.
 - Behavior data with explanation of any lack of progress.
 - Crisis management plan.
 - Transition plan to lower level of care.
 - Supervision protocol (only applicable to agencies providing ABA therapy services).
 - Hours and codes being requested for subsequent treatment period.
- 6) Treatment updates are due three weeks prior to the end of the previous authorization period.
- 7) In addition to the treatment plan and treatment update requirements, providers of ABA, habilitative and rehabilitative services must also submit a quarterly progress report for each applicable quarter in which services were rendered (e.g., 3, 6, 9 and 12 month quarterly progress reports).
- 8) Requests for assessments must include hours, type of assessment and clinical justification for the hours requested.
- 9) Once documentation is received, the reauthorization process begins. The Case Management division will review clinical notes for medical necessity and compliance with AmeriHealth Caritas DC's Autism Spectrum Disorders & Behavior Therapy coverage determination guidelines.
- 10) Approved reauthorizations will be faxed and emailed to the provider with a follow-up telephone call to confirm receipt.
- 11) The AmeriHealth Caritas DC Case Management division will notify the parent or guardian of approved authorizations within 24 to 48 hours of the determination.

Concurrent reviews may be conducted at any time during an authorized period of service delivery.

Denials

The following items may lead to denial of requests for authorization of services:

- Teaching interventions used in an ABA therapy program do not meet the criteria of research-based, effective interventions for children with ASD and, therefore, do not demonstrate a beneficial health outcome.
- ABA therapy inconsistent with accepted standards of practice or AmeriHealth Caritas DC's best practice guidelines for the treatment of ASD, developmental delays and disabilities.
- Services are covered as part of the Individual Education Plan (school-based services).
- Treatment plans do not take into consideration AmeriHealth Caritas DC's stated treatment plan requirements, e.g., treatment plans that do not reflect coordination of care with other providers.
- Treatment updates do not take into consideration AmeriHealth Caritas DC's treatment update stated requirements, e.g., treatment updates that do not contain a graphical display of behavior data.
- Quarterly progress reports are incomplete and do not take into consideration AmeriHealth Caritas DC's and the Office of the State Superintendent's stated requirements.
- Treatment does not meet medical necessity criteria.
- ABA therapy and other services exceed the necessary period for effective treatment, diagnosis, evaluation and/or crisis intervention.

Treatment Delivery Settings

The standard of care provides for treatment to be delivered in multiple settings in accordance with clinical judgment to promote generalization and maintenance of therapeutic benefits. Where possible, most children under 3 years of age who require treatment should receive at least some of the treatment in their home. However, treatment should not be withheld, nor should family members be expected to forego employment, etc., in order to receive such treatment. Under certain circumstances, clinic-based services may be most appropriate.

Age at Initiation of Services

Services should be provided as soon as possible after diagnosis. Evidence-based research suggests the earlier treatment begins, the greater the likelihood of positive long-term outcomes and that comprehensive ABA therapy can, in some cases, reduce the need for services as the child grows older. Other research suggests that ABA therapy can be effective across the life span.

Incorporating ABA Therapy with Other Forms of Treatment

Findings from several studies suggest that an eclectic model, that is where ABA therapy is combined with other forms of treatment, is less effective than ABA therapy alone. Therefore, treatment plans which involve a mixture of methods, especially those that lack proven effectiveness, should be considered with caution.

Assessment, Treatment Plan Formulation and Measurement of Progress

The Assessment Process

An ABA therapy assessment plan identifies strengths and weaknesses across developmental domains. Data collected from this plan forms the basis for the development of the individual's treatment plan. The treatment plan coincides with the individual's IFSP. It addresses goals, baseline and mastery criteria; parent training; transition planning; crisis planning; and psychological information. (Please see Appendix B for an example treatment plan.)

Direct observation and measurement of behavior

Direct observation, measurement and recording of behavior are all cardinal features of ABA therapy. The collected data serve to form the basis for establishing behavior baseline and discharge goals, evaluating treatment progress, and modifying treatment protocols on a continuous basis.

Interviews with the parent and caregivers

Parents and caregivers should participate whenever possible in devising the individual's treatment plan. Interviews, rating scales and social validity measures should be used to evaluate the parents' or caregivers' assessments of their children's skill and behavioral deficits.

Treatment Plan Requirements (Intensive/Non-Intensive)

Treatment plans must be updated in accordance with changes in the individual's condition.

Selection of a target-behavior definition, method and frequency of measurement approach, and data presentation must be individualized to each situation, behavior and available resources.

