Molina Clinical Policy
Applied Behavioral Analysis for Autism Spectrum Disorder
Policy No. 482

Last Approval: 06/10/2026
Next Review Due By: June 2027

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Autism Spectrum Disorder (ASD) is a neurodevelopmental condition with persistent deficits in social communication and social interaction across multiple domains, in addition to restricted, repetitive patterns of behaviors and interests. The term spectrum underscores the concept that each individual may be affected in certain aspects to varying degrees. ASD is a chronic condition, and management requires a comprehensive, multidisciplinary approach that focuses on the individual's condition and needs. Diagnostic criteria are based on the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5).

Evidence supports that early behavioral and educational interventions addressing specific skills and symptoms can lead to better outcomes in individuals with ASD. **Applied Behavior Analysis (ABA)** is an evidence-based behavioral health intervention that applies principles of learning and behavior to develop, maintain, or restore socially significant functioning. For individuals with ASD, ABA addresses impairments in adaptive, communication, social, cognitive, behavioral, safety, and community participation domains (Hale 2025; Hyman et al. 2020).

Some alternatives to ABA include pharmacotherapy, cognitive behavioral therapy, social skills training, therapeutic services (e.g., occupational therapy, speech therapy), positive behavior support, and mental health support.

COVERAGE POLICY

Initiation Criteria of Applied Behavior Analysis (ABA) Treatment

Initiation of Applied Behavior Analysis (ABA) may be **considered medically necessary** in Members with Autism Spectrum Disorder (ASD) when ALL the following are met:

1. A comprehensive assessment is conducted, and a valid diagnosis of Autism Spectrum Disorder (ASD) is rendered that includes ALL the following components:
   a. ASD initiation age is 18 months or older
   b. Documentation from the Member's primary care physician noting initial developmental concerns, screenings, referrals, and treatments provided
   c. Diagnosis established in accordance with DSM-5 or DSM-5-TR criteria, including persistent deficits in social communication and social interaction deficits exhibited across multiple contexts**,** along with repetitive or restrictive behavior, including differentiation from Social Communication Disorder
   d. Diagnosis is determined by a multidisciplinary team with expertise in diagnosing ASD utilizing at least ONE clinically validated tool (e.g. Autism Diagnostic Interview-Revised [ADI-R], Autism Diagnostic Observation Schedule [ADOS-2], Childhood Autism Rating Scale [CARS-2], or Diagnostic Interview for Social and Communication Disorders [DISCO])
      Note: In general, clinical evaluation, testing, direct observation, and collateral information are often needed before deriving an ASD diagnosis. Screening instruments, when used, support referral and clinical context but do not independently establish an Autism Spectrum diagnosis or medical necessity for Applied Behavioral Analysis (ABA) services.
   e. Diagnostic evaluations and functional assessments are conducted by a qualified provider or

multidisciplinary team with ASD expertise (e.g., clinical psychologists, developmental pediatrician, pediatric neurologist, psychiatrist, or other licensed clinicians permitted under applicable state law to diagnose ASD)

f. Diagnosis is informed by direct clinical observation across settings and interactions with supporting documentation
g. Diagnosis is supported by thorough and comprehensive clinical documentation of ALL the following:
    i. Documentation includes adaptive and functional assessments (e.g., Vineland Adaptive Behavior Scales [VABS], Adaptive Behavior Assessment System [ABAS]) to establish baseline status, as this aids in ascertaining appropriate therapies
    ii. If a standardized diagnostic assessment is **more than 24 months old,** updated documentation must describe current ASD symptoms and functional impact
    iii. Reasonable efforts toward collaboration with Member receiving treatment, the parent or guardians, and other care teams
h. A comprehensive assessment identifying relevant comorbid medical, psychiatric, developmental, or behavioral conditions, with associated evaluations when needed to understand functional impairment, safety, treatment priorities, or care coordination
    Note: The presence or absence of comorbidities does not independently determine medical necessity for ABA services

2. Severity is demonstrated by the extent to which core ASD symptoms and associated behaviors interfere with daily functioning, independence, safety, and participation across applicable domains. Established by at least ONE of the following:
    a. Serious deterioration in interpersonal interactions (e.g., impulsive or abusive behaviors)
    b. Significant withdrawal and avoidance of almost all social interaction
    c. Consistent failure to achieve self-care as appropriate to age or developmental level
    d. Inability to perform adequately in school (including specialized settings) due to disruptive or aggressive behavior, with supporting school documentation (e.g., Individualized Education Program [IEP], Behavior Intervention Plan) when applicable
    e. Severely diminished ability to assess consequences of own actions (e.g., acts of severe property damage)
    f. Other evidence of serious dysfunction as documented by clinical assessment

