Detroit Wayne Mental Health Authority
AUTISM BEHAVIORAL HEALTH TREATMENT BENEFIT
COMPRENSIVE DIAGNOSTIC EVALUATION & REEVALUATION FORM

Referral Date: ____________ **Assessment Date:** ______________ **PIHP:** ______________ **MCPN:** _____________

Consumer Name: ____ **Consumer Age:** ____________________

Medicaid #: ____ **Provider:** ____________________________________

Evaluator Name/Credential: ____

Tools Administered: ADOS-2 ☐ ADIR ☐ Cognitive ☐ Adaptive ☐ DD-GAS ☐ Other: _________________________

ADOS-2 Module Administered: Todd A☐ Todd B ☐ Mod 1A☐ Mod 1B ☐ Mod 2A☐ Mod 2B☐ Mod 3☐ Mod 4☐

ADOS-2 Overall Total Score: __________ **DD-GAS Total Score:** _____________
***Mod. 4 Only*:** Communication Score: ________ Social Interaction Score: ________ Comm. + Soc.Int Score: _________

<u>Diagnosis / ADOS-2 Classification:</u>

☐ Autism Disorder
☐ Autism Spectrum Disorder
☐ PDD-NOS
☐ Other(s) Specify: ___________________________

<u>Medical Necessity Criteria for this child:</u>

A) Currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, Lack of:

	Social-emotional reciprocity, *ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.*
	Nonverbal communicative behaviors used for social interaction, *ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.*
	Developing, maintaining, and understanding relationships, *ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.*

B) Currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by the following:

	Stereotyped or repetitive motor movements, use of objects, or speech (*e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases*).
	Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (*e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day*).
	Highly restricted, fixated interests that are abnormal in intensity or focus (*e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest*).
	Hyper- or hypo activity to sensory input or unusual interests in sensory aspects of the environment (*e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement*).

Date Feedback Session Completed with Family: ☐ Yes ☐ No

Was IPOS Case Holder Provider Present: ☐ Yes ☐ No If yes, ☐ Face-to-face ☐ Teleconference

Case Action Requested: Not Qualified ☐ Declined Benefit/Eval. Only ☐ Enrollment into ASD BHT Benefit ☐

If not qualified list date AAN was sent: ____

For cases requesting Enrollment into the ASD BHT Benefit:

1. **Medical necessity and recommendation for Behavioral Health Treatment/ABA was made by a physician or other licensed qualified practitioner in the State of Michigan:** ☐ Yes ☐ No

2. Has parent reported completion of medical/physical examination: ☐ Yes ☐ No

3. Does the child has the developmental capacity to clinically participate in the available interventions covered by the benefit: ☐ Yes ☐ No

4. Child is medically able to benefit from the BHT treatment. ☐ Yes ☐ No

5. Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the BHT interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social-communication, increased interactive play/age-appropriate leisure skills, increased reciprocal communication, etc. ☐ Yes ☐ No

6. Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings. ☐ Yes ☐ No

7. Services are able to be provided in the child's home and community, including centers and clinics. ☐ Yes ☐ No

8. Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life). ☐ Yes ☐ No

9. Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence. ☐ Yes ☐ No

10. A qualified licensed practitioner recommends BHT services and the services are medically necessary for the child. ☐Yes ☐ No

11. Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month. ☐Yes ☐ No

12. **Which agency has accepted case to provide BHT Services:** ☐ Centria Healthcare
    ☐ Neighborhood Service Organization ☐ Special Education Behavioral Connections ☐ Starfish Family Services
    ☐ Starr Commonwealth/PsychSystems ☐ The Children's Center ☐ The Guidance Center
    ☐ University Pediatrics Autism Center ☐ Other Specify: ____

13. **Date BHT Provider Agency Accepted Case for BHT Services:** ____________________________________

Comments: *(Indicate any notes, cancellations, reschedules, no call no shows, etc with dates & reasons for delay in services)*

UPLOAD FORM TO MH-WIN SCANNED DOCUMENTS AND REQUEST AUTHORIZATION FOR CONTINUED SERVICE