BSC3.01	Applied Behavior Analysis for Autism Spectrum Disorder or Pervasive Developmental Disorder		
Original Policy Date:	July 1, 2012	**Effective Date:**	August 1, 2026
Section:	3.0 Mental Health	**Page:**	Page 1 of 18

Policy Statement

I. Applied Behavior Analysis (ABA) Initial Assessment may be **medically necessary** when all the following are met:
   A. A member is new to the requesting provider.
   B. There is a diagnosis of Autism Spectrum Disorder based on DSM-5-TR or Pervasive Developmental Disorder using clinical observations or validated assessment tools, made by a licensed qualified health care provider.
   C. The hours / units of service requested for each CPT code are provided.

II. ABA services may be **medically necessary** when all the following are met:
   A. There is a diagnosis of Autism Spectrum Disorder based on DSM-5-TR or Pervasive Developmental Disorder using clinical observations or validated assessment tools, made by a licensed qualified health care provider.
   B. There is a comprehensive assessment that describes specific levels of behavior(s) at baseline and informs the subsequent establishment of meaningful treatment goals.
      1. The standard of care requires the use of multi-method, multi-informant data sources to provide a comprehensive view of member functioning at intake and throughout treatment.
      2. Assessment activities typically include direct observation and measurement of behavior in conjunction with other activities such as file review, interviews, and the administration of standardized instruments (i.e., a rigorously developed tool that measures a concept in an objective, standardized manner).
      3. Standardized assessments are well-researched, valid, and reliable instruments that are carefully selected for each member and can provide important information about the strengths and needs of the member for the purposes of establishing baselines, treatment planning, and evaluating progress.
      4. The goal of the assessment is to:
         a. Determine the member's baseline skills.
         b. Develop the treatment plan and goals.
         c. Identify measures to report progress in treatment.
   C. There is consistent, ongoing, objective data analysis to inform clinical decision making. Including baseline data satisfies this requirement for an initial request.
   D. There are reasonable efforts toward collaboration with the person receiving treatment, their guardians if applicable, and those who support them (e.g., caregivers, care team) in developing meaningful treatment goals.
   E. There is a practical focus on establishing small units of behavior that build toward larger, more significant changes in abilities related to improved health, safety, skill acquisition, and/or levels of independence and autonomy.
      1. Each goal should be medically necessary and able to be addressed through behavior analytic practices.

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2. Each goal (target behavior) should be measured using procedures that yield objective, valid, accurate evidence as to whether and how much it changes, i.e., whether treatment is producing progress toward the member's treatment goals.
3. No progress on any goals during an authorization period should prompt a careful review of the treatment plan and utilization of authorized services.
4. The scope of treatment should be aligned with the breadth and depth of behaviors targeted to address the needs of the member.

F. There is collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals.
   1. The outcomes reported should come from established methods that are informed by the best available evidence. Including baseline data satisfies this criterion for an initial request.
   2. The provider should consider whether a particular domain is well-supported by research for the specific treatment target or treatment model provided to the individual member.
   3. Regular data analyses allow the behavior analyst to quickly intervene if a member is not making the expected progress toward goals and objectives. Including baseline data satisfies this criterion for an initial request.
   4. A comprehensive review of progress may occur weekly, bimonthly, or monthly depending on member need and intensity of services. Including baseline data satisfies this criterion for an initial request.
   5. Case conceptualization involves identifying environmental variables to inform the selection, focus, and sequence of interventions, and to identify potential barriers to treatment.

G. There is an approach to the treatment of challenging behavior that links the function(s) of, or the reason(s) for, the behavior with programmed intervention strategies.

H. There is use of a carefully constructed, individualized, and detailed behavior-analytic treatment plan that utilizes reinforcement and other behavioral principles and excludes methods or techniques not based on established behavioral principles and theory.

I. There is use of treatment protocols that are implemented repeatedly, frequently, and consistently across environments until discharge criteria are met. Including baseline data satisfies this criterion for an initial request.