3. ABA intervention is considered the clinically appropriate and medically necessary treatment as evidence by ALL the following:
    a. ABA treatment plan is based on an established ASD diagnosis rendered by a qualified provider or multidisciplinary team, as ABA services and treatment plans do not substitute for a diagnostic evaluation
    b. ABA must represent the **least intensive, most effective behavioral intervention** capable of addressing identified functional impairments
    c. Less intensive interventions or alternative therapies are insufficient to treat identified functional impairments, with rationale documented in medical record
    d. ABA is expected to provide *significant* improvement in at least ONE of the following identified functional impairment areas that interfere with daily living:
        i. Functional communication
        ii. Adaptive behavior
        iii. Social interaction
        iv. Safety-related behaviors
    e. Member is not at imminent risk for requiring acute or crisis-level care
    f. Structured parent or caregiver participation is documented

4. A Focused or Comprehensive ABA individualized treatment plan is developed and includes ALL the following:
    a. Behavioral assessment and treatment plan developed by a Board-Certified Behavior Analyst (BCBA) or BCBA-Doctoral (BCBA-D), consistent with Behavior Analyst Certification Board (BACB) standards. BCBA or BCBA-D provides direct and consistent supervision to Board-Certified Assistant Behavior Analyst (BCaBA) or Registered Behavior Technicians (RBTs) or another appropriately certified behavior technician as allowed by state mandate
    b. The provider attests the requested service model (hours, staffing, setting) is feasible and will be implemented as authorized, or identified constraints are documented with a proposed phased implementation plan

c. Clearly defined measurable goals and objectives are designed to target identified functional deficits, with progress tracked using clinically appropriate tools (e.g., Verbal Behavior Milestones and Assessment Placement Program [VB-MAPP])
d. Management and assessment of Member's social and care settings is employed to minimize triggers and maximize rate of progress
e. Objective measurements of target goals, including but not limited to, collection, quantification, and analysis of data and observations
f. Treatment goals are appropriate and reasonable given the Member's age and level of functioning with measurable defined outcomes
g. Treatment goals are directly related to the Member's ASD diagnosis and associated functional deficits/symptoms
h. Interventions are designed to target specific identified functional impairments related to the Member's ASD and are not intended to primarily address academic instruction or replace services required under an IEP
i. Interventions are not intended to substitute educational or academic instruction or for needs better addressed through occupational therapy, physical therapy, or speech-language services
j. Treatment intensity is chosen using a validated measurement tool (e.g., The Autism Treatment Evaluation Checklist [ATEC], Social Skills Improvement System [SSIS], VB-MAPP)
k. Treatment plan includes expected participation of the Member's parent/caregiver, if applicable. When caregiver participation is limited by documented barriers, the treatment plan must include documented alternative strategies to support skill generalization and maintenance of progress outside of therapy sessions
l. Regular assessment intervals are identified to track progress and occur AT LEAST every 6 months
m. Documentation supports individualized treatment intensity (i.e., number of hours per week) and duration (i.e., length of service intervention) based on clinical need and response to treatment
n. Documented description of service modalities and settings (e.g. home, clinic, community) consistent with the authorized treatment plan and supervision model

5. **For high intensity services**: If proposed treatment intensity exceeds **25 direct hours per week,** ALL the following must be met:
   a. Documentation of functional impairment as evidenced by ONE of the following:
      i. Significant deficits across multiple domains
      ii. Persistent and challenging behaviors that threaten Member's safety and significantly interfere with progress
   b. Documentation addresses the necessity for requested intensity to treat specific functional impairments
   c. Documentation outlines a defined treatment period for the intense services including a defined timeframe for reassessment and planned tapering
   d. Ongoing review of relevant comorbid conditions and their impact on functional impairment inform decisions regarding continuation, modification, reductions, or transition of ABA services
   e. Reassessments of high intensity services occur AT LEAST every 6 months

Continuation Criteria of Applied Behavior Analysis (ABA) Treatment

Continuation of ABA may be **considered medically necessary** when ALL the following are met:

1. Documentation demonstrating treatment goals established in initial plan of care have not yet been met, with evidence of ONE of the following:
   a. Frequent and continued reassessment of treatment goals based on quantifiable metrics, and measurable progress toward initial goals that can be attributed to ABA intervention (not age alone) has been demonstrated
   b. A demonstrated risk of deterioration without continued services

2. Documentation supports continued needs for ABA services to address one of more ASD-related functional domains (i.e., aggression, ADLs, instrumental activities of daily living, social communication or language deficits, restrictive or repetitive behaviors)

3. Documentation of ongoing primary care physician care coordination, well child visits, and appropriate follow up

4. Severity and functional impairment are reassessed to determine whether continuation, modification, reduction, or transition to a less intensive service is clinically appropriate. Reassessment findings are documented and reflected in an updated ABA treatment plan

5. Reassessments occur AT LEAST every 6 months

6. Reassessment and functional progress are documented with accompanying ABA treatment plan update demonstrating updated goals and plan to address outstanding treatment needs

7. Member is actively participating in treatment and demonstrates meaningful improvements outside of treatment (e.g., in the home, community, school)

8. Any areas demonstrating inadequate progress toward goals have been assessed for barriers and adequately modified, including but not limited to:
   a. Co-occurring psychiatric disorders and Member has been evaluated for potential modifications in environmental triggers, medication, and/or behavioral plans
   b. Family and provider scheduling conflicts
   c. Co-occurring medical complications that may affect and aggravate ASD symptoms

9. Documentation demonstrates ongoing parent and/or caregiver training with clinically appropriate supervision by a qualified behavioral analyst, consistent with the authorized treatment plan

10. Treatment intensity and service model (e.g., focused or comprehensive ABA) remain individualized based on clinical need, severity of functional impairment, response to treatment, and the Member's ability to tolerate services, and are adjusted as clinically indicated

11. **For high intensity services**: If proposed treatment intensity **exceeds 25 direct hours per week**, ALL the following must be met:
    a. Documentation of continued functional impairment as evidenced by ONE of the following:
       i. Significant deficits across multiple domains
       ii. Persistent and challenging behaviors that threaten Member's safety and significantly interfere with progress
    b. Documentation addresses why the requested intensity is necessary to treat specific functional impairments
    c. Documentation addresses why goals cannot be met with fewer hours or alternative models
    d. Documentation outlines a defined treatment period for the intense services including a defined timeframe for reassessment of AT LEAST every 6 months and planned tapering
    e. Ongoing review of comorbid conditions and their impact on functional impairment may inform decisions regarding continuation, modification, reduction, or transition of ABA services

Telehealth Delivery of ABA Services

Telehealth may be used as a modality for the delivery of select components of ABA services when ALL the following criteria are met:

1. Telehealth is limited to caregiver training, coaching and supervision, or other indirect service components

2. Documentation of ALL the following:
   a. Telehealth used in conjunction with in-person ABA services as part of a clinically justified hybrid service model documented in the authorized ABA treatment plan
   b. How telehealth supports individualized treatment plans and goals
   c. Demonstration that telehealth use facilitates skill generalization, caregiver competency, treatment fidelity, or continuity of care
   d. Member's behaviors, safety risk, and clinical needs do not require in-person observation and intervention during the telehealth component
   e. Member's symptoms, behaviors, safety risks, and clinical needs can be adequately assessed, monitored, and managed through remote service delivery

f. Appropriate clinical oversight and supervision are maintained
g. Telehealth is selected based on clinical need and treatment design and not used solely for convenience, access, geographic distance, or provider preference

ABA Treatment Staff Delivered Services

ABA services may be delivered by ABA treatment staff when ALL the following criteria are met and documented:

1. ABA treatment staff provide services only within the scope of an approved ABA treatment plan that clearly specifies treatment goals, prescribed interventions, and methods for data collection

2. Services are provided **under the direction and clinical oversight of a qualified behavior analyst**, who retains responsibility for assessment, treatment design, progress monitoring, clinical decision-making, and modification of the treatment plan

3. Documentation in the treatment plan demonstrating that services are conducted with a supervision approach sufficient to ensure treatment fidelity and safety

4. ABA treatment staff ONLY provide the following:
   a. Actively implement prescribed interventions as directed
   b. Collect, document, and report treatment data

