CareSource

MEDICAL POLICY STATEMENT
Georgia, Indiana, Ohio, West Virginia Marketplace

Policy Name & Number	Date Effective
Applied Behavior Analysis for Autism Spectrum Disorder-MP-MM-1329	10/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are developed from a review of the available evidence-based, clinical information based on and supported by clinical guidelines from medical specialties, peer-reviewed medical and scientific studies, nationally recognized utilization and technology assessment guidelines, and other medical management industry standards to aid in determining the medical necessity of a service. Medically necessary services are defined in the plan-specific Evidence of Coverage, Member Handbooks, Provider Manuals, Medical Policy Statements, and/or other plan policies and procedures.

Medical Policy Statements do not guarantee an authorization or payment of services. Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Medical Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject

Applied Behavior Analysis for Autism Spectrum Disorder

B. Background

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revised (DSM-5-TR) classifies Autism Spectrum Disorder (ASD) as a neurodevelopmental disorder with varied severity and symptoms affecting socialization, communication, academic and personal functioning, typically diagnosed before school age. Symptoms are noticed across multiple contexts (eg, social reciprocity, nonverbal communicative behaviors, skills in developing, maintaining and understanding relationships), and restricted, repetitive patterns of behavior, interests or activities are often present.

There is no cure or single treatment, but management involves therapies (eg, behavioral, cognitive, pharmacologic, educational) to minimize symptom severity and improve quality of life. Applied behavior analysis (ABA) is an evidence-based, individualized therapy focused on learning and behavior change delivered by qualified practitioners in-person or via telehealth based on member needs.

CareSource follows state law and guidelines in the provision of ABA services based on a DSM-5-TR diagnosis. Severity levels are divided into 2 domains and are defined as follows:

Severity Levels for Autism Spectrum Disorder		
Severity Level	Social Communication	Restricted, Repetitive Behaviors
Level 3 – "Requiring very substantial support"	Severe deficits in verbal & nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/ repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 – "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills, social impairments apparent even with supports in place, limited initiation of social interactions, and reduced or abnormal responses to social overtures from others.	Inflexibility of behavior, difficulty coping with change, or other restricted/ repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 – "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

Social skills training through group therapy and cognitive behavioral interventions has demonstrated short-term improvements in social competence and school readiness.

Effective programs have clear goals, reinforcement, and promote generalization outside therapy.

Once school-age, the public school system provides ASD services via an Individualized Education Program (IEP) governed by the Individuals with Disabilities Education Act (IDEA) and subsequent amendments, ensuring support within the educational setting. ASD services do not include education services otherwise available via IDEA.

C. Definitions

- **ASD Levels** – Based on the DSM and describes the degree of support an individual might need in daily life.
  - **Level 1** – Requiring the least amount of support but with noticeable deficits in social communication, initiating social interactions and problems with organization and planning. Restricted and repetitive behaviors can be managed with support.
  - **Level 2** – Requiring substantial support with marked deficits in verbal and nonverbal communication, pronounced social impairments and obvious restricted repetitive behaviors.
  - **Level 3** – Requiring very substantial support with severe deficits in verbal and nonverbal communication, very limited social interactions, minimal response to others, and markedly interfering restricted and repetitive behaviors.
- **Caregiver/Family Training** – Training taught by a therapist to parent/caregiver(s) on the implementation of methods utilized in a clinical setting into other environments, such as the home or community, to maximize outcomes furthering generalization of skills and maximizing and reinforcing methods being taught.
- **Independent Practitioner** – A Behavior Analyst Certification Board (BACB)-certified behavior professional or paraprofessional supervised appropriately according to applicable state regulations providing services for ABA.
- **SMART Goals** – Goals that are specific (S), measurable (M), attainable (A), relevant (R), and time-bound (T).
- **Standardized Diagnostic Assessment Tools** – Direct assessment, evidence-based tools that assist with identification of symptoms and criteria for a diagnosis.
- **Supervision** – Directing, guiding, training, and assessing individuals who provide behavior-analytic services with responsibilities in accordance with the Board from which the practitioner received a license.
  - Services delivered by a BCaBA must be supervised by a BCBA, BCBA-D, or a licensed psychologist who tested in ABA and is certified by the American Board of Professional Psychology in Behavioral and Cognitive Psychology. A BCaBA must be enrolled in the Marketplace program and affiliated with the organization under which the provider is employed or contracted.