J. There is an emphasis on frequent, ongoing analysis and adjustments to the treatment plan based on member progress. Including baseline data satisfies this criterion for an initial request.

K. There is direct training of caregivers and other involved laypersons and professionals, as appropriate, to support increased abilities and generalization and maintenance of behavioral improvements.

L. Transition and Discharge planning is included.
   1. Discharge and transition criteria should be measurable, realistic, and individualized.
   2. The criteria for moving through a transition plan and discharging a member should be documented at the initiation of services and refined and modified throughout the treatment process based on ongoing evaluations of skills and needs.
   3. The transition plan should specify the starting point of treatment and describes to the extent known:
      a. the member's symptomatology and level of functioning
      b. the presence or absence of skills
      c. the member's strengths and barriers to skill acquisition
      d. the member's rate of learning and optimal learning strategies
      e. previous treatment strategies and the member's response to any previous treatment (e.g., highly effective, ineffective)
      f. the desired outcomes of treatment

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4. The transition plan should specify monitoring and evaluation details. This may include:
   a. assessing generalization across environments and people
   b. assessing maintenance of treatment gains
   c. monitoring the effectiveness of interventions for challenging behavior
   d. measuring skill maintenance
5. The transition plan should outline multiple stages of transition, from more support to less support and a more independent level of care.

M. The hours / units of service requested for each CPT code for the service, reassessment or report, as applicable, are provided.
1. The member should be able to receive treatment at the intensity that is most effective to achieve the treatment goals.
2. Moving to a lower level of intensity is appropriate only when it is deemed safe to do so and when the lower level is equally effective as treatment at the higher level or service intensity.
3. Treatment intensity is specified in the treatment plan and defined as the number of direct ABA treatment hours per week, not including case supervision by the behavior analyst, caregiver training, and other services.
4. One to two hours of case supervision for every 10 hours (1–2:10) of direct treatment is the general standard of care.

III. ABA services are considered **not medically necessary** and discharge should be initiated when any of the following is met:
A. The member has achieved the desired socially significant outcomes as developed in collaboration between the provider, the member, and the family, and treatment is not required to maintain functioning or prevent regression.
B. The member's diagnosis no longer materially impacts functioning, and treatment is not required to maintain functioning or prevent regression.
C. The member is no longer benefiting from services.

NOTE: Refer to Appendix A to see the policy statement changes (if any) from the previous version.

Policy Guidelines

This Medical Policy is based on The Council of Autism Service Providers (CASP) Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder: Guidance for Healthcare Funders, Regulatory Bodies, Service Providers, and Consumers 3rd edition.[3]

Outpatient ABA is generally *not a covered benefit** for **any** of the following purposes:

- Respite
- Day care
- Educational services
- To reimburse a parent for participation in the treatment

* See Benefit Application Section

Except as noted, ABA must be prior authorized by Blue Shield and home-based services (or other non-institutional setting) must be obtained from participating providers.

Blue Shield covers ABA when state mandated or when ABA is specifically included in a member's benefit plan.

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Coverage of ABA treatment should not be excluded, denied, or limited based on the degree of caregiver participation.

Coding
See the Codes table for details.

Description

Medically necessary treatment or services for autism spectrum disorder or pervasive developmental disorder may **include, but is not limited to, speech therapy, occupational therapy, and behavioral health treatment (BHT).** BHT consists of professional services and treatment programs, including ABA and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism spectrum disorder. This medical policy pertains to ABA in the outpatient setting only.

