Coverage Policy

Effective Date	**5/15/2026**
Next Review Date	**12/15/2026**
Coverage Policy Number	**EN0499**

Intensive Behavioral Interventions

Table of Contents

Overview 1
Coverage Policy 2
Coding Information 9
General Background 10
Health Equity Considerations 22
References 23
Revision Details 26

Related Coverage Resources

Autism Spectrum Disorders/Pervasive Developmental Disorders: Assessment and Treatment

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines.

Overview

This Coverage Policy addresses intensive behavioral interventions (e.g., adaptive behavior treatment, applied behavior analysis). Intensive behavior intervention (IBI) is the intensive application of the science of applied behavior analysis (ABA). Adaptive behavior treatment is a component of ABA therapy.

Coverage Policy

Some states mandate coverage of intensive behavioral interventions and/or treatment of autism spectrum disorders (ASD) for benefit plans regulated under state law. For example, New York law requires regulated benefit plans to provide coverage for the screening, diagnosis and treatment of ASD, including applied behavioral analysis. Virginia fully insured business is not subject to this coverage policy.

Please refer to the applicable benefit plan document to determine terms, conditions and limitations of coverage.

Applied Behavior Analysis (ABA) is the science in which tactics derived from the principles of behavior are applied systematically to improve socially significant behavior and experimentation is used to identify the variables responsible for behavior change (Cooper, et al., 2020).

For interventions to meet the established practice guidelines, standards of care, and definitions of ABA, the following components should be evident and well documented throughout assessment and treatment:

- **Comprehensive assessments that describe specific levels of skills and behavior(s) at baseline and informs the subsequent establishment of meaningful treatment goals.**
- **Collection and analysis of qualitative information and quantitative data on skill development and behavior reduction targets throughout intervention to facilitate progress toward established treatment goals and support development of areas for continued and future focus.**
- **Case supervision performed by a Board Certified Behavior Analyst® (BCBA®), Licensed Behavior Analyst (LBA), or a mental health professional who is licensed to practice independently and who has documented training in ABA, to best ensure treatment protocols are delivered with integrity and as designed, and treatment decisions are informed by data collection, collaboration with the person receiving treatment and key stakeholders, and are conceptually systematic with the principles and practices of ABA.**
- **Coordination and collaboration with the person receiving treatment, as well as key stakeholders such as guardians, caretakers, and any other impacted/invested medical and mental health providers, and with government mandated/school services.**
- **Consideration of cultural factors that may impact treatment.**
- **Review of relevant biopsychosocial history such as co-morbid conditions, vision and hearing evaluations, current medications, etc.**
- **Ongoing analysis and data-informed decision-making in establishing and adjusting the plan of care based on progress and potential barriers.**
- **Stakeholder (e.g., parent/caregiver, relative, teacher, and/or other impacted/invested party) training and collaboration to support progress, generalization, and maintenance.**
- **A clear plan to ensure generalization and maintenance of acquired skills.**
- **Clearly defined, measurable, individualized, and realistic transition plan that includes a plan for fading services from all settings and environments in which treatment is being or will be provided.**
- **Establishment of individualized discharge criteria that are clearly defined, measurable, realistic, and are directly related to the symptoms of ASD and their effects as defined by the DSM-5-TR indicating the point at which services are appropriate for discontinuation and/or transfer to alternative or less intrusive levels of care (CASP, 2024).**

<u>Criteria for Assessment to receive Applied Behavior Analysis (ABA) services</u>

An assessment for ABA is considered medically necessary when ALL the following criteria are met:

Diagnosis

- The individual has a confirmed diagnosis of autism spectrum disorder (ASD); (ICD-10-CM Diagnosis Codes F84.0 – F84.9, with the exception of F84.2, Rett syndrome) based on the criteria in the Diagnostic

and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) by a healthcare professional who is licensed to practice independently and whose licensure board considers diagnostics to be within their scope of practice and ALL of the following must be provided:

- The name, credentials, and type of licensure of the individual who made the diagnosis
- The date on which the diagnosis was most recently made

Assessment

- The assessment will be performed by a Board Certified Behavior Analyst® (BCBA®), Licensed Behavior Analyst (LBA), or a mental health clinician who is licensed to practice independently and who has documented training in ABA.

- The full and comprehensive ABA assessment will include ALL the following:

  - Administration of a reliable, valid, and standardized assessment instrument that measures the individual's functioning in the domains included in the diagnostic criteria for ASD in the DSM-5-TR as applicable to the individual and their individualized treatment plan/plan of care: social communication and social interaction; and restricted, repetitive patterns of behavior, interests, or activities.
  - ALL the following must apply in relation to the assessment instrument:

    - must be completed in its entirety and as designed
    - the reliability and validity have been established for use with members of the population tested (e.g., age, language preference, etc.)
    - completed by an individual who has been trained to administer the assessment tool and interpret the results
    - the instrument used represents the most current version, and does not represent obsolete editions of the assessment (e.g., must be the Vineland-3 vs. Vineland-II)
    - the instrument used assesses the individual's specific and current abilities and skills
    - must include the date of administration, name of the respondent and/or participant in the assessment, and the form type when applicable

<u>Criteria for Initiation of Treatment with Applied Behavior Analysis (ABA)</u>

ABA is considered medically necessary when ALL the following criteria are met:

Diagnosis

- The individual has a confirmed diagnosis of autism spectrum disorder (ASD); (ICD-10-CM Diagnosis Codes F84.0 – F84.9, with the exception of F84.2, Rett syndrome) based on the criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) by a healthcare professional who is licensed to practice independently and whose licensure board considers diagnostics to be within their scope of practice and ALL of the following must be provided:

  - The name, credentials, and type of licensure of the person who made the diagnosis
  - The date on which the diagnosis was most recently made

Assessment

- A full and comprehensive ABA assessment, performed by a BCBA®, LBA, or a mental health clinician who is licensed to practice independently and who has documented training in ABA, must have been completed that includes all the criteria from the Assessment for ABA section above regarding the specifications of the assessment tool, as well as ALL the following criteria:

  - Standardized scores and score tables, and/or scoring grids/figures must be provided, when applicable.

- Administration of the assessment instrument has been completed within 60 days prior to the start of treatment.
- The results of the reliable, valid, and standardized assessment instrument utilized indicates deficits in areas measuring the domains included in the diagnostic criteria for ASD as defined by the DSM-5-TR: social communication and social interaction; and restricted, repetitive patterns of behavior, interests, or activities.
- Areas of deficit identified using the assessment tool correspond with the content of the skill development and behavior reduction goal(s)/objective(s) included within the submitted treatment plan/plan of care.

- In the event the reliable, valid, and standardized assessment was completed by a professional other than the requesting provider BOTH of the following criteria are met:

  - There is clear and documented evidence of collaboration and coordination with the administering professional by the requesting provider.
  - There is documentation that the assessment results accurately reflect the individual's current functioning and correspond with the requesting provider's direct observation of the individual.

Treatment Plan/Plan of Care

- An individualized treatment plan/plan of care has been developed and provided that includes ALL the following:

Goals/Objectives:

- Clearly defined and measurable goals designed to target specific behaviors and skills across all settings and environments where treatment will occur (e.g., home, clinic, school, community setting, etc.) as identified by ALL the following:

  - specifically indicates the target behaviors and expectations included for measurement within the treatment goal.
  - identifies the method by which progress will be measured.
  - operationally defines the behavioral expectation of the individual and degree of independence necessary for mastery of the goal/objective.

- Treatment goals have been identified and individualized for intervention based on the details and results gathered through the full and comprehensive ABA Assessment (as noted in the sections above) and the individual's current level of functioning.

- Treatment goals are developmentally appropriate given the individual's age, assessment results, and level of functioning.

- Treatment goals are directly related to the individual's diagnosis of ASD and the symptoms of ASD defined by the DSM-5-TR (e.g., social communication and social interaction; restricted, repetitive patterns of behavior, interest, or activities).

Data and Reporting:

- Quantitative baseline data have been obtained and provided, with dates reported from when the data were collected, for all behaviors and skills identified for intervention across all settings and environments in which treatment will occur.

- Quantitative baseline data have been collected within 60 days prior to the start of treatment, with dates reported from when the data were collected.

- When service initiation has occurred greater than 60 days prior to the date the authorization request is received, quantitative baseline, interim, and current data have been obtained and provided, to

include baseline data collected and provided within 60 days prior to the start of treatment, and interim, and current data (as applicable) collected and provided within no more than 60 days prior to the date the authorization request is received, with dates reported from when the data were collected, for all behaviors and skills identified for intervention across all settings and environments in which treatment will/has occurred.

