



TRIWEST ABA Session Note Template

Identifying Information

97151	<input type="checkbox"/> 97153	<input type="checkbox"/> 97155	<input type="checkbox"/> 97156
97157	<input type="checkbox"/> 97158	<input type="checkbox"/> 99366	<input type="checkbox"/> 99388

Beneficiary Name:	Date & Time: Include only billed time	Length of Session: Include only billed time
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Rendering Provider with credentials:	Authorized ABA Supervisor (Required):
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Additional Participants, Name and Relationships:

Rendering Provider Type	<input type="checkbox"/> RBT <input type="checkbox"/> BCAT <input type="checkbox"/> ABAT <small>Can bill 97153</small>	<input type="checkbox"/> BCABA <input type="checkbox"/> QASP-S <small>Can bill 97153. May bill for 97155, 97151, 97158, and 97157 under ABA Supervisor delegation</small>	<input type="checkbox"/> BCBA <input type="checkbox"/> BCBA-D <small>Can bill for all ACD service codes</small>
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Location	<input type="checkbox"/> Clinic <input type="checkbox"/> Home <input type="checkbox"/> Community (please list community location): _____ <input type="checkbox"/> Telehealth
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Clinical Status

<input type="checkbox"/> Engaged with staff	<input type="checkbox"/> Responsive to staff	<input type="checkbox"/> Observed affect: _____
<input type="checkbox"/> Approached staff independently	<input type="checkbox"/> Transitioned independently to session	<input type="checkbox"/> Transitioned with behaviors
<input type="checkbox"/> Not attentive to staff	<input type="checkbox"/> Independently greeted staff	<input type="checkbox"/> Engaged in target behaviors
<input type="checkbox"/> Neutral affect	<input type="checkbox"/> Ready to learn	<input type="checkbox"/> Other: _____

As evidenced by:

Barriers to Treatment

<input type="checkbox"/> Lack of sleep	<input type="checkbox"/> Maladaptive behaviors	<input type="checkbox"/> Stereotypy	<input type="checkbox"/> Change in medication	<input type="checkbox"/> Sick
<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Irritability	<input type="checkbox"/> Parent out of town	<input type="checkbox"/> Gap in services	<input type="checkbox"/> Other: _____

97153 Techniques Used in Session

<input type="checkbox"/> NET	<input type="checkbox"/> DTT	<input type="checkbox"/> DRO	<input type="checkbox"/> DRA
<input type="checkbox"/> DRI	<input type="checkbox"/> Pairing	<input type="checkbox"/> Reinforcement	<input type="checkbox"/> Redirection
<input type="checkbox"/> Prompting	<input type="checkbox"/> Modeling	<input type="checkbox"/> Extinction	<input type="checkbox"/> FCT

97153 Narrative Content of Session

In this section, discuss targets and programs that were implemented during the session and how the beneficiary responded to the interventions that were used during the session.

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Overall Response to Treatment

- Upward Trend
 Downward Trend
 No change/Variable Trend

97155 Modifications to Treatment (ABA Supervisor Only or Delegated Assistant)

- Added goals
 Probed goals
 Moved goals to mastered/maintenance
 Modeled new or modified interventions to staff
 Modified current interventions or BIP
 No modifications needed

97155 Narrative BCBA or Delegated Assistant

Add information as to what was modified during the program modification session. If no modifications were warranted, please check box above and include how this determination was made.

Response to Treatment

- Upward trend
 Downward trend
 Stable trend
 Variable trend

97156 Narrative – BCBA or Delegated Assistant

In this section address the parent goals that were targeted during this session. Please indicate the level of progress made towards goals.

97151 – BCBA or Delegated Assistant

- Completed PSI / SIPA
 Completed teacher PDDBI
 Completed parent PDDBI
 Conducted assessment
 Completed parent interview
 Updated goals
 Reported on goals
 Treatment plan review with parents
 Direct observation
 Informal screenings
 Review medical history
 Review previous treatment

Degree of Progress – All CPT Codes

- Progressing towards goals
 Variable progress towards goals
 Not progressing towards goals

Signatures

Rendering Provider & Credentials _____ Date _____
 ABA Supervisor Signature (if required) _____ Date _____

**Compliance Check
TO BE COMPLETED BY RENDERING PROVIDER**

- Clinical status
 Response to treatment
 Techniques used
 Degree of progress
 Signature and date

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