Applied Behavior Analysis
ABA is a discipline that applies human behavior principles in various settings, i.e., clinics, schools, homes, and communities, to diminish substantial deficits in a recipient's adaptive functioning or significant behavior problems due to autism spectrum disorder. This technique applies interventions to address three core areas of behavioral functioning:

1. Deficits in developmentally appropriate self-care include, but are not limited to:
    - Feeding
    - Grooming
    - Activities of daily living (e.g., dressing, preparing for school)
    - Preoccupation with one or more restricted, stereotyped patterns of behavior that are abnormal in intensity or focus
    - Inflexible adherence to specific, nonfunctional routines or rituals
    - Stereotyped, repetitive motor mannerisms
    - Persistent preoccupation with parts of objects

2. Impairments in social adaptive skills include, but are not limited to:
    - Delay in or lack of spoken language
    - Inability to sustain adequate conversation with others
    - Impairment in non-verbal behaviors in social interaction
    - Failure to develop peer relationships
    - Lack of spontaneous seeking to share emotions in relationships
    - Lack of social or emotional reciprocity

3. Prevention of harm to self or others (safety concerns) include, but are not limited to:
    - Aggression directed to self or others (e.g., hitting, biting)
    - Engaging in dangerous behaviors (e.g., eating nonfood items, running into the street, elopement)

Autism Spectrum Disorders
The diagnostic category of autism spectrum disorders refers to a group of developmental conditions that involve delayed or impaired communication and social skills, behaviors, and cognitive skills. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR®) has established a category for autism spectrum disorders which allows for the accountability of variations in symptoms and behaviors.[1]

An **initial assessment** may be performed for the first time for a member, or if this is the first assessment performed by this provider (as in the case where a member changes provider), or if the provider has not seen a previously established member in over 12 months

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Initiation of care is either when a member has never been treated with ABA or it has been more than 12 months since last receiving ABA services

A board-certified behavior analyst (BCBA) can prescribe ABA treatment for autism spectrum disorder or pervasive developmental disorder

Administration of some standardized assessment instruments and related activities (e.g., assessments intended to make differential diagnoses or assessments restricted to use by other professions) may fall outside the scope of competence of behavior analysts. In these situations, behavior analysts would collaborate with providers who have the appropriate competence.

A comprehensive infrastructure for case supervision by a behavior analyst of all assessments and treatment is an essential practice element of ABA. Some case supervision activities, such as treatment planning, should be reserved for the behavior analyst. There should be a compelling rationale to ensure that patient needs are being met when not following CASP recommended staffing and service-delivery models, for example, when a behavior analyst consistently provides less than 25% of the case supervision across their caseload.

Related Policies

- N/A

Benefit Application

Benefit determinations should be based in all cases on the applicable member health services contract language. To the extent there are conflicts between this Medical Policy and the member health services contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal law may prohibit health plans from denying FDA-approved Healthcare Services as investigational or experimental. In these instances, Blue Shield of California may be obligated to determine if these FDA-approved Healthcare Services are Medically Necessary.

Regulatory Status

California Law

This medical policy is based on the Cal. Health & Safety Code § 1374.73 which requires health care service plans to provide coverage of behavioral health treatment for individuals with autism spectrum disorders.

In addition, pursuant to Cal. Health & Safety Code §§ 1367.03, 1374.72, 1374.721, 1374.722, and 1374.73, and 28 C.C.R. §§ 1300.74.72 and 1300.74.72.01, health care service plans are required to provide coverage for mental health and substance use disorders (MH/SUD) services that are medically necessary, and in accordance with geographical and timely access standards. Further, plans must ensure they have a provider network that is sufficient for enrollees to receive these services in a timely manner or provide coverage for out-of-network (OON) providers. The new regulations also expand the scope of required benefits that plans must cover, including benefits for preventive, diagnostic, and treatment of MH/SUD. Lastly, these regulations include utilization review requirements for MH/SUD services. The regulations make health plans responsible for ensuring compliance and applying the most recent clinical criteria developed by nonprofit professional associations.