5. ABA treatment staff do NOT independently assess, diagnose, or modify treatment

6. Use of ABA treatment staff delivered services is appropriate based on the Member's clinical needs, individualized treatment goals, severity of functional impairment, safety considerations, and ability to meaningfully benefit from the service delivery model

7. ABA treatment staff delivered services do not reduce or replace required direct involvement of the supervising behavioral analyst

Observational Activities Within ABA Treatment

Observational activities may ONLY occur as part of active ABA treatment when ALL the following criteria are met:

1. Observational activities are integrated into an authorized ABA treatment plan as part of supervised implementation, not as stand-alone services

2. Documentation demonstrates observational activities are clinically justified and support at least ONE of the following treatment purposes:
   a. Treatment fidelity
   b. Skill acquisition
   c. Generalization of skills
   d. Caregiver training
   e. Safety monitoring

3. Observational activities do NOT constitute a separate covered service and are not authorized independently of the authorized ABA treatment plan

Discharge and Tapering Criteria of Applied Behavior Analysis (ABA) Treatment

Discharge or tapering of ABA is appropriate when at least ONE of the following are met:

1. Treatment goals are achieved and sustained with demonstrated generalization of skills across relevant settings and caregivers

2. There is no meaningful progress toward treatment goals, and documentation indicates no significant risk of deterioration in functioning if ABA services are reduced or discontinued

3. Member is no longer demonstrating functional improvements or progress on standardized or clinically accepted measures of functioning, and there is no demonstrated significant risk of deterioration if services are discontinued

4. Member is unwilling or unable to participate in treatment for successive utilization periods, despite reasonable efforts to address identified barriers

5. Parent or caregivers' participation is insufficient to participate in treatment planning and delivery to the extent that compromises the effectiveness of care. The documented efforts to address barriers or implement alternative generalization strategies have been unsuccessful, such that continued ABA services are unlikely to be effective

Limitations and Exclusions

Applied Behavior Analysis (ABA) is considered **not medically necessary** for ANY of the following situations:

1. For all indications except diagnosed ASD including, but not limited to, Rett syndrome and Down syndrome in the absence of ASD

2. When requested to maximize developmental potential without documented impairment

3. **Exceptions to any of the criteria in this policy require Medical Director review**

DOCUMENTATION REQUIREMENTS: Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the Member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

Early identification of Autism Spectrum Disorder (ASD), ideally by age 3 years, is encouraged as the initiation of early intervention strategies are more effective long-term (Anixt et al. 2024). The diagnosis and treatment of ASD involve a robust multidisciplinary team. There are multiple therapeutic treatments and disciplines that can address issues associated with ASD (e.g., behavioral interventions, cognitive behavioral therapy, modeling, naturalistic teaching strategies, parent training, peer training). Applied behavioral analysis (ABA) is a commonly used intensive behavioral intervention to address behaviors associated with ASD that result in functional limitations. ABA encompasses different evidence-based interventions that are individually tailored to provide skills that an individual diagnosed with ASD is not learning on their own and to reduce behaviors that interfere with daily life (Steinbrenner et al. 2020). Evidence supports that ABA provides some benefit for individuals with ASD (Anixt et al 2025; Lotfizadeh et al. 2020; Reichow et al. 2018; Sandbank et al. 2023; Steinbrenner et al. 2020; Wong et al. 2015). ABA should be conducted in multiple settings that reflect the common settings of patient's life (e.g., home, school, work, outpatient facilities). There is minimal and low-quality evidence demonstrating positive findings that ABA conducted via telehealth is more beneficial than being waitlisted for in person therapy (Lindgren et al. 2021; Marino et al. 2020).

Comprehensive or focused treatment models are best started as early as possible, as implementation between the ages of 3 – 9 years helps build foundations skills. Comprehensive treatment models are comprised of ABA and naturalistic approaches and are characterized by a substantial number of hours per week, treatment occurring for a year or longer, and a focus on broad outcomes (Anixt et al 2025; Steinbrenner et al. 2020; Wong et al. 2015). There is a lack of evidence supporting discrete guidelines for intensity and duration, though emerging evidence suggests that moderate intensity (i.e., 10 – 20 hours a week) or individually tailored modular behavior approaches at 5-10 hours a week is non-inferior to high intensity (i.e., more than 20 hours a week) (Anderson et al., 2024; Lotfizadeh et al. 2020; Rogers et al. 2020; Samelson et al. 2026; Sandbank et al. 2024). Additionally, parental involvement with either training or education induces a positive effect on therapeutic outcomes (Anderson et al. 2024; Bearss et al. 2015).

