Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.
# Applied Behavior Analysis

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CONTACT INFORMATION  APPENDIX A
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The Louisiana Department of Health established coverage of applied behavior analysis (ABA) under the Medicaid State Plan for recipients under the age of 21. ABA therapy is the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA-based therapies are based on reliable evidence and are not experimental.

This provider manual chapter specifies the requirements for reimbursement for services provided by an enrolled, licensed practitioner and provides direction for provision of these services to eligible recipients in the State of Louisiana.

These regulations are established to assure minimum compliance under the law, equity among those served, provision of authorized services, and proper fund disbursement. Should a conflict exist between manual chapter material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.
COVERED SERVICES

Medicaid covered applied behavior analysis (ABA)-based therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement, or prompting, to teach each step of targeted behavior. ABA-based therapies are based on reliable evidence and are not experimental.

Medicaid covered ABA-based therapy must be:

- Medically necessary;
- Prior authorized by Medicaid or its designee; and
- Delivered in accordance with the recipient’s behavior treatment plan.

Services must be provided by, or under the supervision of, a behavior analyst who is currently licensed by the Louisiana Behavior Analyst Board, or a licensed psychologist or licensed medical psychologist, hereafter referred to as the licensed professional. Payment for services must be billed by the licensed professional.

Prior to requesting ABA services, the recipient must have documentation indicating medical necessity for the services through a completed comprehensive diagnostic evaluation (CDE) which has been performed by a qualified health care professional (QHCP). (See Appendix A for contact information on arranging a CDE.)

**NOTE:** Medical necessity for ABA-based therapy services must be determined according to the provisions of the *Louisiana Administrative Code* (LAC), Title 50, Part I, Chapter 11.

A QHCP is defined as a:

- Pediatric neurologist;
- Developmental pediatrician;
- Psychologist (which includes a medical psychologist);
- Psychiatrist (particularly pediatric and child psychiatrist); or
Licensed individual that has been approved by the Medicaid medical director as meeting the requirements of a QHCP when:

- The individual’s scope of practice includes differential diagnosis of Autism Spectrum Disorder and comorbid disorders for the age and/or cognitive level of the recipient; and
- The individual has at least two years of experience providing such diagnostic assessments and treatments.

The CDE must include at a minimum:

- A thorough clinical history with the informed parent/caregiver, inclusive of developmental and psychosocial history;
- Direct observation of the recipient, to include but not be limited to, assessment of current functioning in the areas of social and communicative behaviors and play or peer interactive behaviors;
- A review of available records;
- A valid *Diagnostic and Statistical Manual of Mental Disorders* (DSM) V (or current edition) diagnosis;
- Justification/rationale for referral/non-referral for an ABA functional assessment and possible ABA services; and
- Recommendations for any additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or any additional recommended standardized measures, labs or other diagnostic evaluations considered clinically appropriate and/or medically necessary.

When the results of the screening are borderline, or if there is any lack of clarity about the primary diagnosis, comorbid conditions or the medical necessity of services requested, the following categories of assessment should be included as components of the CDE and must be specific to the recipient’s age and cognitive abilities:

- Autism specific assessments;
- Assessments of general psychopathology;
• Cognitive assessment; and

• Assessment of adaptive behavior.

Assessment and Plan Development

The licensed professional is required to perform a functional assessment of the recipient utilizing the outcomes from the CDE, and develop a behavior treatment plan.

Services for “behavior identification assessment” must be prior authorized. This is for the initial assessment only. Only one authorization will be approved for a period not to exceed the first 180 days of ABA services.

Services for “observational behavioral follow-up assessment” includes the licensed behavior analyst and direction with interpretation and report, administered by one technician; 30 minutes of the technician's time, face-to-face with the patient." This may be approved every 180 days as treatment continues for a child if medically necessary. Up to eight units of this service may be approved per prior authorization period (unless otherwise clinically indicated).

Behavior Treatment Plan

The behavior treatment plan identifies the treatment goals along with providing instructions to increase or decrease the targeted behaviors. Treatment goals and instructions target a broad range of skill areas such as communication, sociability, self-care, play and leisure, motor development and academic, and must be developmentally appropriate. Treatment goals should emphasize skills required for both short- and long-term goals. The instructions should break down the desired skills into manageable steps that can be taught from the simplest to more complex.

The behavior treatment plan must:

• Be person-centered and based upon individualized goals;

• Delineate the frequency of baseline behaviors and the treatment development plan to address the behaviors;

• Identify long-term, intermediate, and short-term goals and objectives that are behaviorally defined;

• Identify the criteria that will be used to measure achievement of behavior objectives;
• Clearly identify the schedule of services planned and the individual providers responsible for delivering the services;

• Include care coordination, involving the parents or caregiver(s), school, state disability programs, and others as applicable;

• Include parent/caregiver training, support, and participation;

• Have objectives that are specific, measurable, based upon clinical observations of the outcome measurement assessment and tailored to the recipient; and

• Ensure that interventions are consistent with ABA techniques.

