

Maryland Medicaid ABA Treatment Plan Template Instructions

The following treatment plan template was developed to assist with making treatment request reviews more efficient. All providers must use the template when submitting treatment requests.

The template highlights and emphasizes providers supplying individualized medical necessity rationales based on the participant's own presentation of symptoms of ASD. Providers should take special care to determine how ABA services and specific goals will work towards alleviating the participant's specific presenting symptoms of ASD.

Providers may use the template as is or load each element into the electronic health record (EHR) system used by the company. Below is a list of all the sections in the order they should appear in the final treatment plan submitted. If loading the template into an EHR system, please ensure each section is clearly labeled in the order they appear in the template/list provided below and ALL information in each section is accounted for. For areas with check boxes, we ask those check boxes remain (school year, severity level, etc.). Please use the treatment plan requirements document available on the website for further description of the information to be included in each section. Many sections have bullet points with further guidance for providers. These bullet points can be left in the final draft sent in with an authorization or deleted. If you choose to delete the bullet points, it's advised to keep them in until the BCBA completing the assessment has ensured each is addressed. Providers can delete the boxes marked *optional*. Providers who separate the treatment plan and behavior intervention plan will need to ensure the behavior intervention plan is included in the treatment plan as one cohesive document. Final drafts sent to Optum Maryland should be sent as PDFs. Please do not submit Word documents to avoid any inadvertent edits to the document. Providers who submit treatment plans where the order of sections are changed will be directed to reorder the sections to match the template format and may be required to resubmit their request.

Required Treatment Plan Sections

- Client Information
- Biopsychosocial Information
- Narrative
- Goal/Objective Summary
- Skill Acquisition Goals
- Behavior Intervention Plan
- Behavior Reduction Goals
- Caregiver Training
- Generalization Plan
- Transition and Fading Plan
- Discharge Plan
- Recommendations for ABA Services
- Anticipated Schedule
- Provider Information

If using the template as is, please remove this page before converting the treatment plan to PDF and submitting for review.

INSERT COMPANY LOGO

Maryland Medicaid ABA Treatment Plan Template

Client Information	
Participant Name	
Date of Birth	
Date of Initial Assessment	
Date of Current Reassessment	
Parent/Guardian Contact	Name: Phone: Email:

Biopsychosocial Information		
Current Family Structure		
Medications <i>Include ALL medications (OTC, Psych meds or behavioral meds), dosage and prescribing physician</i>		
Medical History		
School Placement <i>Include schedule of academic activities: e.g., math, science, reading, etc.</i>	School setting (K-12): <input type="checkbox"/> Public school, <input type="checkbox"/> Private school, <input type="checkbox"/> Home School, <input type="checkbox"/> Virtual school, <input type="checkbox"/> NA	
	<table border="1"> <tr> <td>Grade: <input type="checkbox"/> K <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> 4th <input type="checkbox"/> 5th <input type="checkbox"/> 6th <input type="checkbox"/> 7th <input type="checkbox"/> 8th <input type="checkbox"/> 9th <input type="checkbox"/> 10th <input type="checkbox"/> 11th <input type="checkbox"/> 12th</td> <td> Start and end time of school hours: Schedule of academic activities: Total number of hours spent in school per week: </td> </tr> </table>	Grade: <input type="checkbox"/> K <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> 4th <input type="checkbox"/> 5th <input type="checkbox"/> 6th <input type="checkbox"/> 7th <input type="checkbox"/> 8th <input type="checkbox"/> 9th <input type="checkbox"/> 10th <input type="checkbox"/> 11th <input type="checkbox"/> 12th
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History of ABA Services <i>(indicate N/A if no prior history)</i>	Provider name: Start Date: End Date: Outcomes:	

	Provider name: Start Date: End Date: Outcomes:
Other Mental Health Services <i>Include any mental health hospitalizations</i>	
Other Services <ul style="list-style-type: none"> e.g., Occupational therapy, speech therapy, physical therapy, feeding therapy, etc. Include how many sessions per week and how many hours overall. Indicate NA if none. 	
Coordination of care with other providers <i>Psychologists, psychiatrists, OT, SLP, PT, School personnel, etc.</i>	
Major Life Changes (Indicate NA if none)	

Narrative	
Direct Observation <i>Provide observations in all settings services will occur such as home, clinic, school, etc.</i>	Date of Observation: Clinical Narrative:
Language/Communication <i>Include details about progress from the previous authorization.</i>	Strengths: Challenges: Severity Level: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Social Skills <i>Include details about progress from the previous authorization.</i>	Strengths: Challenges: Severity Level: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Adaptive/Self-Care <i>Include details about progress from the previous authorization.</i>	Strengths: Challenges: Severity Level: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

