

EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION (EIDBI)

Comprehensive Multi-Disciplinary Evaluation (CMDE) Medical Necessity Summary Information

- **What is this form for?**

The Comprehensive Multi-Disciplinary Evaluation (CMDE) form documents and summarizes the results of the CMDE. The CMDE determines medical necessity and makes overall recommendations for Early Intensive Developmental and Behavioral Intervention (EIDBI) services.

- **Who completes this form?**

An enrolled CMDE provider must complete the CMDE. It must include information from a medical professional.

- **How do I submit the CMDE?**

The qualified mental health professional must submit the completed CMDE for medical necessity determination.

- For fee-for-service recipients, send to the DHS medical review agent
- For managed care recipients, send to the recipient's health plan.

Please see the [EIDBI Policy Manual](#) for complete instructions.

651-431-4300 or 866-267-7655

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သုဉ်ဟ်သးဘဉ်တက့ၢ်. ဝဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလိလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မိတခါအံၤန့ၢ်,ကိးဘဉ် လိတံာ်နီၢ်ဂံၢ်လၢထးအံၤန့ၢ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ, ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງໂທໂປທິໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)



For accessible formats of this information or assistance with additional equal access to human services, call 651-431-4300 (local) or 866-267-7655 (toll free), write to dhs.info@state.mn.us or use your preferred relay service. (ADA1[2-18])

CMDE Medical Necessity Summary Information

- Answer all questions the best you can
- Do not leave fields blank, instead use "NA" when not applicable

NOTE: This document meets the requirements of a diagnostic assessment.

Indicate the type of diagnostic assessment: <input type="checkbox"/> Standard <input type="checkbox"/> Extended	INITIAL CMDE DATE	ANNUAL CMDE DATE	PERSON'S PMI NUMBER
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A. Personal information for person who receives services							
FIRST NAME	MI	LAST NAME	GENDER Male Female Non-binary			DATE OF BIRTH	AGE YEARS MONTHS
HOME ADDRESS			CITY	STATE	ZIP CODE	COUNTY	
MAILING ADDRESS (if different)			CITY	STATE	ZIP CODE	COUNTY	

Parent/guardian information (if applicable)

PARENT 1/GUARDIAN Is this person the legal guardian?					Yes	No
FIRST NAME	LAST NAME		RELATIONSHIP TO PERSON	HOME PHONE	CELL PHONE	
Is this parent's address the same as the person's?					Yes	No — if no, fill in below
HOME ADDRESS			CITY	STATE	ZIP CODE	
PARENT 2/GUARDIAN Is this person the legal guardian?					Yes	No
FIRST NAME	LAST NAME		RELATIONSHIP TO PERSON	HOME PHONE	CELL PHONE	
Is this parent's address the same as the person's?					Yes	No — if no, fill in below
HOME ADDRESS			CITY	STATE	ZIP CODE	

Insurance

Is the person on a health plan through Medical Assistance?		Yes	No — if yes, provide Member ID	MEMBER ID
PRIMARY INSURANCE	POLICY HOLDER		POLICY NUMBER	
SECOND TYPE OF INSURANCE	POLICY HOLDER		POLICY NUMBER	
THIRD TYPE OF INSURANCE	POLICY HOLDER		POLICY NUMBER	
FOURTH TYPE OF INSURANCE	POLICY HOLDER		POLICY NUMBER	

Current living situation

Home with family	Foster care	Group home	Other (describe) _____
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Race and ethnicity

Check all that apply	Asian	White	Black or African American	American Indian or Native Alaskan	Hispanic or Latino?
	Pacific Islander or Native Hawaiian	Other (specify) _____		Prefer not to answer	Yes No

Language

What is the primary language spoken at home? English Other (specify) _____	What is the person's primary language? English Other (specify) _____
Language interpreter used? Yes No	IF SO, WHAT LANGUAGE?
Sign language interpreter used? Yes No	

B. CMDE referral, diagnostic information and EIDBI recommendations

DATE OF CMDE REFERRAL	PERSON WHO MADE REFERRAL
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REASON FOR CMDE REFERRAL

PRIMARY CMDE PROVIDER

NAME	TITLE	NPI NUMBER
AGENCY NAME	PHONE NUMBER	FAX NUMBER
		AGENCY NPI NUMBER
AGENCY STREET ADDRESS	CITY	STATE ZIP CODE

PRIMARY CARE PHYSICIAN/MEDICAL PROVIDER

NAME	TITLE	NPI NUMBER
CLINIC NAME	PHONE NUMBER	FAX NUMBER
		CLINIC NPI NUMBER
CLINIC STREET ADDRESS	CITY	STATE ZIP CODE

Diagnostic information

Please list primary diagnosis of autism spectrum disorder or related condition first and then list other diagnosis as appropriate.