- When treatment is delivered, and/or is planned to be delivered, across multiple settings and environments (e.g., home, clinic, school, community setting, etc.), quantitative data have been obtained, provided, and are clearly identified separately by location/setting for all behaviors and skills corresponding within each specific location of service and in accordance with the reporting specifications noted throughout this section.

- Each goal includes clearly defined mastery criteria indicating the standards for determining whether a goal/objective has been/will be met.

- Quantitative data (e.g., baseline, interim, and current) reported, the quantitative unit(s) of measurement identified within the treatment goal/objective to notate progress, and the mastery criteria identified within the treatment goal/objective are consistent (e.g., percent per opportunity, cumulative mastered targets, duration, etc.).

Group Treatment (*as applicable*):

- If group treatment is planned, the treatment plan/plan of care must include clearly defined, measurable goals (see above for specifications) that include ALL the following:
  - are specifically notated to be addressed within the group therapy format
  - are specific to the individual and their targeted behaviors and skills
  - include quantitative data (baseline, interim, and current as relevant and applicable) specific to the group therapy format
  - have been identified for intervention based on the details and results gathered through the full and comprehensive ABA Assessment (as noted in the sections above).

Treatment Intensity:

- The planned intensity of treatment reflects the severity of the impairments, goals of treatment, and/or response to treatment across all settings and environments where treatment will occur.

Supervision / Direction of Treatment:

- Case supervision will be performed by a BCBA®, LBA or a mental health professional who is licensed to practice independently and who has documented training in ABA and includes ALL of the following:
  - Direct case supervision (occurs concurrently with the delivery of direct treatment to the individual and consists of BCBA® face-to-face with the individual and either the Registered Behavior Technician® [RBT®] or the Board Certified Assistant Behavior Analyst® [BCaBA®]) and indirect case supervision is consistent with the general accepted standard of care of one to two hours per ten hours of direct treatment.

  - When direct treatment is 10 hours per week or less, a minimum of one to two hours per week of direct case supervision is provided.
  - Supervisory services requested/provided coincide with Current Procedural Terminology (CPT®) code descriptions as identified by the American Medical Association (AMA).
  - The name and credentials of the individual who will provide supervision must be documented.

Stakeholder Training:

- Stakeholder (e.g., parent/caregiver, relative, teacher, and/or other impacted/invested party) training will be conducted by a BCBA®, LBA, or a mental health professional who is licensed to practice independently and who has documented training in ABA and includes ALL the following:

  - ➢ There are clearly defined, measurable stakeholder goals with mastery criteria that are individualized to the stakeholder(s) and the individual's needs designed to teach all relevant stakeholder(s) the basic behavioral principles of ABA and how to continue behavioral interventions in the home and community, as well as across all relevant settings and environments.
  - ➢ If group stakeholder training is planned, there are clearly defined, measurable stakeholder training goals for the group training that are individualized to the stakeholder(s) and the individual's needs.
  - ➢ Quantitative baseline data have been obtained and provided, with dates reported from when the data were collected for all stakeholder behaviors and skills identified for intervention across all settings and environments in which treatment will occur.
  - ➢ There is a clear and documented plan to collect data to demonstrate the stakeholder(s) are making progress toward meeting identified stakeholder training goals.
  - ➢ When stakeholder training is conducted with various stakeholders from multiple settings (e.g., parents/caregivers and school personnel, parents/caregivers and grandparents, parents/caregivers living separately, etc.), quantitative data as noted above is included and documented separately as relevant to each stakeholder.
  - ➢ The name and credentials of the individual who will provide stakeholder training must be documented.

Service Description:

- When services are delivered within environments that may also include additional and/or alternative behavioral expectations (e.g., academic setting, vocational placement, services delivered via telehealth modalities, etc.), ALL the following must be clearly identified and documented:

  - ➢ Services meet the definition of direct treatment / direct engagement (as noted in the Glossary of Terms) regardless of treatment location or modality.
  - ➢ Indication if direct service provision consists entirely of implemented ABA treatment aimed at ameliorating the symptoms of ASD as defined by diagnostic criteria in DSM-5-TR across all settings and environments where treatment will occur.
  - ➢ Identification that direct service provision is conducted in accordance with the goals identified within the treatment plan / plan of care (see above for goal/objective criteria).
  - ➢ Documentation that the ABA provider will remain in line of sight, direct engagement, and within close enough proximity to the individual (e.g., face-to-face with the individual) to allow for consistent presentation of learning opportunities that relate to the goals and objectives identified within the treatment plan / plan of care (this does not apply to telehealth services, when applicable).
  - ➢ For services that are focused primarily on addressing, preventing or responding to behaviors targeted for reduction (i.e., maladaptive behavior, challenging behavior, behavioral excesses, etc.) the data demonstrates the identified behavior(s) occur at a frequency and/or severity (as documented through data collection methods noted above) that requires direct intervention throughout the time the ABA provider is with the individual.
  - ➢ Identification that the ABA services are not utilized to replace or replicate activities that are the responsibility of the setting and environment where services occur (e.g., classroom aide, 1:1 teacher, tutor, vocational assistant/coach, respite services, etc.).

Other Factors

- ABA services delivered by multiple ABA provider organizations/agencies/companies during the same authorization period are not considered medically necessary unless ALL the following are present and documented:

    - There is a clear plan to coordinate care across providers, to ensure the services are not duplicative, and are consistent with clinical needs of the individual as supported by reported documentation and data collection.
    - Behavioral intervention strategies used across providers are consistent and not contradictory.
    - The planned intensity of treatment in combination of all ABA providers collectively reflects the severity of the impairments, goals of treatment, and/or response to treatment across all settings and environments where treatment will occur.

- When the goals of treatment include feeding conditions and toileting concerns, BOTH of the following must be met, if applicable:

    - The treatment plan/plan of care includes specific safety measures and protocols.
    - Consultation with medical and/or dietary/nutritional professionals has occurred prior to the initiation of the intervention, will be continued on an ongoing basis, and is specifically documented.

- When the goals of treatment are implemented as part of Severe Behavior Programs and/or include severe behavior, ALL the criteria from initiation of treatment section (and continued treatment section as applicable) are currently met, as well as ALL the following must be met:

    - A complete treatment history is obtained and documented including relevant co-morbid conditions, current medications, previous treatment/intervention (including participation in higher levels of care as applicable), and any currently implemented treatment/intervention.
    - A complete history of the targeted severe behavior(s) is obtained and documented (e.g., involvement of emergency services, bodily injury, collateral damage, property destruction, distance/duration of elopement, etc.).
    - Response to previous and/or current treatment is documented indicating necessity of participation in Severe Behavior Program.
    - Administration of the assessment instrument must have been completed by the requesting provider or by a professional other than the requesting provider (see above Assessment sections for criteria) within 60 days prior to the start of treatment with the Severe Behavior Program.
    - Quantitative baseline (interim and current as applicable) data (e.g., rate, duration, intensity, and/or episodic severity) of targeted behavior(s) have been obtained, and provided, with dates reported from when the data were collected, for all behaviors and skills identified for intervention as obtained through consultation/coordination with current ABA provider (as applicable) and/or direct observation by the requesting Severe Behavior Program provider completed within 60 days prior to the start of the treatment with the Severe Behavior Program.
    - Data presented in relation to target behavior meet the definition of Severe Behavior per the Glossary.
    - The treatment plan/plan of care includes specific safety measures and protocols.
    - Consultation with medical and/or mental health professionals has occurred prior to the initiation of the intervention, will be continued on an ongoing basis, and is specifically documented.

- When authorization requests involve coverage of services conducted retrospectively, ALL the criteria from initiation of treatment section (and continued treatment section as applicable) are met, coinciding with the dates of service identified with the request

- Reimbursement for ABA services are based on the specific service description, regardless of the use of Artificial Intelligence (AI) based technologies to deliver the service (CASP, 2025).

Criteria for Continued Treatment with ABA

Continued treatment with ABA is considered medically necessary when: (1) the first bullet in the above section for initiation of treatment section was met at the time treatment was initiated; (2) ALL of criteria from initiation of treatment section above are currently met and (3) ALL the following criteria are met:

- The treatment plan/plan of care has been updated to address the current identified skill deficits and behaviors, as well as any progress made across all targeted areas.

