

Attachment A – DDS Evaluation Guidelines And Eligibility Criteria For Individuals Thought To Have A Diagnosis Of Autism Spectrum Disorder

In order to establish whether an individual meets all eligibility criteria, reviews will be based on Evaluations that utilize uniform assessment instrument(s), documentation and by the procedures established by the Department and outlined in this Attachment A.

Each Waiver participant must meet the following general criteria:

- **Applicant must either have Connecticut Medicaid (Title 19) or be eligible for Medicaid. (NO services will begin until the applicant has been granted Medicaid by the Department Of Social Services).**
- **A primary diagnosis of an Autism Spectrum Disorder. A determination that a person meets the eligibility criteria is based on Evaluations conducted as outlined in this Attachment through a review of personal, clinical, and educational records. Records need to indicate a diagnosis of an Autism Spectrum Disorder made through Evaluations that clearly outline the justification for the differential diagnosis, and utilized appropriate testing protocol and instruments.**
- **Legal residency in the State of Connecticut**
- **Impairment prior to age 22 years; and**
- **Impairment expected to continue indefinitely; and**
- **Impairment of Adaptive functioning must be in at least 3 of 6 areas as measured by appropriate evaluation test(s)**
- **Cognitive and adaptive functioning above the level of mental retardation (i.e. IQ equal to or greater than 70).**
- **For children 3-7 a valid IQ cannot be determined. Eligibility for these children will be based upon a diagnosis of ASD and developmental delays. Once a child receives a valid IQ and if their IQ is below 70, they will disenrolled from this waiver.**

Evaluation Guidelines

For Individuals Thought To Have A Diagnosis Of Autism Spectrum Disorder

I. Essential Components of Diagnostic Evaluation

- A.** Autism Spectrum Disorders (ASDs) are a complex developmental condition requiring comprehensive evaluation procedures. There is no objective or conclusive test for Autism. Rather, it requires the integration of data, from a range of sources using different methods, by a professional trained and experienced with the diagnosis of ASDs in the age range of the individual. The following guidelines describe the components of an evaluation which would allow DDS to make a determination of the diagnosis of ASD for the purposes of qualifying for DDS services.
1. **Evaluators:** The evaluation is conducted by a professional who through education, training and/or certification is qualified to both conduct a diagnostic evaluation and to diagnose Autism Spectrum Disorder. The evaluator should have a specialty in the age range of the individual and have training, experience and a competency in diagnosing Autism Spectrum Disorders. This might include a psychiatrist, psychologist, neurologist, developmental pediatricians, certified school psychologist, or any other appropriately trained professional with expertise in this area. In some cases, there may be a multidisciplinary diagnostic team including other specialists (e.g. speech and language therapists, occupational therapists).
 2. **Record Review:** Previous findings from all relevant disciplines examining development or medical status are reviewed and integrated into the diagnostic process. This includes reports of previous psychiatric, psychological, pediatric, speech and language, occupational therapy, and physical therapy evaluations and treatment, as well as educational records.
 3. **Developmental History:** Parents/caregivers are administered a comprehensive interview covering the individual's developmental history (e.g. Autism Diagnostic Interview-Revised). This includes pre- and peri-natal course, early developmental milestones, and later development with an emphasis on social interactions/relationships, communication, behavior, emotion, academic achievement, adaptive skills, sensory functioning, fine and gross motor functioning, and significant pediatric illness/injury.
 4. **Standardized Tests:** The evaluation includes standardized tests examining cognitive functioning and academic skills in order to assess the level of cognitive development, level of overall intellectual ability, the profile of cognitive skills, and the possible presence of learning disabilities. Standardized tests should also include those specifically designed to evaluate Autism Spectrum Disorder.
 5. **Direct Interaction and Observation:** The evaluator directly observes and interacts with the individual through a structured interview and/or play session (depending on age and developmental level) in order to view communication skills, social interactions, play patterns, responses to the environment, and stereotypical behaviors (e.g. Autism Diagnostic Observation Schedule).
 6. **Behavioral Rating/Adaptive Scales:** The evaluation includes standardized ratings of behavior by parents, teachers, or other people who regularly see the individual (e.g. Vineland Adaptive Behavior Scales). These ratings may address symptomatic behaviors, social functioning, communication, adaptive skills, sensory processing, or other relevant conduct.
 7. **Formulation:** The evaluation integrates the findings and draws conclusions about the point of onset, course, and extent of the disorder, emphasizing social functioning, communication, restricted interests/repetitive behaviors, and sensory processing. The formulation carefully considers ASDs and other diagnoses that may be supported by the data, concluding with a differential diagnosis. This process collects and integrates data to determine whether an ASD diagnosis is warranted, and to differentiate ASDs from other disorders with similar or overlapping presentations.
 8. **Diagnosis:** The report contains a clear statement denoting diagnoses utilizing the DSM IV/V or ICD 10 systems, or indicating that a diagnostic determination cannot be made. **A possible diagnosis based solely on a Screening tool will not constitute eligibility for the Autism Waiver.**