D. Policy

I. General Guidelines

A. Members and providers must adhere to the Plan's Evidence of Coverage document and schedule of benefits. The member's treatment record (eg, plans of care, treatment plans, behavior support plans, functional assessments) must be completed

by the provider or practitioner and submitted to CareSource prior to claim submission.

B. Medical necessity review is required for all ABA services initially with a baseline and then, again, every 6 months. Appropriate documentation, as indicated in this policy, must be submitted for review. Treatment should not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.
C. ABA therapy should begin early in life, ideally by the age of 2, typically lasting 3 to 4 years and is subject to the member's response to treatment.
D. Treatment goals and intensity will be based on individual needs and progress in treatment with a focus on remediation of symptoms.

II. Initiation of ABA Services

CareSource uses MCG Health for the review of medical necessity criteria for ABA.

A. CareSource must receive documentation that confirms the following medical criteria:
    1. definitive, primary diagnosis of ASD and the ASD level made by 1 of the following upon evaluation independent of the ABA provider and with a relationship with the member:
        a. child and adolescent psychiatrist
        b. clinical psychologist
        c. child neurologist
        d. developmental pediatrician
    2. standardized diagnostic assessment tools used as part of a referral for services (eg, Autism Diagnostic Observation Schedule [ADOS], Autism Diagnostic Interview Revised [ADI-R], Childhood Autism Rating Scale, 2nd edition [CARS-2])
    3. description of clinical symptoms (eg, provider letter) present within the past year that require treatment if the diagnostic evaluation was completed more than 24 months from the date of the request

       NOTE: Documentation should show that the member has symptoms that would benefit from treatment and must be related to the diagnosis. Symptoms reported should be specific to the member and not a repetition of DSM criteria or language (eg, stereotyped or repetitive motor movements vs. lining up toy cars by size or hypo-reactivity to sensory input vs. frequently and consistently scalds hands with use of water that is too hot).
B. A licensed ABA practitioner will perform a behavioral assessment (BA) and develop a treatment plan before services are provided. Generally, BAs are not to exceed 8 hours every 6 months unless additional justification is provided. The BA should not be older than 2 months when requesting an authorization for treatment services, and additional assessment units will not be approved for assessments completed over 2 months from the requested start date of services.
C. An initial ABA treatment plan, generally effective for 26 weeks, will be individualized to the caregiver/family needs, values, priorities and circumstances for member goals. Parent/caregiver training will be developed by the member, family/caregiver and provider, signed by the parent/caregiver and must include the following:
    1. biopsychosocial information, including, but not limited to the following:
        a. current family structure

b. medication history, including dosage and prescribing provider
c. medical history
d. school placement and hours in school per week, including homeschool instruction and applicable IEP(s) to avoid duplication of services
NOTE: IEP/504 information must be provided for consideration of services.
e. history of ABA services, including service dates (duration), type of therapy received, results, and progress notes (When previous ABA therapy information is unknown, documentation must be provided regarding why the information is inaccessible and how or if this will affect treatment.)
f. all behavioral health diagnoses and services, including any hospitalizations
g. other services the member is receiving or has received (eg, speech therapy [ST], occupational therapy [OT], physical therapy [PT]), including evidence of coordination with other disciplines involved in the assessment
h. caregiver proficiency and involvement in treatment
i. any major life changes

2. rationale for services and how ABA addresses current areas of need, including
   a. a history with symptom intensity and symptom duration, as well as how the symptoms affect the member's ability to function in various settings
   b. evidence of previous therapy (eg, outcomes from previous ABA treatment, ST, OT, PT) and how results influence proposed treatment
   c. type, duration, and frequency for services
3. goals related to core deficits (eg, communication problems, relationship development, social and problem behaviors) and including the following:
   a. outcome driven, performance-based, and individualized focused on targeted symptoms, behaviors, and functional impairments
   b. based on direct behavioral assessment and a standardized developmental and functional skills assessment/curriculum (eg, Verbal Behavior Milestones Assessment and Placement Program [VB-MAPP], Assessment of Basic Language and Learning Skills [ABLLS-R])
   NOTE: For comprehensive, high intensity services direct assessments should be completed and updated with each care plan every 6 months, including initial submission. Social Savvy can be utilized for group hours in conjunction with another tool.
   c. a description of treatment activities and documentation of active participation by caregiver/family in the implementation of the treatment program **OR** documentation detailing barriers to family/ caregiver participation and how those barriers are being actively addressed
   d. SMART goals that define how improvement will be noted, frequency of treatment (number of hours per week) and duration of treatment
   e. graphs and any baseline to current data that shows progress over time
4. a hypothesis for maintaining function for targeted behaviors for deceleration (maladaptive) and functionally equivalent replacement behaviors (FERBS) for those identified deceleration behaviors
5. Behavioral Intervention Plan and/or a Plan of Care (POC)
6. requested number of ABA hours per week based on the member's specific needs, not on a general program structure, as evidenced by **all** the following:

a. Treatment is provided at the lowest level of intensity appropriate to the member's clinical needs and goals with the number of hours requested reflecting the actual number of hours intended to be provided.
b. A detailed description of problems, goals and interventions support the requested intensity of treatment.

7. a plan to modify the intensity and duration of treatment over time based on the member's progress, including an individualized discharge plan specific to treatment needs
8. coordination with other behavioral health and medical providers

D. Authorization for Initial Course of Treatment
1. Once the diagnostic evaluation is authorized and completed, the treatment plan signed by the parent/guardian or member if 18 or older (see above) must be submitted for approval. Any guardianship documentation must also be submitted, if applicable, for any member 18 or older.
2. In addition to the submitted treatment plan, the treating BCBA must include
   a. any baseline measurements, graphs and current measurements
   b. progress reports, particularly documentation of rationale for any adjustment of hours per week upon regular treatment review
3. Individualized parent/caregiver training, including documented plans for the training and parent/caregiver ability and willingness to learn and use therapy techniques in the home must be included.
4. School transition plans that include the following:
   a. attendance at school, if age appropriate
   b. plans to transition to school, if not currently attending
   c. plans to attend school without additional ABA therapy outside the school setting
5. Documentation that a licensed or certified behavior analyst will be providing ABA services.

III. Continuation of ABA
Requests for continuation of ABA services are to be submitted every 6 months, and documentation must meet **EITHER** A-C or D:

A. A definitive diagnosis of ASD persists, and the member continues to demonstrate ASD symptoms that will benefit from treatment in at least 2 settings.
B. A treatment plan as noted in D. II. C., including the following:
1. an updated progress report with assessment scores that note improvement and member response to treatment from baseline targeted symptoms, behaviors and functional impairments using the same modes of measurement utilized for baseline measurements
2. a plan to transition services in intensity over time
3. utilization of prior approved hours

C. Parent/caregiver(s) are involved and making progress in development of behavioral interventions. **OR**
D. When requesting continuation with inadequate progress on targeted symptoms or behaviors or no demonstrable progress within a 6-month period, an assessment of the reasons for lack of progress should be documented and provided. Treatment

interventions should be modified to achieve adequate progress. Documentation should include

1. change in possible treatment techniques
2. increased parent/caregiver training
3. increased time and/or frequency working on specific targets
4. identification and resolution of barriers to treatment efficacy
5. any newly identified co-existing disorders and possible treatment
6. modified or removed goals and interventions

IV. Discontinuation of ABA Therapy

Titration and/or discontinuation of ABA therapy should occur when the following conditions are met (not an all-inclusive list):

A. Treatment ceases to produce significant meaningful progress or maximum benefit has been reached.
B. Member behavior does not demonstrate meaningful progress for 2 successive 6-month authorization periods demonstrated via standardized assessments.
C. ABA therapy worsens symptoms, behaviors or impairments.
D. Symptoms stabilize, allowing the member to transition to less intensive treatment or level of care.
E. Parents/caregivers refused treatment recommendations, are unable to participate in the treatment program, and/or do not follow through on treatment recommendations to an extent that compromises the efficacy of services for member progress.

V. Parent/Caregiver Training

CareSource will require inclusion of caregiver (ie, parent, guardian) coaching in all ABA therapy PA requests.