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Cal. Health & Safety Code § 1374.73 requires that behavioral health treatment meet all of the following criteria[2]:

- The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.
- The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
  - A qualified autism service provider.
  - A qualified autism service professional supervised by the qualified autism service provider.
  - A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
  - Describes the patient's behavioral health impairments or developmental challenges that are to be treated.
  - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
  - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
  - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

A qualified autism service provider is defined by CA Bus & Prof Code § 4999.200 as either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.
- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

A qualified autism service professional is defined by CA Bus & Prof Code § 4999.201 as an individual who meets all of the following criteria:

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A. Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
B. Is supervised by a qualified autism service provider.
C. Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
D. Is either of the following:
   (i) Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
   (ii) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.
E. (i) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
   (ii) If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.
F. Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

A qualified autism service paraprofessional is defined by CA Bus & Prof Code § 4999.202 as an unlicensed and uncertified individual who meets all of the following criteria:

- Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
- Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

Additionally, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing pursuant to Cal. Health & Safety Code § 1374.73 (g).

Rationale

This medical policy adheres to the standards established by the Council of Autism Service Providers (CASP).[3]

References

1. American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.).

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2. Cal. Health & Safety Code § 1374.73. 2012. Amended by Stats. 2023, Ch. 635, Sec. 1. (SB 805) Effective January 1, 2024. Accessed September 11, 2025, from http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.73&lawCode=HSC
3. The Council of Autism Service Providers [CASP] (2024). Applied Behavior Analysis Practice Guidelines for the treatment of Autism Spectrum Disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers [Clinical practice guidelines]. 3rd Edition. https://www.casproviders.org/asd-guidelines

Documentation for Clinical Review

Please provide the following documentation:

- ABA treatment plan and/or progress report, including:
  - Clear identification of the service type, number of hours of direct service(s), observation and direction, guardian training, support, and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan/criteria, crisis plan, and each individual provider who is responsible for delivering services.
  - Documentation of the type and degree of behaviors needing treatment (including frequency of baseline behaviors).
  - Documentation of the member's baseline skills and problems (functional and skill-based assessments).
  - Clinical findings (i.e., pertinent symptoms and duration).
  - Recent assessments/reports, assessment procedures and results, and evidence-based ABA services.
  - Comorbidities.
  - Demographics: living situation, school, and work information.
  - Summary of clinical interview and direct observation.
  - Proposed/current treatment plan including but not limited to the anticipated response to treatment, goals (date of introduction, estimated date of mastery) and other types of treatment that have been tried (with results) or considered but excluded.
  - Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
  - Outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
  - Specify the instruments that will be used (for example: Vineland, BRIEF, SSIS, SR-2, ADOS-2, TOPL-2, ABAS-3, etc.).
  - Discharge plan.
  - Care coordination that involves the guardian, school, state disability programs, and other programs and institutions, as applicable.

Coding

The list of codes in this Medical Policy is intended as a general reference and may not cover all codes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy.

Type	Code	Description
CPT®	0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more

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Type	Code	Description
		technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.
	0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.
	97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
	97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
	97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
	97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
	97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
	97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
	97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
	97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
HCPCS	G9012	Other specified case management service not elsewhere classified
	H0031	Mental health assessment, by nonphysician
	H0032	Mental health service plan development by nonphysician
	H2014	Skills training and development, per 15 minutes
	H2019	Therapeutic behavioral services, per 15 minutes
	S5108	Home care training to home care client, per 15 minutes
	S5110	Home care training, family; per 15 minutes