- Quantitative baseline, interim and current data have been obtained, and provided, with dates reported from when the data were collected for all behaviors and skills previously identified and/or proposed for intervention (as applicable) across all settings and environments where treatment has been provided or will occur.
- There is documentation of current data must be collected within no more than 60 days prior to the start date of the continued treatment request, as well as collected within no more than 60 days prior to the date the authorization request is received, with dates reported from when the data were collected, for all behaviors and skills identified for intervention across all settings and environments in which treatment will/has occurred.
- The data indicate that there has been ongoing and sustained progress toward mastering the treatment goals.
- There is evidence of measurable and/or maintained improvement in targeted behaviors and skills as demonstrated with the use of a reliable, valid, and standardized assessment instrument completed no more than one year prior to the start date of the continued treatment request.
- When progress toward mastering and/or maintaining treatment and/or stakeholder goals, and/or evidence of measurable and maintained improvement is not demonstrated through the submitted assessment instrument(s), barriers toward progress and/or maintenance have been identified, and there is a specific and documented plan to address barriers and evidence of interventions being adjusted through protocol modification, with continued data monitoring and assessment for effectiveness by the provider.
- When behaviors and skills have been identified for new and/or proposed intervention (e.g., goals and objectives), baseline data have been obtained and provided, with dates reported from when the data were collected across all settings and environments in which treatment will occur, or are planned to occur, and are updated as necessary to have been collected within no more than 60 days prior to the implementation of the intervention associated with the identified behavior and skill.
- Administration of a reliable, valid, and standardized assessment instrument (see above Assessment sections for criteria) is completed following any break in treatment greater than 60 calendar days.
- Updated/current data have been collected with dates reported from when the data were collected for all behaviors and skills identified for intervention across all settings and environments in which treatment will occur following any break in treatment greater than 60 calendar days.
- Quantitative baseline, interim, and current data related to stakeholder training goals have been obtained and provided, with dates reported from when the data were collected, indicating all relevant stakeholders continue to actively participate in the treatment and that they are making sustained and ongoing progress toward mastering the stakeholder goals.
- When stakeholder training is conducted with various stakeholders from multiple settings (e.g., parents/caregivers and school personnel, parents/caregivers and grandparents, parents/caregivers living separately, etc.), quantitative data as noted above is included and documented separately as relevant to each stakeholder.
- When an increase in treatment intensity is requested either within a currently authorized period, or at the start of a subsequent authorization period, the request should include ALL the following (in addition to the details of the relevant sections noted throughout this document):
  - Description and clinical rationale related to the increase in treatment intensity
  - Documented evidence and quantitative data demonstrating how the increase in intensity would improve outcome.
  - Description and quantitative data related to how the increase in intensity would be utilized, as well as its clinical basis.

Documentation Expectations

A separate written record is expected for each individual receiving ABA intervention corresponding with each service noted through identified CPT® Code that includes at least ALL the following:

- Start date and time for each service
- End date and time for each service
- Location of service delivery
- The focus of service
- A detailed description of intervention conducted by the ABA provider during the time of service

- Individuals present during the time of service
- The specific service delivered (e.g., direct service, supervision, stakeholder training, etc.)
- Name, credential (if applicable), and signature of ABA provider who rendered the service

Not Medically Necessary

Applied Behavior Analysis (ABA) is considered not medically necessary for all non- autism spectrum disorders (ASD) indications including Rett syndrome.

Not Covered or Reimbursable

Intensive behavioral interventions other than ABA are not covered or reimbursable.

Services that are considered primarily educational or vocational in nature, or related to academic or work performance are not covered or reimbursable.

Provision of ABA treatment is not covered or reimbursable when delivered to the same individual, at the same time as any other treatment modality (e.g., ABA and speech therapy, or ABA and occupational therapy).

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	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 guardian(s)/caregivers, each 15 minutes

CPT® Codes	Description
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

***Current Procedural Terminology (CPT®) ©2025 American Medical Association: Chicago, IL.**

General Background

Glossary of Terms

TERM	DEFINITION
Applied Behavior Analysis	The science in which tactics derived from the principles of behavior are applied systematically to improve socially significant behavior and experimentation is used to identify the variables responsible for behavior change (Cooper, et al., 2020).
Assessment	A comprehensive assessment [that] describes specific levels of behavior(s) at baseline and informs the subsequent establishment of meaningful treatment goals (CASP, 2024).
Baseline Data	Quantifiable information regarding performance of skill development and behavior reductive targets (as applicable) collected prior to implementation of the independent variable identified as intervention/treatment from which areas of treatment focus and intervention can be identified, the effects of the independent variable can be recognized, and comparative progress can be determined (see Demonstration of Progress). Reporting of baseline data includes dates on which the information was collected (Cooper, et al., 2020).
Clearly Defined Goals	Specifically indicates the target behaviors and expectations included for measurement within the treatment goal. Identifies the method in which progress will be measured. Operationally defines the behavioral expectation of the patient and degree of independence necessary for mastery of the goal/objective.
Clinical Note	Requirements for written record of documentation for each CPT® code billed that includes the start date and time for each service, the end date and time for each service, location of service, the focus of service, a detailed description of what was conducted by the provider during the time of service demonstrating ABA treatment was performed, who was present/who participated in the service, and who rendered the service. Signatures and time stamps of when the note was completed are included. May also be referred to as "Progress Note," "Psychotherapy Note," or "Session Note" (United States, The Health Insurance Portability and Accountability Act, 2004). The behavior analyst may analyze program data when they first arrive to observe a treatment session as well as summarize and analyze those data when documenting services in a session note after services have ended (CASP, 2024).
Comprehensive ABA	ABA treatment provided directly to the patient to improve or maintain behaviors in many skill areas across multiple domains (e.g., cognitive, communicative, social, behavioral, adaptive). Treatment often emphasizes establishing new skills but may also focus on reducing challenging behaviors, such as elopement, and stereotypy, among others (CASP, 2024).

TERM	DEFINITION
Continued Treatment with ABA Authorization Request	An ABA treatment authorization request when, regardless of funding source, the patient has participated in ABA services with the requesting provider within 90 days from the date the authorization request was made.
Criterion Referenced Assessments	A psychometric property of a standardized assessment that relates to some unit of measure based on the test taker's performance on a set of standard criteria. Scores on criterion referenced assessments are developed by demonstration of a particular skill, milestone or measurable outcome, and are not impacted by other test takers' performances. The test is designed to measure the extent to which an patient has met performance standards and compare an patient's performance to a pre-determined standard or criterion (Patten & Newhart, 2023; CASP, 2024).
Current Data	Quantitative information regarding performance collected within no more than 60 days prior to the start date of the continued treatment request, as well as collected within no more than 60 days prior to the date the authorization request is received, with dates reported from when the data were collected, for all behaviors and skills identified for intervention across all settings and environments in which treatment will/has occurred.
Data	The identification of some dimension of behavior, as collected through measurement procedures and presented in a quantifiable format (Cooper et al., 2020).
Demonstration of Progress	Quantitative information regarding performance as demonstrated through current data in relation to treatment goals/objectives and/or formally administered assessment results, indicating comparable, measurable and meaningful behavior change in relation to quantifiable baseline and/or interim data. Demonstration of progress indicates practical importance when altering of the behavior produces socially significant and socially important change (Baer et al., 1968). The measurement system for tracking progress toward goals should be individualized to the patient, the treatment context, the critical features of the behavior, and the available resources of the treatment environment. (CASP, 2024).
Diagnosis	A diagnosis of autism spectrum disorder (ASD) is confirmed when the diagnosis has been made based on the criteria in the DSM-5-TR. A confirmed diagnosis of ASD may also be termed a "medical diagnosis" of ASD when the diagnosis is made by a healthcare professional who is licensed to practice independently and whose licensure board considers diagnostics to be within their scope of practice. By contrast, educational identification or meeting educational eligibility for services related to autism through the Patients with Disabilities Education Act (IDEA) may not meet criteria as a formal diagnosis of ASD, unless the above mentioned specifications have also been met. Similarly, a diagnosis is not considered confirmed when it has been termed "provisional," "proposed," "potential," "at risk of," "rule out" or any other term used by the diagnosing clinician to indicate that more information may be necessary prior to confirming the diagnosis.
Direct Case Supervision	Occurring concurrently with direct treatment, the BCBA® is face-to-face with the patient and the technician (e.g., RBT® or the BCaBA®) delivering the direct treatment. This can include direct observation of treatment by technician, clinical direction on new and revised treatment protocols, and/or monitoring integrity (CASP, 2020).
Direct Treatment / Direct Engagement	Treatment is performed in a manner in which the interventionist is within close enough proximity to the patient (e.g., face-to-face) to allow for direct engagement in presenting, creating and/or contriving consistent learning opportunities based on structured, planned and intentional intervention strategies or naturally occurring environmental stimuli. Direct treatment involves regular engagement of an patient and their significant stakeholders and may include both systematic and naturalistic techniques across both patient and group settings (Association of Professional Behavior Analysts [APBA], 2017; Pellecchia, et al., 2015).