Challenging Behaviors <i>Include details about progress from the previous authorization.</i>	Narrative/Description: Severity Level: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Standardized Assessment <i>Include analysis of the results, participant's current functioning, and clinical observations through a detailed narrative (VB-MAPP, PEAK, ABLLS-R, Essentials for Living, etc.)</i>	

Goal/Objective Summary	
<ul style="list-style-type: none"> <i>In the rows below please indicate how many goals are being targeted during this treatment period, how many goals were mastered from the last treatment period along with totals for in-progress goals, goal on-hold, discontinued goals, and new goals introduced.</i> 	
Total # of goals:	
Total # of goals mastered:	
Total # of goals in-progress:	
Total # of goals on-hold:	
Total # of goals discontinued:	
Total # of new goals:	
Response to Treatment/Authorization Summary	
<ul style="list-style-type: none"> <i>Include details about how the participant is responding to treatment, any changes made to increase the rate of acquisition of skills.</i> <i>If this is an initial plan, indicate N/A below.</i> 	

Skill Acquisition Goals	
<ul style="list-style-type: none"> <i>Must have measurable baseline.</i> <i>Should be derived from the functional assessment and/or skills-based assessments that occurred prior to initiating treatment.</i> <i>Should not duplicate other services such as academic, OT, SLP, PT, feeding therapy, etc.</i> <i>Should not be related to vocational skills.</i> <i>Should be broken into short-term and long-term, if needed.</i> DO NOT use individual targets as a goal. <i>Must have measurable progress in the same unit of measure as the reported baseline.</i> <i>Steps on how the team will ensure maintenance of skills.</i> <i>If applicable, indicate if goal is a replacement behavior for a behavior targeted for decrease.</i> <i>If applicable, separate goals that will be worked on in different settings.</i> <i>In the "Medical Necessity Rationale" area please provide a description of how the goals being targeted relate to the core deficits of ASD and how they will alleviate the symptoms of ASD being experienced by the participant.</i> 	
Language/Communication	
Medical Necessity Rationale:	
Goal Statement: Goals should include mastery criteria.	
Baseline: <i>Must be a quantitative measure. (e.g., per hour/week/month, etc.)</i>	
Date of Introduction:	

Projected Mastery:	
Progress Data: <ul style="list-style-type: none"> Measure must match baseline measure (e.g., per hour/week/month, etc.). If applicable, include narrative of any changes in teaching procedures that occurred to assist with acquisition rate 	
Graphs (optional):	

Social	
Medical Necessity Rationale:	
Goal Statement: Goals should include mastery criteria.	
Baseline: <i>Must be a quantitative measure. (e.g., per hour/week/month, etc.)</i>	
Date of Introduction:	
Projected Mastery:	
Progress Data: <ul style="list-style-type: none"> Measure must match baseline measure (e.g., per hour/week/month, etc.). If applicable, include narrative of any changes in teaching procedures that occurred to assist with acquisition rate 	
Graphs (optional):	

Adaptive/Self-Care	
Medical Necessity Rationale:	
Goal Statement: Goals should include mastery criteria.	
Baseline: <i>Must be a quantitative measure. (e.g., per hour/week/month, etc.)</i>	
Date of Introduction:	
Projected Mastery:	
Progress Data: <ul style="list-style-type: none"> Measure must match baseline measure (e.g., per hour/week/month, etc.). If applicable, include narrative of any changes in teaching procedures that occurred to assist with acquisition rate 	
Graphs (optional):	

Behavior Intervention Plan

- Any behavior targeted with a goal for reduction must include a behavior plan.
- If applicable ensure to include restricted/repetitive patterns of behavior.
- Include definition of the behavior, quantitative baseline, hypothesized function of behavior, antecedent interventions, consequence strategies, replacement behaviors, and any de-escalation procedures if applicable.
- Should be continually modified and adjusted based on participant's response to intervention.

Behavior Assessment <i>If using, include a summary of any behavior assessments (FAST, RAISD, etc.)</i>	
Target Behavior:	
Operational Definition:	
Hypothesized Function:	
Replacement Behavior:	
Antecedent Interventions (proactive strategies):	
Consequence Procedures (reactive strategies):	
De-escalation Procedures:	

Behavior Reduction Goals

- Should be derived from the functional assessment and/or skills-based assessments that occur prior to initiating treatment.
- Should be broken into short-term and long-term, if needed.
- Must report measurable progress in the same unit of measure as the reported baseline.

Goal Statement: <ul style="list-style-type: none"> • Goals should include mastery criteria. 	
Baseline: <i>Must be a quantitative measure. (e.g., per hour/week/month, etc.)</i>	
Date of Introduction:	
Projected Mastery:	
Progress Data: <i>Measure must match baseline measure (e.g., per hour/week/month, etc.)</i>	
Graphs (optional):	
Barriers: <ul style="list-style-type: none"> • Include specific actionable measures you completed to remediate these barriers as well as actionable steps for the next authorization period. • If applicable, include narrative of any changes in the behavior intervention plan that occurred to assist with reduction of the behavior. 	