National and Specialty Organizations

The **American Academy of Pediatrics** published the clinical report *Identification, Evaluation, and Management of Children with Autism Spectrum Disorder* (Hyman et al. 2020) that was reaffirmed in October 2025. The report supports the DSM-5 criteria in the diagnosis of ASD, even in younger children, and acknowledges the need for multiple additional tools/scales to assess severity, functionality, and co-morbidities. The AAP endorses early and repeats screenings of all children for ASD. The report endorses treatment models based on ABA principles as the most evidence-based approach to behavioral intervention and support early initiation in individuals diagnosed with ASD.

The **European Society of Child and Adolescent Psychiatry (ESCAP)** published the *ESCAP practice guidance for autism: A summary of evidence-based recommendations for diagnosis and treatment* (Fuentes et al. 2021) that endorses official diagnosis of ASD with the DSM-5 criteria. Pre-treatment assessment of functional limitations, severity of symptoms, and comorbidities is recommended for the creation of an individualized treatment plan. Intervention should be based on a functional analysis of behavior with the aim of therapy to ensure daily opportunities are used to facilitate progress and minimize difficulties instead of therapy based on a prescribed number of hours or sessions per day or week.

The **National Institute for Health and Care Excellence (NICE)** published the clinical guideline *Autism Spectrum Disorder in Adults: Diagnosis and Management* [CG142]. The clinical guideline recommends that factors and triggers for behaviors should be identified and managed, prior to initiating behavioral interventions. Functional analysis should be used to facilitate the planning of interventions to address behavioral issues. The choice of interventions should also include the nature and severity of the behavior, individual physical needs and capabilities, physical and social environment, the capacity of staff and support systems, and the preferences of the individual being treated.

The **National Institute for Health and Care Excellence (NICE)** published the clinical guideline *Autism Spectrum Disorder in Under 19s: Support and Management* [CG170] recommend assessing factors that may increase the risk of challenge behavior in assessments and care planning. A care plan should be developed with the individual with autism and their support system and should outline individualized steps needed to address behavior challenges, including treatment of comorbidities, support for care givers, and necessary adjustments, for example, by increasing structure and minimizing unpredictability. If behavior remains challenging despite attempts to address the underlying possible causes, undertake a multidisciplinary review and create a comprehensive behavioral care plan.

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology)

Code	Description
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
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.

HCPCS (Healthcare Common Procedure Coding System)

Code	Description
H0031	Mental health assessment, by nonphysician
H0032	Mental health service plan development by nonphysician

CODING DISCLAIMER: Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

04/08/2026 New policy. IRO peer reviewed on April 30, 2026, by a practicing physician board certified in Psychiatry Child & Adolescent.