TERM	DEFINITION
Discharge Criteria	Typically identified as the end of services between a provider and an patient (CASP 2024), consisting of clearly defined, measurable, realistic, and individualized criteria indicating the point at which services are appropriate for discontinuation and/or transfer to alternative or less intrusive levels of care. Criteria should identify quantifiable skill development and behavior reductive targets considered necessary and socially significant, specific to the patient, and be related to the current course of treatment identified through the patient's treatment plan/plan of care. Discharge criteria should be identified at initiation of treatment and reviewed and adjusted as appropriate throughout the course of services (ABA Coding Coalition, 2022; CASP, 2020; CASP, 2024).
Focused ABA	Focused ABA treatment, provided directly to the patient, to improve or maintain behaviors in a limited number of domains or skill areas. Access to focused intervention should not be restricted by age, cognitive level, diagnosis, or co-occurring conditions (CASP, 2024).
Generalization	Behavior change that is durable over time, appears in a wide variety of possible environments, can be demonstrated across patients, or spreads to a wide variety of related behaviors (Baer, et al., 1968).
Goals/Objectives	Specific, clearly and operationally defined, measurable, realistic and individualized description of the precise skill development and behavior reductive targets that represent the focus of intervention within the treatment plan/plan of care. Treatment goals/objectives are based on the areas of deficit identified through the assessments/evaluations administered and include data collection procedures that are consistent with mastery criteria and allow for frequent evaluation. Treatment goals/objectives indicate the number of targets required toward meeting mastery criteria (when applicable) and are consistent with the intensity and setting of service provision. New treatment goals/objectives are considered on a consistent basis (CASP, 2020).
Indirect Case Supervision	Case supervisory activities occurring outside of the treatment setting and/or in the absence of the patient or relevant stakeholders. This can include development of treatment goals, protocols, and data collection systems, analysis of data, evaluation of progress, coordination of care activities with other professionals, meetings with direct staff outside of the treatment setting or without the patient present (CASP, 2020).
Initiation of Treatment with ABA Authorization Request	An ABA treatment authorization request when the patient has not participated in ABA services with the requesting provider within 90 days from the date the authorization request was made.
Interim Data	Quantitative information regarding performance from the period of time between when the goal was introduced into treatment and 60 days prior to the time the treatment plan/plan of care was submitted for review. Reporting of interim data includes dates on which information were obtained. At a minimum, interim data should include data as collected within the previous 6 months of treatment (or less if treatment has been in place for less than 6 months), and may be reported as patient data points and/or as a relevant average.
Maintenance	The extent to which the patient continues to perform the target behavior after a portion or all of the intervention has been terminated (Cooper, et al., 2020).
Mastery Criteria	Socially validated performance criteria (Cooper, et al., 2020) that includes quantitative and measurable conditions and standards that are clearly defined, based on collected data that identifies when a particular target, goal, objective, skill set or behavior has been achieved/accomplished and no longer requires focused and targeted treatment/intervention. Mastery criteria should be consistent with the units of measurement identified within the goal indicating the standards for determining when a goal/objective has been/will be met and specifies the number of targets required to meet the goal/objective (when applicable).

TERM	DEFINITION
Measurable Goals	Indicates the method in which data will be collected as a means of demonstrating progress toward mastery of the treatment goal. Includes an operational description of the target behavior using quantifiable terms. Measurable goals incorporate quantitative data collection that coincides with data collection methods used for identifying baseline data, interim data and description of progress through current data.
Multiple Procedures	Regardless of the funding source, multiple providers bill for services rendered to the same patient when those services occur at the same time. Also referred to as concurrent billing (American Medical Association [AMA], 2022).
Norm Referenced Assessments	A psychometric property of a standardized assessment that is designed to compare and rank test takers in relation to the general population. Norm referenced assessments allow for appraisal of the test taker to a hypothetical average test taker, which is determined by comparing scores against the performance results of a statistically selected group of test takers, typically of the same age or grade level (Patten & Newhart, 2023). Norm-referenced assessments compare an patient’s responses to those of samples of other patients with similar characteristics, such as chronological age or diagnosis CASP, 2024).
Observational Treatment	Treatment is performed in a manner in which the interventionist does not present consistent learning opportunities (related to reduced proximity and/or limited occasion), and engagement with the patient and their significant others is inconsistent, infrequent, irregular and unreliable.
Operational Definition	Clearly stated description of the behavior characteristics that is observable, measurable, repeatable and agreeable (Alberto & Troutman, 2013).
Qualitative Data	Categorized based on traits and characteristics (e.g., anecdotal accounts, descriptive reports, etc.) (Kazdin, 2011).
Quantitative Data	Counted or measured and reported using numbers (e.g., rate, frequency, percent of opportunities, cumulative mastered targets, percent of momentary time sampling, etc.) (Kazdin, 2011).
Reliable Assessments	An assessment instrument that produces consistent results across administrations, and when implemented by different people (Patten & Newhart, 2023).
Retrospective Treatment with ABA Authorization Request	A retrospective authorization request is any request made after a specific amount of time for both initial and continued stay requests. A retrospective authorization request for ABA is any request made when more than 90 days have passed since the start date of the requested authorization, or any time after the patient has discharged.
Severe Behavior	Behaviors occur at a rate, duration, intensity and/or episodic severity that directly interferes with autonomy and independence, as well as participation in available learning opportunities presented both through the natural environment and applied treatment programs (as applicable). Behaviors are destructive and disruptive to daily life, may result in a risk of harm, and are considered dangerous to the patient, those in direct vicinity of the patient, and/or property (Salvatore, et al., 2022). Destructive behaviors may include but are not limited to “… self-injurious behavior, aggression, property destruction, pica, elopement, and other behaviors associated with high-risk medical consequences or property damage” (ABA Coding Coalition. Frequently Asked Questions)
Severe Behavior Program	Provide treatment focused with patients who engage in Severe Behavior. Participation in treatment is often short-term and directed specifically toward analysis, evaluation, remediation, replacement and/or reduction of severe behavior (Fisher, et al., 2021).
Socially Significant Behaviors	Behaviors that have immediate and long-lasting effects for the person and for those who interact with that person (Cooper, et al., 2020).

TERM	DEFINITION
Stakeholder(s)	An patient, other than the person directly receiving services, who is impacted and invested in the behavior analyst's services (e.g., parent, caregiver, relative, legally authorized representative, collaborator, employer, agency or institutional representative, licensure board, funder, third-party contractor for services) (RBT Ethics Code [2.0], 2021).
Standardized Assessments	Requires all test takers to answer the same questions or meet the same criteria. Tests are administered and scored in a similar manner across participants to allow for comparison of performance across administrations and with other test takers (Patten & Newhart, 2023).
Transition Plan	A coordinated set of individualized and results-oriented activities designed to move the patient through treatment toward discharge. The transition plan should be a written document that specifies the starting point of treatment and specify monitoring and evaluation details. The transition plan should be reviewed often and should account for the rights of the patient and caregiver to resume treatment if necessary. The transition plan should outline multiple stages of transition, from more support to less support and a more independent level of care (CASP, 2024).
Treatment Plan / Plan of Care	Submitted documentation outlining the course and direction of intervention that guides procedures, and determines recommendations for areas of focus, goals of treatment, intensity of service, and mode of service delivery (Luiselli, 2006). Treatment plans / plans of care include information to substantiate that the medical necessity criteria for Applied Behavior Analysis as outlined in Evernorth Behavioral Health Coverage Policy EN0499 Intensive Behavioral Interventions are met.
Valid Assessments	An assessment instrument that has been psychometrically tested for reliability (see Reliable Assessments), validity (refers to the test's ability to measure what it is intended to measure), and sensitivity (the probability that the assessment will accurately identify and distinguish test taker's performance in meeting set criteria) (Patten & Newhart, 2023).

Autism Spectrum Disorder (ASD)
ASD is a developmental disability characterized impairments in reciprocal social communication and social interaction, and restricted, repetitive patterns of behavior, interests, or activities. Deficits often occur across multiple contexts and may result in challenges across multiple areas of functioning. Symptoms associated with ASD must be present in the early developmental period but may not be identified until later. The presentation, impact, and severity of characteristics associated with ASD may vary greatly amongst individuals who meet criteria for the diagnosis.

The precise etiology of ASD is unknown, although there appears to be a high heritability associated with it. The etiology can be identified for between 15% and 20% of individuals with autism; in the others the cause remains unknown. This is a field of active research.

Associations between ASD and a number of other medical conditions have been proposed. Other medical conditions include but are not limited to:

- Epilepsy or seizure disorder
- Tuberous sclerosis
- Fragile X syndrome
- Intellectual disability

American Academy of Child & Adolescent Psychiatry (AACAP): The American Academy of Child & Adolescent Psychiatry (AACAP) 2022 Policy Statement on Autism and Vaccines states “Multiple studies conducted in several different countries have demonstrated that there is no causal association between vaccines or their preservatives and ASD. Further, vaccines do not change the timing of the onset of ASD symptoms, nor do they

affect the severity of ASD symptoms. Even in families who have a greater risk for ASD, such as those who already have a child with ASD, there is no increased likelihood that the second child will have ASD if vaccinated" (AACAP, 2022).