The provider may use the treatment plan template provided (Attachment C) which can also be found electronically at www.lamedicaid.com, or the provider may use their own form. If the provider chooses to use their own form, the provider must address all of the relevant information specified in the Louisiana Department of Health (LDH) treatment plan template. Any missing information may delay approval of prior authorization of service.

The behavior treatment plan must indicate that direct observation occurred and describe what happened during the direct observation. If there are behaviors being reported that did not occur and these behaviors are being addressed in the plan, indicate all situations and frequencies at which these behaviors have occurred and have been documented. If there is documentation from another source, that documentation must be attached. If there is any other evidence of the behaviors observed during the direct observation and that are proof of these behaviors, these must be reported on the behavior treatment plan as well.

The behavior treatment plan shall include a weekly schedule detailing the number of expected hours per week and the location for the requested ABA services. In addition, the provider shall indicate both the intensity and frequency of the therapy being requested and the justification for this level of service.

In order to help LDH understand all the services the child needs and is receiving, the provider should enclose with the plan of care a copy of the child’s individualized educational plan (IEP). If the provider does not enclose the IEP, the provider should explain why he or she is unable to furnish a copy of the IEP.

A behavior treatment plan calling for services to be delivered in a school setting will not be approved until an IEP is provided to LDH. ABA therapy recommended in an IEP and delivered by the Local Education Authority is eligible for reimbursement from Louisiana Medicaid,
provided all other conditions for coverage of ABA therapy are met (e.g., the service is medically necessary).

The behavior treatment plan should indicate if the recipient is in a waiver and which waiver the recipient is in. (This can be determined by checking the MEDS/REVS system). If the child is in a waiver, the treatment plan must include a copy of the Plan Profile Table and the Schedule page from the certified plan of care. This can be obtained by contacting the waiver Support Coordinator. Communication should be maintained between the ABA provider and the support coordinator.

ABA and waiver services can overlap depending on the service description in the waiver document and the need for the services to overlap. This should be clearly documented in an addendum to the behavior treatment plan.

This addendum should detail the frequency and duration of sessions when the ABA provider and the direct support worker are required to be present at the same time, and include an outline of information the direct support worker needs to correctly implement the skill, several measurable and objective goals defining and leading to the direct support worker’s competency (i.e., correct implementation), and the methods for collecting data on the direct support worker’s performance. It should identify strategies the ABA provider will use, such as, but not limited to, demonstration, modeling, coaching and feedback, and providing repeated opportunities for direct support worker practice (role playing and in “real life” situations with the recipient). This pairing of the direct support worker and the ABA provider should be specific, time limited, measureable and individualized.

**Therapeutic Behavioral Services**

Therapeutic behavioral services include the design, implementation and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior. This includes one-on-one services that teach skills for each step of targeted behavior(s) through the use of behavioral observation and reinforcement or prompting.

Services for “adaptive behavior treatment by protocol” administered face-to-face with one patient must be requested for all the additional time the tech needs with the recipient). The licensed professional must frequently review the recipient’s progress using ongoing objective measurement and adjust the instructions and goals in the behavior treatment plan as needed.

**Supervision**
The licensed professional shall provide case oversight and management of the treatment team via adaptive behavior treatment with protocol modification by supervising and consulting with the recipient’s team. The licensed professional must also conduct regular meetings with family members to plan ahead, review the recipient’s progress and make any necessary adjustments to the behavior treatment plan. LDH expects part of the supervision to be done in the presence of the recipient receiving treatment and state-certified assistant behavior analyst or the registered line tech.

**Role of the Parent/Caregiver**

Treatment plan services must include care coordination involving the recipient’s parent/caregiver. Services must also include parent/caregiver training, support and participation. ABA is a recipient-focused service, and it is not practical or within the standard of practice to require the parent/caregiver to be present at all times while services are being rendered to the recipient. There is the expectation that recipients may be unaccompanied by a parent/caregiver while receiving services at a center-based program, especially for recipients receiving services for multiple hours per day. To the extent that parental/caregiver presence is required is a therapeutic decision, even when therapy is provided in the home.

Services for “Family adaptive behavior treatment guidance”, administered by a physician or other qualified health care professional, should be included in a behavior treatment plan for prior authorization in order to transfer skills to the parents or caregivers of the recipients to ensure that the recipient has consistency across environments, and therapy can be reinforced at home and in other locations with their caregiver.

Services for “Multiple-family group adaptive behavior treatment guidance”, administered by a physician or other qualified health care professional, should be included in a behavior treatment plan for prior authorization in order to transfer skills to the parents or caregivers of the recipient to ensure that the recipient has consistency across environments, and therapy can be reinforced at home and in other locations with their caregiver. The multiple-family group therapy should be used when caregivers of two or more recipients are present. The recipients should have similar diagnosis, behaviors and treatment needs.

**Limitations**

A prior authorization period shall not exceed 180 days. Services provided without prior authorization will not be considered for reimbursement, except in the case of retroactive Medicaid eligibility.