REFERENCES

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Association; 2013
2. Anderson C, Hochheimer S, Warren Z, et al. Comparative effectiveness trial: Modular behavior approach for young autistic children compared to comprehensive behavioral intervention. Autism Res. 2024 Nov;17(11):2430-2446. doi: 10.1002/aur.3240. Epub 2024 Oct 7. PMID: 39375937.
3. Anixt JS, Ehrhardt J, Duncan A. Evidence-Based Interventions in Autism. Pediatr Clin North Am. 2024 Apr;71(2):199-221. doi: 10.1016/j.pcl.2024.01.001. Epub 2024 Jan 30. PMID: 38423716; PMCID: PMC11788931.
4. Bearss K, Johnson C, Smith T, et al. Effect of parent training vs parent education on behavioral problems in children with autism spectrum disorder: a randomized clinical trial. JAMA. 2015 Apr 21;313(15):1524-33. doi: 10.1001/jama.2015.3150. Erratum in: JAMA. 2016 Jul 19;316(3):350. doi: 10.1001/jama.2016.9050. Erratum in: JAMA. 2016 Jul 19;316(3):350. doi: 10.1001/jama.2016.9558. PMID: 25898050; PMCID: PMC9078140.
5. Behavior Analyst Certification Board. 2026. Accessed April 30, 3036. https://www.bacb.com/
6. 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]. https://www.casproviders.org/asd-guidelines
7. Fuentes J, Hervás A, Howlin P; (ESCAP ASD Working Party). ESCAP practice guidance for autism: a summary of evidence-based recommendations for diagnosis and treatment. Eur Child Adolesc Psychiatry. 2021 Jun;30(6):961-984. doi: 10.1007/s00787-020-01587-4. Epub 2020 Jul 14. PMID: 32666205; PMCID: PMC8140956.
8. Hale LW. Autism spectrum disorder in children and adolescents: Overview of management and prognosis. Updated July 8, 2025. Accessed March 19, 2026. http://www.uptodate.com.
9. Hyman SL, Levy SE, Myers SM; COUNCIL ON CHILDREN WITH DISABILITIES, SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS. Identification, Evaluation, and Management of Children With Autism Spectrum Disorder. Pediatrics. 2020 Jan;145(1):e20193447. doi: 10.1542/peds.2019-3447. Epub 2019 Dec 16. PMID: 31843864.
10. Lindgren S, Wacker D, Schieltz K, et al. A Randomized Controlled Trial of Functional Communication Training via Telehealth for Young Children with Autism Spectrum Disorder. J Autism Dev Disord. 2020 Dec;50(12):4449-4462. doi: 10.1007/s10803-020-04451-1. PMID: 32300910; PMCID: PMC7572463.
11. Lotfizadeh AD, Kazemi E, Pompa-Craven P, Eldevik S. Moderate Effects of Low-Intensity Behavioral Intervention. Behav Modif. 2020 Jan;44(1):92-113. doi: 10.1177/0145445518796204. Epub 2018 Aug 23. PMID: 30136599.
12. Marino F, Chilà P, Failla C, et al. Tele-Assisted Behavioral Intervention for Families with Children with Autism Spectrum Disorders: A

Randomized Control Trial. Brain Sci. 2020 Sep 18;10(9):649. doi: 10.3390/brainsci10090649. PMID: 32961875; PMCID: PMC7563357.
13. National Institute for Health and Care Excellence. Autism Spectrum Disorder in Adults: Diagnosis and Management. Clinical guideline [CG142]. Published: 27 June 2012. Updated: 14 June 2021. Accessed March 20, 2026. https://www.nice.org.uk/guidance
14. National Institute for Health and Care Excellence. Autism spectrum disorder in under 19s: support and management. Clinical guideline [CG170]. Published: 28 August 2013. Updated: 14 June 2021. Accessed March 20, 2026. https://www.nice.org.uk/guidance
15. Reichow B, Hume K, Barton EE, Boyd BA. Early intensive behavioral intervention (EIBI) for young children with autism spectrum disorders (ASD). Cochrane Database Syst Rev. 2018 May 9;5(5):CD009260. doi: 10.1002/14651858.CD009260.pub3. PMID: 29742275; PMCID: PMC6494600.
16. Rogers SJ, Yoder P, et al. A Multisite Randomized Controlled Trial Comparing the Effects of Intervention Intensity and Intervention Style on Outcomes for Young Children With Autism. J Am Acad Child Adolesc Psychiatry. 2021 Jun;60(6):710-722. doi: 10.1016/j.jaac.2020.06.013. Epub 2020 Aug 24. PMID: 32853704; PMCID: PMC8057785.
17. Samelson D, Pfingston B, Sneed L. Dosage in Applied Behavior Analysis: Effect on Adaptive Behavior, Goal Attainment, and Dangerous Behavior. J Autism Dev Disord. 2026 Jan 9. doi: 10.1007/s10803-025-07203-1. Epub ahead of print. PMID: 41511730.
18. Sandbank M, Bottema-Beutel K, Crowley LaPoint S, et al. Autism intervention meta-analysis of early childhood studies (Project AIM): updated systematic review and secondary analysis. BMJ. 2023 Nov 14;383:e076733. doi: 10.1136/bmj-2023-076733. PMID: 37963634; PMCID: PMC10644209.
19. Sandbank M, Pustejovsky JE, Bottema-Beutel K, Caldwell N, Feldman JI, Crowley LaPoint S, Woynaroski T. Determining Associations Between Intervention Amount and Outcomes for Young Autistic Children: A Meta-Analysis. JAMA Pediatr. 2024 Aug 1;178(8):763-773. doi: 10.1001/jamapediatrics.2024.1832. PMID: 38913359; PMCID: PMC11197026.
20. Steinbrenner JR, Hume K, Odom SL, et al. Evidence-based practices for children, youth, and young adults with Autism, 2020, The University of North Carolina at Chapel Hill, Frank Porter Graham Child Development Institute, National Clearinghouse on Autism Evidence and Practice Review Team, Chapel Hill; NC. https://files.eric.ed.gov/fulltext/ED609029.pdf
21. Wong C, Odom SL, Hume KA, et al. Evidence-Based Practices for Children, Youth, and Young Adults with Autism Spectrum Disorder: A Comprehensive Review. J Autism Dev Disord. 2015 Jul;45(7):1951-66. doi: 10.1007/s10803-014-2351-z. PMID: 25578338.