American Academy of Pediatrics (AAP): The AAP 2020 Clinical Report on Identification, Evaluation, and Management of Children With Autism Spectrum Disorder states that "The scientific literature does not support an association of vaccination as an environmental factor that increases the risk for ASD. Children with ASD should be vaccinated according to the recommended schedule" (AAP/Hyman, et al., 2020)

Diagnostic criteria for Autism Spectrum Disorder from: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR)
A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of the following, currently or by history (examples are illustrative, no exhaustive; see text of DSM-5-TR) 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 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.**
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, no exhaustive; see text of DSM-5-TR): 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 of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same 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 interests). 4. Hyper- or hyporeactivity to sensory input or unusual interest 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). Specify current severity: **Severity is based on social communication impairments and restricted, repetitive patterns of behavior.**
C. Symptoms must be present in the early developmental period (but may not be 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 disorders 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 diagnosis of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

The DSM-5-TR notes that individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specific 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.

Intensive Behavioral Interventions
Intensive behavioral interventions are comprehensive treatment programs that utilize a combination of interventions with the aim of improving cognitive and intellectual function, social and adaptive skill development and behavior problems. They have been proposed to treat autism spectrum disorders as well as other conditions that involve behavioral difficulties. The programs emphasize early intervention, individualization of treatment and an intensive approach. The programs may also be referred to as early intensive behavior intervention (EIBI), intensive behavior intervention (IBI) or early intensive behavioral treatment (EIBT). At times, the terms EIBI, IBI, EIBT are used interchangeably with applied behavior analysis (ABA), Lovaas therapy or Lovaas University of California Los Angeles (UCLA) Program. The term intensive behavioral interventions is used in this coverage policy, but this aligns with Adaptive Behavior Treatment that is referenced in Current Procedural Terminology (CPT®) codes section.

Behavior Analyst Certification Board, Inc.® (BACB®)
There is a formal credentialing process of professional behavior analysts through the Behavior Analyst Certification Board® (BACB). The BACB offers 3 certifications at different experience levels:

- Board Certified Behavior Analyst® (BCBA®): A graduate-level professional in behavior analysis who is able to practice independently and provide supervision for BCaBAs® and RBTs®.
- Board Certified Assistant Behavior Analyst® (BCaBA®) - An undergraduate-level professional in behavior analysis who practices under the supervision of a BCBA® or FL-CBA.
- Registered Behavior Technician® (RBT®) - A paraprofessional in behavior analysis who practices under the close, ongoing supervision of a BCBA®, BCaBA®, or FL-CBA. (Source: https://www.bacb.com/)

Council of Autism Service Providers (CASP)
The Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders, Regulatory Bodies, Service Providers, and Consumers (CASP, 2024) provides clinical guidelines and other information about ABA as a treatment for ASD. As a behavioral health treatment, ABA includes a number of unique clinical and delivery components. Thus, it is important that those charged with building a provider network understand these unique features of ABA. (The ASD Practice Guidelines were originally published by the Behavior Analyst Certification Board. In March 2020, the Guidelines were transferred to CASP.)

The CASP Practice Guideline notes that the BACB® credentials and recognizes practitioners at four levels, including those mentioned above as well as a Board Certified Behavior Analyst – Doctoral™ (BCBA-D®). (Source: https://www.casproviders.org/asd-guidelines).

<u>Applied Behavior Analysis</u>
The core characteristics of ABA are as follows:
- Objective assessment and analysis of the person's condition by observing how the environment affects their behavior, as evidenced through appropriate measurement.
- Understanding the context of the behavior and the behavior's value to the person, their caregivers, their family, and the community.
- Promotion of the person's dignity.
- Utilization of the principles and procedures of behavior analysis to improve the person's health, skills, independence, quality of life, and autonomy.
- Consistent, ongoing, objective data analysis to inform clinical decision making.

<u>Assessment</u>
Individualizing ABA care is critical to achieving optimal individual outcomes. Behavior analysts, after undertaking the appropriate training and supervision, may implement a variety of assessment activities. The goal of these assessment activities is to:

- Determine individual baseline skills.
- Develop the treatment plan and goals.

- Identify measures to report progress in treatment.

These assessment activities typically include:

- Record Review
- Interview
- Direct Observation and Measurement of Behavior
  - Functional Behavior Assessments
  - Skills-Based Assessments
  - Standardized Assessments
    - Norm-referenced assessments compare an individual's responses to those of samples of other individuals with similar characteristics, such as chronological age or diagnosis.
    - Criterion-referenced assessments compare an individual's performance to a pre-determined standard or criterion (e.g., of proficiency or mastery of a set of skills).
- Risk Assessment
- Assessments from Other Professionals

Treatment Planning

The delivery of quality ABA services requires careful planning by the behavior analyst. The treatment plan is based on information gathered during assessment, ongoing data review, and best practices.
To individualize care, ABA treatments will differ in scope, intensity, staffing, and duration of treatment. The extent to which peers or caregivers are involved in the delivery of treatment will also vary. Decisions on how to integrate these and other elements into individual treatment plans should consider the research evidence, the individual's age and functioning, characteristics of target behaviors, the individual's rate of progress, caregiver
circumstances and skills, and the resources required to implement the treatment plan across various settings.

Scope of Treatment

Scope of treatment should be aligned with the breadth and depth of behaviors targeted to address the needs of each individual. Scope of treatment is operationalized in the overall goal of treatment as well as in specific objectives and behavioral targets. Appropriate scope is determined by multiple data sources, including but not limited to direct and indirect assessments and the individual's response to treatment. Scope of treatment can be conceptualized as existing on a continuum, with "comprehensive" representing one end and "focused" representing the other.

- Focused ABA refers to treatment, provided directly to the individual, to improve or maintain behaviors in a limited number of domains or skill areas.
- Comprehensive ABA refers to treatment provided directly to the individual to improve or maintain behaviors in many skill areas across multiple domains (e.g., cognitive, communicative, social, behavioral, adaptive).

Treatment Intensity

Multiple considerations are relevant to determining appropriate treatment intensity. Individuals should be able to receive treatment at the intensity that is most effective to achieve treatment goals. Decisions to adjust treatment intensity should be individualized and based on the individual's response to treatment (i.e., data supporting the need to increase or decrease). The recommended intensity of treatment should be based on what is medically necessary for the individual independent of the individual's schedule of activities outside of treatment or previous utilization of services. 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.

Regardless of whether the treatment is focused or comprehensive, the specific number of hours of services should be individually determined based on data collected during evaluations, assessments, and clinical impressions. Providers assess treatment needs and required dosage based on a multidimensional assessment that considers a wide variety of information about the individual.

Case Conceptualization

Case conceptualization is the process of gathering and analyzing complex information about the individual's history, presenting symptoms, behavioral excesses, and deficits. Case conceptualization involves identifying environmental variables to inform the selection, focus, and sequence of interventions, and to identify potential barriers to treatment. Information necessary for case conceptualization is gathered by:

- Assessing the individual's skills and needs
- Interviewing caregivers and other treatment providers
- Reviewing prior documentation
- Identifying potential barriers to treatment

This information is synthesized to develop a comprehensive picture of the individual and the individual's needs. The results guide treatment and promote coordination of care. A individual's needs and support systems will change over time. Thus, case conceptualization is a dynamic and ongoing process.

Goal and Protocol Development

Behavior analysts target critical domains, including but not limited to adaptive skills, behavioral concerns, and communication, across all relevant settings to optimize the individual's independence, autonomy, and quality of life. Behavior analysts are well equipped to address goals in areas such as, but not limited to, activities of daily living (ADLs), adaptive skills, social development, and cognitive functioning within ABA service delivery. The number and complexity of goals should determine scope of treatment, the intensity (dosage) level, and the settings in which it is delivered. The appropriateness of existing and new goals should be continually considered.

Treatment Settings

The individual's clinical needs and targeted goals should determine the location(s) where ABA services are delivered, as not all settings will facilitate the desired outcomes and specific settings may be necessary to achieve treatment objectives. Care must be deliverable in any setting that is relevant for the individual to achieve treatment goals—whether in the home, at school, in a clinic or center, or in the community.
ABA may be provided in any site medically necessary to address individual needs, such as:

- residential treatment facilities
- inindividual and outindividual programs
- childcare facilities
- homes
- schools
- transportation
- community settings
- clinics
- vocational or other educational classes
- recreational and social environments

Behavior analysts ensure individual safety across all environments where the individual spends time and interacts with others. Behavior analysts specify the settings required to target the individual's goals in the treatment plan.

