Medical Policy Manual Behavioral Health, Policy No. 18

Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder

Effective: November 1, 2026

Next Review: April 2027
Last Review: June 2026

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Applied Behavior Analysis (ABA) is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. The goal of ABA is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement. An initial assessment is completed before the initiation of ABA-based therapy.

MEDICAL POLICY CRITERIA

Notes:

- This policy only applies to member contracts that are subject to preauthorization for Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder, as specified by their group plan. Please check the preauthorization website for the member contract to confirm requirements.
- Members are limited to ABA treatment by one authorized ABA provider at any given time.
- Clinical documentation to support criteria is required (See Required Documentation)

Medically Necessary

I. An Applied Behavior Analysis (ABA)-based therapy initial assessment may be considered medically necessary when all of the following criteria (A.-C.) are met:

   A. The member has been diagnosed with Autism Spectrum Disorder by a qualified treating health care professional as defined by state law (see Policy Guidelines); and

   B. The Autism Spectrum Disorder (ASD) related symptoms and behaviors are impairing the member's communication, social and/or behavioral functioning such that the member is a safety risk to self or others and/or is unable to participate in age-appropriate home or community activities; and

   C. ABA therapy must be recommended or prescribed by a qualified treating health care professional (e.g. psychiatrist, pediatrician, pediatric neurologist, developmental pediatrician, psychologist) experienced in the diagnosis and treatment of autism, as defined by state law (see Policy Guidelines).

II. Initiation of Applied Behavior Analysis (ABA)-based therapy may be considered **medically necessary** when both of the following criteria (A. - B.) are met:

   A. Criteria I. A. - C. are met; and

   B. An individualized treatment plan (ITP) has been documented and includes all of the following criteria (1. – 8.):

      1. The ITP is prepared by a treating provider who is certified to provide ABA therapy (see Policy Guidelines); and

      2. The ITP is documented in the medical record; and

      3. A detailed description of specific behaviors targeted for therapy. Note: Targeted behaviors must be ASD related symptoms and behaviors that are impairing the member's communication, social and/or behavioral functioning such that the member is a safety risk to self or others and/or is unable to participate in age-appropriate home or community activities; and

      4. For each targeted behavior identified in I.B.3. there must be documentation of the current level of functioning and severity using objective measurements and at least one standardized assessment (See Policy Guidelines); and

      5. A detailed description of evidence-based treatments (see Policy Guidelines) and techniques specific to each of the targeted behaviors, and how the interventions will address the ASD related symptoms and behaviors that are impairing the member's communication, social and/or behavioral functioning; and

      6. A description of training, participation, and progress of guardian(s)/caregiver(s) that directly support member's ITP goals; and

      7. Clinical justification for the number of days per week and hours per day of direct ABA services provided to the member and guardian(s)/caregiver(s) ,and the hours per week of each modality (e.g., face-to-face supervision, intensive group therapy) of the treatment being delivered and observation of the child in their natural setting.

Note: Required documentation includes specific services with the number of units/hours requested per specified period of time including authorization date range, CPT codes and units requested; and

8. Measurable discharge and/or transition goals.

III. Continuation of ABA-based therapy may be considered **medically necessary** when there has been functional and measurable progress in the ITP goals, demonstrated when all the following criteria (A. - D.) are met:

A. The member has been diagnosed with Autism Spectrum Disorder (ASD) by a qualified treating health care professional, as defined by state law (see Policy Guidelines); and

B. The member continues to meet all the Criteria II.B. above; and

C. Progress toward each of the defined goals is documented including all of the following criteria (1. – 5.):

1. Skill acquisition, behavior reduction, and caregiver goals are documented using data collected during treatment sessions and/or assessments (including criterion referenced assessments); and
2. Documentation that clinically significant improvements are maintained both during treatment sessions and outside the treatment setting; and
3. The same measurement tool that was used for baseline assessments is used to describe the current progress on treatment goals; and
4. Objective measurements of the treatment goals occur at a minimum of every six months; and
5. Standardized assessments of the treatment goals occur annually; and

D. There is documentation that the current targeted behaviors and ASD related symptoms require the recommended intensity of ABA therapy and cannot be managed in a less intensive level of care.

Not Medically Necessary

IV. An Applied Behavior Analysis (ABA)-based therapy initial assessment is considered **not medically necessary** when Criterion I is not met.

V. Initial or continued ABA-based therapy for all indications is considered **not medically necessary** when Criterion II is not met including but not limited to when ABA based therapy is used for educational, vocational or custodial purposes.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

POLICY GUIDELINES

APPLICABLE BENEFITS

This policy applies to member contracts with applicable benefits subject to the following:

- Washington's Mental Health Parity Act (RCW 48.44); or

- Oregon's Mental Health Parity Act (ORS 743.168) effective August 8, 2014; or
- Idaho's Clarification Regarding Coverage of Treatments for Autism Spectrum Disorder (Bulletin No. 18-02), or
- Utah's Autism Services Amendment, SB 57 (UCA 31A-22-642) effective 2016.