Behavioral targets should be selected based on the risk posed to the individual's health and safety.

Baseline performance, mastery criteria and treatment goals should be developed for each critical area. They should be clearly defined, observable and quantifiable. They should be derived from assessments and should include the level of service being provided to the individual and the location of the service delivery. They should be specific about the amount of improvement expected, the probable time frame and clinical and functional endpoints realistically expected to be obtained.

Frequent data collection and analysis should be done in order to adjust or modify the individual's treatment plan.

The data should be recorded in a graphical format. The treatment plan should:

- Include a crisis management and behavior reduction plan.
- Demonstrate how the parents or guardians will be trained in management skills that can be generalized to the home.
- Include coordination with other health professionals currently providing services.
- Include supervision and treatment planning hours if applicable.

- Reflect the child’s IFSP.

Authorization Types

Types of Services

AmeriHealth Caritas DC’s authorizations may include some or all of the services listed below:

- Assessment.
- Treatment plan development.
- Direct treatment.
- Supervision (direct and indirect).
- Parent and community caregiver training.
- Consultation to ensure continuity of care.
- Discharge planning.

If there is a question as to the appropriateness or effectiveness of ABA therapy for a particular individual, reviews of treatment data may be conducted more frequently.

Treatment Intensity and Duration

The intensity of a treatment varies with each individual and is dependent on the individual’s unique needs and response to treatment. Treatment is defined by intensity and duration.

Intensity

Intensity is usually measured by the number of hours per week of direct treatment. It demonstrates whether treatment is comprehensive, crossing multiple domains or is focused, involving a limited number of behavior targets.

When the goal of treatment is to bring the individual’s level of functioning up to his or her chronological age, then comprehensive ABA therapy may require intensive and direct treatment for 26 – 40 hours per week.

Treatment hours for children less than three years of age may range from 26 – 30 hours per week. Children over age 3 may be treated 30 – 40 hours per week.

When the goal of treatment is to address a small number of target areas, then focused ABA therapy may be indicated.

Direct treatment hours will be related to the individual’s unique needs and learning history, the need to train direct-care staff, assessment time, and data analysis.

Duration

Treatment duration depends largely on the individual’s response to treatment. An evaluation should be performed prior to the end of the previous authorization period.

Working with Caregivers and Other Professionals

Parents, Caregivers and Family Members

Parents and caregivers, including family members, are encouraged to participate at various levels and times during both focused and comprehensive ABA therapy programs. They provide important relevant background information pertaining to the individual's home and community life. They should receive training and be consulted throughout the treatment and discharge process.

Due to the fact that individuals with ASD have behavior deficits that significantly impact the family's health and functioning, treatment protocols should take into consideration the family's health and well-being when it comes to assessing treatment outcomes. It is important that the family or caregiver is able to support the treatment goals in the home environment, as a deficit in this area can affect treatment outcomes.

Parent and Caregiver Training

Parent and caregiver training is part of both focused and comprehensive ABA therapy models. Emphasis is usually placed on developing skills and support. The objective of parent training is to enable the parent or caregiver to implement the treatment protocols in the home environment and outside of the treatment setting.

Parents and caregivers are usually trained in the basics of ABA therapy. The training that parents receive is usually individualized and customized to include, but may not be limited to, didactic presentations, behavioral assessments, modeling and skill demonstration. Parents may also receive coaching and support for solving various problems, implementing strategies in new environments and maintaining behavior changes in the individual resulting from treatment he or she has received.

Examples of Behavioral Targets

Below are behavioral targets for which parents or caregivers frequently seek assistance:

- Assistance to generalize skills acquired in treatment settings into the home and the community.
- Treatment to reduce or replace self-injurious or aggressive behaviors.
- Training in functional communication and participation in routines that promote healthy habits.
- Reduction in ritualistic or preservative behaviors.

Program Components

Providers should adopt a multifaceted approach to treatment (e.g., role-play, in-vivo practice, modeling and feedback), or one that includes didactic instruction for the caregivers and family members.

Coordination with Other Health Professionals

ABA therapy providers should consult and coordinate care with other professionals to ensure the individual's progress. There is a better chance of the individual achieving the treatment goals when there is a coordination of care among all health care providers involved in the individual's treatment.

Treatment Discontinuation, Discharge and Transition Planning

Transition and discharge planning from a treatment program should be documented to include details of appropriate follow-up for the individual and the family. Discharge and transition planning from all treatment programs should be done gradually. Discharge from a comprehensive ABA therapy program may require six months or longer.