**Group Therapy**
When part of the approved behavior treatment plan, services for “Adaptive behavior treatment social skills group” shall be face-to-face with two or more patients. The recipients should have similar diagnosis, behaviors and treatment needs.

When part of the approved behavior treatment plan, “Group adaptive behavior treatment” may be administered by a registered line tech. This shall be face-to-face with two or more patients. The recipients should have similar diagnosis, behaviors and treatment needs.

**Place of Service**

Services must be provided in a natural setting (e.g., home and community-based settings, including clinics and school). Medically necessary ABA services provided by enrolled licensed professionals in school settings are allowed.

**Exclusions**

The following services do not meet medical necessity criteria, and do not qualify as Medicaid covered ABA-based therapy services:

- Therapy services rendered when measureable functional improvement or continued clinical benefit is not expected, and therapy is not necessary or expected for maintenance of function or to prevent deterioration;
- Service that is primarily educational in nature;
- Services delivered outside of the school setting that duplicate services under an individualized family service plan (IFSP) or an IEP, as required under the federal Individuals with Disabilities Education Act (IDEA);
- Treatment whose purpose is vocationally or recreationally-based;
- Custodial care that:
  - Is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating and maintaining personal hygiene and safety;
  - Is provided primarily for maintaining the recipient’s, or anyone else’s, safety; or
  - Could be provided by persons without professional skills or training; and
- Services, supplies or procedures performed in a non-conventional setting
including, but not limited to:

- Resorts;
- Spas;
- Therapeutic programs; or
- Camps.
RECIPIENT REQUIREMENTS

Applied behavior analysis (ABA)-based services are available to Medicaid recipients under 21 years of age who:

- Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (e.g., aggression, self-injury, elopement, etc.),

- Have been diagnosed with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder, by a qualified health care professional,

- Had a comprehensive diagnostic evaluation by a qualified health care professional, and

- Have a prescription for ABA-based therapy services ordered by a qualified health care professional.

NOTE: All of the above criteria must be met to receive ABA-based services.
CHAPTER 4: APPLIED BEHAVIOR ANALYSIS
SECTION 4.3: SERVICE AUTHORIZATION PROCESS

SERVICE AUTHORIZATION PROCESS

All Applied Behavior Analysis (ABA) services must be prior authorized by the Bureau of Health Services Financing (BHSF) or its designee. Recipients must select a provider of their choice based on the availability of Medicaid enrolled providers.

Prior Authorization Requests

Prior authorization is a two-fold process. An authorization is first requested for approval to perform a functional assessment and to develop a behavior treatment plan. A second authorization is needed for approval to provide the ABA-based derived therapy services. (See Appendix B for procedure code and description.)

All prior authorization requests must be submitted to the fiscal intermediary’s Prior Authorization Unit (PAU) through the electronic prior authorization (e-PA) process via e-PA Transaction using the individual attending provider number. (See Appendix A for information about PAU and e-PA.)

For adaptive behavior treatment protocol and group adaptive behavior treatment protocol, modifiers do not need to be requested during prior authorization but should be added at claims submission. Documentation must be kept on file to show that the credentials of the person performing the services match the modifier.

NOTE: Do not use the group provider number on the e-PA.

Functional Assessment and Development of the Behavior Treatment Plan

A prior authorization request must be submitted by the ABA provider to conduct a functional assessment and to develop a behavior treatment plan (Mental Health Services Plan Development by Non-Physician). The prior authorization request must include a comprehensive diagnostic evaluation (CDE) that has been conducted by a qualified health care professional (QHCP) prescribing and/or recommending ABA services.

All CDEs completed by QHCPs will be reviewed and considered when making prior authorization decisions.

Follow up assessments should be requested 45 days in advance of the date to renew ABA services. No documentation needs to be submitted with this request. Also modifiers do not need to be requested during prior authorization but added at claims submission. Documentation must be kept on file to show that the credentials of the person performing the services match the modifier.
NOTE: CDEs completed more than 18 months prior to the date of service authorization requests may require an update, progress report, or re-evaluation by a QHCP.

The authorization request will be reviewed by the PAU’s ABA consultant and a decision will be made regarding the approval of the services. The decision is entered into the e-PA system and will be available for the provider to review during the following business day. A letter is also sent to the recipient, the ABA provider, and case manager (if applicable) advising of the decision.

**Request to Provide ABA-Based Therapy Services**

A separate authorization request must be submitted by the ABA provider to request approval to provide the ABA-based therapy services to the recipient. This authorization request must include:

- The CDE;
- The behavior treatment plan;
- The IEP; and
- The waiver plan profile table and the schedule from the certified plan of care (if the recipient is in a waiver and services are being requested that will occur at the same time as waiver services).

Authorizations for ABA-derived therapy services shall be authorized for a time period not to exceed 180 days.

**Reconsideration Requests**

If the prior authorization request is not approved as requested, or an existing authorization needs to be adjusted, the provider may submit a request for reconsideration of the previous decision. When submitting a reconsideration request, providers should include the following:

- A copy of the prior authorization decision notice with the word “Recon” written across the top;
- The reason the reconsideration is being requested written across the bottom of the notice;
• All original documentation submitted from the original request; and
- Any additional information or documentation which supports the reconsideration request.

After the reconsideration request has been reviewed, a new notification letter with the same prior authorization number will be generated and mailed to the provider, recipient, and case manager (if the recipient has one).

Prior Authorization Liaison

The Prior Authorization Liaison (PAL) was established within the PAU to facilitate the authorization process for those Medicaid recipients who are under the age of 21 and are on the Developmental Disabilities Request for Services Registry. The PAL assists when a prior authorization request cannot be approved by the PAU because of a lack of documentation or a technical error. Before the notice of decision is issued, the PAL contacts the provider, recipient, and case manager (if the recipient has one) and informs all parties of the documentation or correction needed to prevent an unfavorable decision.

Changing Providers

Recipients have the right to change providers every 180 days unless a change is requested for good cause. If a provider change is requested based on good cause before the authorization period ends, the recipient or case manager (if the recipient has one) must contact BHSF. (See Appendix A for contact information.)
PROVIDER REQUIREMENTS

In order to participate as an applied behavior analysis (ABA) service provider in the Medicaid Program, a provider must:

- Be a Louisiana licensed psychologist or medical psychologist;
- Be a licensed behavior analyst that:
  - Is licensed by the Louisiana Behavior Analyst Board;
  - Is covered by professional liability insurance to limits of $1,000,000 per occurrence, $1,000,000 aggregate; and
  - Has no sanctions or disciplinary actions on their Board Certified Behavior Analyst (BCBA®) or Board Certified Behavior Analyst – Doctoral (BCBA-D) certification and/or state licensure;
- Be a certified assistant behavior analyst that renders ABA-based therapy services that:
  - Is certified by the Louisiana Behavior Analyst Board;
  - Works under the supervision of a licensed behavior analyst with supervisory relationship documented in writing; and
  - Has no sanctions or disciplinary actions, if state-certified or board-certified by the BACB®; or
- Be a registered line technician that renders ABA-based therapy services that:
  - Is registered by the Louisiana Behavior Analyst Board; and
  - Works under the supervision of a licensed behavior analyst with supervisory relationship documented in writing.

The licensed professional (licensed psychologist, licensed medical psychologist or behavior analyst), certified assistant behavior analyst, or registered line technician shall not have any Medicare/Medicaid sanctions, or be excluded from participating in federally funded programs (i.e., Office of Inspector General’s list of excluded individuals/entities (OIG-LEIE), system for award management (SAM) listing and state Medicaid sanctions listings).

Criminal Background Checks

Completed criminal background checks must be conducted to include federal criminal, state criminal, parish criminal, and sex offender reports for the state and parish of employment and residence.
Criminal background checks must be conducted according to the following schedule:

<table>
<thead>
<tr>
<th>Role</th>
<th>Initials</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed behavior analyst</td>
<td>Enrollment application (current within a year prior to initial Medicaid application) or at time of hire</td>
<td>Update performed at least every five years thereafter</td>
</tr>
<tr>
<td>Certified assistant analyst</td>
<td>At time of hire</td>
<td></td>
</tr>
<tr>
<td>Registered line technician</td>
<td>At time of hire</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Evidence of background checks must be provided by the employer.
Reimbursement shall only be made for services authorized by Medicaid or its designee. It is the responsibility of the provider to verify the recipient’s Medicaid eligibility prior to providing services.

Reimbursement shall be made available for applied behavior analysis (ABA)-based therapy services to enrolled providers (psychologists, medical psychologists or behavior analysts) who are currently licensed and in good standing with the Louisiana Behavior Analyst Board. Reimbursement for ABA services shall not be made to, or on behalf of, services rendered by a parent, a legal guardian or a legally responsible person.
## CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Prior Authorization Unit</td>
<td>Molina Medicaid Solutions</td>
</tr>
<tr>
<td></td>
<td>1-800-807-1320</td>
</tr>
<tr>
<td>Prior Authorization Liaison</td>
<td>(225) 216-6011</td>
</tr>
<tr>
<td>Provider Enrollment Unit</td>
<td>Molina Medicaid Solutions</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 80159</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70898</td>
</tr>
<tr>
<td></td>
<td>Phone: (225) 216-6370</td>
</tr>
<tr>
<td>Provider Relations Unit</td>
<td>Molina Medicaid Solutions</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 91024</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70821</td>
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<tr>
<td></td>
<td>Phone: (225) 924-5040 or 1-800-473-2783</td>
</tr>
<tr>
<td>Recipient Eligibility Verification System (REVS)</td>
<td>Phone: (225) 216-7387 or 1-800-766-6323</td>
</tr>
<tr>
<td>Bureau of Health Services Financing</td>
<td>1-888-758-2220</td>
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<tr>
<td>Arrange a Comprehensive Diagnostic Evaluation</td>
<td>Contact Your Healthy Louisiana Plan</td>
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<tr>
<td></td>
<td>Aetna Better Health 1-855-242-0802 TTY: 711 Available 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td></td>
<td>Amerigroup RealSolutions 1-800-600-4441 TTY: 711 Available Monday – Friday, 7:00 a.m. - 7:00 p.m.</td>
</tr>
<tr>
<td></td>
<td>AmeriHealth Caritas 1-888-756-0004 TTY: 1-866-428-7588 Available 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td></td>
<td>Louisiana Healthcare Connections 1-866-595-8133 TTY: 1-877-4285-4514 Available Monday – Friday, 7:00 a.m. – 7:00 p.m.</td>
</tr>
<tr>
<td></td>
<td>UnitedHealthcare 1-866-675-1607 TTY: 1-877-4285-4514 Available Monday – Friday, 7:00 a.m. – 7:00 p.m.</td>
</tr>
<tr>
<td>Division of Administrative Law Health and Hospitals Section</td>
<td>Division of Administrative Law – Health and Hospitals Section</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 4189</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70821</td>
</tr>
<tr>
<td></td>
<td>(225) 342-0443</td>
</tr>
<tr>
<td></td>
<td>Fax: (225) 219-0443</td>
</tr>
<tr>
<td></td>
<td>Phone for oral appeals: (225) 342-5800</td>
</tr>
</tbody>
</table>
CLAIMS FILING

