Optum | Maryland

Updated: 4/2024

Clinical Confirmation Form (CCF)

Instructions: This document is to confirm the diagnosis of Autism Spectrum Disorder (ASD) and is required for the participant to continue ABA services. Please complete the following checklist and include **a copy of a visit summary dated within the last 6 months** from the date this form is completed.

This form is necessary ONLY in the following circumstance:

Participant was younger than 3.0 years old at time of ASD diagnosis; AND
2 years or more has passed since the participant was diagnosed with ASD

Name of Medicaid Participant: _____ **Date of Birth**: _____

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

Section 1	**Check one:**		
Please complete the following: *(a response for each section is required)*	**Yes**	**No**	**N/A**
1. I am one of the following with the training and experience to diagnose ASD (circle one): Pediatrician or Developmental Pediatrician / Pediatric Neurologist Child Psychiatrist / Clinical Psychologist Nurse Practitioner / Neuropsychologist			
2. I have attached a copy of **my** most recent face-to-face evaluation completed with this participant and his/her parent or caregiver within the past 6 months.			
3. If this participant has been receiving Applied Behavior Analysis (ABA) services, I have reviewed his/her progress and response to intervention.			
4. Based on **my** history, direct observation of the participant, and review of any relevant records, he/she continues to meet criteria for a diagnosis of ASD.			

Section 2	**Check one:**		
1. I have observed persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (***must have all 3***):	**Yes**	**No**	**N/A**
a) 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.			
b) 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.			
c) 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.			

Section 3	Check one:		
1. I have observed restricted, repetitive patterns of behavior, interests, or activities, as manifested by the following, currently or by history ***(must have at least 2)***:	**Yes**	**No**	**N/A**
a) Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).			
b) 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).			
c) 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).			
d) 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, visual fascination with lights or movement).			
2. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.			
3. I recommend that this participant receive ABA services.			

Please provide any additional information relevant to this participant's diagnosis and need for ABA services:

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I attest that I am the qualified health care professional providing care for this Medicaid participant and 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.

Printed Name: _____ **Signature:** _____ **Date:**_____