[Below Is A Detailed Outline To Be Utilized When Either Reviewing An Evaluation For An ASD Diagnosis, Or It Can Be Utilized By The Clinician To Better Understand What Will Be Looked For In An Evaluation.]

II. General Comments Regarding A Diagnostic Evaluation For ASD

- A. During the diagnostic evaluation, the lead clinician collects sufficient data in the domains required by diagnostic criteria to determine whether a diagnosis of ASD or another neurodevelopmental or psychiatric disorder is warranted. Although additional assessment is needed for intervention planning, completion of components not essential to diagnosis should not delay the initial diagnostic evaluation. Therefore, this document distinguishes between *diagnostic evaluation* and *assessment for intervention planning* and identifies the components that are essential for diagnosis in order to increase access to services and timeliness of initial diagnosis.
- B. Autism spectrum disorders (ASDs) are defined behaviorally with respect to three key areas of functioning: (a) reciprocal social interaction, (b) communication, and (c) restricted interests and repetitive behaviors. The diagnostic evaluation process requires thorough examination of these components as well as their relationships with family functioning and medical and health history. The diagnostic evaluation for ASD necessarily considers data from multiple sources about the individual's functioning across multiple domains. All comprehensive diagnostic evaluations, regardless of the tier at which they are conducted, include a *minimum* of two components:
1. a thorough history based on obtaining and reviewing available records and a parent/caregiver interview,
-- and --
 2. direct interaction and behavioral observation of the individual engaged in tasks that allow sufficient opportunity to gauge his or her behavioral presentation (e.g., play, social interaction, etc.).
- C. Although practices vary somewhat across clinical settings, a comprehensive diagnostic evaluation might progress as follows:
1. Review relevant records.
 2. Interview parents/caregivers and individual (as appropriate).
 3. Observe and interact with the individual.
 4. Evaluate using standardized instruments (if indicated).
 5. Consider alternative diagnoses.
 6. Make a diagnostic determination.
 7. Communicate findings and next steps to the family.
- D. Best Practice —
1. The lead diagnostic clinician has the knowledge, experience, and clinical judgment to conduct comprehensive evaluations that include two core elements: the individual's history, and direct interaction and observation of the individual.
 2. The lead diagnostic clinician allots adequate time and materials to complete a review of relevant records, a thorough parent interview, and direct interaction and behavioral observation of the individual.
 3. Face-to-face behavioral observation and interaction are essential components of diagnostic evaluation.

III. The Diagnosis of Autism Spectrum Disorders

- A. **Screening:** For the diagnosis, problems in at least one of the areas of communication, socialization, or restricted behavior must be present before the age of 3. The diagnosis requires a two-stage process. The first stage involves developmental screening during “well child” check-ups; the second stage entails a comprehensive evaluation by a multidisciplinary team.
1. Several screening instruments have been developed to quickly gather information about a child's social and communicative development within medical settings. Among them are the Checklist of Autism in Toddlers (CHAT), the modified Checklist for Autism in Toddlers (M-CHAT), the Screening Tool for Autism in Two-Year-Olds (STAT), and the Social Communication Questionnaire (SCQ) (for children 4 years of age and older).

2. Some screening instruments rely solely on parent responses to a questionnaire, and some rely on a combination of parent report and observation. Key items on these instruments that appear to differentiate children with autism from other groups before the age of 2 include pointing and pretend play. Screening instruments do not provide individual diagnosis but serve to assess the need for referral for possible diagnosis of ASD. These screening methods may not identify children with mild ASD, such as those with high-functioning autism or Asperger syndrome.
3. During the last few years, screening instruments have been devised to screen for Asperger syndrome and higher functioning autism. The Autism Spectrum Screening Questionnaire (ASSQ), the Australian Scale for Asperger's Syndrome,¹⁵ and the most recent, the Childhood Asperger Syndrome Test (CAST), are some of the instruments that are reliable for identification of school-age children with Asperger syndrome or higher functioning autism. These tools concentrate on social and behavioral impairments in children without significant language delay.
4. If, following the screening process or during a routine “well child” check-up, your child's doctor sees any of the possible indicators of ASD, further evaluation is indicated. A possible diagnosis based solely on a Screening tool will not constitute eligibility for the Autism Waiver.