Transition/Discharge

Transition and discharge planning should begin when the following occurs:

- Treatment goals have been achieved and any remaining behaviors can be self-managed or managed by the parent. An appropriate termination plan should be developed.
- The individual no longer meets the diagnostic criteria for ASD treatment, developmental delay or disability.
- The individual shows no progress towards goals to justify successive authorization periods.
- The individual will age out of EI services.

Transition notification must be provided to AmeriHealth Caritas DC as follows:

- Notify AmeriHealth Caritas DC three weeks prior to a transition in care.
- Notify AmeriHealth Caritas DC 90 days prior to transition if the individual is ageing out of EI services.

The transition of care plan should include the following:

- A final treatment plan reflecting the individual's progress.
- Reason for the transition.
- Next level of care.

Treatment Discontinuation

Treatment discontinuation may be warranted if:

- The parent refuses treatment or does not comply with the treatment protocol despite the supports provided.
- The treatment plan does not address any lack of progress toward the treatment goals by making adjustments or modifications.
- Treatment is otherwise no longer necessary.

Contracting and Credentialing Process

In order to provide habilitative, rehabilitative or ABA therapy services, you must first become contracted and credentialed to provide service for AmeriHealth Caritas DC.

Contracting and Credentialing Process

The following steps describe the contracting and credentialing process:

- Potential providers must register with the Council for Affordable Quality Healthcare's (CAQH) universal credentialing data source. Complete your online application at: <http://www.caqh.org/access-upd.php>.
- Contact the AmeriHealth Caritas DC Provider Network Management department at 1-202 408-2237 to initiate the contracting process.
- AmeriHealth Caritas DC will verify your W-9 information and clear potential providers through the Office of the Inspector General's (OIG) excluded provider list.
- Once you are cleared as a potential ABA therapy provider, an AmeriHealth Caritas DC provider account executive will begin the contract development process.
- The credentialing process may be completed within 60 days for clean files. Files that contain adverse actions may take up to six months for processing and approval.
- After all contracts and applicable documents have been signed, the contract execution process will proceed. This process involves loading the contract into AmeriHealth Caritas DC's system, creating a provider ID number and configuring the provider for payment.
- AmeriHealth Caritas DC will begin the provider training process by conducting a new provider orientation session. This training session will cover AmeriHealth Caritas DC's policies and procedures. AmeriHealth Caritas DC Network Management staff will also initiate the process to get you connected to AmeriHealth Caritas DC's online resources.
- For ABA therapy providers, this Provider Guide to the Early Intervention Program can be downloaded online at www.amerihhealthcaritasdc.com, or obtained by contacting Provider Network Management.

Credentialing and Contracting Requirements

The following will be required during the credentialing and contracting process:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans known as National Provider Identifier (NPI).
- AmeriHealth Caritas DC requires all claims submitted to include an NPI number for reimbursement. To obtain an NPI number, follow the instructions on the NPI website <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

The
Credentialing
process may
take up to six
months.
However,
clean files may
take up to 60
days.

- Tax Identification Number (TIN), Employee Identification Number (EIN) or Social Security Number (SSN) information:
 - <http://www.irs.gov>.
 - <http://www.irs.gov/businesses/small/article/0,,id=102767,00.html>.
- Professional liability insurance, minimum \$1 million per occurrence and \$3 million aggregate and sufficient to meet applicable requirements of relevant licensing boards in the District of Columbia. The Behavior Analyst Certification Board website (<http://www.bacb.com>) includes information pertaining to insurance. This information can be accessed by entering the word “liability” in the site’s “Search” feature located on the left side of the menu.

Network Participation Qualification Criteria for ABA Therapy Services, Developmental Therapy (Special Instruction) and Habilitative Service Providers

Members receiving ABA, habilitative, rehabilitative or developmental therapy (special instruction) services are referred to an assigned network provider who has been credentialed by AmeriHealth Caritas DC as having expertise in ABA therapy, speech therapy, occupational therapy, physical therapy and developmental therapy (special instruction). Such expertise is demonstrated by any of the following:

ABA therapy service provider

- A provider who has a doctorate with a specialty in psychiatry, medicine or psychology; is actively licensed by the applicable state licensing board; and has one year of direct experience in behavioral therapies consistent with best practices and research on effectiveness for people with ASD.
- A provider who has a doctorate with a specialty in psychiatry, medicine or psychology; is actively licensed by the applicable state licensing board; and is nationally certified as a Board Certified Behavior Analyst (BCBA) or certified by a similar, nationally recognized organization.
- A provider who has a master’s degree or higher in one of the behavioral or health sciences and is nationally certified as a BCBA or certified by a similar, nationally recognized organization.
- A provider who has a bachelor’s degree or higher in one of the behavioral or health sciences and is nationally certified as a Board Certified Associate Behavior Analyst (BCaBA) or certified by a similar, nationally recognized organization.