A. Up to 18 hours over a standard 6-month authorization period or a proportionally reduced, medically necessary amount will be authorized when the PA duration or total treatment hours are lower.
B. Minimum requirements will include at least 2 hours per month or 12 hours per standard 6-month authorization period. If minimum requirements are not met, other authorized ABA units may be reduced in subsequent authorization periods.
C. Training will evolve as goals are met. Parent/caregiver must be actively working on at least 1-3 unmet goal(s). ABA services must include documentation of the following:
    1. understanding/agreement to comply with the requirements of treatment
    2. how the parent/caregiver(s) will be trained in skills that can be generalized to the home and other environments
    3. methods by which parent/caregiver(s) will demonstrate trained skills
    4. barriers to parent involvement and plans to address (eg, are treatment goals addressed when professionals are not present, overall skill abilities)
    5. time involvement, including any materials or meetings occurring on a routine basis

VI. Telehealth

Telehealth services may be provided when appropriate in instances deemed medically necessary with supporting documentation that provides a plan for the provision of service delivery, primarily adaptive behavior treatment with protocol modification or family adaptive behavior treatment guidance. Providers using telehealth must base decisions on current best evidence and clinical consensus, considering members' needs, strengths, preferences, and resources and must adhere to the same professional ethics as in-person care while addressing limitations, such as licensure, regulatory issues, technology challenges, and cultural acceptance. Providers should establish protocols for appropriateness (eg, risk assessment, safety planning), ensure therapeutic benefit and competence, and use peer-reviewed evidence to guide screening and suitability for telehealth.

VII. Exclusions

A. reimbursement for the following services or activities is not permitted:
   1. any services not documented in the treatment plan, considered not medically necessary, out of the scope of practice of ABA, or services considered experimental, unproven or investigational in nature
   2. education-related services or activities described under IDEA
   3. vocational services or those available under the Rehabilitation Act of 1973
   4. components of adult day care programs
   5. services for members receiving other duplicative therapy services
B. treatment solely for the benefit of the family, caregiver, or therapist or for symptoms/behaviors not part of core symptoms of ASD
C. any procedure or physical crisis management technique that involves the use of seclusion or manual, mechanical, or chemical restraint to control behaviors
D. treatment worsening symptoms, prompting member regression or unexpected to cause improvement
E. more than 1 program manager or lead behavioral therapist or more than 1 agency or organization providing ABA for a member at any 1 time
F. services for the delivery of individual supervision, personal care assistance, companionship, chaperoning, or shadowing regardless of activity (eg, spas, camps, wilderness programs) or setting, including those reimbursed through a different payer or provided by individuals without professional skills or training, including family members
G. concurrent, overlapping billing (eg, speech therapy, occupational therapy, physical therapy) occurring during the provision of ABA services

   Example: CareSource receives a claim for the same member on the same date of service from an RBT for ABA therapy from 10:00 a.m. to 11:30 a.m. and speech therapy with a speech therapist from 10:15 a.m. to 11:15 a.m. This is considered overlapping billing and is not allowed. If the services were delivered concurrently and were not overlapping, RBT 10:00 a.m. to 11:30 a.m. and speech therapy from 11:45 a.m. to 12:45 p.m., the services would be billable. Services must be distinct in time, scope and provider.

H. services more costly than alternative service(s) likely to produce equivalent diagnostic or therapeutic results or duplicative therapy services addressing the same behavioral goals as the treatment plan
I. any program or service performed in nonconventional settings, even if performed by a licensed provider
J. breaks in service delivery for rest, lunch, and recess in accordance with the developmental level of each member's needs
K. childcare or caregiver services
L. psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or long-term counseling
M. services provided simultaneously by more than 1 ABA provider, unless determined to be medically necessary, prior authorized and indicated in the approved behavior plan
N. services provided by a healthcare provider located in-state when an individual receiving ABA services is out of state
O. travel time

E. Conditions of Coverage
   I. Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis, subsequent medical review audits, recovery of overpayments identified, and provider prepayment review.

   II. CareSource reserves the right to request documentation, particularly related to telehealth services or supervision. Lack of timely record submission may result in recoupment.