B. Comprehensive Diagnostic Evaluation

1. Because ASDs are complex disorders and may involve other neurological or genetic problems, a comprehensive evaluation should entail neurologic and genetic assessment, along with in-depth cognitive and language testing. In addition, measures developed specifically for diagnosing autism are often used. These include the Autism Diagnosis Interview-Revised (ADI-R) and the Autism Diagnostic Observation Schedule (ADOS-G). The ADI-R is a structured interview that contains over 100 items and is conducted with a caregiver. It consists of four main factors—the child's communication, social interaction, repetitive behaviors, and age-of-onset symptoms. The ADOS-G is an observational measure used to “press” for socio-communicative behaviors that are often delayed, abnormal, or absent in children with ASD.
2. Still another instrument often used by professionals is the Childhood Autism Rating Scale (CARS). It aids in evaluating the child's body movements, adaptation to change, listening response, verbal communication, and relationship to people. It is suitable for use with children over 2 years of age. The examiner observes the child and also obtains relevant information from the parents. The child's behavior is rated on a scale based on deviation from the typical behavior of children of the same age.
3. Two other tests that should be used to assess any child with a developmental delay are a formal audiologic hearing evaluation and a lead screening. Although some hearing loss can co-occur with ASD, some children with ASD may be incorrectly thought to have such a loss. In addition, if the child has suffered from an ear infection, transient hearing loss can occur. Lead screening is essential for children who remain for a long period of time in the oral-motor stage in which they put any and everything into their mouths. Children with an autistic disorder usually have elevated blood lead levels.⁹
4. History
 - a. Obtain and Review Available Records
 - Results of any developmental and/or ASD screening completed
 - Relevant records may include:
 - medical records

- prior developmental or behavioral evaluation reports
 - intervention records
 - school records
 - parent records of early development
 - Additional information from parents, teachers, and others familiar with the child such as standardized behavioral rating scales
- b. Parent/Caregiver Interview
- Developmental and behavioral history and current functioning of the child with particular attention to diagnostic criteria for ASD including milestones, delays, and any concerns about regression; development of social, communication, and play skills; and presence of any repetitive behaviors or unusual interests
 - Family social, medical, and mental health history
5. Behavioral Observation And Interaction
- a. During face-to-face interaction, the clinician observes behaviors relevant to ASD diagnostic criteria and differential diagnosis such as:
- Reciprocal social interaction
 - social approach and response
 - sharing interests or enjoyment
 - joint attention
 - response to name
 - Communication
 - quality, quantity, content, and use of verbalizations
 - use of nonverbal communication to compensate for delays in spoken language
 - play skills including imitation and imagination
 - Restricted interests and repetitive behaviors
 - use of toys and objects
 - any problem behaviors
 - any preoccupations
 - repetitive behaviors

IV. Differential Diagnosis

A. General Issues To Consider

1. Considerable experience and knowledge in working with ASDs are critical clinical issues with older children and adolescents to differentiate ASDs from other diagnostic alternatives.
2. It is important to examine possible factors that have prompted suspicions of an ASD and ask why this child has either (a) presented at this age or (b) not been identified earlier. The clinician must have knowledge of the qualitative and quantitative indicators of ASDs, as well as the developmental expression of behaviors in both typical and atypical development in childhood and adolescence.
3. Individuals can remain undiagnosed until adolescence or adulthood, particularly when symptoms are relatively mild (such as with Asperger's Disorder) or when access to health care is limited. Also, some persons may have reached adulthood prior to more widespread awareness of ASDs and remain undiagnosed despite fairly significant symptomatology and otherwise adequate healthcare access.
4. Many of the same issues pertinent to individuals age 6 years or older also pertain to adolescents and adults. However, with increasing age, the record review and the critical elements of early development in the parent/caregiver interview become increasingly challenging. In some cases, this information may be unavailable.

5. Furthermore, the diagnosis can significantly evolve with age in response to therapies and as a result of coping mechanisms to the point of differing significantly from the initial diagnosis (Seltzer et al., 2003). Early developmental history can be critical for establishing a diagnosis, but current behaviors are critical for treatment. Later onset disorders, such as schizophrenia, can share common features with ASDs, but will not be associated with the characteristic early developmental history of ASDs. Therefore, often input from a variety of specialists is critical in the accurate diagnosis of older persons with ASDs. Employment history, capacity for functional independence, and history of social interactions including any potential romantic relationships are additional issues that are important in the histories of older persons.

B. Key Considerations Related to Differential Diagnosis

1. Throughout the diagnostic evaluation process, the lead diagnostic clinician collects and integrates data to determine whether an ASD diagnosis is warranted. This requires both collection of sufficient data and clinical skill to differentiate ASDs from other disorders with similar or overlapping presentations, identify which specific ASD diagnosis is most appropriate, and identify difficulties that may coexist with ASDs.

C. Common Differential Dilemmas

1. Diagnosis of ASDs is based on presentation of specific behaviors and deficits in the domains of communication, reciprocal social interaction, and restricted interests and repetitive behaviors as specified by *DSM-IV-TR* diagnostic criteria. There are several non-autism spectrum disorders that may be associated with difficulties in one or more of these behavioral domains. Symptoms often associated with ASDs may not be specific to ASDs. For example, hand flapping or other repetitive movements may occur in the context of global developmental delay, a stereotypic movement disorder, or intense anxiety. The lead diagnostic clinician is able to differentiate between ASDs and other developmental or psychiatric disorders with overlapping symptoms including:
 - disorders associated with multiple areas of difficulty,
 - disorders associated with deficits in language and/or communication,
 - disorders associated with social interaction problems,
 - disorders associated with restricted interests or repetitive behaviors, and
 - other disorders associated with ASDs.

D. According to DSM-IV-TR — Some psychiatric disorders cannot be comorbid with, Autistic Spectrum Disorders. It is not uncommon to see some of these disorders historically. Rightfully, these diagnoses may be considered provisional or rule out of the ASD diagnoses. These diagnoses include:

1. Attention Deficit Hyperactivity Disorder (very controversial – DSM IV-TR says that ADHD cannot be diagnosed along with an ASD, but some experts suggest to the contrary; in addition, treatment may be helpful even if diagnosis is not allowed)
2. Personality Disorders, especially Avoidant, Schizotypal, Schizoid (Autistic disorders have an earlier onset and greater severity than these personality disorders)
3. Communication Disorders – cannot be comorbid-(With Communication Disorders, there is no qualitative social impairment; receptive language impairments co-occur with autistic disorders. With Asperger’s Disorder, cognitive testing usually reveals a high verbal/low performance pattern when the FSIQ is over 85, but a separate Learning or Communication Disorder is not diagnosed)
4. Reactive Attachment Disorder (Abnormal social relatedness of RAD overlaps with autism, but RAD includes a history of severe neglect/abuse and improves with consistent care-giving)
5. Stereotypic Movement Disorder
6. Rett’s Disorder
7. Childhood Disintegrative Disorder
8. Intermittent Explosive Disorder (According to the DSM IV, this diagnosis should be used only after other mental disorders that might account for episodes of aggressive behavior have been ruled out. Autism has a range of behavioral symptoms including impulsivity, aggressiveness, self-injurious behavior, and temper tantrums noted as associated symptoms).
9. Selective Mutism

E. Disorders Associated with Multiple Areas of Difficulty — ➤Mental Retardation; ➤Schizophrenia; ➤Reactive Attachment Disorder; ➤Early Onset Psychosis; ➤Traumatic Brain Injury; ➤Childhood Onset Dementia

1. The lead diagnostic clinician is able to differentiate ASDs from cognitive impairment and identify their co-occurrence. Cognitive impairment often co-occurs with ASDs. Therefore, it is important to describe the cognitive abilities of individuals diagnosed with ASDs and determine whether an additional diagnosis of **Mental Retardation** is warranted. However, individuals with significant cognitive impairment who do not have ASDs may exhibit ASD-like behaviors including social communication deficits and/or motor stereotypies, such as hand-flapping (Bradley, Summers, Wood, & Bryson, 2004; Wing, 1981). Because of this overlap in symptoms, it is difficult to differentiate ASDs from Mental Retardation in children with mental ages below 2 years (Lord, 1995; Rutter & Schopler, 1992). Differential diagnosis requires consideration of how an individual's behaviors relate to his or her overall developmental profile, as well as use of evaluation procedures that identify any behaviors strongly indicative of ASDs (e.g., using another person's hand as a tool). When diagnosis is complicated by possible cognitive impairment, use of standardized instruments to assess cognitive and adaptive functioning, as well as ASD symptoms, is indicated.
2. Diagnostic evaluation may require differentiation from **Reactive Attachment Disorder** or **Traumatic Brain Injury**. In rare cases, evaluation may require differentiation from conditions such as **Schizophrenia**, **Early Onset Psychosis**, or **Childhood Onset Dementia**.