Staffing should be individualized. In some cases, due to a determination that a individual's behavior is dangerous to themself or others, increased staff ratios may be required during assessment and intervention. In addition, higher staffing ratios may be needed to effectively implement protocols.

Behavior analysts consider many variables when choosing treatment settings and developing a treatment plan, including environmental variables that may impact progress or outcome.
One consideration in treatment planning and setting selection is that critical environmental variables, such as the physical structure or the level and type of activity, may only be present in a specific location (e.g., place of work, recreational or social settings) or may present in a specific way in these settings.

Treatment Modality

ABA treatment may be rendered via traditional in-person service delivery, telehealth, or a hybrid of in-person and telehealth service modalities. The modality selected for delivery of ABA services to individuals is determined based on a variety of factors, including but not limited to:

- individual characteristics
- treatment plan
- caregiver participation
- environment
- evidence of efficacy and safety
- technological requirements

Ratio to Direct Treatment

The number of direct treatment hours received by individuals is commonly used to determine the number of case supervision hours necessary to adequately oversee ABA services. ABA services generally require relatively high levels of case supervision due to (a) frequent adjustments to the treatment plan based on ongoing evaluation of progress and (b) oversight of the behavior technicians who most commonly deliver services.

An individual's needs will dictate the amount of case supervision required for each individual case. For example, individuals making rapid progress may need more frequent case supervision to keep up with the pace of skill acquisition, individuals with barriers to acquisition may need more frequent case supervision to problem-solve and adapt programming, or individuals with severe behavior may require more intense case supervision for safety and to achieve successful outcomes.

Treatment of severe behavior that requires focused treatment in more intensive settings, such as specialized intensive-out individual, day-treatment, residential, or in individual programs typically requires higher staff-to-individual ratios and a richer ratio of case supervision to direct treatment, especially during assessment and the early stages of treatment

Progress and Outcome Measures

The general goal of ABA services is to develop skills to enhance the individual's physical and psychological well-being, independence, autonomy, and relationships with others and their environment. While seemingly straightforward, measuring the outcomes of ABA services is a complex undertaking. Progress and outcome measures should be determined by the treating behavior analyst to ensure their appropriateness for the individual.

Data from treatment targets are most often collected by the behavior technician and analyzed by the behavior analyst on a regular basis to monitor progress towards goals and determine if assessment or intervention procedures need to be modified. These analyses assess the effectiveness of the current programs and interventions. Regular data analyses allow the behavior analyst to quickly intervene if a individual is not making the expected progress toward goals and objectives.

Metrics of individual progress may include but are not limited to:

- Degree of change in levels of target behaviors over time as shown in data
- Number or rate of treatment targets on which criteria were met (e.g., for mastery of a skill or reduction of a challenging behavior)
- Changes in certain scores on standardized assessments over time.

Transition and Discharge Planning

Transition and discharge planning is not a single event that occurs at the end of the treatment period. Abrupt termination of services may be detrimental to a individual's progress.

- Transition is a coordinated set of individualized and results-oriented activities designed to move the individual through treatment toward discharge.
- Discharge is defined as the end of services between a provider and a individual. Discharge can be initiated by the provider or the individual for a multitude of reasons and should occur in compliance with any state laws or regulations pertinent to discharge.

Transition and discharge planning should be conducted in collaboration with the individual, family, and other professionals involved in the individual's treatment (CASP, 2024).

American Academy of Pediatrics (AAP)

The AAP 2020 Clinical Report on Identification, Evaluation, and Management of Children With Autism Spectrum Disorder (AAP/Hyman, et al., 2020) notes the following:

Most evidence-based treatment models are based on principles of applied behavior analysis (ABA). ABA has been defined as “the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior.” The use of ABA methods to treat symptoms of ASD suggests that behaviors exhibited can be altered by programmatically reinforcing skills related to communication and other skill acquisition. Thus, ABA treatments may target development of new skills (eg, social engagement) and/or minimize behaviors (eg, aggression) that may interfere with a child’s progress

ABA interventions vary from highly structured adult-directed approaches (eg, discrete trial training or instruction, verbal behavior applications, and others) to interventions in natural environments that may be child led and implemented in the context of play activities or daily routines and activities and are altered on the basis of the child’s skill development (eg, pivotal response training, reciprocal imitation training, and others).

A comprehensive ABA approach for younger children, also known as early intensive behavioral intervention, is supported by a few randomized controlled trials (RCTs) and a substantial single-subject literature (AAP/Hyman, et al., 2020).

Agency for Healthcare Research and Quality (AHRQ)
In 2014, the AHRQ published a systematic review that updated the behavioral intervention portion of the comprehensive review of therapies for children with ASD that was published in 2011 (Weitlauf, et al., 2014). The review included 65 studies comprising 48 randomized trials and 17 nonrandomized comparative studies (19 good, 39 fair, and 7 poor quality) published since the prior review. The quality of studies improved compared with the earlier review; however, the assessment of the strength of evidence (SOE), confidence in the stability of effects of interventions in the face of future research, remains low for many intervention/outcome pairs. The authors concluded that a growing evidence base suggests that behavioral interventions can be associated with positive outcomes for children with ASD; however, despite improvements in the quality of the included literature, a need remains for studies of interventions across settings and continued improvements in methodologic rigor. Substantial scientific advances are needed to enhance understanding of which interventions are most effective for specific children with ASD and to isolate elements or components of interventions most associated with effects.

Cochrane Review
In a 2018 Cochrane Review, Reichow et al. reviewed the evidence for the effectiveness of Early intensive behavioral intervention (EIBI) in increasing functional behaviors and skills, decreasing autism severity, and improving intelligence and communication skills for young children with ASD. The review included five studies (one RCT and four controlled clinical trials [CCTs]) with a total of 219 children: 116 children in the EIBI groups and 103 children in the generic, special education services groups. The age of the children ranged between 30.2 months and 42.5 months. Three of the five studies were conducted in the USA and two in the UK, with a treatment duration of 24 months to 36 months. All studies used a treatment-as-usual comparison group.

- The authors found evidence at post-treatment that EIBI improves adaptive behavior (5 studies, 202 participants; low-quality evidence) and found no evidence at post-treatment that EIBI improves autism symptom severity (2 studies, 81 participants; very low-quality evidence).
- No adverse effects were reported across studies.
- The author found evidence at post-treatment that EIBI improves IQ (5 studies, 202 participants; low-quality evidence) and expressive (4 studies, 165 participants; low-quality evidence) and receptive (4 studies, 164 participants; low-quality evidence) language skills.
- They found no evidence at post-treatment that EIBI improves problem behavior (2 studies, 67 participants; very low-quality evidence).
- They noted that additional studies using rigorous research designs are needed to make stronger conclusions about the eHects of EIBI for children with ASD (Cochrane Review / Reichow, et al., 2018).

Other Intensive Intervention Programs
Intensive intervention programs other than those that focus on behavior analytic treatment have also been developed. The published evidence is preliminary and does not support the efficacy of these programs. These include, but are not limited to:

- TEACCH program: The TEACCH program (Treatment and Education of Autistic and Related Communication Handicapped Children) is an educational intervention focused on improving motor coordination and cognitive skills and has been implemented in many special education programs for autistic children. It includes behavioral analytic approaches for some skills but uses other interventions as well.
- Denver Model: The focus of the Colorado Health Sciences program (Denver Model) is learning through play based on Piaget and object relations theories. Behavior analytic techniques are included for behavior management.
- Rutgers program: The Rutgers program is known as the Douglass Developmental Disabilities Center (based at Rutgers University), has three programs small group segregated preschool, and integrated preschool and intensive home-based intervention, and uses ABA techniques and similarities to the Lovaas program. Families are trained in the program and provide the treatment when they are available and or hire staff trained in the program.
- Learning Experiences and Alternative Program (LEAP): LEAP program includes both a preschool program and a behavioral skill training
- program for parents, as well as national outreach activities. The program includes an individualized curriculum that targets goals in social, emotional, language, adaptive behavior, cognitive, and physical developmental areas.
- Relationship Development Intervention (RDI): RDI is a program designed to empower and guide parents of children, adolescents and young adults with ASD and similar developmental disorders to function as facilitators for their children’s mental development. RDI is based on instructing the parents to have an important role in improving critical emotional, social and meta-cognitive abilities through carefully graduated, guided interaction in daily activities.
- Floortime: this is also referred to as DIR® (Developmental, Individual Difference, Relationship-based model), DIR® Floortime, or Greenspan Floor-Time Model. This is a developmentally-based, one-on-one treatment program delivered 10 to 25 hours per week. The primary intervention method used in this model is intensive interactive “floor-time” play sessions, in which an adult follows a child’s lead in play and interaction. The program consists of three components: home-based play sessions, individual therapies, and early education programs.