Habilitative or rehabilitative service provider

- A provider that has a master’s degree or higher in one of the health sciences and is actively licensed by the applicable state licensing board as a physical therapist, occupational therapist, or speech therapist.

Developmental therapy (special instruction) service provider

- A provider with a teacher endorsement in early childhood education (ECE) or special education.
- A provider with a bachelor’s degree or higher from an accredited institution in early childhood development, early childhood education, early childhood special education, special education, or related health, human service or education field with one year of direct experience with children from birth to age 3. Such a provider must be able to perform global evaluations and assessments and therefore must demonstrate competency in administering and interpreting a variety of approved assessment tools specific to young children with disabilities.

- A provider with a current license in speech language pathology, occupational therapy or physical therapy, or any other type of therapy that is characterized as rehabilitative or habilitative in nature. Such a provider must have documented completion of educational experiences approved by an accredited institution that include a minimum of three semester hours (or 30 continuing education unit credit hours) from a national organization in the following Early Intervention core knowledge content areas: the Development of Young Children; Typical and Atypical; Working with Families of Young Children with Disabilities; Intervention Strategies for Young Children with Special Needs; plus one year of direct experience with children birth to age 3 demonstrating competent knowledge and skills in developmentally appropriate practice with children with suspected developmental delays and diagnosed disabilities.

ABA, Habilitative and Rehabilitative Provider Billing and Reimbursement

Prior to service delivery, providers should ascertain whether the member is eligible to receive services.

Member Eligibility

Providers should verify the following:

- The member's eligibility for the services.
- The member's benefit coverage relating to both the service (e.g., Is ABA-based therapy covered?) and the diagnosis (e.g., Is autism covered? Is Asperger disorder covered?).
- The service has been prior authorized, as appropriate.

Providers must submit a completed CMS-1500 or clean claim to be reimbursed.

CMS Health Insurance Form (CMS-1500)

The CMS-1500 is the standard claim form used by health care professionals to bill Medicaid and Medicare carriers. A claim is a request for payment of Medicaid or Medicare benefits for services provided by a health care professional. Claims must be submitted within 180 days of the date services were rendered. For an example of the CMS-1500 form and additional guidance on the submission of paper or electronic claims, please refer to the Claims and Billing Manual available online in the provider area of www.amerhealthcaritasdc.com.

All providers must submit a complete, accurate CMS-1500 (also known as a clean claim) on paper or electronically in order to be reimbursed for services. The following are resources and items to guide the completion of the claims form:

- The AmeriHealth Caritas DC Claims and Billing Manual, available online at www.amerhealthcaritasdc.com.
- Diagnostic coding.
- Guides for coding.
- DSM-IV TR.
- CPT coding guidelines.
- HCPC coding guidelines.
- ICD-9 coding guidelines.

Examples of Typical ABA Therapy CPT Codes

CPT Code	DESCRIPTOR
97532	Developmental therapy — special instruction.
98960-HO	Cognitive skills development (ABA services rendered by BCBA).
98960-HN	Cognitive skills development (ABA services rendered by BCaBA).
99080	ABA treatment plan update.
90887	ABA progress meetings.
S5108	Behavior assessment and initial treatment plan. Use modifier “HT” for multi-clinician administered evaluations.
90853	Group therapy.
96111	Developmental evaluation and assessment (AEPS).
96110	Developmental assessment (BDI). Use modifier “HT” for multi-clinician administered evaluations.
97003, 97530	OT evaluation and corresponding OT therapy, respectively.
97001, 97110	PT evaluation and corresponding PT therapy, respectively.
92506, 92507	Speech evaluation and corresponding speech therapy, respectively.

Note: All reimbursement is contingent upon the provider’s contractual agreement or Letter of Agreement (Single Case Agreement) with AmeriHealth Caritas District of Columbia, the eligibility of the member at the time services are rendered, the proper administration of services, the member’s medical need for services, and the appropriate medical record documentation.

Appendix A — Sample Treatment Plan

For the treatment of autism spectrum disorders.