Parent or Caregiver Training

- Parent or caregiver (i.e. family, daycare staff, school staff) training is a required component of treatment under this benefit.

<ul style="list-style-type: none"> Goals should target identifying and utilizing specific ABA strategies to reduce maladaptive behaviors and promote skill acquisition. 1:1 meeting with BCBA or participation/observation of sessions with RBT do not meet requirements for parent or caregiver training under this ABA benefit. Include a narrative discussing the overall progress with implementing ABA strategies and progress toward goals. Include any barriers to conducting parent or caregiver training with actionable efforts to mitigate the barriers. If requesting 97157, include separate goals that will be addressed during group parent or caregiver training. If RBT/BT staffing is a barrier to providing services, best practice standards dictate parent or caregiver training should be provided to support the family. 	
Goal Statement: <ul style="list-style-type: none"> Goals should include mastery criteria. 	
Baseline: <i>Must be a quantitative measure. (e.g., per hour/week/month, etc.)</i>	
Date of Introduction:	
Projected Mastery:	
Progress Data: <ul style="list-style-type: none"> Measure must match baseline measure (e.g., per hour/week/month, etc.). Include narrative of parent/caregiver's progress with implementing ABA strategies. 	
Barriers: <i>Include specific actionable measures you completed to remediate these barriers as well as actionable steps for the next authorization period.</i>	
Graphs (optional):	

Generalization Plan
<ul style="list-style-type: none"> List specific steps ABA team will take to help facilitate generalization of skills learned across people (i.e., family, daycare staff, school staff, other providers), environments (i.e., home, school, community, daycare), and stimuli. Include a specific generalization plan if services are occurring more than 50% in a clinic setting.

Transition and Fading Plan
<ul style="list-style-type: none"> The transition plan should address how the participant will move from the current level of service to lower intensity (hours) of service through discharge; this should be directly related to how the participant is meeting objectives and based on measurable outcomes. If applicable, provide a fading plan for transition services from one location of service to another. Include a specific titration plan from clinic setting if services are occurring more than 50% in a clinic setting. Provided that the benefit is only available until age 21, as the participant approaches adolescence, include steps to assist the family with transitioning to adult services.

Discharge Criteria
<ul style="list-style-type: none"> Discharge criteria should be established when services begin and adapted throughout the duration of treatment. Individualize discharge criteria to be measurable and directly related to the attainment and maintenance of the participants' goals. The discharge plan should include: <ul style="list-style-type: none"> o Next level of care (e.g., outpatient mental health services, medication management, mainstream school, etc.)

<ul style="list-style-type: none"> o Linkages with other services o How the family can contact the provider for additional assistance o Community resources for the family

<h3>Crisis Plan</h3>
<ul style="list-style-type: none"> • Include the steps for prevention and de-escalation of crisis, it should address the following types of situations: <ul style="list-style-type: none"> o Emergency, such as a weather or medical emergency (e.g., seizures), including who should be contacted which includes appropriate supervisors or emergency personnel. o Protocol for responding to significant behaviors that have the potential for injury to self or others. o Names and phone numbers of contacts that can assist the participant in resolving crisis, such as other treatment providers who may assist in the prevention or de-escalation of behaviors, even for those participants who do not currently display aberrant behaviors.

<h3>Recommendations for ABA Services</h3>
<ul style="list-style-type: none"> • The maximum allowable for reassessment is 3 hours (12 units) total per authorization. Any additional hours should be requested through an addendum AFTER using the initial 12 units. • 97151 and 97152 are complementary codes. They share 12 standard units (reassessment). When requesting both codes, distribute the units accordingly. • Supervision is typically in the range of 10-20% ratio of 1:1 direct care hours, depending on need/medical necessity. Include specific medical necessity rationale if requesting over 20%. • H2012 is a great resource for collaboration, treatment planning, and data analysis. You are allotted a maximum of 4 hours/month of this code. • If requesting 97154, please include medical necessity. Confirm within report if the participant is ready to learn in a group setting without direct, 1-1 RBT support. This code means that there are several children per 1 RBT. • 97157- If requesting this code, please include specific goals you will be targeting during group parent training. • Do Not split the requested units into separate rows to indicate service codes with and without the GT modifier. Codes eligible for telehealth should be requested as one sum. • If requesting 0362T or 0373T: T codes are reserved for high intensity cases where 2:1 staffing is required. Please seek out guidance on use of these codes BEFORE requesting to avoid complications with approvals. • Delete any service codes not being requested. • Add lines for the T codes if requesting. • Indicate all locations of service for each code. • DO NOT modify the columns on the grids. Can add rows as needed. • Calculations per week: hours X 4 X 26 weeks • Calculations per month: hours X 4 X 6 months

