MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Subject: **Clinical Practice**	Procedure: **Flow of Autism Services Through MCCMH**	
Last Updated: **7/6/26**	Owner: **MCCMH Clinical Department**	Pages: **6**

I. PURPOSE:

To provide operational guidance to Macomb County Community Mental Health (MCCMH) directly operated and contract providers who conduct case management and ABA services within the autism services benefit.

II. DEFINITIONS:

Applied Behavior Analysis (ABA):
A behavioral therapy that applies the principles of learning to change socially significant behavior. The goal is to increase behaviors that are helpful and decrease behaviors that are harmful or affect learning. This is a Medicaid funded service for children under 21 years of age diagnosed with Autism Spectrum Disorder (ASD).

Comprehensive Diagnostic Evaluation:
A neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning. This is a complex assessment procedure in which a qualified practitioner determines a diagnosis based on the multimodal assessment and integration of clinical information. The utilization of multiple data modes and sources improves the reliability of a differential diagnosis of ADHD. (The recommendation is to use the gold standard tools such as the ADOS-2, ADI-R, CARS-2 and DD-CGAS. Other tools should be used if the clinician feels it necessary to determine diagnosis/medical necessity).

III. PROCEDURE:

Referral for ABA Services
Screening is completed by primary care provider with a referral for further evaluation. The child must have had a full medical and physical exam done by a doctor (such as a pediatrician or family doctor) within the past year. The exam should show that more testing for ASD is needed. It must also confirm that hearing and vision have been checked and are not causing the child's ASD symptoms. The guardian needs to bring documentation of this exam to the intake appointment. The exam must be provided before a child is scheduled for a diagnostic evaluation. The intake assessment should reflect that the screening by primary

care provider occurred and the screening documentation should be scanned into the medical record.

Family calls Managed Care Operations (MCO). MCO staff makes a referral for case management.

Comprehensive Diagnostic Evaluation

A. CM requests the pre-autism insurance layer be opened in FOCUS for diagnostic evaluation by emailing autism.services@mccmh.net. CM also enters any third-party insurance layer.

B. CM makes a referral for diagnostic evaluation.

C. Evaluator completes a comprehensive diagnostic evaluation and behavioral assessment. Report to indicate a diagnosis of Autism Spectrum Disorder and include a recommendation for Applied Behavior Analysis (ABA) therapy.

D. CM to upload evaluation report to FOCUS under Psychological Testing-Scanned section of the chart.

E. CM to email autism.services@mccmh.net with notification that an Autism Enrollment insurance layer is requested and the diagnostic evaluation is available for review.

Medical Necessity Criteria

A. Impairment in social communication and social interaction (all 3 must be met).

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 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. Restricted, repetitive, and stereotypical patterns of behavior, interests and activities (at least 2 must be met).

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or 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, and/or need to take same route or eat the 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 and/or excessively circumscribed or perseverative interest).

4. Hyper- or hypo-reactivity 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, and/or visual fascination with lights or movement).

Diagnostic Evaluation Eligibility Met and Individualized Plan of Service

A. CM requests the autism enrollment insurance layer be opened in FOCUS for autism services for three years based on the start date of the diagnostic evaluation by emailing autism.services@mccmh.net o CM makes referral(s) to ABA provider(s)

B. CM completes/updates the individualized plan of service (IPOS) ABA goals, objectives, amount, scope and duration. This document is amended and updated as necessary at regular intervals (minimally every 6 months).

Behavioral Assessment and Level of Service

A. Behavioral assessment is completed at least every 6 months and one of the following is used:
   1. VB-MAPP
   2. ABLLS-R
   3. AFLS
   4. BCBA indicates actual hours/services needed.

B. Assessment indicates the service level:
   1. Focused Behavioral Intervention (average of 5-15 hours per week)
   2. Comprehensive Behavioral Intervention (average of 16-25 hours per week)
   3. BCBA indicates actual hours/services needed.

Behavioral Assessment and IPOS Completion Timeframes (Example)

A. The initial behavioral assessment is completed prior to starting ABA services. (Ex. The initial behavior assessment is completed on 2/10/26 identifying a six month time frame of 2/10/26 through 8/9/26).

B. The ABA agency and CM will communicate so that the assessment is completed and uploaded to FOCUS. The case manager will update the IPOS and request authorizations based on the recommendations in the assessment.

C. The case manager updates the IPOS upon receipt of the assessment and requests authorization for ABA for assessment evaluation period. Auth request is 14 or more days before expected start date of services (no backdating). The effective dates for this example would be the start of services date through 8/9/26 to align with the 6 month time frame from the initial assessment on 2/10/2.

D. Re-assessment: ABA provider completes the re-assessment 4 to 6 weeks prior to current auth expiration, still indicating evaluation as the next 6 month period, 8/10/26 through 2/10/27 on the re-assessment document (Ex. The ABA provider completes the reassessment on 7/10/26 for auth period 8/10/26 through 2/9/27. Note: It is important for the ABA provider to indicate on the re assessment that the date range for the current service period is for 6 months from 8/10/26 through 2/9/27.

E. The case manager updates the IPOS upon receiving the reassessment and requests a 6 month auth for assessment for re-evaluation period effective 8/10/26 through 2/9/27. Authorization request is 14 or more days before the effective date (no backdating).

Example:
BEHAVIORAL ASSESSMENT and IPOS COMPLETIOM TIMEFRAMES (Column View)

Initial behavior assessment; completion and evaluation period	2/10/26; 2/10/26 through 8/9/26
CM updates IPOS and requests 6 month auth for assessment evaluation period. Auth request is 14 or more days before the effective date (no backdating)	Auth request for effective dates - start of services through 8/9/26
ABA provider completes the re-assessment 4 to 6 weeks prior to current auth expiration still indicating evaluation as the next 6 month period	Reassessment on 7/10/26 For auth period 8/10/26 through 2/9/27
CM updates IPOS and requests 6 month auth for assessment evaluation period. Authorization request is 14 or more days before the effective date (no backdating)	Auth request for effective dates 8/10/26 through 2/9/27

Re-evaluations

Comprehensive diagnostic re-evaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. (The recommendation is to use the gold standard tools such as the ADOS-2, ADI-R, CARS-2 and DD-CGAS. Other tools should be used if the clinician feels it necessary). Insurance layer extensions may be requested if the testing is scheduled outside of the current date range. Email autism.services@mccmh.net

Discharge Criteria

A. The child has achieved treatment goals and less intensive modes of services are medically necessary and appropriate.

B. The child is either no longer eligible for Medicaid or is no longer a State of Michigan resident.

C. The child has not demonstrated measurable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through a period of six months.

D. Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations.

E. The child no longer meets the eligibility criteria as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.

F. The child and/or parent/guardian is not able to meaningfully participate in the BHT services, and does not follow through with treatment recommendations to a degree that compromises the potential effectiveness and outcome of the BHT service.

IV. REFERENCES:

Michigan Medicaid Manual

V. RELATED POLICIES:

MCCMH MCO Policy 12-004, "Service Authorizations"

VI. EXHIBITS:

None

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1		Creation of Procedure.	