Intensive Behavioral Interventions for Other Conditions
Although intensive behavioral interventions were developed initially to treat children with autism spectrum disorders (ASD) they have been proposed to treat children with other conditions, including Down syndrome, learning disabilities and Attention-Deficit/Hyperactivity Disorder (ADHD). There is a lack of scientific evidence to support the efficacy of the programs for other conditions.

ABA has been proposed to treat individuals with Down syndrome. The behavior and psychiatric problems associated with Down syndrome Assessment should include evaluation of the problem at school and at home, behavior management techniques, and medication as needed (Ostermaier, 2022). The role of ABA in treatment of this condition is unproven (Neil, et al., 2021; Feeley, et al., 2008).

Neurodiversity Considerations
Neurodiversity acknowledges the wide array and variability of how people perceive and process information and interact with others. The neurodiversity framework recognizes neurological differences, such as those commonly characterized in Autism Spectrum Disorder (ASD), attention-deficit hyperactivity disorder (ADHD), dyslexia, Tourette’s syndrome, and other patterns of cognitive, behavioral, and sensory experiences, as natural variations in human brain function that are necessary and valuable to the individual and society.

While many aspects of these conditions may pose significant impediments and may require clinical attention, the neurodiversity perspective emphasizes that individuals experience and interact with the world in diverse ways, and that challenges often arise when societal expectations fail to recognize, involve and adapt. Neurodiversity-affirming practice acknowledges the symptoms and challenges commonly associated with a diagnosis, while emphasizing the significant benefit of public support, acceptance of difference, and societal adjustments and accommodations.

Embracing neurodiversity aligns with broader movements for inclusion and equity by valuing strengths, supporting autonomy, and promoting environments that reduce potential barriers toward connection and fulfilment.

In consideration of Applied Behavior Analysis (ABA) services in relation to ASD, neurodiversity-affirming approaches complement clinical practice by promoting meaningful, person-centered intervention that enhances quality of life, while respecting and incorporating individualization. Engaging in this manner encourages collaboration with Autistic individuals and their families to define goals that support self-determination, functional skill development, and participation in enriching activities. Recognizing and affirming the importance of neurological diversity and integrating strength-based perspectives into service delivery aligns with Evernorth's commitment to respectful, inclusive care that supports the distinctive needs and preferences of the individuals and communities it serves.

Clinical practice developed from a neurodiverse perspective often includes informed caregiver involvement, when appropriate and applicable, that equips key stakeholders with the knowledge and strategies needed to respond flexibly to the individual, rather than expecting the individual to adapt to the caregiver or broader environment. Doing so may empower stakeholders to understand sensory, communication, and processing differences, be better equipped to recognize indicators of potential challenges, and support the individual's needs that honors their strengths and preferences.

Training and collaboration grounded in a neurodiverse approach encourages:

- Shifting expectations from compliance to partnership, emphasizing shared problem-solving and respect for autonomy.
- Adapting environments rather than focusing on the individual's expectations to change.
- Using strength-based communication strategies, which may include adaptive skill development, supportive technology, alternative communication methods, consideration of routines, etc.
- Incorporating tactics that enhance affirming interactions, choice-making, trust, and participation.

By focusing on competency in these areas, services may promote sustainable skill development, improved well-being, and stronger alliances aligned with neurodiversity-affirming values. (Sush, et al., 2025)

Health Equity Considerations

Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

A CDC Morbidity and Mortality Weekly Report published April 17, 2025, is titled Prevalence and Early Identification of Autism Spectrum Disorder Among Children Aged 4 and 8 Years — Autism and Developmental Disabilities Monitoring Network, 16 Sites, United States (Shaw, et al., 2025).

- It states that the Autism and Developmental Disabilities Monitoring (ADDM) Network is an active surveillance program that estimates prevalence and characteristics of ASD and monitors timing of ASD identification among children aged 4 and 8 years. It is a program funded by Centers for Disease Control and Prevention (CDC) to collect data to better understand the number and characteristics of children with autism spectrum disorder (ASD) and other developmental disabilities living in different areas of the United States.
- In 2022, a total of 16 US sites conducted surveillance for ASD among children aged 4 and 8 years and suspected ASD among children aged 4 years. Surveillance included children who lived in the surveillance area at any time during 2022. Children were classified as having ASD if they ever received:
  1) an ASD diagnostic statement in a comprehensive developmental evaluation,
  2) autism special education eligibility, or

3) an ASD International Classification of Diseases, Ninth Revision (ICD-9) code in the 299 range or International Classification of Diseases, Tenth Revision (ICD-10) code of F84.0, F84.3, F84.5, F84.8, or F84.9.

- Children aged 4 years were classified as having suspected ASD if they did not meet the case definition for ASD but had an evaluator's suspicion of ASD documented in a comprehensive developmental evaluation.
- For Children aged 8 years in 2022, Shaw reported "Prevalence of ASD among children aged 8 years was higher in 2022 than previous years. ASD prevalence was higher among Asian or Pacific Islander (A/PI), Black, and Hispanic children aged 8 years than White children aged 8 years, continuing a pattern first observed in 2020. A/PI, Black, and Hispanic children aged 8 years with ASD were also more likely than White or multiracial children with ASD to have a co-occurring intellectual disability. Identification by age 48 months was higher among children born in 2018 compared with children born in 2014, suggesting increased early identification consistent with historical patterns (Shaw, 2025).

References

1. ABA Coding Coalition. Model Coverage Policy for Adaptive Behavior Services. September 2020, Second edition January 2022. Accessed Nov 2025. Available at URL address: https://abacodes.org/wp-content/uploads/2022/01/Model-Coverage-Policy-for-ABA-01.25.2022.pdf https://abacodes.org/coalition-updates-its-model-coverage-policy/ https://abacodes.org/resources/

2. ABA Coding Coalition. Reporting CPT® Codes for Telehealth Delivery of Adaptive Behavior (ABA) Services. April 2020. Accessed Nov 2025. Available at URL address: https://abacodes.org/resources/ https://abacodes.org/wp-content/uploads/2020/05/ABACC-Reporting-CPT-Telehealth-Delivery.pdf

3. ABA Coding Coalition. Frequently Asked Questions. Accessed Nov 2025. Available at URL address: https://abacodes.org/frequently-asked-questions/

4. Alberto PA, Troutman AC. Applied Behavior Analysis for Teachers: Ninth Edition. Upper Saddle River, New Jersey: Pearson, 2012.

5. American Academy of Child & Adolescent Psychiatry (AACAP). Policy Statements. Autism and Vaccines. Approved by Council March 2016. Revised June 2022. Accessed Nov 2025. Available at URL address: https://www.aacap.org/AACAP/Policy_Statements/Home.aspx

6. American Psychiatric Association (APA). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision. DSM-5-TR™. Arlington, VA. American Psychiatric Association, 2022. Revised edition.

7. American Medical Association. CPT® Assistant, Vol. 28 Issue 11. Chicago: 2018, November.

8. American Medical Association. AMA CPT® Professional 2025.

9. Association for Science in Autism Treatment. Leap Model. Accessed Oct 2024. Available at URL address: https://asatonline.org/for-parents/learn-more-about-specific-treatments/treatments-in-alphabetical-order/ https://asatonline.org/for-parents/learn-more-about-specific-treatments/leap-model/

10. Association for Science in Autism Treatment. Learn More About Specific Treatments. Accessed Nov 2025. Available at URL address: https://asatonline.org/for-parents/learn-more-about-specific-treatments/treatments-in-alphabetical-order/

11. Association of Professional Behavior Analysts. Identifying Applied Behavior Analysis Interventions. 2017. Accessed Nov 2025. Available at URL address: https://abacodes.org/resources/ https://abacodes.org/wp-content/uploads/2019/06/APBAwhitepaperABAinterventions.pdf

12. Association of Professional Behavior Analysts. Guidelines & Statements. Nov 2025. Available at URL address: https://www.apbahome.net/practice-guidelines

13. Baer DM, Wolf MM, Risley TR. Some current dimensions of applied behavior analysis. J Appl Behav Anal. 1968 Spring;1(1):91-7.

