MARYLAND Department of Health

beacon health options

Physician Confirmation of Autism Spectrum Disorder Diagnosis

Please complete the following steps to confirm a diagnosis of Autism Spectrum Disorder for your patient upon reviewing a diagnostic evaluation completed by a non-qualified health care professional (e.g., school psychologist).

Step 1: Please complete the Physician Confirmation checklist on page 2

- ☐ Check the appropriate boxes as they relate to your patient.
- ☐ In the open text boxes please provide supporting evidence of Autism Spectrum Disorder diagnosis from patient history (parent/caregiver interview) and direct observation.
- ☐ Include the previous diagnostic evaluations completed by non-qualified health care professionals.
- ☐ Include any records that support your responses.

Step 2: If applicable, include a written referral for Applied Behavior Analysis (ABA) services.

Step 3: E-Mail/Fax/Mail the requested documentation to:

E-Mail abaservices@beaconhealthoptions.com

Fax Attn: ABA Services (1-877-502-1044)

Mail ABA Services: Beacon Health Options
P.O. Box 166 Linthicum, MD 21090

Name of Medicaid Participant: _____ Date of Birth: _____

Yes	No	**Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (must have all 3):**
☐	☐	1. Deficits in 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.
☐	☐	2. Deficits in 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.
☐	☐	3. Deficits in developing, maintaining, and understand 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.
Evidence from Direct Observation and Patient History (parent/caregiver interview):		

Yes	No	**Restricted, repetitive patterns of behavior, interests, or activities, as manifested by the following, currently or by history (must have at least 2):**
☐	☐	1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
☐	☐	2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
☐	☐	3. 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 interests).
☐	☐	4. Hyper- or hyporeactivity to sensory input or unusual interest 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).
Evidence from Direct Observation and Patient History (parent/caregiver interview):		

Yes	No	
☐	☐	These disturbances are not better explained by intellectual disability or global developmental delay. Intellectual disability and Autism Spectrum Disorder frequently co-occur; to make comorbid diagnoses of Autism Spectrum Disorder and intellectual disability, social communication should be below that expected for general developmental level.
☐	☐	Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
Evidence from Direct Observation and Patient History (parent/caregiver interview):		

Yes	No	
☐	☐	This patient meets criteria for a diagnosis of Autism Spectrum Disorder.

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 _____