Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Behavioral health medical record documentation requirements for autism treatment services

For Blue Cross commercial, Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠

Revised July 2026

Service / practitioner	Behavioral health medical record documentation requirements for autism treatment services
Scope of practice	Providers are expected to deliver and document services based on their education, training and scope of practice.
All services for practitioners with a medical degree	Providers with a medical degree must follow the medical record documentation guidelines published by the Centers for Medicare & Medicaid Services in the Medical Learning Network guide MLN006764. The providers who must follow these guidelines are: • Physicians • Nurse practitioners • Physician assistants
General guidelines: Adaptive Behavior Assessment for practitioners without a medical degree For assessment and analysis by the LBA (CPT code *97151)	For the initial outpatient visit for a specific problem or group of problems, the medical record must include legible documentation of the items listed here. Note: If the initial visit is provided by a psychiatrist, a medical history — including all prescriptions, over-the-counter medications, and holistic and "natural" supplements — must be documented. The following information must be kept in the medical record: ○ Date of birth / calculated age ○ Gender ○ Home address ○ Home / work telephone numbers ○ Contact name and relationship ○ Employer or school ○ Marital or legal status ○ Emergency contact information ○ Appropriate consent forms / guardianship information ○ Active problem list ○ List of current medications (periodically reconciled with or by prescribing provider) ○ Michigan Automated Prescription System queries as indicated or required by state law The initial outpatient evaluation must include: • Visit information: ○ Date of the initial visit ○ Start and stop times ○ Names of those present during the session. If separate individuals are interviewed, include the duration for which each is present. • Presenting circumstances / clinical presentation: ○ Presenting problems and precipitating factors ○ Caregiver report and primary concerns including skill development and behavior management history • Comprehensive history: ○ Results of the relevant diagnostic testing available, including results completed with interpretation and screening tools when available

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	○ Medical history and current medications along with prescribing medical provider, including evidence of coordination of care ○ Psychosocial history including, as appropriate, the case developmental and family history ○ Complete mental status examination ○ Past psychiatric and substance use disorder history, including inpatient or outpatient treatment • Extensive examination: ○ Results of the comprehensive diagnostic evaluation from an approved autism evaluation center (AAEC) or other independent evaluator ○ Other relevant diagnostic testing, including results completed with interpretation and screening tools ○ Results of the most recent applied behavior analysis (ABA), assessment and/or other clinical assessments not included in the comprehensive diagnostic evaluation ○ Results of plan of care assessments, including skill assessments and interfering behavior assessments ○ All graphs used in the assessments ○ Interpretation / summary of findings • Clinical decision making / plan of care: ○ Objectively stated treatment plan and rationale with as much detail as possible outlining interventions and monitoring protocols ○ Dietary restrictions, sleep, toileting, psychosocial, reported preference / reinforcers, as applicable ○ Child goals: ▪ Acquisition goals, prioritized ▪ Behavior management goals (only if present) ▪ Describe target child behavior(s) and rationale ○ Transition and termination goals / benchmark levels of behavior for termination: Discharge from services occurs when the child has mastered the skills considered to be consistent with the typical developmental age. Examples include when a child demonstrates: ▪ Retention of taught skills ▪ A skill acquisition rate consistent with a neuro-typical peer ▪ The ability to learn from the natural environment, respond to generalized reinforcement, and adapt to both perform and excel in a novel environment Discharge is determined by ongoing assessment and discussion with legal guardians. Additionally, discharge planning should be considered when:

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	▪ A child has not made measurable progress toward meeting goals identified on the ABA plan of care after successive progress review periods and repeated modifications to the plan of care ▪ ABA plan of care gains don't generalize over time and don't transfer to the larger community setting after successive progress review periods and repeated modifications to the treatment plan ▪ An individual can no longer participate in ABA therapy due, but not limited, to medical problems, family problems, or other factors that may inhibit participation Should discharge occur in any one of the above conditions, legal guardians will be provided with a list of referrals to pursue services elsewhere, should they feel continued therapy is necessary and to support child in attaining needed resources. ○ Care coordination goals: ▪ A board-certified behavior analyst (BCBA), will communicate with other professionals involved in child's care with consent from child's parents or guardians ▪ BCBA's may consult with other professionals including pediatricians, child psychiatrists, speech and language pathologists, occupational therapists, neurologists, neuropsychologists, nutritionists, education staff (coordination with IEP), or anyone else who is authorized by the legal guardian to make contact ▪ Communication may be by means of secured email, phone calls, in-person meetings, or faxes ○ Family / caregiver participation goals: To receive the maximum benefit for the identified member receiving direct treatment, parents / guardians need to do the following: ▪ Participate in at least two (2) hours per month of direct parent / guardian / caregiver training with the licensed behavior analyst (LBA) and BCBA ▪ Demonstrate proficiency in newly taught skills while the child is at home and in the community ▪ Bring the child to a minimum of 80% of scheduled ABA therapy sessions Note: The family is responsible for keeping the data and bringing the data to meetings with the treatment team. • Summary and recommendations / documentation of process: ○ Referrals to other services / disciplines ○ Assignment of appropriate DSM codes ○ Treatment or education provided in the session ○ Instructions, recommendations and precautions given to the patient or other significant parties • Signature and credentials of the treating provider