Hard copy billing of applied behavior analysis (ABA) services is billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as required, situational or optional.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

Molina Medicaid Solutions
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

- The rendering provider’s individual provider number as the billing provider number for independently practicing providers; or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a ‘group/clinic’ practice.

NOTE: Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link “HIPAA Information Center, sub-link “5010v of the Electronic Transactions” – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and
- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.
<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung</td>
<td><strong>Required</strong> – Enter an “X” in the box marked Medicaid (Medicaid #).</td>
<td></td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s I.D. Number</td>
<td><strong>Required</strong> – Enter the recipient’s 13 digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS or REVS. <strong>NOTE:</strong> The recipients’ 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is <strong>NOT</strong> acceptable. The ID number must match the recipient’s name in Block 2.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Patient’s Name</td>
<td><strong>Required</strong> – Enter the recipient’s last name, first name, middle initial.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Birth Date</td>
<td><strong>Situational</strong> – Enter the recipient’s date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an “X” in the appropriate box to show the sex of the recipient.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
<td><strong>Situational</strong> – Complete correctly if the recipient has other insurance; otherwise, leave blank.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address</td>
<td><strong>Optional</strong> – Print the recipient’s permanent address.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Patient Relationship to Insured</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other Insured’s Name</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured’s Policy or Group Number</td>
<td><strong>Situational</strong> – If recipient has no other coverage, leave blank. <strong>If there is other coverage, the state assigned 6-digit TPL carrier code is required in this field. The carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</strong></td>
<td><strong>ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.</strong></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>9b</td>
<td>RESERVED FOR NUCC USE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>9c</td>
<td>RESERVED FOR NUCC USE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan Name or Program Name</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Is Patient's Condition Related To:</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Insured's Policy Group or FECA Number</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11a</td>
<td>Insured's Date of Birth Sex</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11b</td>
<td>OTHER CLAIM ID (Designated by NUCC)</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11d</td>
<td>Is There Another Health Benefit Plan?</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient's or Authorized Person's Signature (Release of Records)</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Patient's or Authorized Person's Signature (Payment)</td>
<td>Situational – Obtain signature if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Date of Current Illness / Injury / Pregnancy</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>OTHER DATE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Provider or Other Source</td>
<td>Situational – Complete if applicable</td>
<td></td>
</tr>
<tr>
<td>17a</td>
<td>Unlabeled</td>
<td>Situational – Enter if applicable or leave blank.</td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>NPI</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates Related to Current Services</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab?</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>--------------</td>
<td>--------</td>
</tr>
</tbody>
</table>
| 21        | ICD Indicator | Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.  
9  ICD-9-CM  
0  ICD-10-CM | The most specific diagnosis code must be used. General codes are not acceptable. |
| 22        | Resubmission Code | Situational – If filing an adjustment or void, enter an “A” for an adjustment or a “V” for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the “Code” portion of this field.  
Enter the internal control number from the paid claim line as it appears on the remittance advice in the “Original Ref. No.” portion of this field.  
Appropriate reason codes follow:  
Adjustments  
01 = Third Party Liability Recovery  
02 = Provider Correction  
03 = Fiscal Agent Error  
90 = State Office Use Only – Recovery  
99 = Other  
Voids  
10 = Claim Paid for Wrong Recipient  
11 = Claim Paid for Wrong Provider  
00 = Other | Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12). |

NOTE: The ICD-9-CM “E” and “M” series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.

ICD-9 diagnosis codes must be used for claims for dates of service prior to 10/1/15.

ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.

Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).
<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Prior Authorization (PA) Number</td>
<td><strong>Required</strong> – When prior authorization is required for services, the prior authorization number must be entered in this field.</td>
<td>For authorized services, the PA number MUST be entered here.</td>
</tr>
<tr>
<td>24</td>
<td>Supplemental Information</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>24A</td>
<td>Date(s) of Service</td>
<td><strong>Required</strong> – Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</td>
<td></td>
</tr>
<tr>
<td>24B</td>
<td>Place of Service</td>
<td><strong>Required</strong> – Enter the appropriate place of service code for the services rendered.</td>
<td></td>
</tr>
<tr>
<td>24C</td>
<td>EMG</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, Services, or Supplies</td>
<td><strong>Required</strong> – Enter the procedure code(s) for services rendered in the un-shaded area(s). Acceptable procedure codes are located in Appendix B of this manual chapter. (1 unit = 1 hour)</td>
<td></td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis Pointer</td>
<td><strong>Required</strong> – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“A”, “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.</td>
<td></td>
</tr>
<tr>
<td>24F</td>
<td>Amount Charged</td>
<td><strong>Required</strong> – Enter usual and customary charges for the service rendered.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>24G</td>
<td>Days or Units</td>
<td>Required -- Enter the number of units billed for the procedure code entered on the same line in 24D</td>
<td>Refer to 24D</td>
</tr>
<tr>
<td>24H</td>
<td>EPSDT Family Plan</td>
<td>Situational -- Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.</td>
<td></td>
</tr>
<tr>
<td>24I</td>
<td>I.D. Qual.</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>24J</td>
<td>Rendering Provider ID#</td>
<td>Situational -- If appropriate, entering the Rendering Provider’s Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider’s NPI in the non-shaded portion of the block is required if the Provider’s Medicaid ID number is entered above.</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax I.D. Number</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Patient’s Account No.</td>
<td>Situational -- Enter the provider specific identifier assigned to the recipient. This number will appear on the remittance advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td>Required -- Enter the total of all charges listed on the claim.</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
<td>Situational -- If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter ‘0’ if the third party did not pay. If TPL does not apply to the claim, leave blank.</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Balance Due</td>
<td>Situational -- Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician or Supplier Including Degrees or Credentials Date</td>
<td>Optional -- The original signature of the provider is no longer required. Enter the date of the signature.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>32</td>
<td>Service Facility Location Information</td>
<td>Situational – Complete as appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>32a</td>
<td>NPI</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>32b</td>
<td>Unlabeled</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Info &amp; Phone #</td>
<td>Required – Enter the provider name, address including zip code and telephone number.</td>
<td></td>
</tr>
<tr>
<td>33a</td>
<td>NPI</td>
<td>Required – Enter the billing provider’s 10-digit NPI number.</td>
<td></td>
</tr>
<tr>
<td>33b</td>
<td>Unlabeled</td>
<td>Required – Enter the billing provider’s 7-digit Medicaid ID number.</td>
<td>The 7-digit LA Medicaid provider number must be entered here.</td>
</tr>
</tbody>
</table>
ABA – Example Claim Form for Individual Billing with ICD-9 Diagnosis Code
(Dates BEFORE 10/1/15)

**HEALTH INSURANCE CLAIM FORM**

**PREA**

1. **MEDICARE**
   - **MEDICAID**
   - **TRICARE**
   - **CHAMPVA**
   - **GROUP HEALTH PLAN**
   - **PEACE ALLIANCE**
   - **OTHER**

2. **PATIENT'S NAME**
   - **Last Name, First Name, Middle Initial**
   - **07 31 2001**
   - **F**

3. **PATIENT'S ADDRESS (No., Street)**
   - **City**
   - **State**
   - **ZIP Code**

4. **INSURED'S NAME (Last Name, First Name, Middle Initial)**
   - **Insured's ID Number**

5. **OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)**
   - **Insured's Policy Group or PECA Number**
   - **Insured's State of Birth**
   - **Sex**

6. **OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)**
   - **Covered Person**
   - **Place of Birth**
   - **Place of Residence**

7. **INSURED PLAN NAME OR PROGRAM NAME**
   - **Residence State**
   - **Residence City**

8. **INSURED PLAN NAME OR PROGRAM NAME**
   - **Residence Zip Code**

9. **INSURED PLAN NAME OR PROGRAM NAME**
   - **Residence Zip Code**

10. **INSURED PLAN NAME OR PROGRAM NAME**
    - **Residence Zip Code**

11. **INSURED PLAN NAME OR PROGRAM NAME**
    - **Residence Zip Code**

**Additional Information**

12. **PATIENT'S OTHER HOSPITALIZATION OR MEDICAL CARE**
    - **Other Hospitalization or Medical Care**
    - **Other Hospitalization or Medical Care**

13. **PATIENT'S OTHER HOSPITALIZATION OR MEDICAL CARE**
    - **Other Hospitalization or Medical Care**
    - **Other Hospitalization or Medical Care**

14. **DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (DIP)**
    - **Other Date**
    - **Other Date**

15. **NAME OF REFERRING PROVIDER OR OTHER SOURCE**
    - **Referral Date**
    - **Referral Date**

16. **ADDITIONAL CLAIM INFORMATION (Examinated by NUCC)**
    - **Referral Date**
    - **Referral Date**