F. Disorders Associated With Deficits in Language and/or Communication — ➤Expressive Language Disorder; ➤Mixed Receptive-Expressive Language Disorder; ➤Receptive Language Disorder; ➤Selective Mutism

1. The lead diagnostic clinician is able to differentiate ASDs from other developmental and psychiatric disorders that also are associated with deficits in language and/or communication. Developmental Language Disorders such as Expressive Language Disorder, Receptive Language Disorder, or Mixed Receptive-Expressive Language Disorder are marked by deficits in the individual's ability to understand or use language or both. Such language deficits may result in social interaction problems because of the individual's frustration with understanding or expressing himself or herself to others. However, language disorders are not associated with idiosyncratic language usage, deficits in social reciprocity, or restricted interests and repetitive behaviors. In addition, individuals with language impairments typically can be distinguished from individuals with ASDs based on intact nonverbal communication. In Selective Mutism, the individual does not speak or communicate in certain settings, but exhibits intact communication in some environments and does not exhibit the marked social impairments and restricted and repetitive behaviors associated with ASDs.

G. Disorders Associated with Social Interaction Problems — ➤Attention Deficit Hyperactivity Disorder; ➤Reactive Attachment Disorder; ➤Social Phobia; ➤Personality Disorders; ➤Depression

1. Social interaction and peer relationship problems are a prominent feature of multiple developmental and psychiatric disorders. The lead diagnostic clinician is able to differentiate the impairments in social-emotional reciprocity and social communication that are core features of ASDs from the social difficulties associated with Attention Deficit Hyperactivity Disorder (ADHD), Social Phobia or another anxiety disorder, Depression, Reactive Attachment Disorder (RAD), and Personality Disorders.

H. Disorders Associated with Restricted Interests or Repetitive Behaviors — ➤Stereotypic Movement Disorder; ➤Obsessive Compulsive Disorder; ➤Tourette's Disorder

1. The lead diagnostic clinician is able to determine whether restricted interests or motor stereotypies occur in combination with the deficits in social reciprocity and communication required for an ASD diagnosis or present as a Stereotypic Movement Disorder or in the context of another disorder such as Tourette's or Obsessive Compulsive Disorder (OCD).

I. Other Disorders Associated with ASDs – ➤Nonverbal Learning Disorder; ➤Semantic-Pragmatic Disorder

1. The lead diagnostic clinician is aware of other conditions associated with ASDs (e.g., Nonverbal Learning Disorder, Semantic-Pragmatic Disorder) that are not included in the *DSM-IV-TR* and is able to explain the difference between these labels and medically accepted categories.

J. Disorders that Commonly Coexist with ASDs That The Clinician Should Be Aware Of

- Obsessive Compulsive Disorder
- Attention Deficit Hyperactivity Disorder
- Medical Problems
- Affective Disorders
- Atypical Response to Environment

K. Issues Associated With Mental Retardation Which Can Coexist With ASD

1. Although estimates of the co-occurrence of Autism and Mental Retardation were once as high as 70% to 80% (Bryson & Smith, 1998), **current estimates range from 30% to 60%** (Chakrabarti & Fombonne, 2005; Shea & Mesibov, 2005).
2. Higher rates of diagnosis of Mental Retardation typically are found among individuals diagnosed with Autistic Disorder, with lower rates among individuals diagnosed with another ASD.
3. In very young children, the primary challenge related to the overlap and co-occurrence of ASDs and Mental Retardation often is to differentiate among ASDs alone, Mental Retardation alone, and an ASD combined with Mental Retardation.
4. For individuals diagnosed with ASDs who have mild global impairments, the possibility of a diagnosis of Mental Retardation may not emerge until the child enters or progresses through elementary school and differences from same-age peers become more pronounced.
5. In cases where the possibility of Mental Retardation complicates diagnosis, use of standardized instruments to assess cognitive and adaptive functioning as well as ASD symptoms is indicated.