APPENDIX

Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*

Initiation Criteria of Applied Behavior Analysis (ABA) Treatment

1. A comprehensive assessment is conducted, and a valid diagnosis of Autism Spectrum Disorder (ASD) is rendered that includes ALL the following components:

   b. Documentation from the Member's primary care physician noting initial developmental concerns, screenings, referrals, and treatments provided

SC ASD policy permits families to self-refer for a diagnostic evaluation with no PCP input and then the family can self-refer for ABA services: "Referral Process; An eligible Medicaid member self-refers to an ASD network LIP or physician for a comprehensive diagnostic assessment to establish an ASD diagnosis and medical necessity." (South Carolina Department of Health and Human Services; Autism Spectrum Disorder Services Provider Manual; Section 6, Reporting and Documentation)

   e. Diagnostic evaluations and functional assessments are conducted by a qualified provider or multidisciplinary team with ASD expertise (e.g., clinical psychologists, developmental pediatrician, pediatric neurologist, psychiatrist, or other licensed clinicians permitted under applicable state law to diagnose (ASD)

*SC ASD policy permits licensed PCPs and licensed Pediatricians to perform diagnostic/functional assessments: "Comprehensive Diagnostic Assessment for ASD: For members to be authorized for ASD services, **the assessment must be administered directly by a licensed physician (MD/DO)**, licensed psychologist (PhD/PsyD), or LPES." (South Carolina Department of Health and Human Services; Autism Spectrum Disorder Services Provider Manual; Section 8, Benefit Criteria and Limitations)*

   g. Diagnosis is supported by thorough and comprehensive clinical documentation of ALL the following:
      i. Documentation includes adaptive and functional assessments (e.g., Vineland Adaptive Behavior Scales [VABS], Adaptive Behavior Assessment System [ABAS]) to establish baseline status, as this aids in ascertaining appropriate therapies

SC ASD policy does NOT require adaptive and functional assessments to diagnosis (ASD). SC ASD policy does not require VABS or ABAS to diagnosis ASD. (South Carolina Department of Health and Human Services; Autism Spectrum Disorder Services Provider Manual; Section 8, Benefit Criteria and Limitations)

4. A Focused or Comprehensive ABA individualized treatment plan is developed and includes ALL the following:

   a. Behavioral assessment and treatment plan developed by a Board-Certified Behavior Analyst (BCBA) or BCBA-Doctoral (BCBA-D), consistent with Behavior Analyst Certification Board (BACB) standards. BCBA or BCBA-D provides direct and consistent supervision to Board-Certified Assistant Behavior Analyst (BCaBA) or Registered Behavior Technicians (RBTs) or another appropriately certified behavior technician as allowed by state mandate

SC ASD policy permits a BCaBA to develop the individualized plan of care (IPOC-tx plan). (South Carolina Department of Health and Human Services; Autism Spectrum Disorder Services Provider Manual; Section 3, Eligible Providers)

   c. Clearly defined measurable goals and objectives are designed to target identified functional deficits, with progress tracked using clinically appropriate tools (e.g., Verbal Behavior Milestones and Assessment Placement Program [VB-MAPP])

SC ASD policy requires at least two of the following skills or functional assessments:(selected based on member's developmental age and cognitive abilities) must be included: Behavior Identification Assessment (BIA; 97151)

- *Promoting the Emergence of Advanced Knowledge (PEAK)*
- *Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) – **MUST include the Barriers Assessment AND the Transitions Assessment***
- *Assessment of Basic Language and Learning Skills- Revised (ABLLS-R)*
- *Social Responsiveness Scale (SRS)*
- *Assessment of Functional Living Skills (AFLS)*
- *Essentials for Living (EFL)*
- *Early Start Denver Model*
- *PEAK Autism Symptoms and Behavioral Observation Summary (PAS-BOS)*