17. **DIAGNOSIS**
    - **Diagnosis Code**
    - **Original Ref No.**

18. **DIAGNOSIS**
    - **Diagnosis Code**
    - **Original Ref No.**

19. **DIAGNOSIS**
    - **Diagnosis Code**
    - **Original Ref No.**

20. **DIAGNOSIS**
    - **Diagnosis Code**
    - **Original Ref No.**

21. **DIAGNOSIS**
    - **Diagnosis Code**
    - **Original Ref No.**

22. **DIAGNOSIS**
    - **Diagnosis Code**
    - **Original Ref No.**

23. **DIAGNOSIS**
    - **Diagnosis Code**
    - **Original Ref No.**

24. **DIAGNOSIS**
    - **Diagnosis Code**
    - **Original Ref No.**

**PHYSICIAN OR SUPPLIER INFORMATION**

25. **FEDERAL TAX ID NUMBER**
    - **Federal Tax ID Number**
    - **Enrolled**

26. **PATIENT'S ACCOUNTING**
    - **Accept Assignment: Issuer Claim**
    - **Accept Assignment: Issuer Claim**

27. **TOTAL CHARGE**
    - **Total Charge**
    - **Amount Paid**

28. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR DIRECTION**
    - **Signature**
    - **Date**

29. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR DIRECTION**
    - **Signature**
    - **Date**

30. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR DIRECTION**
    - **Signature**
    - **Date**

**EXAMPLE OF ICD-9**

```
03 28 14 03 26 14 11 H2019 A 150 00 10 NPI
```

**NUCC Instruction Manual available at:**

www.nucc.org

**PLEASE PRINT OR TYPE**

APPROVED CMN-06-35-15/18 FORM CMN-1560 (02-12)

**PAGE(S) 16 Appendix C**
ABA – Example Claim Form for Group Billing with ICD-9 Diagnosis Code
(Dates BEFORE 10/1/15)
ABA – Example Claim Form for Individual Billing with ICD-10 Diagnosis Code
(Dates ON OR AFTER 10/1/15)
ABA – Example Claim Form for Group Billing with ICD-10 Diagnosis Code
(Dates ON OR AFTER 10/1/15)
Adjustments and Voids

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

The provider should complete the information on the adjustment exactly as it appeared on the original claim, changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim.

If a paid claim is being voided, the provider must enter all the information on the void from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided, thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.

- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under Adjustment or Voided Claim. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.
When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

Sample forms are on the following pages.
Sample CMS-1500 Form Billed as an Adjustment with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)
Sample CMS-1500 Form Billed as an Adjustment with ICD-10 Diagnosis Code
(Dates ON OR AFTER 10/1/15)
Sample CMS-1500 Form
BEHAVIOR TREATMENT PLAN

The provider is not required to use this plan of care form. However, if not using this form, the plan of care must address all the information specified in the Medicaid State Plan for Applied Behavior Analysis (ABA) and the most recent version of the ABA Provider Manual.

Recipient

Type or print the patient’s full name, Medicaid ID number, date of birth, address and home and cell phone number in the space provided.

Provider Information

Type or print the name of the provider, the provider’s Medicaid ID number, phone number, address and contact person’s email address.

Medical Reason Supporting the Need for ABA Services

Type or print the recipient’s diagnosis.

Requested Hours of Services

- Type or print the number of tutor/RBT hours requested per week.
- Type or print the number of supervision hour conducted by the (BCBA/-D) per week.
- Type or print the number of direct services hour provided by a BCBA/-D per week (this may include caregiver training as well).
- Type or print the total number of requested hours for all services per week.

Baseline Level of Behaviors Addressed in the Plan Based on Assessment Results

- Type or write a narrative description of the baseline level of all behaviors assessed for which a goal is developed. This section must be completed.
Examples:

- “Daniel did not use words to communicate during the assessment.”;
- “James used ten mand forms inconsistently during assessment.”;
- “Sharlee could tact ten animals and four colors during assessment.”; and
- “Silvia made eye-contact two of 12 times after given the direction, look at me.”

- If the document is a treatment plan renewal, list the present level of performance for skills under treatment and any goals mastered during the previous authorization period.

- Do not refer to idiosyncratic, proprietary assessment instrument results to describe baseline performance.

Examples:

- “Harry could perform skills 4L to 5G on ABEL4 assessment”; and
- “Wilma performed at a level 2 across all language skills on VBMZT assessment.”

**NOTE:** May use another sheet for this section and attach it to this form, but the section must be labeled.

**Treatment Goals**

- Type or write a goal for each behavior/skill identified for treatment not including behavior reduction goals. Each goal should have a performance standard and criterion for mastery.

Examples

- “Jon will tact 26 upper case letters independently across two consecutive treatment sessions;
- “Susan will use quantifying autoclitics while manding for chips, (e.g., Can I have two chips please) for ten mand forms.”; and
- “Marvin will make eye contact when his name is called on 90% of the instructional trials across three tutors.”
The provider may NOT use idiosyncratic, proprietary nomenclature to specify treatment goals.