QUALIFIED TREATING HEALTHCARE PROFESSIONAL

Certified Providers

Treating providers who are certified to provide ABA therapy include a qualified Lead Behavior Analysis Therapist (LBAT), and in Idaho, a credentialed provider with a Board-Certified Behavioral Analysis (BCBA) certification issued by the Behavioral Analyst Certification Board.

Provider Types and Supervision Requirements

Board Certified Behavior Analysts (BCBAs) and Board Certified Behavior Analysts – Doctoral (BCBA-Ds) are considered independently qualified providers and may oversee all aspects of assessment, treatment planning, and supervision of support staff in accordance with BACB guidelines.

Board Certified Assistant Behavior Analysts (BCaBAs) must work under the supervision of a BCBA or BCBA-D. BCaBAs may assist with service delivery and program development as permitted by their scope of practice, but they may not practice independently.

Behavior Analysts in Training, defined as individuals enrolled in an accredited graduate program in behavior analysis completing coursework and supervised fieldwork toward certification, must be under the supervision of a BCBA or BCBA-D. Their scope of practice is limited to tasks delegated to them as part of their training and supervision requirements.

Registered Behavior Technicians (RBTs) are direct service providers who must be under the ongoing supervision of a BCBA, BCBA-D, or qualified supervisor. These individuals implement treatment protocols but do not design programs or perform independent assessments.

All supervision must be conducted in accordance with the behavior analyst certification board's professional and ethical compliance code and current supervision standards.[1]

ASSESSMENTS

A standardized assessment is administered and scored in a consistent, pre-determined manner. Standardized assessments typically compare an individual's performance to a normative sample, allowing practitioners to understand how the individual's skills or behaviors compare to those of their same-age peers. These tools are often norm-referenced, reliable, and validated through large-scale research. Examples include but are not limited to the Social Responsiveness Scale, Second Edition (SRS-2), Vineland Adaptive Behavior Scales, Third Edition (Vineland-3), Adaptive Behavior Assessment System, Third Edition (ABAS-3), Social Skills Improvement System Rating Scales (SSIS), Behavior Rating Inventory of Executive Function, Second Edition (BRIEF-2), Pervasive Developmental Disorders Behavior Inventory (PDDBI).

Curriculum based or criterion referenced assessments evaluate a learner's performance against a specific set of skills or criteria, rather than comparing them to a normative sample.

Criterion referenced assessments are often tied to a curriculum or developmental sequence and are used to guide treatment planning and skill acquisition, rather than diagnosis or eligibility. These tools are not standardized in the traditional sense—there's no normative comparison group—but they are highly structured and often validated within the ABA field. Examples include but are not limited to Verbal Behavior Milestones Assessment and Placement Program (VB-Mapp), Promoting the Emergence of Advanced Knowledge (PEAK), Assessment of Basic Language and Learning Skills -Revised (ABLLS-R), Assessment of Functional Living Skills (AFLS), and Measure of Observable Task Analysis Steps (MOTAS). Evidence-Based Treatment.

Evidence-based treatment refers to interventions that are grounded in rigorous scientific research demonstrating their effectiveness in improving meaningful outcomes for individuals on the autism spectrum. These treatments are supported by multiple high-quality studies, conducted by independent researchers, using established research designs and are published in peer-reviewed journals. Evidence-based practices in ABA include but are not limited to Natural Environment Training (NET), Discrete Trial Training (DTT), Shaping, Chaining, Differential Reinforcement, Incidental Teaching, Pivotal Response Training (PRT), Direct Instruction, Referent-Based Instruction, Skills Based Training, and Relational Frame Theory (RFT).

REQUIRED DOCUMENTATION

The following information is required for review of ABA services:

Initiation

- Documentation of the following from the prescribing qualified treating healthcare professional (I.A. and I.B., above):
    - Diagnosis of Autism Spectrum Disorder (ASD)
    - Documentation that ASD is impairing the member's functioning such that the member is a safety risk and/or is unable to participate in age-appropriate activities
- Written recommendation, clinical order, or prescription for ABA services from the provider (Criteria I.C, above).
- Documentation of an individualized treatment plan (ITP) that supports Criteria II.B.1.-8. including but not limited to:
    - Requested treatment intensity (i.e., recommended hours of ABA services) with clinical justification based on individualized member needs (e.g., severity and frequency of problem behaviors, assessment scores in comparison to age-matched peers, the degree and impact of skill deficits across developmental domains, caregiver training needs, and other relevant clinical factors.) Note: Dosage recommendations must not be based solely on diagnosis, caregiver availability, or scheduling preferences. ABA treatment recommendations must be supported by ASD symptoms and functional need.
    - Clinical justification is required for the use of intensive group adaptive behavior treatment demonstrating why a group treatment format is necessary to address the member's identified deficits and why the requested frequency and duration are medically necessary.
    - Clinical justification is required for excessive hours (e.g., above recommended standards) of supervision, assessment, social skills, or parent training sessions.

