Q. COMPREHENSIVE DIAGNOSTIC EVALUATION – AUTISM SPECTRUM DISORDER (ASD)

Definition

A Comprehensive Diagnostic Evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive and social functioning skills and should use validated evaluation tools in order to diagnose and recommend general ASD treatment interventions in an evaluation report. It assists in gaining an understanding of an individual's diagnostic presentation and informs the appropriate course of treatment. The comprehensive diagnostic evaluation determines the individual's diagnosis and can be completed in one day or over multiple days. Results would be used to determine the best possible treatment approaches, clarify specific individual needs, identify individual strengths, or distinguish necessary interventions for best clinical outcomes.

The comprehensive diagnostic evaluation must be performed by a licensed practitioner (e.g. psychiatrist, neurologist, pediatrician including a developmental pediatrician, psychologist, licensed clinical social worker, licensed professional counselor) working within his/her scope of practice to diagnose and who is qualified and experienced in providing ASD evaluation services.

The comprehensive diagnostic evaluation must include a review of the most recent medical evaluation. The most recent medical evaluation must have been completed in the last twelve months. If the practitioner diagnoses the individual with ASD based on the comprehensive diagnostic evaluation, the practitioner should make recommendations for a behavior assessment and specific interventions to be provided in treatment.

The comprehensive diagnostic evaluation is available to Medicaid enrolled members (HUSKY A, C, or D) under the age of 21 for whom ASD services are being considered.

Authorization Process and Time Frame for Service:

This service requires registration on the web-based system for up to 3 units, 1 unit = 1 encounter. Providers must use 1 encounter per day in order to bill Medicaid. Units beyond 3 require prior authorization. Authorization decisions will be based upon the individual clinical presentation and treatment history presented at the time of initial authorization. Additional units/encounters requested will be based upon medical necessity.

Level of Care Guidelines

Q.1.0 Clinical Eligibility Criteria

Q.1.1 Symptoms and functional impairment include the following:

Q.1.1.1 The individual demonstrates symptoms consistent with ASD as defined in the most current DSM, and

Q.1.1.2 As part of the comprehensive diagnostic evaluation, medical/physical examination has been reviewed and identified medical or behavioral conditions that may co-occur with ASD and ruled out any conditions that may be misinterpreted as ASD, and

Q.1.1.3 The individual evidences functional impairment directly related to the suspected ASD.

Q.1.2 Intensity of Service Need

Q.1.2.1 Traditional clinical assessment has not proven effective in investigating and identifying the underlying cause for the individual's behavioral/developmental concerns and an evaluation is needed to determine diagnosis and the most appropriate course of treatment, or

Q.1.2.2 The individual's response to prior treatment suggests the need for further evaluation and differential diagnosis.

Q.1.3 Additional variables to be considered:

Q.1.3.1 If an individual had a previously established ASD diagnosis by a qualified and experienced ASD evaluator, the comprehensive diagnostic evaluation need not be repeated. If the diagnosis is older than 36 months, it must be confirmed by a licensed practitioner within the previous 36 months.

Q.1.3.2 Comprehensive diagnostic evaluation is initially completed and only repeated as medically necessary, and

Q.1.3.3 Primary purpose of comprehensive diagnostic evaluation is not solely for educational, vocational, or legal purposes

Q.2.0 Continued Care Criteria

Not applicable

Note: Making Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making Level of Care Decisions and in these cases the individual shall be granted the level of care requested when:

1) Those mitigating factors are identified and
2) Not doing so would otherwise limit the individual's ability to be successfully engaged in the community or is needed in order to succeed in meeting the individual's treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Medicaid's definition of medical necessity and, for anyone under 21, does not meet the EPSDT criteria.