Examples:

- “Seth will complete goals A-K, M-R, and Q-T on the MASP.”;
- “Roger will master ADL skills 1-2 to 4-6 on the ACQMOT program.”

NOTE: A separate sheet may be used for this section and attach it to this form, but the section must be labeled.

Behavior Reduction Plan

According to state guidelines, if the provider is going to intervene on problem behaviors, the provider MUST conduct a functional assessment or a functional analysis (preferred method) and develop a function based treatment plan.

- The provider may NOT make a grid sheet with intervention tactics that is not tied to a narrative description/date analysis of the results of a functional assessment/analysis.
- Type or write the behavior topography of the problem behavior and state the frequency/duration/latency/intensity of all the problem behaviors for which a goal is developed.
- Type or write the results of the functional assessment and type or write a hypothesis statement or describe the results of a functional analysis.
- Type or write a behavior improvement goals with a performance standard and criteria for mastery.

Examples:

- “Terrance will decrease hitting others by 50 percent week for four consecutive weeks. Terrance will ask mand for attention by saying “help” when prompted on 100 percent of the opportunities.”; and
- “William ask mand for an independently break at least five times/session.”
Type or write the behavior intervention plan that addresses the function of the problem behavior that includes strengthening a functional replacement behavior.

Parent/guardian training and support goals

Type or write caregiver training with a performance standard and criteria for mastery.

Example:

- After role-play training, Mrs. Jones will implement Terrance’s behavior reduction plan with 100 percent fidelity across three sessions

Statement of justification for ABA Therapy Hours Requested

Type or write the specific criteria used to determine the need for ABA therapy at the hours requested.

Example:

- Terrance presents with clinically significant deficits in listener behavior (receptive identification, direction following) and currently does not use vocal verbal, sign language or augmentative communication to communicate. He engages in high frequency and high intensity aggressive and self-injurious behavior that presents a substantial risk to himself, others, and property.

Predominant Location

Specify the predominant location where all services will take place.

Check off the environment where services will occur. If services will occur in more than one setting, you may check more than one box.

Hours of Service

Specify the hours of service each day during the school year and summer (if necessary).

Type or write the anticipated total hours (therapy + supervision) for each day.
Signatures

Provide signatures as necessary. **Must sign and date the plan.**

**Plan of Care Form**

The form below may be used to document the POC. For a copy of this form in Microsoft Excel format please contact the ABA Program Manager, Rene Huff, at 225-342-3935 or at Rene.Huff@la.gov.

**NOTE:** Use of this POC form is not required. However, ALL POCs must address all of the information specified in the Medicaid State Plan for Applied Behavior Analysis (ABA) and the most recent version of the ABA Provider Manual.
ABA Therapy- Plan of Care

<table>
<thead>
<tr>
<th>Recipient Information</th>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Provider Name</td>
</tr>
<tr>
<td>ID#</td>
<td>DOB</td>
</tr>
<tr>
<td>Address</td>
<td>Provider Number</td>
</tr>
<tr>
<td></td>
<td>Phone</td>
</tr>
<tr>
<td></td>
<td>Address</td>
</tr>
</tbody>
</table>

Home Phone | Cell Phone | Contact Person e-mail |

Medical Reasons Supporting the Need for ABA Services
(Patient Diagnosis)

Tutor Hours/week | Supervision Hours/week | BCBA Direct Services/week | Total Hours/week |

Baseline Level of Behaviors Addressed in the Plan Based on Assessment Results
(If necessary, you may use a separate sheet)
<table>
<thead>
<tr>
<th><strong>Treatment Goals</strong> (if necessary, you may use a separate sheet)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavior Reduction Plan</strong> (if necessary, you may use a separate sheet)</td>
</tr>
<tr>
<td>Problem Behavior Topography (SIB, property destruction, tantrums, hitting, etc)</td>
</tr>
<tr>
<td>The provider must state the baseline frequency/duration/latency/intensity of all problem behaviors for which a goal is developed</td>
</tr>
<tr>
<td>Recipient Name</td>
</tr>
<tr>
<td>---------------</td>
</tr>
</tbody>
</table>

**Functional Assessment/Analysis Results** (must state a hypothesis of function or provide a finding of function based on a functional assessment).

<table>
<thead>
<tr>
<th>Behavior Plan Goals</th>
</tr>
</thead>
</table>

| Behavior Improvement Plan | (must address the function of the problem behavior and include strengthening a functional alternative behavior) |

Tentative form (v.1)
ABA Therapy - Plan of Care

Parent/Guardian Training and Support Goals

Recipient Name

Recipient ID#

Statement of Justification for ABA Therapy Hours Requested
(Provide specific information you used to determine the need for ABA therapy at the hours requested)

Specify the predominant location where all services will take place

Home □  Clinic □  School □

Specify the hours of service each day during the school year

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday
Specify the hours of service each day during the summer (if necessary)

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Signatures

Parent/guardian | Provider Representative | Physician

Date | Date | Date

Recipient Name | Recipient ID#