(South Carolina Department of Health and Human Services; Autism Spectrum Disorder Services Provider Manual; Section 8, Benefit Criteria and Limitations)

5. **For high intensity services**: If proposed treatment intensity exceeds **25 direct hours per week,** ALL the following must be met:

*SC ASD policy requires full functional behavior assessment **after 15 hours**: Direct Treatment Adaptive Behavior Treatment by Protocol (97153); Administered by a BCBA-D, BCBA, BCaBA, or a technician face-to-face with one member under the direction of a BCBA-D, BCBA or BCaBA, utilizing a behavioral intervention protocol designed in advance by the enrolled BCBA-D, BCBA or BCaBA responsible for the duration of the member's treatment during the prior authorization period. "Treatment protocols must be designed to clearly address specific individualized goals from the IPOC and be tailored to a specific setting. A functional behavior assessment is required, and maladaptive/problematic behaviors must be prioritized **if treatment is planned for greater than 15 hours per week** of 97153, or if any maladaptive behaviors are addressed, or if treatment by 97153 is planned to be delivered in a school service location. (South Carolina Department of Health and Human Services; Autism Spectrum Disorder Services Provider Manual; Section 8, Benefit Criteria and Limitations)*

Telehealth Delivery of ABA Services

Telehealth may be used as a modality for the delivery of select components of ABA services when ALL the following criteria are met:

Telehealth services must meet all the requirements as defined in the South Carolina Department of Health and Human Services; Autism Spectrum Disorder Services Provider Manual July 1, 2026.

1. Telehealth is limited to caregiver training, coaching and supervision, or other indirect service components

*SC ASD policy does NOT cover/pay for **"coaching"** (97156) must be used to target treatment goal, and train to generalization: "Individualized Plan of Care (IPOC); parent/caregiver participation is required and is designated through specific parent/caregiver goals that must be addressed during the delivery of family adaptive behavior treatment guidance (97156), and follow an evidence-based parent treatment curriculum. **Generalized caregiver coaching services are not reimbursable**; however safety care training for families in a 1:1 setting are authorized when tied to*

IPOC goals related to address severe maladaptive behaviors."(South Carolina Department of Health and Human Services; Autism Spectrum Disorder Services Provider Manual; Section 6, Reporting and Documentation)

SC ASD policy does NOT permit ABA providers to be reimbursed for indirect RBT ***"supervision"*** *by billing (97155). (97155) is not routinely allowed, and it must be requested during prior authorization, and maxed out at 25% of hours rendered. It can ONLY be billed for time the BCBA spent in the room with the member: "Adaptive Behavior Treatment with Protocol Modification (97155); 97155 is intended to be delivered in person, directly to the patient. This code will not be reimbursed through telehealth on a routine basis. Up to 25% of the authorized and rendered 97155 units may be approved for use with a GT modifier on a case by case basis; provided that the GT modifier is requested during the prior authorization process for a member who will only be receiving in-home ABA services in a rural location with limited access to ABA treatment. Post-payment review must indicate an "In-Person to Telehealth delivery ratio" of no more than 3:1.Post-payment review will also be conducted to verify that 97155 service units have not been used to document professional BACB supervision requirements, asynchronous telehealth services, or direct case supervision that does not explicitly meet the requirements for adaptive behavior with protocol modification." (South Carolina Department of Health and Human Services; Autism Spectrum Disorder Services Provider Manual; Section 8, Benefit Criteria and Limitation)*

Telehealth services must meet all the requirements as defined in the South Carolina Department of Health and Human Services; Autism Spectrum Disorder Services Provider Manual July 1, 2026.

Limitations and Exclusions

Applied Behavior Analysis (ABA) is considered **not medically necessary** for ANY of the following situations:

1. For all indications except diagnosed ASD including, but not limited to, Rett syndrome and Down syndrome in the absence of ASD
2. When requested to maximize developmental potential without documented impairment
3. **Exceptions to any of the criteria in this policy require Medical Director review**

SC ASD policy has an extensive listing of exclusions (non-covered services). Please refer to *(South Carolina Department of Health and Human Services; Autism Spectrum Disorder Services Provider Manual; Section 4, Covered Services and Definitions)*