CURRENT DIAGNOSTIC ASSESSMENT DATE	DIAGNOSIS CODE (ICD)	DESCRIPTION	DC:0-5 CODE
1.			
2.			
3.			
IF ASD, INITIAL DIAGNOSIS DATE	What is the level of intellectual disability? Mild Moderate Severe None		

Summary of clinical findings

Provide a summary of all key findings, including: Evidence of ASD diagnosis or related condition, description of level of support needed across the core symptoms, including social Interaction and communication and restricted/ repetitive interests or behaviors. If alternative diagnosis cannot be definitively ruled out, describe the plan for further evaluations of presenting symptoms.

C. EIDBI treatment recommendations

Parent/ guardian preference for family/caregiver training and counseling services (select one)	
Intensive training in person’s treatment	Limited, but regular training in person’s treatment
Frequent, regular training in person’s treatment	Indirect and limited training in person’s treatment

EIDBI treatment recommendations

The CMDE provider recommends the range of service intensity and preference for setting in partnership with the parent/legal representative.

SERVICE NAME	RANGE OF HOURS (INTENSITY)	WEEKLY OR MONTHLY	SETTING (HOME, OFFICE, CENTER, CLINIC)
EIDBI Intervention	to		
Family/Caregiver training and counseling	to		

Exceptions to medical necessity treatment guidelines

If applicable, provide clear rationale and supporting documentation for consideration of an exception to the recommended treatment guidelines as defined in the medical necessity criteria. This could include information from other qualified professionals that work with the person and family. (select one)

<p>No exception needed</p> <p>Less than 10 hours/week minimum (include rationale below)</p> <p>More than the recommended 20 hours/week for school-age children who are more than 7 years old (include rationale below)</p>
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D. Medical and developmental history

DATE/AGE SYMPTOMS WERE FIRST NOTICED	WHO NOTICED SYMPTOMS
DESCRIBE SYMPTOMS	

Family histories and priorities

Describe the person and family’s primary areas of need and priorities, including but not limited to, basic needs and economic status, education level and employment status, belief systems and perception of condition.

Medical history

Information from the person’s medical provider is required for completion of the CMDE.

NAME OF PERSON WHO IS PRIMARY SOURCE OF MEDICAL INFORMATION	TITLE
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Is there anything in the person’s medical history or current health state that must be taken into account in making medical necessity determination and developing treatment recommendations and plan (including but not limited to, history of mental health treatment, maltreatment/abuse and mental status exam)? If so please identify and explain.

List any other known medical condition(s) or history of substance abuse.

Prior medical evaluations

Use most recent information from the primary care physician/ medical provider to complete this section.

EVALUATION PERFORMED	DATE OF EVALUATION	BY WHOM	REASON/RESULTS
Well person check/annual physical			
Social emotional screening			
Developmental screening			
Hearing			
ENT/allergies			
Neurology			
Genetic testing			
Occupational therapy			
Physical therapy			
Speech language pathology			
Trauma screening			
Other			
Are immunizations current? Yes No Unknown — If no, describe reason			

Current medications

Does person take medications? Yes No Unknown — If yes, list below					
MEDICATION	DOSAGE	FREQUENCY	START DATE	REASON FOR USE	PRESCRIBING PHYSICIAN
1.					
2.					
3.					
4.					
5.					
6.					

Allergies

Does the person have allergies? Yes No Unknown — If yes, explain type of allergy and reaction, including to any medications.	
ALLERGY	REACTION
1.	
2.	
3.	
4.	
5.	