Parent/legal guardian and patient information

Subscriber's last name/first name: _____

Subscriber #: _____ Subscriber phone: _____

Patient's last name: _____ First name: _____

Patient's DOB: _____

Provider information: _____

Name of facility/group/individual provider federal tax ID#: _____

Name of executive director telephone #/email address: _____

Street address, city, state, ZIP: _____

Name of practitioner supervising treatment licensure/certification state: _____

BCBA or licensed supervisor and phone number: _____

For any other individuals providing services, please provide information below:

Other provider's name:	Degree credentials/license/ other training:	Background check:	
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Assessment, treatment information and recommendations

Supervision protocol (frequency, duration and team members involved):

Psychosocial information (including family composition, recent family changes, medications, medical conditions, other psychological conditions, other treatments the client is receiving, school functioning and supports):

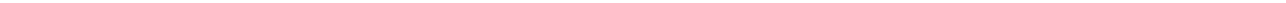
Current problem areas and how they relate to ASD diagnosis:

Assessment of current functioning (observed via FBA, ABLLS, VB-MAPP, etc.):

Clinical interpretation/response to treatment (including a description of why ABA services are needed; explain progress to treatment):

Behavior intervention plan (if needed):

Crisis management (medical/ behavioral crisis):



Transition plans (how services will be faded, transitions to school or adulthood):

Coordination of care (i.e., speech therapy, occupational therapy, physical therapy, outpatient therapy, medication management, interventions in the school):

Parent involvement (current level of involvement, how involved, parent goals/training):

Discharge criteria (see treatment plan guidelines):

Behaviors targeted for reduction

For current level, indicate percentage of average. In addition, should provide baseline data and progress data. Use additional sheets and/or attach graphs as needed.

Behavior	Objective	Baseline Data	Current Level	Mastery Criteria	Target Date

Behaviors targeted for increase for current level

Indicate percentage or average. In addition, should provide baseline data and progress data. Use additional charts and/or attach graphs as needed.

Behavior	Objective	Baseline Data	Current Level	Mastery Criteria	Target Date

Service Request for ABA, Habilitative and Related Services

Examples of Typical ABA Therapy CPT Codes

CPT Code	Descriptor
97532	Developmental therapy — special instruction.
98960-HO	Cognitive skills development (ABA services rendered by BCBA).
98960-HN	Cognitive skills development (ABA services rendered by BCaBA).
99080	ABA treatment plan update.
90887	ABA progress meetings.
S5108	Behavior assessment and initial treatment plan. Use modifier “HT” for multi-clinician administered evaluations.
90853	Group therapy.
96111	Developmental evaluation and assessment (AEPS).
96110	Developmental assessment (BDI). Use modifier “HT” for multi-clinician administered evaluations.
97003, 97530	OT evaluation and corresponding OT therapy, respectively.
97001, 97110	PT evaluation and corresponding PT therapy, respectively.
92506, 92507	Speech evaluation and corresponding speech therapy, respectively.

Note: All reimbursement is contingent upon the provider’s contractual agreement or Letter of Agreement (Single Case Agreement) with AmeriHealth Caritas District of Columbia, the eligibility of the member at the time services are rendered, the proper administration of services, the member’s medical need for services, and the appropriate medical record documentation.

Provider (BCBA or licensed mental health provider)

Date

Parent signature

Date

Appendix B — Sample Quarterly Progress Report

Office of the State Superintendent of Education ♦ Division of Special Education

STRONG START

Provider Progress Notes (Check 3 6 9 12 month interval)

Complete this progress report and review with parent/guardian. Submit the completed report to the service coordinator no later than 2 weeks prior to the 6 month review (submit 3 and 6 months notes) or annual meeting (submit 9 & 12 month notes). All questions must be answered or the report will be returned. Use additional pages if needed. [This is a fillable PDF. You may navigate the form by clicking in the fillable areas or by tabbing through the document.](#)

Child's Name:	SS #	Date of Birth:
IFSP Period From:	To:	
Provider Agency:		
Name of Interventionist:		
Discipline: <input type="checkbox"/> SLP <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> DT <input type="checkbox"/> AUD <input type="checkbox"/> OM <input type="checkbox"/> Spec: _____		
Service Type: <input type="checkbox"/> ST <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> DT <input type="checkbox"/> AT <input type="checkbox"/> AUD <input type="checkbox"/> VIS <input type="checkbox"/> Other:		
Interventionist Phone Number:		
Date reviewed with parent/guardian:		
Parent's/Guardian's Signature:		
Authorized Frequency?	Date you started working with this child:	
Where have services been delivered? <input type="checkbox"/> Home <input type="checkbox"/> Child Care Center <input type="checkbox"/> Other:		
Has the parent(s) been present for the sessions? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, how have you communicated with the family?		
If there have been any gaps in service delivery of more than three consecutive scheduled visits, describe the length and the reason(s).		
List the child's medical diagnosis(es) (if any):		
Is the child using assistive technologies? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is a new AT Device being requested? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, identify the Functional Outcomes (from the IFSP) and specify how the device is helping (or will help) to achieve the Outcome.		