14. Behavior Analyst Certification Board, Inc.® (BACB®). Accessed Oct 2024. Available at URL address: https://www.bacb.com/

15. Behavior Analyst Certification Board. Ethics Code for Behavior Analysts. (2020). Effective January 1, 2022. (Includes Glossary). Accessed Nov 2025. Available at URL address: https://www.bacb.com/ethics-information/ethics-codes/ https://www.bacb.com/wp-content/uploads/2022/01/Ethics-Code-for-Behavior-Analysts-240830-a.pdf

16. Behavior Analyst Certification Board. RBT® Ethics Code 2.0. (2021) (Includes Glossary) Effective January 1, 2022. Accessed Nov 2025. Available at URL address:
https://www.bacb.com/ethics-information/ethics-codes/
https://www.bacb.com/wp-content/uploads/2022/01/RBT-Ethics-Code-240830-a.pdf

17. Behavior Analyst Certification Board. About Behavior Analysis. Accessed Nov 2025. Available at URL address: https://www.bacb.com/about-behavior-analysis/

18. CDC. Autism and Developmental Disabilities Monitoring (ADDM) Network Data Resources. May 16, 2024. Accessed Nov 2025. Available at URL address: https://www.cdc.gov/autism/data-research/new-addm-data.html
https://www.cdc.gov/autism/articles/ (by year)
https://www.cdc.gov/autism/addm-network/sites.html

19. Cohen H, Amerine-Dickens M, Smith T. Early intensive behavioral treatment: replication of the UCLA model in a community setting. J Dev Behav Pediatr. 2006 Apr;27(2 Suppl):S145-55.

20. Cooper JO, Heron T, Heward W. Applied Behavior Analysis, 3rd. Edition. Pearson, 2020.

21. Council of Autism Service Providers (CASP). Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2nd ed.) 2020. Accessed November 1, 2022.

22. 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. April 2024. Accessed Nov 2025. Available at URL address:
https://abacodes.org/resources/
https://www.casproviders.org/asd-guidelines

23. Council of Autism Services Providers (CASP). Practice Parameters for Artificial Intelligence use in Applied Behavior Analysis. Accessed October 2025. Available at URL address: https://assets-002.noviams.com/novi-file-uploads/casp/pdfs-and-documents/AI_Guidelines/aipracticeparameters.pdf

24. Dawson G, Rogers S, Munson J, Smith M, Winter J, Greenson J, et al. Randomized, controlled trial of an intervention for toddlers with autism: the Early Start Denver Model. Pediatrics. 2010 Jan;125(1):e17-23.

25. DIR® Floortime. The Interdisciplinary Council on Developmental & Learning Disorders. Accessed Nov 2025. Available at URL address: https://www.icdl.com/

26. Douglass Developmental Disabilities Center (DDDC). Accessed Nov 2025. Available at URL address: https://dddc.rutgers.edu/about-dddc/about-dddc

27. Feeley K, Jones E. Strategies to address challenging behaviour in young children with Down syndrome. Downs Syndr Res Pract. 2008 Oct;12(2):153-63.

28. Fisher WW, Piazza CC, Fuhrman AM. Developing a severe behavior program: A toolkit. Autism Speaks Though Leadership Summit on Challenging Behaviors. Autism Speaks, Princeton, NJ. 2021. Accessed Nov 2025. Available at URL address: https://docs.autismspeaks.org/behavior-program/

29. Greenspan Floortime Approach™. Accessed Nov 2025. Available at URL address: https://stanleygreenspan.com/resources-about-floortime/

30. Gutstein SE. Empowering families through Relationship Development Intervention: an important part of the biopsychosocial management of autism spectrum disorders. Ann Clin Psychiatry. 2009 Jul-Sep;21(3):174-82.

31. 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.

32. Ichikawa K, Takahashi Y, Ando M, Anme T, Ishizaki T, Yamaguchi H, Nakayama T. TEACCH-based group social skills training for children with high-functioning autism: a pilot randomized controlled trial. Biopsychosoc Med. 2013 Oct1;7(1):14.

33. Jobin A. Varied treatment response in young children with autism: A relative comparison of structured and naturalistic behavioral approaches. Autism. 2020 Feb;24(2):338-351.

34. Kazdin AE. Single-Case Research Designs: Second Edition. New York, NY: Oxford University Press, 2011.

35. Lounds Taylor J, Dove D, Veenstra-VanderWeele J, Sathe NA, McPheeters ML, Jerome RN, Warren Z. Interventions for Adolescents and Young Adults With Autism Spectrum Disorders [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2012 Aug. Accessed Nov 2025. Available from URL address: http://www.ncbi.nlm.nih.gov/books/NBK107275/

36. Luiselli JK. Antecedent Assessment and Intervention. Baltimore, MD. Paul H. Brookes Publishing Co. 2006.

37. Maenner MJ, Warren Z, Williams AR, Amoakohene E, Bakian AV, et al. Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years - Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2020. MMWR Surveill Summ. 2023 Mar 24;72(2):1-14. https://www.cdc.gov/mmwr/volumes/72/ss/ss7202a1.htm
https://www.cdc.gov/autism/articles/ (by year)

38. Neil N, Amicarelli A, Anderson BM, Liesemer K. A Meta-Analysis of Single-Case Research on Applied Behavior Analytic Interventions for People With Down Syndrome. Am J Intellect Dev Disabil. 2021 Mar 1;126(2):114-141.

39. Pajareya K, Nopmaneejumruslers K. A pilot randomized controlled trial of DIR/Floortime™ parent training intervention for pre-school children with autistic spectrum disorders. Autism. 2011 Sep;15(5):563-77.

40. Patten ML, Newhart M. Understanding Research Methods: An Overview of the Essentials. New York, NY: Taylor & Francis, 11th Edition. 2023.

41. Pellecchia M, Connell JE, Beidas RS, Xie M, Marcus SC, Mandell DS. Dismantling the Active Ingredients of an Intervention for Children with Autism. J Autism Dev Disord. 2015 Sep;45(9):2917-27.

42. 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:CD009260.

43. Rogers SJ, Estes A, Lord C, Vismara L, Winter J, Fitzpatrick A, et al. Effects of a Brief Early Start Denver Model (ESDM)-Based Parent Intervention on Toddlers at Risk for Autism Spectrum Disorders: A Randomized Controlled Trial. J Am Acad Child Adolesc Psychiatry. 2012 Oct;51(10):1052-65.

44. Salvatore GL, Simmons CA, Tremoulet PD. Physician Perspectives on Severe Behavior and Restraint Use in a Hospital Setting for Individuals with Autism Spectrum Disorder. J Autism Dev Disord. 2022 Oct;52(10):4412-4425.

45. Shaw KA, Williams S, Patrick ME, et al. Prevalence and Early Identification of Autism Spectrum Disorder Among Children Aged 4 and 8 Years — Autism and Developmental Disabilities Monitoring Network, 16 Sites, United States, 2022. MMWR Surveill Summ 2025;74(No. SS-2):1–22. DOI: http://dx.doi.org/10.15585/mmwr.ss7402a1.
https://www.cdc.gov/autism/articles/ (by year)
https://www.cdc.gov/mmwr/volumes/74/ss/ss7402a1.htm

46. Shea V. A perspective on the research literature related to early intensive behavioral intervention (Lovaas) for young children with autism. Autism. 2004 Dec;8(4):349-67.

47. Shi B, Wu W, Dai M, Zeng J, Luo J, Cai L, Wan B, Jing J. Cognitive, Language, and Behavioral Outcomes in Children With Autism Spectrum Disorders Exposed to Early Comprehensive Treatment Models: A Meta-Analysis and Meta-Regression. Front Psychiatry. 2021 Jul 26;12:691148.

48. Solomon R, Necheles J, Ferch C, Bruckman D. Pilot study of a parent training program for young children with autism: the PLAY Project Home Consultation program. Autism. 2007 May;11(3):205-24.

49. Sush DJ, Lustig SL, Morrison LP. A Neurodiverse Perspective on Autism Spectrum Disorder and the Medical Necessity of Applied Behavior Analysis. J Am Acad Child Adolesc Phychiatry. 2025 Dec;S0890-8567(25)02242-7. doi:10.1016/j.jaac.2025.12.012

50. United States. The Health Insurance Portability and Accountability Act (HIPAA). Washington, DC: U.S. Department of Labor, Employee Benefits Security Administration. 2004.

51. Virues-Ortega J, Julio FM, Pastor-Barriuso R. The TEACCH program for children and adults with autism: a meta-analysis of intervention studies. Clin Psychol Rev. 2013 Dec;33(8):940-53.

Revision Details

Type of Revision	Summary of Changes	Date
Focused review	• No clinical policy statement changes.	5/15/2026
Annual review	• Numerous policy statement revisions.	12/15/2025
Focused review	• No clinical policy statement changes.	4/01/2025
Annual review	• Numerous policy statement revisions.	1/15/2025
Focused review	• No clinical policy statement changes.	11/15/2024

All Evernorth Health Services products and services are provided exclusively by or through affiliates of the Evernorth companies. © 2026 Evernorth Health Services