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

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Effective Date	Action
07/01/2012	New policy
08/29/2014	Coding update
05/01/2016	Policy title change from Behavioral Health Treatment for Pervasive Developmental Disorders Policy revision without position change
05/01/2017	Policy revision without position change
06/01/2018	Policy revision without position change
01/01/2019	Coding update
06/01/2019	Policy revision without position change
06/01/2020	Annual review. Policy statement and literature updated.
06/01/2021	Annual review. No change to policy statement. Literature review updated.
06/01/2022	Annual review. No change to policy statement. Literature review updated.
06/01/2023	Annual review. No change to policy statement. Literature review updated.
06/01/2024	Annual review. No change to policy statement. Literature review updated.
03/01/2025	Annual review. Policy statement and literature updated. Policy title changed from Behavioral Health Treatment for Autism Spectrum Disorders to current one.
10/01/2025	Policy statement and literature updated. Policy title changed from Behavioral Health Treatment for Autism Spectrum Disorders and/or Other Neurodevelopmental Disorders to current one.
12/01/2025	Administrative update.
01/01/2026	Administrative update. Policy title changed from Behavioral Health Treatment for Autism Spectrum Disorder or Pervasive Developmental Disorder to current one. Policy statement clarification.
02/01/2026	Administrative update.
03/01/2026	Annual review. Policy statement, guidelines and literature updated.
05/01/2026	Policy statement updated.
08/01/2026	Annual review. Policy statement, guidelines and literature updated. Policy title changed from Applied Behavioral Analysis for Autism Spectrum Disorder or Pervasive Developmental Disorder to current one.

Feedback

Blue Shield of California is interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration. Our medical policies are available to view or download at www.blueshieldca.com/provider.

For medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as member health services contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member health

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services contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

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Appendix A

POLICY STATEMENT	
BEFORE Red font: Verbiage removed	**AFTER** Blue font: Verbiage Changes/Additions
Applied Behavioral Analysis for Autism Spectrum Disorder or Pervasive Developmental Disorder BSC3.01 **Policy Statement:** I. Applied Behavioral Analysis (ABA) Initial Assessment may be **medically necessary** when all the following are met: A. A member is new to the requesting provider. B. There is a diagnosis of Autism Spectrum Disorder based on DSM-5-TR or Pervasive Developmental Disorder using clinical observations or validated assessment tools, made by a licensed qualified health care provider. C. The hours / units of service requested for each CPT code are provided. II. ABA services may be **medically necessary** when all the following are met: A. There is a diagnosis of Autism Spectrum Disorder based on DSM-5-TR or Pervasive Developmental Disorder using clinical observations or validated assessment tools, made by a licensed qualified health care provider. B. There is a comprehensive assessment that describes specific levels of behavior(s) at baseline and informs the subsequent establishment of meaningful treatment goals. 1. The standard of care requires the use of multi-method, multi-informant data sources to provide a comprehensive view of member functioning at intake and throughout treatment. 2. Assessment activities typically include direct observation and measurement of behavior in conjunction with other activities such as file review, interviews, and the administration of standardized instruments (i.e., a rigorously developed tool that measures a concept in an objective, standardized manner).	**Applied Behavior Analysis for Autism Spectrum Disorder or Pervasive Developmental Disorder BSC3.01** **Policy Statement:** I. Applied Behavior Analysis (ABA) Initial Assessment may be **medically necessary** when all the following are met: A. A member is new to the requesting provider. B. There is a diagnosis of Autism Spectrum Disorder based on DSM-5-TR or Pervasive Developmental Disorder using clinical observations or validated assessment tools, made by a licensed qualified health care provider. C. The hours / units of service requested for each CPT code are provided. II. ABA services may be **medically necessary** when all the following are met: A. There is a diagnosis of Autism Spectrum Disorder based on DSM-5-TR or Pervasive Developmental Disorder using clinical observations or validated assessment tools, made by a licensed qualified health care provider. B. There is a comprehensive assessment that describes specific levels of behavior(s) at baseline and informs the subsequent establishment of meaningful treatment goals. 1. The standard of care requires the use of multi-method, multi-informant data sources to provide a comprehensive view of member functioning at intake and throughout treatment. 2. Assessment activities typically include direct observation and measurement of behavior in conjunction with other activities such as file review, interviews, and the administration of standardized instruments (i.e., a rigorously developed tool that measures a concept in an objective, standardized manner).