Hospitalization

Has the person been hospitalized? Yes No Unknown — If yes, enter information below			
DATE	LOCATION	REASON	SOURCE OF INFORMATION

Developmental history

PREGNANCY AND DELIVERY
Describe the pregnancy (including but not limited to: length, morning sickness, complications, hospitalizations, infections, illness of the mother, any substance exposure, etc.)
Describe the labor (where it occurred, complications, immediate concerns, etc.)
Was the person admitted to the NICU as an infant? Yes No Unknown — If yes, for what length of time?
DEVELOPMENTAL MILESTONES
Describe history of developmental milestones, including but not limited to, the age at which the person sat independently, walked, talked, was toilet trained, fed self, and slept through the night.
Describe the person's overall physical health.

Developmental history

SIGNIFICANT EVENTS

Describe significant events or environmental factors which may have impacted development or contributed to the person’s presenting condition.

HISTORY OF DEVELOPMENTAL CONDITIONS IN OTHER FAMILY MEMBERS

Describe relevant developmental concerns, medical conditions/diagnosis of other family members.

STRENGTHS

Describe person’s strengths and resources that were observed/reported by the person or family (including extent and quality of social networks).

FAMILY STRENGTHS

Describe the family’s strengths that were observed or reported by the parent/ guardian (including cultural influences and impact).

E. Observation

Document and describe the face-to-face or telemedicine observation of the person’s core symptoms and overall development (including under what circumstances, other people involved and any critical developmental findings).

OBSERVATION RESULTS AND SUMMARY

DATE	BY WHOM	PROVIDER NPI NUMBER	SETTING Clinic Home Center School
DATE	BY WHOM	PROVIDER NPI NUMBER	SETTING Clinic Home Center School

F. Summary results for autism core deficits and related conditions

Score each domain based on information from standardized, formal and informal assessment tools, additional reports, observations, medical and developmental history, parent/ guardian/caregiver interviews and clinical judgement.

Select one score in each domain.

DOMAINS	TIER I	TIER II	TIER III	TIER IV
SOCIAL INTERACTION	Primarily initiates and responds to social Interaction in a reciprocal manner appropriate to person's age. Generally does not interfere with functioning. SCORE = 0	Some initiation and response to social Interaction in a reciprocal manner appropriate to person's age depending on activity. SCORE = 1	Requires moderate levels of support to initiate and respond to others in a social manner. SCORE = 2	Needs constant 1:1 support to notice and socially initiate and respond to others. SCORE = 3
SOCIAL COMMUNICATION	Primarily demonstrates integrated use of verbal and non-verbal communication appropriate to person's age. Generally does not interfere with functioning. SCORE = 0	Some abnormalities in eye contact, body language and use of gestures for purposes communication. SCORE = 1	Moderate abnormalities in eye contact, body language and use of gestures for purposes communication. SCORE = 2	Total lack of facial expressions, body language and gestures for purposes of communication. SCORE = 3
RESTRICTIVE, REPETITIVE BEHAVIORS/ INTERESTS	Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input generally do not interfere with daily functioning. SCORE = 0	Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input cause mild interference with daily functioning. Can be verbally re-directed. SCORE = 1	Fixations, preoccupations inflexibility and/or hyper/hypo reactivity to sensory input cause moderate interference with daily functioning. May need visual or physical re-direction. SCORE = 2	Fixations, preoccupations, inflexibility and/or hyper/hypo reactivity to sensory input cause significant interference with daily functioning are extremely difficult to re-direct. Requires physical re-direction. SCORE = 3

SUBTOTAL _____

Summary results for additional developmental domains

Score each additional domain based on information from standardized, formal and informal assessment tools, additional reports, observations, medical and developmental history, parent/guardian/caregiver interviews and clinical judgement.

Select one score in each domain.

DOMAINS	TIER I	TIER II	TIER III	TIER IV
SELF-CARE SKILLS	Able to perform most age-appropriate self-help skills. SCORE = 0	Requires some assistance or verbal/visual cues, but performs some self-help skills independently. SCORE = 1	Requires moderate verbal, visual and hands-on assistance for most self-help skills. SCORE = 2	Requires constant hands-on assistance for all self-help and daily cares. SCORE = 3
INTERFERING OR UNWANTED BEHAVIORS	Age appropriate behavioral challenges in familiar and unfamiliar environments. SCORE = 0	Mild behavioral challenges in one or more familiar and unfamiliar environments. SCORE = 1	Moderate behavioral challenges across most familiar and all unfamiliar environments. SCORE = 2	Severe behavioral challenges across all familiar and unfamiliar environments. SCORE = 3