<p>Medical Necessity Must include the medical necessity rational as it relates to this participant's core deficits of ASD and the participant's functioning level in relation to the intensity of services and the location of services.</p> <p>This should be a synopsis of the participant's clinical profile that justifies the level of care being requested.</p> <p>i.e.: Given the participants presentation of symptoms of ASD, how will ABA services benefit this participant at the intensity of care being recommended and at the location being recommended?</p> <p>Include specific medical necessity rationale if requesting a change (increase or decrease) in any service codes.</p>	
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<p>Barriers to Treatment e.g., home environment, scheduling, location, staffing, lapses in services etc.</p>	
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<p><i>Include how you plan to, or already have, remediated these barriers.</i></p> <p><i>If staffing is a barrier, document attempts to procure a staff member with the corresponding dates of when the attempts occurred.</i></p>			
Requested CPT Codes			
<u>CPT Code</u>	<u>Number of Hours Requested</u>	<u>Total Units</u>	<u>Place of Service</u>
97151	<input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> per auth.		
97152	<input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> per auth.		
97153	<input type="checkbox"/> per week <input type="checkbox"/> per month		
97154	<input type="checkbox"/> per week <input type="checkbox"/> per month		
97155 <i>Include 97155 and 97155-GT as one sum of units.</i>	<input type="checkbox"/> per week <input type="checkbox"/> per month		
97156 <i>Include 97156 and 97156-U2/GT as one sum of units.</i>	<input type="checkbox"/> per week <input type="checkbox"/> per month		
97157 <i>Include 97157 and 97157-GT as one sum of units.</i>	<input type="checkbox"/> per week <input type="checkbox"/> per month		
97158	<input type="checkbox"/> per week <input type="checkbox"/> per month		
H2012	<input type="checkbox"/> per week		

	<input type="checkbox"/> per month <input type="checkbox"/> per auth.		
Prior Utilization of All Codes:			
<u>CPT Code</u>	<u>Number of Units Utilized</u>	<u>Place of Service</u>	<u>Barrier to Utilization</u>
97153			
97154			
97155			
97156			
97157			
97158			

Anticipated Schedule							
<ul style="list-style-type: none"> • Add additional rows and codes as necessary. • If sessions occur at multiple locations in a day then please indicate that in the space provided below. 							
Code	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
97153							
97154							
97155							
97156							
97157							
97158							

Provider Information	
Provider Name:	
Provider Credentials:	
Provider Signature:	
Date:	

Telehealth Readiness Checklist

Date completed:		
Participant Name:		BCBA Name:
Personnel Education/Qualifications		Yes / No
Did each practitioner (BCBA/RBT/BT) attend training on technology related to telehealth (hardware, software, camera)?		
Did each practitioner (BCBA/RBT/BT) attend training or obtain supervision related to telehealth-specific ABA interventions?		
Technology and Data Confidentiality		Yes / No
Do each of the practitioners (BCBA/RBT/BT) have the necessary equipment to provider telehealth services per COMAR10.09.49 (appropriate internet capabilities, two-way HIPAA compliant platform, ability to alter resolution, focus, and zoom)?		
Do the parents/caregivers have the necessary equipment to receive telehealth services?		
Is there a process in place in the event technological issues arise during telehealth services?		
Has the practitioner explained the risks related to use of technology for telehealth services?		
Implementation and Evaluation		Yes / No
Does the practitioner have monitoring tools in place to evaluate the implementation of telehealth services?		
Does the practitioner have monitoring tools in place to evaluate the effectiveness of telehealth services related to the participant's progress or lack of progress?		
Environmental Evaluation		Yes / No
Is the participant's environment set up to accommodate telehealth services (i.e., clean, private, free of distractions)?		
Is there a process in place to ensure the participant's environment remains telehealth ready?		
Is the BCBA's environment safe to conduct telehealth services (free of distraction, private)?		
Capabilities of Participant/Parent		Yes / No
Is the participant able to see the practitioner on the screen without displaying interfering behaviors that would cause the practitioner to block the two way camera?		
Is the participant able to follow directions given by parents/caregivers without in-person supports?		
Are the parents/caregivers able to follow technical instructions given by the practitioner?		
Standard of Care Considerations and Consent		Yes / No
Has the practitioner taken into account any cultural considerations when proposing telehealth services?		
Is the parent/caregiver interested in telehealth services and signed consent for telehealth services?		
Does the consent form include information related to the risks and benefits of telehealth services including confidentiality?		
Does the consent form include the ability to opt out of telehealth services?		