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3. Standardized assessments are well-researched, valid, and reliable instruments that are carefully selected for each member and can provide important information about the strengths and needs of the member for the purposes of establishing baselines, treatment planning, and evaluating progress. 4. The goal of the assessment is to: a. Determine the member's baseline skills. b. Develop the treatment plan and goals. c. Identify measures to report progress in treatment. 5. Administration of some standardized assessment instruments and related activities (e.g., assessments intended to make differential diagnoses or assessments restricted to use by other professions) may fall outside the scope of competence of behavior analysts.	3. Standardized assessments are well-researched, valid, and reliable instruments that are carefully selected for each member and can provide important information about the strengths and needs of the member for the purposes of establishing baselines, treatment planning, and evaluating progress. 4. The goal of the assessment is to: a. Determine the member's baseline skills. b. Develop the treatment plan and goals. c. Identify measures to report progress in treatment.
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3. No progress on any goals during an authorization period should prompt a careful review of the treatment plan and utilization of authorized services. 4. The scope of treatment should be aligned with the breadth and depth of behaviors targeted to address the needs of the member. F. There is collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals. 1. The outcomes reported should come from established methods that are informed by the best available evidence. 2. The provider should consider whether a particular domain is well-supported by research for the specific treatment target or treatment model provided to the individual member. 3. Regular data analyses allow the behavior analyst to quickly intervene if a member is not making the expected progress toward goals and objectives. 4. A comprehensive review of progress may occur weekly, bimonthly, or monthly depending on member need and intensity of services. 5. Case conceptualization involves identifying environmental variables to inform the selection, focus, and sequence of interventions, and to identify potential barriers to treatment. G. There is an approach to the treatment of challenging behavior that links the function(s) of, or the reason(s) for, the behavior with programmed intervention strategies. H. There is use of a carefully constructed, individualized, and detailed behavior-analytic treatment plan that utilizes	3. No progress on any goals during an authorization period should prompt a careful review of the treatment plan and utilization of authorized services. 4. The scope of treatment should be aligned with the breadth and depth of behaviors targeted to address the needs of the member. F. There is collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals. 1. The outcomes reported should come from established methods that are informed by the best available evidence. Including baseline data satisfies this criterion for an initial request. 2. The provider should consider whether a particular domain is well-supported by research for the specific treatment target or treatment model provided to the individual member. 3. Regular data analyses allow the behavior analyst to quickly intervene if a member is not making the expected progress toward goals and objectives. Including baseline data satisfies this criterion for an initial request. 4. A comprehensive review of progress may occur weekly, bimonthly, or monthly depending on member need and intensity of services. Including baseline data satisfies this criterion for an initial request. 5. Case conceptualization involves identifying environmental variables to inform the selection, focus, and sequence of interventions, and to identify potential barriers to treatment. G. There is an approach to the treatment of challenging behavior that links the function(s) of, or the reason(s) for, the behavior with programmed intervention strategies. H. There is use of a carefully constructed, individualized, and detailed behavior-analytic treatment plan that utilizes