    - Discharge goals must specify the functional skills or developmental milestones that, when achieved, will indicate the member has progressed sufficiently to no longer require the current intensity of services. Note: These goals reflect individualized, meaningful progress—not timelines or generalized benchmarks—and clearly define what successful transition or reduction in services will look like.
- Documentation of the member's most recent date of service with any previous ABA provider, if applicable.
- Documentation indicating of the reason for discharge from the prior provider, if applicable.
- Documentation of the specific services (including modality) with the number of units/hours requested per specified period (including authorization date range, CPT codes and units).

Continuation

The following documentation should be submitted within five business days prior to the end of a current authorization (and no more than 30 days prior to the end of the authorization period):

- Updated ITP with the information listed in Criteria III.A.- D., above.
- In any instance where treatment goals are not demonstrating progress, a clinical rationale should be provided explaining the lack of progress. This should include:
    - A brief analysis of potential barriers to progress, and
    - A specific plan for modification or intensification of treatment to support progress moving forward.

This information must be documented clearly in the treatment plan and submitted with all progress reports and authorization requests.

CROSS REFERENCES

None

BACKGROUND

AUTISM SPECTRUM DISORDER

Autism Spectrum Disorder (ASD) is a neurodevelopment disorder characterized by impaired social communication and interaction and atypical interests and behavioral patterns. ASD may be accompanied by other conditions, such as epilepsy and cognitive impairment.

Diagnostic criteria for ASD as defined by the DSM-5[2], are listed in Appendix 1.

BEHAVIORAL INTERVENTIONS FOR AUTISM SPECTRUM DISORDER

Numerous studies and evidence based national reviews continue to affirm that ABA-based interventions, particularly when delivered intensively and early in development, can lead to significant improvements in cognitive, communication, and adaptive functioning. Applied Behavioral Analysis remains the gold standard for behavioral intervention in ASD, endorsed by organizations such as the U.S. Surgeon General, the American Academy of Pediatrics, and the Behavior Analyst Certification Board (BACB).[3-8]

SUMMARY

Medically Necessary

Applied Behavior Analysis (ABA) is applied in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. This method of treatment is often used for Autism Spectrum Disorder (ASD). Individual states have mandated requirements for the assessment and treatment of ASD, which the policy criteria align with. Therefore, ABA initial assessment, initiation and continuation of treatment for ASD may be considered medically necessary when policy criteria are met.

Not Medically Necessary

When policy criteria are not met, ABA initial assessment, initiation and continuation of treatment for ASD is considered not medically necessary.

REFERENCES

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2. American Psychiatric Association (2013): Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Arlington VA: American Psychiatric Press.
3. Behavior Analyst Certification Board. Applied Behavior Analysis treatment of autism spectrum disorder: Practice guidelines for healthcare funders and managers (2nd ed.). . [cited 05/04/2026]. 'Available from:' https://www.bacb.com/wp-content/uploads/2020/05/ABA_Guidelines_for_ASD.pdf.
4. National Clearinghouse on Autism Evidence and Practice (NCAEP). Evidence-based practices for children, youth, and young adults with autism: 2020 report. Frank Porter Graham Child Development Institute, University of North Carolina. [cited 05/04/2026]. 'Available from:' https://ncaep.fpg.unc.edu/.
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9. ABA Coding Coalition. Supplemental guidance on interpreting and applying the 2019 CPT codes for adaptive behavior services. Published January 9, 2019. [cited 06/02/2026]. 'Available from:' https://abacodes.org/supplemental-guidance-resource/.

CODES

NOTES:

- Providers are expected to bill using the appropriate CPT codes, including modifiers.
- Code 0373T may not be billed concurrently with 97153 or 97155. Activities typically reported under these codes are considered part of the 0373T service and are not separately reimbursable.[9]

Codes	Number	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 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	None	

APPENDIX 1

Diagnostic and Statistical Manual of Mental Disorders, *5th Edition* *(DSM-5)*

Autism Spectrum Disorder, 299.00 (F84.0)

Diagnostic Criteria

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:

Severity is based on social communication impairments and restricted repetitive patterns of behavior (see Table 1).

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

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Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table 1).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:

With or without accompanying intellectual impairment

With or without accompanying language impairment

Associated with a known medical or genetic condition or environmental factor

Table 1. Severity levels for autism spectrum disorder

Severity level	Social communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communizations skills cause severe impairment sin functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences,	Inflexibility of behavior, difficulty coping with change or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in

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	whose interaction is limited to narrow special interests, and who has markedly odd nonverbal communication.	a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 “Requiring support”	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with other fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

Date of Origin: *January 2012*