DOMAINS	TIER I	TIER II	TIER III	TIER IV
EXPRESSIVE COMMUNICATION	Able to spontaneously verbally express ideas and needs at a level appropriate to the person's age. SCORE = 0	Some spontaneous verbal expression of simple familiar or rote phrases to communicate ideas or express needs. SCORE = 1	Limited spontaneous expression of single words, signs, gestures, and/or Picture Exchange Communication System (PECS) or other augmentative device to request items or basic needs. SCORE = 2	Has no spontaneous functional communication strategies. SCORE = 3
RECEPTIVE COMMUNICATION	Able to respond appropriately to familiar and unfamiliar verbal requests, at a level expected for age. SCORE = 0	Able to respond appropriately to simple familiar/rote verbal requests, but has difficulty responding to unfamiliar requests. SCORE = 1	Limited response to simple familiar requests even when paired with visual cues or gestures and is unable to respond to unfamiliar requests even when paired with visual cues and gestures. SCORE = 2	Does not respond when spoken to or when words are paired with visual cues and/or gestures. SCORE = 3
COGNITIVE FUNCTIONING	Cognitive skills appear to be at or above age appropriate level. No interference with age appropriate activities and interpersonal and daily life functioning. SCORE = 0	Mild cognitive challenges present minimal interference with age appropriate activities and interpersonal and daily life functioning. SCORE = 1	Moderate cognitive challenges interfere with age appropriate activities and interpersonal and daily life functioning. SCORE = 2	Severe cognitive challenges interfere with all aspects of daily life including lack of age-appropriate activities and interpersonal and daily life functioning. SCORE = 3
SAFETY	Able to occupy self alone or with siblings safely for age appropriate periods of time. SCORE = 0	Able to occupy self safely depending on activity, but requires moderate level of supervision for person's age. SCORE = 1	Able to occupy self safely for brief periods of times, but requires high level of supervision for person's age. SCORE = 2	Requires constant supervision to ensure safety. SCORE = 3
LEARNING/PLAY/MOTOR SKILLS	Needs no assistance in participating in age appropriate activities. SCORE = 0	Able to participate in age appropriate activities with minimal support and cues from others. SCORE = 1	Requires moderate level of support and cues from others needed to participate in age appropriate activities. SCORE = 2	Requires constant support and cues from others to participate in all age appropriate activities. SCORE = 3
BEHAVIOR/SENSORY REGULATION	Need no assistance to manage sensory needs/behavior. Requires no cues or supports from others. Regulates sensory needs and behaviors independently at an age appropriate level. SCORE = 0	Able to regulate sensory needs and behavior with minimal support or cues. Requires a few cues and supports from others to regulate sensory needs and behaviors. Typically able to recognize when sensory needs or behaviors are interfering and adjust behavior. SCORE = 1	Requires moderate level support from others to regulate sensory needs and behaviors. Requires frequent cues and supports from others to regulate sensory needs and behaviors. Often unable to recognize when sensory needs or behaviors are interfering. SCORE = 2	Requires a high level of support from others to regulate sensory needs and behaviors. Requires constant cues and supports from others to regulate sensory needs and behaviors. SCORE = 3

SCORE TOTAL (include previous page subtotal) _____

G. Parent/caregiver informational interview

DATE	NAME OF PERSON INTERVIEWED	RELATIONSHIP TO PERSON	NAME OF INTERVIEWER
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PARENT/CAREGIVER INTERVIEW RESULTS
Based on parent interview and clinical judgment, select one score for each domain.