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reinforcement and other behavioral principles and excludes methods or techniques not based on established behavioral principles and theory. I. There is use of treatment protocols that are implemented repeatedly, frequently, and consistently across environments until discharge criteria are met. J. There is an emphasis on frequent, ongoing analysis and adjustments to the treatment plan based on member progress. K. There is direct training of caregivers and other involved laypersons and professionals, as appropriate, to support increased abilities and generalization and maintenance of behavioral improvements. L. There is a comprehensive infrastructure for case supervision by a behavior analyst of all assessments and treatment. M. Transition and Discharge planning is included. 1. Discharge and transition criteria should be measurable, realistic, and individualized. 2. The criteria for moving through a transition plan and discharging a member should be documented at the initiation of services and refined and modified throughout the treatment process based on ongoing evaluations of skills and needs. 3. The transition plan should specify the starting point of treatment and describes to the extent known: a. the member's symptomatology and level of functioning b. the presence or absence of skills c. the member's strengths and barriers to skill acquisition d. the member's rate of learning and optimal learning strategies e. previous treatment strategies and the member's response to any previous treatment (e.g., highly effective, ineffective)	reinforcement and other behavioral principles and excludes methods or techniques not based on established behavioral principles and theory. I. There is use of treatment protocols that are implemented repeatedly, frequently, and consistently across environments until discharge criteria are met. Including baseline data satisfies this criterion for an initial request. J. There is an emphasis on frequent, ongoing analysis and adjustments to the treatment plan based on member progress. Including baseline data satisfies this criterion for an initial request. K. There is direct training of caregivers and other involved laypersons and professionals, as appropriate, to support increased abilities and generalization and maintenance of behavioral improvements. L. Transition and Discharge planning is included. 1. Discharge and transition criteria should be measurable, realistic, and individualized. 2. The criteria for moving through a transition plan and discharging a member should be documented at the initiation of services and refined and modified throughout the treatment process based on ongoing evaluations of skills and needs. 3. The transition plan should specify the starting point of treatment and describes to the extent known: a. the member's symptomatology and level of functioning b. the presence or absence of skills c. the member's strengths and barriers to skill acquisition d. the member's rate of learning and optimal learning strategies e. previous treatment strategies and the member's response to any previous treatment (e.g., highly effective, ineffective)

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f. the desired outcomes of treatment 4. The transition plan should specify monitoring and evaluation details. This may include: a. assessing generalization across environments and people b. assessing maintenance of treatment gains c. monitoring the effectiveness of interventions for challenging behavior d. measuring skill maintenance 5. The transition plan should outline multiple stages of transition, from more support to less support and a more independent level of care. N. The hours / units of service requested for each CPT code for the service, reassessment or report, as applicable, are provided. 1. The member should be able to receive treatment at the intensity that is most effective to achieve the treatment goals. 2. Moving to a lower level of intensity is appropriate only when it is deemed safe to do so and when the lower level is equally effective as treatment at the higher level or service intensity. 3. Treatment intensity is specified in the treatment plan and defined as the number of direct ABA treatment hours per week, not including case supervision by the behavior analyst, caregiver training, and other services. 4. One to two hours of case supervision for every 10 hours (1–2:10) of direct treatment is the general standard of care. III. ABA services are considered **not medically necessary** and discharge should be initiated when any of the following is met: A. The member has achieved the desired socially significant outcomes as developed in collaboration between the provider, the member, and the family, and treatment is not required to maintain functioning or prevent regression.	f. the desired outcomes of treatment 4. The transition plan should specify monitoring and evaluation details. This may include: a. assessing generalization across environments and people b. assessing maintenance of treatment gains c. monitoring the effectiveness of interventions for challenging behavior d. measuring skill maintenance 5. The transition plan should outline multiple stages of transition, from more support to less support and a more independent level of care. M. The hours / units of service requested for each CPT code for the service, reassessment or report, as applicable, are provided. 1. The member should be able to receive treatment at the intensity that is most effective to achieve the treatment goals. 2. Moving to a lower level of intensity is appropriate only when it is deemed safe to do so and when the lower level is equally effective as treatment at the higher level or service intensity. 3. Treatment intensity is specified in the treatment plan and defined as the number of direct ABA treatment hours per week, not including case supervision by the behavior analyst, caregiver training, and other services. 4. One to two hours of case supervision for every 10 hours (1–2:10) of direct treatment is the general standard of care. III. ABA services are considered **not medically necessary** and discharge should be initiated when any of the following is met: A. The member has achieved the desired socially significant outcomes as developed in collaboration between the provider, the member, and the family, and treatment is not required to maintain functioning or prevent regression.

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B. The member's diagnosis no longer materially impacts functioning, and treatment is not required to maintain functioning or prevent regression. C. The member is no longer benefiting from services.	B. The member's diagnosis no longer materially impacts functioning, and treatment is not required to maintain functioning or prevent regression. C. The member is no longer benefiting from services.

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