Child's Name:	SS#	Date of Birth:
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Provider Progress Notes (Check 3 6 9 12 month interval)

1. IFSP Functional Outcome #1:	Rate Progress in this Time Period: <input type="checkbox"/> No Progress <input type="checkbox"/> Little Progress <input type="checkbox"/> Moderate Progress <input type="checkbox"/> Great Deal of Progress <input type="checkbox"/> Outcome Achieved
--------------------------------	--

1a. List the short term objectives that are currently being worked on to achieve the IFSP Functional Outcome:

Check Yes or No to indicate if the objective(s) was achieved in this time period. Check Emerging to indicate if the skills related to the objective are emerging.

1. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
2. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
3. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
4. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
5. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging

1b. State changes/modifications made **to objectives** in order to facilitate developmental progress. Be specific:

1c. What routine activities are you and the family/caregivers using to achieve **each** objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into the routine activities. Which family member(s) have you been working with?

1d. What changes were made if the routine **activities or the strategies/methods/approaches** were ineffective (progress limited), or difficult for the family to incorporate into daily routines?

Child's Name:	SS#	Date of Birth:
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Provider Progress Notes (Check 3 6 9 12 month interval)

2. IFSP Functional Outcome #2:	Rate Progress in this Time Period: <input type="checkbox"/> No Progress <input type="checkbox"/> Little Progress <input type="checkbox"/> Moderate Progress <input type="checkbox"/> Great Deal of Progress <input type="checkbox"/> Outcome Achieved
--------------------------------	--

2a. List the short term objectives that are currently being worked on to achieve the IFSP Functional Outcome:	
Check Yes or No to indicate if the objective(s) was achieved in this time period. Check Emerging to indicate if the skills related to the objective are emerging.	
1. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
2. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
3. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
4. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
5. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging

2b. State changes/modifications made to objectives in order to facilitate developmental progress. Be specific:

2c. What routine activities are you and the family/caregivers using to achieve each objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into the routine activities. Which family member(s) have you been working with?

2d. What changes were made if the routine activities or the strategies/methods/approaches were ineffective (progress limited), or difficult for the family to incorporate into daily routines?

Child's Name:	SS#	Date of Birth:
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Provider Progress Notes (Check 3 6 9 12 month interval)

3. IFSP Functional Outcome #3:	Rate Progress in this Time Period: <input type="checkbox"/> No Progress <input type="checkbox"/> Little Progress <input type="checkbox"/> Moderate Progress <input type="checkbox"/> Great Deal of Progress <input type="checkbox"/> Outcome Achieved
--------------------------------	--

3a. List the short term objectives that are currently being worked on to achieve the IFSP Functional Outcome:	
Check Yes or No to indicate if the objective(s) was achieved in this time period. Check Emerging to indicate if the skills related to the objective are emerging.	
1. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
2. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
3. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
4. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
5. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging

3b. State changes/modifications made to objectives in order to facilitate developmental progress. Be specific:

3c. What routine activities are you and the family/caregivers using to achieve each objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into the routine activities. Which family member(s) have you been working with?

3d. What changes were made if the routine activities or the strategies/methods/approaches were ineffective (progress limited), or difficult for the family to incorporate into daily routines?

Child's Name:	SS#	Date of Birth:
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Provider Progress Notes (Check 3 6 9 12 month interval)

4. IFSP Functional Outcome #4:	Rate Progress in this Time Period: <input type="checkbox"/> No Progress <input type="checkbox"/> Little Progress <input type="checkbox"/> Moderate Progress <input type="checkbox"/> Great Deal of Progress <input type="checkbox"/> Outcome Achieved
--------------------------------	--

4a. List the short term objectives that are currently being worked on to achieve the IFSP Functional Outcome:

Check Yes or No to indicate if the objective(s) was achieved in this time period. Check Emerging to indicate if the skills related to the objective are emerging.

1. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
2. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
3. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
4. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging
5. Objective:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emerging

4b. State changes/modifications made **to objectives** in order to facilitate developmental progress. Be specific:

4c. What routine activities are you and the family/caregivers using to achieve **each** objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into the routine activities. Which family member(s) have you been working with?

4d. What changes were made if the routine **activities or the strategies/methods/approaches** were ineffective (progress limited), or difficult for the family to incorporate into daily routines?

Child's Name:	SS#	Date of Birth:
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Provider Progress Notes (Check 3 6 9 12 month interval)

NOTE: Questions 5, 6, and 7 do NOT need to be answered separately for each outcome.

IFSP Period: From:	To:
5. In addition to working with the family, describe all collaborative efforts made to address the IFSP outcomes of this child. (Examples: interactions with outside medical providers (with written parental permission), other EI therapists, day care staff, other caregivers, community resources).	
6. Based on your ongoing assessment of the child's progress, what is the child's current level(s) of functioning?	
For the 6 and 12 month progress note, please estimate the percentage of delay. Percent Delay:	
Provide an explanation of how the percentage of delay was determined (e.g. standardized instrument and/or informed clinical opinion). If an instrument was administered, please report the results according to the instrument's manual.	
7. What can the child do now that he/she was previously unable to do (child's strengths). Address each functional outcome.	
Note: If the interventionist has additional comments or observations, please provide additional documentation here or on page 9.	

I certify that I have received and reviewed a copy of the child's IFSP and evaluation/progress notes prior to starting services, have provided services in accordance with the IFSP service's specified frequency and duration, and have worked towards addressing the relevant IFSP outcomes. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of therapist completing this report:	
*License number:	Print Name:
<i>*If certified, type "certified" and do not indicate number.</i>	Date Report was Completed:

Child's Name:	SS#	Date of Birth:
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Provider Progress Notes (Check 3 6 9 12 month interval)

ADDITIONAL COMMENTS

STRONG START

INSTRUCTIONS FOR COMPLETION OF PROGRESS NOTES

The therapist must complete this form at the 3, 6, 9 and 12 month intervals after a child's initial IFSP meeting.

- The 3 and 6 month progress note is to be submitted at least two (2) weeks prior to the 6 month review.
- The 9 and 12 month progress note is to be submitted at least two (2) weeks prior to the Annual Review.

At the top of each page, please check the IFSP interval that this progress note covers.

DEMOGRAPHIC / AUTHORIZATION INFORMATION	
Child's Name	Information must be the same as the Strong Start record (do not use nickname).
Strong Start number and Date of Birth	Make sure that all identifying information is correct.
IFSP Period	This is the term of the current IFSP.
Provider Agency Name	Agency for which the interventionist works.
Interventionist Name	Print the name of the interventionist who is completing this form.
Discipline	Interventionist's discipline, e.g. Speech and Language Therapy, Physical Therapy, Occupational Therapy, Developmental Therapy, Audiology, Orientation and Mobility, Specialist.
Service Type	IFSP authorized service delivered by the interventionist SLP—Speech Therapy (SLP), Physical Therapy (PT), Occupational Therapy (OT), Developmental Therapy (DT), Audiology (AUD), Assistive Technology (AT), Vision Services (VIS), Other
Interventionist's Phone Number	Direct number (cell, etc) at which the interventionist can be reached if there are questions about the report. Do not use the provider agency's number.
Date Reviewed with Parent/Parent Signature	The interventionist must review the report with the parent prior to submission and document such review.
Authorized Frequency	How often the service was authorized at the IFSP (e.g. 1 week).
Date you started working with the child	State the date that you delivered the first intervention session.
Where were the services delivered?	Location of services, e.g. parent's home, babysitter's home, daycare center, agency location.
How have you communicated with the parent when they were not present during sessions?	Describe your method of communication with the family (E.g. Phone calls, meetings at work, notebook left in the parent's home or daycare center, etc.)
If there have been any gaps in service delivery of more than three consecutive scheduled visits, describe the length and the reason(s).	Explain the reason for and length of any gaps, whether make up sessions were delivered, whether there was a gap between your service delivery to the child and that of the previous interventionist, etc.
List the child's medical diagnosis(es)	List all diagnoses (indicate if any diagnoses are newly identified).
Is the child using assistive technologies (AT)	Check Yes or No.
Is a new AT device being requested?	Check Yes or No.
Indicate the type of device, and how the device is helping (or will help) to achieve an IFSP Functional Outcome?	If the child is currently using an AT device, or if an AT device is being requested, indicate type of device and how the device will help achieve an IFSP outcome. State which functional outcome(s) in particular.

Clarification of Terms:

Functional Outcome: A practical result that reflects the family's priorities, is developmentally and individually appropriate, and considered critical for the child's participation in daily activities. The outcome should include a measurable skill targeted for a child to achieve in the next 6 months through Strong Start supports and services. The functional outcome **MUST** be written in parent friendly language. All clinical terms must be avoided.

Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome. These small steps should be specific and measurable and written in parent friendly language.

Activities: Routine activities are those that occur within the child's day (e.g: bedtime, snack time, time at the playground) and provide opportunities to learn and practice objectives with family members.

Strategies/methods/approaches: Ways that the family and therapist support the child's learning in routine activities.

Description of Progress in IFSP Outcomes: Pages 2, 3, 4, 5

IFSP Functional Outcome—indicate, on separate pages, each IFSP functional outcome, and the child's progress during the time period covered by this report. **Note: The functional outcomes listed in the progress notes **MUST** be the same functional outcomes that were agreed to in the IFSP. Provide additional functional outcome sheets if necessary on page 9.**

STRONG START

INSTRUCTIONS FOR COMPLETION OF PROGRESS NOTES (CONTINUED)

1a. Break down each functional outcome into short-term objectives that have been, and are currently being worked on.

Example: IFSP Functional Outcome: Jane will be able to pick up small objects, such as raisins or cheerios, with either hand using the thumb and index finger without resting her arm on the table so that she can begin feeding herself everyday during meal time.

Objective 1: Jane will pick up a cheerio with fingers/scrapping movement

Objective 2: Jane will pick up a cheerio with side of finger and thumb

For each direction listed, check the appropriate box to indicate if the objective has been achieved (Y), is not present (N), or is Emerging (E)—the skill has started to develop but has not been incorporated into all aspects of child's routine.

1b. State changes/modifications made to objectives in order to facilitate development progress. Be specific. List changes made to the short term objectives during this IFSP period to facilitate achievement of the functional outcome.

Example: An additional outcome can be added to build upon Jane's progress and achievement of the functional outcome

Objective 3: Jane will pick up a Cheerio with tip of finger and thumb while her arm is on the table.

1c. What routine activities are you and the family/caregivers using to achieve each objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into routine activities. Which family member(s) have you been working with? Indicate what specific routine-based activities the family used to achieve each objective. Include the family's feedback as to how will these activities worked when you were not present.

Example: Objectives 1, 2 and 3: During mealtime. Ms. X presents Jane with small bits of foods on a flat surface (ex: Jane's favorite flat plate); these include peas, diced cooked carrots, and Cheerios. Ms X picks up one cheerio at a time on Jane's high chair tray to show Jane what to do.

Objectives 2 and 3: Ms. X encourages Jane to turn the pages of a book with thin paper during story time.

1d. What changes were made if the routine activities or the strategies/methods approaches were ineffective (progress limited), or difficult for the family to incorporate into daily routines? Explain how you changed your approach or activities when you did not see progress.

Example of a change to an activity: Because Jane prefers to use all her fingers in a raking motion when presented with a plate of Cheerios, Ms X started presenting Jane with one Cheerio at a time in the palm of her hand to encourage that use of Jane's thumb and index finger. In addition, throughout the day, Ms X started encouraging Jane to turn a wall light switch on and off.

Example of a change to intervention approach: I found that Jane was tired at the time of my scheduled visit. We switched the time to after her nap and had better success.

NOTE: Questions below (5, 6, and 7) do not need to be answered separately for each outcome being worked on.

5. Describe all collaborative effort made to address the IFSP outcomes for this child: Describe communication with the other EI therapists and how you worked with them to achieve the functional outcomes. With parental consent, have you communicated with relevant medical providers? At the parent's request, how you assisted the family in finding other resources (e.g. books, articles)? Have you communicated with day care staff, taught techniques to grandparents, nannies, etc.

6. Based on your ongoing assessment of the child's progress, what is the child's current level(s) of functioning? Document the child's current functioning, including the use of standardized instruments (if the therapist chooses to administer) and informed clinical opinion. For 6 months and 12 month progress notes, estimate the percent of delay. Note: if an instrument is administered, report the results according to the instrument's manual.

7. What can the child do now that he/she was unable to do previously (child's strengths). Provide an overall picture of how the child is functioning within daily routines and how the learned skills have been incorporated.

Certification: Sign, date, provide license number and print name. If a certified professional, indicate "certified" and do not write number.

Appendix C — Bibliography

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