MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Subject: **Utilization Management**	Procedure: **Authorizations for Autism Services**	
Last Updated: **10/20/2026**	Owner: **Managed Care Operations**	Pages: **5**

I. PURPOSE

To provide procedural and operational guidance to directly operated and contract providers on the documentation requirements for authorizations of autism services.

II. DEFINITIONS

A. 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).

B. Autism Spectrum Disorder (ASD):
A neurological and developmental disorder that refers to a broad range of conditions characterized by challenges with social skills, repetitive behaviors, speech and nonverbal communication.

C. 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 the differential diagnosis of ASD.

D. Medical Necessity:
Determination that a specific service is medically (clinically) appropriate; necessary to meet needs; consistent with the person's diagnosis, symptomatology, and functional impairments; is the most cost-effective option in the least restrictive environment; and is consistent with clinical standards of care. The medical necessity of a service shall be documented in the individual plan of service (IPOS).

III. PROCEDURE

A. Autism Spectrum Disorder (ASD) services are intended to ensure that children receive early detection and preventative care, in addition to medically necessary treatment services, to lessen the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. To be eligible for the authorization of autism services, the following requirements must be met:

1. The child must have active Medicaid entitlements.

2. The child must be 21 years of age or under.

3. The recommendation for ASD services must come from a physician.

4. The child must receive a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.

5. The child must be medically able to benefit from the treatment.

6. Treatment outcomes are expected to develop, maintain, or restore, to the maximum extent practicable, the functioning of a child with ASD.

7. Symptoms are present that cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintaining health, social inclusion, and increased independence.

B. When a parent/legal guardian of a child notifies their primary case holder of an interest in autism services, the primary case holder shall:

1. Discuss the need for these services as a part of the person-centered planning process.

2. Ensure that these services are identified in the Individual Plan of Service (IPOS). The goal(s) must address the medical necessity of these services, identify the provider, and detail the amount, scope, and duration of these services.

3. Supports and services are not intended to meet all of the individual's needs and preferences, as some may be better met by community and other natural supports.

    a) Natural supports means unpaid assistance provided to the individual by people in their network (Family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. The use of natural supports must be documented in the IPOS.
    b) The documentation must include custody arrangements, visitation time, and legal custody status for minor children, as applicable.

4. Obtain the required medical documentation to support that the referral came from a physician. One of the following must be obtained and uploaded to the FOCUS Electronic Medical Record (EMR):

    a) Documentation of a full physical examination/screening with a medical doctor, such as the child's pediatrician or family primary care provider, within the last twelve (12) months indicating that further evaluation of ASD is recommended.

        i. The medical evaluation must show that hearing, speech, and vision screenings have been completed and determined not to be a contributing factor to the child's ASD presentation.

        ii. A physician's note documenting the reason that they were unable to complete one or more of the above referenced screenings will be accepted provided the physician indicates they do not think that speech, hearing, or vision issues are a contributing factor.

    b) Documentation of a previous comprehensive diagnostic evaluation by a qualified licensed practitioner indicating an ASD diagnosis.

C. Comprehensive Diagnostic Evaluations

1. The comprehensive diagnostic evaluation must be performed to determine the child's diagnosis, recommend general ASD treatment interventions, and refer the child for an applied behavior analysis assessment. The behavior assessment recommends more specific ASD treatment interventions.

2. Comprehensive diagnostic re-evaluations are required once every three (3) years, unless an increased frequency is determined to be medically necessary by a physician or other licensed practitioner working within their scope of practice.

3. The primary case holder assists the child and their family in identifying a provider for the comprehensive diagnostic evaluation. A list of all providers can be found in the MCCMH Provider Directory.

D. The primary case holder submits the prior authorization for the evaluation request to Managed Care Operations (MCO) in the FOCUS Electronic Medical Record (EMR). Authorization requests can be submitted up to sixty (60) calendar days, and no less than fourteen (14) calendar days, prior to the effective date of the authorization.

E. MCO has seven (7) calendar days to make a medical necessity determination on these requests.

1. When it is determined that the individual meets the medical necessity criteria for the authorization of the comprehensive diagnostic evaluation, the

authorization is approved in the Focus EMR, and an electronic notification is sent to the primary case holder.

2. When it is determined that the individual does not meet the medical necessity criteria for the authorization of evaluation, the authorization is denied in the Focus EMR, and an electronic notification is sent to the primary case holder. MCO sends a Notice of Adverse Benefit Determination to the person served and/or their legal guardian.

F. Applied Behavior Analysis (ABA)

1. Behavior Health Treatment (BHT) services include a variety of behavioral interventions including Applied Behavior Analysis (ABA). BHT are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD.

2. A developmentally appropriate ABA assessment identifies specific ASD treatment interventions and provides the basis for the IPOS goals and objectives.

a) The IPOS must match the amount, scope, and duration of services recommended by the ABA provider.

b) BHT/ABA service evaluations are required minimally every six (6) months and must evidence measurable and ongoing improvement in targeted behaviors.

c) As ABA treatment recommendations are continually changing, IPOS Addendums must be completed regularly to ensure that the plan matches the revised ABA provider's recommendations.

d) Authorizations for ABA are not to extend beyond the expiration date of the ABA Assessment.

G. The primary case holder must notify the MCCMH Autism Coordinator to review the comprehensive diagnostic evaluation or re-evaluation to ensure that the autism insurance layer in the FOCUS EMR is added or updated to reflect the current expiration date of eligibility for ABA services.

H. The primary case holder assists the child and their family in identifying an ABA provider. A list of all providers can be found in the MCCMH Provider Directory.

I. The primary case holder submits the prior authorization for ABA services to Managed Care Operations (MCO) in the FOCUS Electronic Medical Record (EMR). Authorization requests can be submitted up to sixty (60) calendar days, and no less than fourteen (14) calendar days, prior to the effective date of the authorization.

J. MCO has seven (7) calendar days to make a medical necessity determination on these requests.

1. When it is determined that the individual meets the medical necessity criteria for the authorization of ABA services, the authorization is approved in the Focus EMR, and an electronic notification is sent to the primary provider.

2. When it is determined that the individual does not meet the medical necessity criteria for all or part of the authorization of ABA services, the authorization is denied in the Focus EMR, and an electronic notification is sent to the primary clinical provider. MCO sends a Notice of Adverse Benefit Determination to the person served and/or their legal guardian.

IV. REFERENCES

None

V. RELATED POLICIES

A. MCCMH MCO Policy 2-032, "Person Center Planning, Training, and the Role of Health and Safety Considerations"

B. MCCMH MCO Policy 4-020, "Medicaid and Non-Medicaid Notice of Adverse Benefit Determination"

B. MCCMH MCO Policy 12-004, "Service Authorizations"

VI. EXHIBITS

None

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	6/30/2025	Implementation of Procedure	MCCMH MCO Division
2	10/20/2026	Update to Procedure	MCCMH MCO Division