F. Related Policies/Rules
   Applied Behavior Analysis for Autism Spectrum Disorder – Reimbursement Policy
   Medical Necessity Determinations

G. Review/Revision History

	Date	Action
Date Issued	10/04/2018	New policy. Approved at Committee.
Date Revised	01/27/2020	Added program attributes, provider definitions, ABA; title changed, clarified services needing PA & provider requirements, changed NP to health care provider trained in ASD; added IV, willingness to participate in program, description of POC, ages, clarified ASD diagnosis, home school and IEP, documentation requirements; must include type of ASD treatment program, revised continuation of ABA therapy, discontinuation criteria & exclusions; added AFLS/ESDM/PEAK-DT assessments; added transitioning ABA therapy to school environment, removed PA checklist.
	01/25/2021	Clarified telehealth coverage, moved documentation requirements to Medical Records Doc for Practitioners; removed transition to school section; updated school section.

	08/31/2021 08/17/2022 04/12/2023 03/13/2024 08/27/2025 07/15/2026	Updated definitions. Sec. DIII 5.g. ABA services must include parent/family training. Edited Sec. V. Removed VII. A Updated template & H. Removed III.B.2; Separated steps for Initial Auth, Eval and Treatment Plan, Auth for Initial Course of Treatment, and Continuation of Services; Combined telehealth. Added VIII. A. in VIII. P for program or service performed in nonconventional settings. Reorganized policy sections. Removed 1:1 ABA therapy from exclusion list. Approved at Committee. Annual review. Added VII, VIII, IX, X. Merged AD policy info to Cond of Coverage section. Updated H. Approved at Committee. Annual review. Split payment information into separate PY policy. Updated references. Approved at Committee. Annual review. Added NOTE II.A.3., II.C.1.d., II.C.3.b., V. A.B; Updated VII. Updated references. Approved at Committee.
Date Effective	10/01/2026	
Date Archived		

H. References

1. Anglim M, Conway EV, Barry M, et al. An initial examination of the psychometric properties of the Diagnostic Instrument for Social and Communication Disorders (DISCO-11) in a clinical sample of children with a diagnosis of autism spectrum disorder. *Ir J Psychol Med*. 2022;39(3):251-260. doi:10.1017/ipm.2020.100
2. Applied Behavior Analysis: B-806-T. MCG, 30th ed. Updated January, 2026. Accessed June 16, 2026. www.careweb.careguidelines.com
3. Augustyn M. Autism spectrum disorder in children and adolescents: evaluation and diagnosis. UpToDate. Accessed June 16, 2026. www.uptodate.com
4. Augustyn M. Autism spectrum disorder (ASD) in children and adolescents: terminology, epidemiology, and pathogenesis. UpToDate. Accessed June 16, 2026. www.uptodate.com
5. Augustyn M, Von Hahn E. Autism spectrum disorder in children and adolescents: clinical features. UpToDate. Accessed June 16, 2026. www.uptodate.com
6. Autism spectrum disorder. American Academy of Pediatrics. Accessed June 16, 2026. www.aap.org
7. *Autism Spectrum Disorder in Young Children: Screening*. US Preventive Services Task Force; 2016. Accessed June 16, 2026. www.uspreventiveservicestaskforce.org
8. Autism spectrum disorders: M-7075. MCG Health, 30th ed. Updated January 2026. Accessed June 16, 2026. www.careweb.careguidelines.com
9. Autism Spectrum Disorders: B-012-HC. MCG, 30th ed. Updated January 2026. Accessed June 16, 2026. www.careweb.careguidelines.com
10. Autism Spectrum Disorders, Outpatient Care: B-012-AOP. MCG, 30th ed. Updated January 2026. Accessed June 16, 2026. www.careweb.careguidelines.com
11. Bak M, Plavnick J, Dueñas A, et al. The use of automated data collection in applied behavior analytic research: a systematic review. *Behav Anal: Res Practice.* 2021;21(4), 376–405. doi:10.1037/bar0000228

