MARYLAND Department of Health

beacon health options

Clinical Review for Autism Spectrum Disorder and Applied Behavior Analysis

Please complete the following checklist to confirm whether your patient continues to meet criteria for an Autism Spectrum Disorder and requires ABA services. *This checklist should be used when it has been 3 years or more since the date that the patient's most recent Comprehensive Diagnostic Evaluation was performed.*

Name of Medicaid Participant: _____ Date of Birth: _____

Date of most recent face-to-face evaluation (must be within the past 6 months):

_____

Please complete the following: (a response for each is REQUIRED)	Check one:		
	YES	**NO**	N/A
I am a developmental pediatrician, pediatrician, pediatric neurologist, child psychiatrist, clinical psychologist, neuropsychologist, or a nurse practitioner with training and experience to diagnose Autism Spectrum Disorders (ASD).	☐	☐	☐
I have attached a copy of my most recent face-to-face evaluation completed with this patient and his/her parent or caregiver within the past 6 months.	☐	☐	☐
Based on my history, direct observation of the patient, and review of any relevant records, he/she continues to meet criteria for a diagnosis of Autism Spectrum Disorder (ASD).	☐	☐	☐
If this patient has been receiving Applied Behavior Analysis (ABA) services, I have reviewed his/her progress and response to intervention.	☐	☐	☐
This patient has social communication deficits and/or maladaptive behaviors directly attributable to ASD for which ABA is a medically necessary intervention. Please list: _____ _____ _____	☐	☐	☐
I recommend that this patient receive ABA services.	☐	☐	☐

Please provide any additional information that you deem relevant to this patient's diagnosis and need for ABA services:

_____

_____

_____

I attest that I am the qualified health care professional providing care for this Medicaid participant and that the medical necessity information contained in this document is true, accurate and complete, and to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Name _____ Signature _____ Date _____