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ABA re-evaluation, supportive assessment For direct observation, data collection, and assessment of behavioral problems to support the development of a behavior treatment plan (CPT code *97152)	For a subsequent re-evaluation visit for a specific problem or group of problems, the medical record must include legible documentation of the following: • Date of the visit • Session start and stop times • Names of those present during the session. If separate individuals are interviewed, include the duration for which each is present • Presenting problems • Techniques that have been utilized up to this time to extinguish the behaviors, and their level of success • Focused mental status examination • New data collected and results of relevant diagnostic testing, graphic reports and monitoring tools • Updated medical history and illness with current medications, along with the prescribing medical provider. Include evidence that coordination of care has taken place at least quarterly. • Psychosocial history if any changes during the interval — either positive or negative — that could affect the patient • Objectively stated treatment plan including modification and rationale, with details outlining interventions and monitoring protocols • Assignment of appropriate DSM codes • Treatment or education provided in the session • Instructions, recommendations and precautions given to the technician, parents / guardians / caregivers or other significant parties • Evaluating treatment fidelity and whether it is taking place in the manner identified • Summary • Signature and credentials of the treating provider
Adaptive Behavior Treatment / ABA therapy (CPT code *97153)	These requirements apply to behavior technicians (BTs), “tutors” and LBAs**, and take into account that both BTs and LBAs provide ABA services. Each provider is expected to document their services based on their scope of practice. In general, the following should be adhered to: BT / RBT: • Session timing • Individuals present • Treatment procedures delivered • Data collected per protocol • Observable, objective behavior

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	LBA / BCBA or medical provider: • Diagnostic conclusions • Clinical status review and impressions • Risk assessments • Interpretation of treatment outcomes • Modifications to treatment plans • Summaries of clinical progress The tutor / technician implements instructional programs designed by the supervising LBA for a member diagnosed with autism spectrum disorder. Primary documentation will focus on implementing treatment protocols, recording data, observing behaviors and carrying out activities under the supervision of the LBA. Each progress note must contain legible documentation of the following based upon the scope of practice provided by the rendering provider: • Patient identification • Location / place of service and if telemedicine delivered technology is utilized • Name of the tutor or technician providing services and the supervising LBA responsible for the services, with credentials • Date of the session, along with start and stop times Due to sessions being 15-minute units, each narrative section of a progress note must be documented in no more than four (4) hour (16 unit) increments of time and must identify the specific location(s) where services are taking place. Time during breaks, napping, or other break activity is not a billable service. • Names of those present during the session. If separate individuals are interviewed, include the duration for which each is present. • Presenting problem: ○ Detailed diagnosis ○ Change in diagnosis and supporting details ○ Patient's current clinical status including patient's signs and symptoms at the time of each session • Progress toward treatment goals: ○ Results of interval "homework" / practice of prior intervention(s) ○ Statement summarizing the relationship between signs and symptoms and the primary focus of the therapy session ○ Assessment of current and long-term risk including Interventions to minimize risk and contingency management (advanced directive or crisis plan) • Interventions used and the patient's response: ○ Statement summarizing the therapeutic interventions used in the therapy session

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	○ Effectiveness of intervention ○ Adjustments to interventions / plan of care • Summary: ○ Statement summarizing the patient's degree of progress toward treatment goals ○ Diagnosis ○ Follow-up appointments, "homework" / practice • Signature and credentials of the RBT and supervising LBA
Adaptive Behavior Treatment / ABA with Protocol Modification (CPT code *97155)	• Date of the session • Session start and stop times • Names of those present during the session and the relationship of the individuals to the patient • Place of service • Mode of treatment: In-person / telehealth • Protocol modification activities that took place at this time • Direction provided to behavior technician while delivering ABA • Summary and implementation of protocol changes made and goals to improve patient progress • If live supervision with technician and LBA, documentation must clearly show *97153 is for direct technician care and *97155 is for the LBA's supervision • Signature and credentials of the LBA
ABA parent / guardian / caregiver training and/or socialization group treatment (CPT codes *97154, *97156, *97157, *97158)	Documentation for each socialization group or parent / guardian / caregiver training session is required. For single family parent / guardian / caregiver training, include legible documentation of the following: • Participant's first and last name • Date of visit / training • Session start and stop times • Names of those present during the session. If separate individuals are interviewed, include the duration for which each is present. • Presenting problems / precipitating factors • The mode of delivery if services are rendered via telemedicine • Summary of the participant's specific participation, contributions and reactions • Signature and credentials of the RBT and supervising LBA (*97154) • Signature and credentials of the LBA (*97156, *97157, *97158)

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	For multifamily parent / guardian / caregiver training, include legible documentation of the following: • Participant's first and last name • Place and date of service • Session start and stop times • If services are rendered via telemedicine / telehealth, the mode of delivery must be included • Names of all participants, including the family members from each family unit • Number of participants in socialization group therapy (minimum of two, maximum of eight) • Relationship of additional participants to the patient in parent / guardian / caregiver training (for example, parent, guardian, grandparent or elder sibling) • Whether the member participated in the socialization group, or how the member participated in the socialization group Note: Other than the group member in whose chart the note is written, don't mention other patients in the socialization group by name. • Attendance and absences • Summary of reactions and interactions of group members • Signature and credentials of the LBA (*97157, *97158) The key components of autism parent / guardian / caregiver training include the following: • Understanding communication methods • Managing challenging behaviors • Creating structured routines • Addressing sensory sensitivities • Promoting social interaction • Developing adaptive skills for daily living • Providing caregivers with self-care strategies • Focusing on tailoring interventions to the specific needs of the individual with autism The specific areas covered in autism parent / guardian / caregiver training may include: • Communication skills • Behavior management • Sensory integration • Daily living skills • Social skills development

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	• Caregiver support Autism parent / guardian / caregiver training is delivered using the following methods: • Individualized approach • Hands-on practice • Home-based coaching • Collaboration with professionals

******Effective Jan. 7, 2020, behavior analysts must be licensed by the state of Michigan to be reimbursed by Blue Cross or BCN.