12. Bearss K, Burrell T, Challa S, et al. Feasibility of parent training via telehealth for children with autism spectrum disorder and disruptive behavior: a demonstration pilot. *J Autism Dev Dis*. 2018;48:1020-3. doi:10.1007/s10803-017-3363-2
13. Blakeley-Smith A, Meyer A, Boles R, et al. Group cognitive behavioral treatment for anxiety in autistic adolescents with intellectual disability: a pilot and feasibility study. *J App Res Intell Disab.* 2021;34(3):777-788. doi:10.111/jar.12854
14. *Board Certified Behavior Analyst Handbook*. Behavior Analyst Certification Board. Accessed June 16, 2026. www.bacb.com
15. *Board Certified Assistant Behavior Analyst Handbook*. Behavior Analyst Certification Board. Accessed June 16, 2026. www.bacb.com
16. Buckley A, Hirtz D, Oskoui M, et al; Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Practice guideline: treatment for insomnia and disrupted sleep behavior in children and adolescents with autism spectrum disorder. *Neurology*. 2020;94(9):392-404. doi:10.1212/WNL0000000000009033
17. Chun T, Mace S, Katz E; American Academy of Pediatrics; Committee on Pediatric Emergency Medicine and American College of Emergency Physicians; Pediatric Emergency Medicine Committee. Evaluation and management of children and adolescents with acute mental health or behavioral health problems, I: common clinical challenges of patients with mental health or behavioral emergencies. *Pediatr.* 2016;138(3):e20161570. doi10.1542/peds.2016-1570
18. Chun T, Mace S, Katz E; American Academy of Pediatrics; Committee on Pediatric Emergency Medicine and American College of Emergency Physicians; Pediatric Emergency Medicine Committee. Evaluation and management of children and adolescents with acute mental health or behavioral health problems, II: recognition of clinically challenging mental health related conditions presenting with medical or uncertain symptoms. *Pediatr.* 2016;138(3):e20161573. doi:10.1542/peds.2016-1573
19. Crockett, JL, Fleming RK, Doepke K, et al. Parent training: acquisition and generalization of discrete trials teaching skills with parents of children with autism. *Res Dev Disabilities*. 2007;*28*(1):23-36. doi:10.1016/j.ridd.2005.10.003
20. Definitions, 42 U.S.C. § 1396d (2019).
21. Dubreucq J, Haesebaert F, Plasse J, et al. A systematic review and meta-analysis of social skills training for adults with autism spectrum disorder. *J Autism Dev Disorders.* 2022;52(4):1598-1609. doi:10.1007/s10803-021-05058
22. Ellison K, Guidry J, Picou P, et al. Telehealth and autism prior to and in the age of COVID-10: a systematic and critical review of the last decade. *Clin Child Family Psych Rev*. 2021;24:599-630. doi:10.1007/s10567-021-00358-0
23. Ethics Code for Behavior Analysts. Behavior Analyst Certification Board; 2020. Accessed June 16, 2026. www.bacb.com
24. Evidence analysis research brief: applied behavior analysis training via telehealth for caregivers of children with Autism Spectrum Disorder. Hayes; 2022. Accessed June 16, 2026. www.evidence.hayesinc.com
25. Evidence analysis research brief: direct-to-patient applied behavior analysis telehealth for children with Autism Spectrum Disorder. Hayes; 2022. Accessed June 16, 2026. www.evidence.hayesinc.com

26. Gates JA, Kang E, Lerner MD. Efficacy of group social skills interventions for youth with autism spectrum disorder: a systematic review and meta-analysis. *Clin Psych Rev*. 2017;52:164-81. doi:10.1016/j.cpr.2017.01.006
27. *Georgia Marketplace Evidence of Coverage*. CareSource; 2026. Accessed June 16, 2026. www.caresource.com
28. Gilmore R, Ziviani J, Chatfield MD, et al. Social skills group training in adolescents with disabilities: a systematic review. *Res Dev Disab*. 2022;125:online. doi:10.1016/j.ridd.2022.104218
29. González MC, Vásquez M, Hernández-Chávez M. Autism spectrum disorder: clinical diagnosis and ADOS Test. *Rev Chil Pediatr*. 2019;90(5):485-491. doi:10.32641/rchped.v90i5.872
30. Health technology assessment: comparative effectiveness review of intensive behavioral intervention for treatment of Autism Spectrum Disorder. Hayes; 2019. Accessed June 16, 2026. www.evidence.hayesinc.com
31. Hyman S, Levy S, Myers S; Council on Children with Disabilities. Developmental and behavioral pediatrics: identification, evaluation, and management of children with autism spectrum disorder. *Pediatr.* 2020;145(1):e20193447. doi:10.1542/peds.2019-3447
32. *Indiana Marketplace Evidence of Coverage*. CareSource; 2026. Accessed June 16, 2026. www.caresource.com
33. Information on autism spectrum disorder for healthcare providers. Centers for Disease Control and Prevention. Accessed June 16, 2026. www.cdc.gov
34. Lebersfeld JB, Swanson M, Clesi CD, et al. Systematic review and meta-analysis of the clinical utility of the ADOS-2 and the ADI-R in diagnosing autism spectrum disorders in children. *J Autism Dev Disord*. 2021;51(11):4101-4114. doi:10.1007/s1083-020-04839-z
35. Lefort-Besnard J, Vogeley K, Schilbach L, et al. Patterns of autism symptoms: hidden structure in the ADOS and ADI-R instruments. *Transl Psychiatry*. 2020;10(1):257. doi:10.1038/s41398-020-00946-8
36. Lim N, Russell-George A. Home-based early behavioral interventions for young children with autism spectrum disorder. *Clin Psychol*. 2022;29(4):415-416. doi:10.1037/cps00117
37. Marino F, Chila P, Failla C, et al. Tele-assisted behavioral intervention for families with children with autism spectrum disorders: a randomized control trial. *Brain Sci*. 2020;10(9):649. doi:10.3390/brainsci10090649
38. MeiMei L, Zenghui M. A systematic review of telehealth screening, assessment, and diagnosis of autism spectrum disorder. *Child Adol Psych Mentl Health*. 2022;16(79):1-15. doi:10.1186/s13034-022-00514-6
39. Moody CT, Laugeson EA. Social skills training in autism spectrum disorder across the lifespan. *Child Adol Psych Clinics N Amer* 2020;29(2):359-371. doi:10.1016/j.chc.2019.1
40. *Ohio Marketplace Evidence of Coverage*. CareSource; 2026. Accessed June 16, 2026. www.caresource.com
41. *Registered Behavior Technician Handbook*. Behavior Analyst Certification Board. Accessed June 16, 2026. www.bacb.com
42. Sneed L, Little S, Akin-Little A. Evaluating the effectiveness of two models of applied behavior analysis in a community-based setting for children with autism spectrum disorder. *Behav Anal: Res Pract*. 2023;23(4):238-253. doi:10.1037/bar0000277

43. Solish A, Klemencic N, Ritzema A, et al. Effectiveness of a modified group cognitive behavioral therapy program for anxiety in children with ASD delivered in a community context. *Molecular Autism* 2020;11(34):1-11. doi.10.1186/s13229020003416
44. Unholz-Bowden E, McComas J, McMaster K, et al. Caregiver training via telehealth on behavioral procedures: a systematic review. *J Beh Educ*. 2020;29:246-281. doi:10.1007/s10864-020-09381-7
45. Volkmar F, Siegel M, Woodbury-Smith M, et al; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter for the assessment and treatment of children and adolescents with autism spectrum disorder. *J Am Acad Child Adolesc Psychiatry*. 2014;53(2):237-57. doi:10.1016/j.jaac.2013.10.013
46. Weissman L. Autism spectrum disorders in children and adolescents: behavioral and educational interventions. UpToDate. Accessed June 16, 2026. www.uptodate.com
47. Weissman L. Autism spectrum disorder in children and adolescents: overview of management. UpToDate. Accessed June 16, 2026. www.uptodate.com
48. Weissman L. Autism spectrum disorder in children and adolescents: pharmacologic interventions. UpToDate. Accessed June 16, 2026. www.uptodate.com
49. Weissman L. Autism spectrum disorder in children and adolescents: screening tools. UpToDate. Accessed June 16, 2026. www.uptodate.com
50. Weissman L. Autism spectrum disorder in children and adolescents: surveillance and screening in primary care. UpToDate. Accessed June 16, 2026. www.uptodate.com
51. Weissman L, Harris H. Autism spectrum disorder in children and adolescents: complementary and alternative therapies. UpToDate. Accessed June 16, 2026. www.uptodate.com
52. Wergeland J, Posserud M, Fjermestad K, et al. Early behavioral interventions for children and adolescents with autism spectrum disorder in routine clinical care: a systematic review and metanalysis. *Clin Psychol*. 2022;29(4):400-414. doi:10.1037/cps0000106
53. *West Virginia Marketplace Evidence of Coverage*. CareSource; 2026. Accessed June 16, 2026. www.caresource.com
54. Witwer A, Walton K, Held M. Taking an evidence-based child- and family-centered perspective on early autism intervention. *Clin Psychol*. 2022;29(4):420-422. doi:10.1037/cps0000122