CONFIDENCE	Parent(s)/primary caregiver(s) understand the diagnosis and feels competent about meeting the person's needs. SCORE = 0	Parent(s)/primary caregiver(s) understand the diagnosis, but is uncertain about how to meet the person's needs. SCORE = 1	Parent(s)/primary caregiver(s) have difficulty understanding the diagnosis and meeting the person's needs. SCORE = 2	Parent(s)/primary caregiver(s) do not understand the diagnosis and do not know how to meet the person's needs. SCORE = 3
STRESS	Parent(s)/primary caregiver(s) experience low to moderate stress and manage it well. SCORE = 0	Parent(s)/primary caregiver(s) experience times of moderate to high stress, but it is manageable. SCORE = 1	Parent(s)/primary caregiver(s) have high level of stress, but usually have the capacity to cope with it. SCORE = 2	Parent(s)/primary caregiver(s) have a high level of stress on a daily basis and struggle to cope with and manage the situation. SCORE = 3
PERCEPTION OF QUALITY OF LIFE	Parents/primary caregivers indicate low to moderate impact of person's disability on quality of life, but manage it well. SCORE = 0	Parents/primary caregivers indicate times of moderate to high impact of person's disability on quality of life, but it is manageable. SCORE = 1	Parents/primary caregivers indicate high impact of person's disability on quality of life, but usually have the capacity to cope with it. SCORE = 2	Parents/primary caregivers indicate high impact of person's disability on quality of life and struggle to cope with and manage the situation. SCORE = 3

SCORE TOTAL _____

H. Summary of referrals made

Does the person need to be referred to other services or evaluations? If yes, identify below.

Auditory	County human/social services agency	Educational	Genetics	Medical
Neurological	Nutritional	Occupational therapy	Physical therapy	Psychiatric
Psychological	Case manager	Speech	Vision	

Other (describe):

REASON FOR REFERRAL TO ANY OF THE SERVICES IDENTIFIED ABOVE

I. ASD diagnostic criteria and related conditions diagnostic assessment tools

DHS encourages the use of standardized assessment tools to diagnose autism and evaluate cognitive/intellectual, adaptive and sensory regulatory abilities. However, no specific assessment tools are required. The DHS Medical Review Agent will **not** accept the extended assessment tool protocols and narrative reports from conducted assessments when submitting the CMDE. This section identifies the assessment tools that may have been used as part of the CMDE.

DSM-5 criteria

Does the person meet criteria for an autism spectrum disorder (ASD) diagnosis? Yes No		DATE CLASSIFIED
Check the appropriate boxes below to identify level of severity/level of support needed.		
LEVEL OF SUPPORT	SOCIAL COMMUNICATION	RESTRICTIVE, REPETITIVE BEHAVIORS, SENSORY REGULATION
LEVEL 3: "REQUIRING VERY SUBSTANTIAL SUPPORT"		
LEVEL 2: "REQUIRING SUBSTANTIAL SUPPORT"		
LEVEL 1: "REQUIRING SUPPORT"		
IDENTIFY IF WITH OR WITHOUT	WITH	WITHOUT
ACCOMPANYING INTELLECTUAL IMPAIRMENT		
ACCOMPANYING LANGUAGE IMPAIRMENT		

Autism assessment tools

Indicate if the person has had each of the following:

ASSESSMENT	DATE	ADMINISTERED?	DETAILS
Autism Diagnostic Observation Schedule (ADOS)		Yes No	BY WHOM
Autism Diagnosis Interview – Revised (ADIR)		Yes No	BY WHOM
Childhood Autism Rating Scale (CARS)		Yes No	BY WHOM Non-autistic Mildly/moderately autistic Severely autistic
Gilliam Autism Rating Scale (GARS)		Yes No	BY WHOM DEGREE OF SEVERITY

Cognitive or development assessment tools

Indicate if the person has had each of the following:

ASSESSMENT	ADMINISTERED?	IF YES, WHO DID THE ASSESSMENT?
Battelle Developmental Inventory	Yes No	
Bayley Scales of Infant and Toddler Development	Yes No	
Mullen Scales of Early Learning (Developmental)	Yes No	
Weschler Preschool and Primary Scale of Intelligence (WPPSI-IV)	Yes No	
WISC Wechsler Intelligence Scale for Children (WISC)	Yes No	
Woodcock Johnson Test of Cognitive Abilities	Yes No	

Other cognitive assessment tools

Please list other cognitive tests, if any.

Other assessment tools

ASSESSMENT	ADMINISTERED?	IF YES, WHO DID THE ASSESSMENT?
Vineland Adaptive Behavior Scales	Yes No	
Adaptive Behavior Assessment System (ABAS)	Yes No	
Sensory profile	Yes No	

List other assessment tools that were administered (e.g., CASII, ESCII, SDQ, WHODAS, CAGE-AID, GAIN-SS, etc.). Include general findings for each: