CareSource

MEDICAL POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Applied Behavior Analysis for Autism Spectrum Disorder-NV MP-MM-1750	01/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) 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, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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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 varying widely in severity and symptoms depending on the member's developmental level and chronological age. ASD is characterized by specific developmental deficits affecting socialization, communication, academic and personal functioning. Diagnoses typically occur before entering grade school, and symptoms are noticed across multiple contexts (eg, social reciprocity, nonverbal communicative behaviors, skills in developing, maintaining and understanding relationships). Restricted, repetitive patterns of behavior, interests or activities are also often present.

There is no cure for ASD, nor is there any single treatment. The diagnosis may be managed through a combination of therapies (eg, behavioral, cognitive, pharmacologic, educational) to minimize the severity of symptoms, maximize learning, facilitate social integration and improve quality of life. Applied behavior analysis (ABA), one such therapy, may be provided in centers or at home and provides an evidence-based practice for the treatment of ASD.

ABA is based on the science of behavior and the premise that understanding behavior functioning, how it is affected by the environment and how learning to change behavior can improve the human condition. It is a flexible treatment that should be adapted to the needs of each member, teaches skills that are useful and generalizable and involves individual, group and family training. Qualified and trained practitioners provide and/or oversee ABA programs and are accountable to state boards for registration, certification or licensure requirements. Clinical decisions on telehealth service delivery models should be selected based on the individual needs, strengths, preference of service modality, caregiver availability and environmental support available.

CareSource follows state law and guidelines in the provision of ABA services, which are based on a diagnosis from the *DSM-5-TR*. Severity levels are divided into 2 domains, social communication and restricted, repetitive behaviors, 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 instruction is an important component of management of the diagnosis. A 2012 meta-analysis of 5 randomized trials (196 participants) found evidence that participation in social skills groups improved overall social competence and friendship quality in the short term. A 2020 study demonstrated efficacy of a modified group cognitive behavioral therapy program in children delivered in a community context. A 2021 study demonstrated benefits of group cognitive behavioral treatment in adolescents diagnosed with autism and intellectual disabilities. As children near entry into various school programs, research supports group therapy for school readiness and improved social skills. Training must include clearly defined goals, teach desired behaviors, provide prompting desired behaviors, provide reinforcement of demonstrated behaviors and include practicing desired behaviors with goals of generalizability outside the therapeutic setting (eg, impairments in social-emotional reciprocity, restrictive or obsessional interests, aggressive behaviors).

As the child becomes eligible for school-based services, the public school system becomes responsible for the provision of services and education. Services provided are outlined in an individualized education program (IEP). ASD services do not include education services otherwise available through a program funded under 20 US Code Chapter 3, section 1400 of the Individuals with Disabilities Education Act (IDEA). Congress reauthorized the IDEA in 2004 and most recently amended the IDEA through Public Law 114-95, Every Student Succeeds Act, in December 2015.

C. Definitions

- **Applied Behavior Analysis (ABA)** – Design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce significant improvements in behavior, including direct observation, measurement and functional analysis of the relationship between environment and behavior.
- **Caregiver/Family Training** – Training taught by a therapist to parent/caregiver(s) to implement methods utilized in a clinical setting into other environments (eg, home, community) to maximize outcomes furthering generalization of skills and reinforcing methods taught during therapeutic sessions.

- **Independent Practitioner** – All ABA services must be provided by a Behavior Analyst Certification Board (BACB)-certified behavior professional or paraprofessional supervised appropriately:
  - Board Certified Assistant Behavior Analyst (BCaBA)
  - Board-Certified Behavior Analyst (BCBA)
  - Board Certified Behavior Analyst - Doctoral (BCBA-D)
  - Registered Behavior Technician (RBT))
- **Provider of Health Care** – A provider of health care services as defined by NEV. REV. STAT. § 629.031.
- **Standardized Diagnostic Assessment Tools** – Direct assessment, evidence-based tools designed to 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 individual is employed or contracted.

D. Policy

I. General Guidelines

A. Members and providers must adhere to the associated Plan's Evidence of Coverage document and schedule of benefits.

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 up to 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

A. CareSource must receive documentation confirming the following medical criteria:

1. A definitive, primary diagnosis of ASD made by a provider of health care services, independent of an ABA provider, and with an established relationship with the member.
2. In accordance with best practice standards, a provider of health care acting within scope of practice will directly observe a member and complete an assessment to determine whether the member has a diagnosis of ASD.
3. If the diagnostic evaluation was completed more than 24 months prior to the date of the request, submit a description of clinical symptoms (eg, provider letter) requiring treatment that have been present within the past year.

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.
C. Initial Treatment Plan: An initial ABA treatment plan individualized to the caregiver/family needs, values, priorities and circumstances for member goals and 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 physician
        c. medical history
        d. school placement and hours in school per week, including homeschool instruction and any applicable individualized education plans (IEP)
        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 ABA services and how ABA addresses current areas of need, including the following:
        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 include 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])
        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

4. Behavioral Intervention Plan and/or a Plan of Care (POC)
5. 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.
6. 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
7. 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 must be submitted, including documented plans for the training and parent/caregiver ability and willingness to learn and use therapy techniques in the home.
4. School transition plan, including
    a. attendance at school, if age appropriate
    b. plans to transition to school, if not currently attending
    c. plans to be able to attend school without additional ABA therapy outside the school setting
5. Documentation must be provided that a licensed or certified behavior analyst will be providing ABA therapy services.

III. Continuation of ABA
Requests for continuation of ABA services are to be submitted every 6 months, and documentation must meet **EITHER** of the following criteria:

A. A definitive diagnosis of ASD persists, and 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 or discontinuation should occur upon the following (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 as demonstrated via standardized assessments.
C. ABA therapy worsens symptoms, behaviors or impairments.
D. Symptoms stabilize allowing member to transition to less intensive treatment or level of care.
E. Parents/caregivers have 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 effectiveness of the services for member progress.

V. Parent/Caregiver Training

Training will evolve as goals are met. Parent/caregiver should actively work on at least 1 unmet goal. Services must include documentation of the following:

A. understanding/agreement to comply with the requirements of treatment
B. how the parent/caregiver(s) will be trained in skills that can be generalized to the home and other environment
C. methods by which the parent/caregiver(s) will demonstrate trained skills
D. barriers to parent involvement and plans to address (eg, are treatment goals addressed when professionals are not present, overall skill abilities)
E. 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.

Providers utilizing telehealth must make decisions consistent with best, currently available evidence and clinical consensus. Clinical rationale must consider assessed needs, strengths, preferences, and available resources of members and caregivers. The same professional ethics governing in-person care must be followed and limitations considered (eg, interstate licensure challenges, state regulatory issues, member/caregiver discomfort with technology, technology limitations, cultural acceptance of virtual visits). Providers must identify protocols for appropriateness (eg, risk assessment, safety planning, patient/caregiver characteristics), ensure therapeutic benefit for recipients and ensure provider competence. Peer reviewed studies and other best evidence literature provides guidance on appropriate screeners and questionnaires for use in the determination of appropriateness of telehealth services for particular clients.

VII. Exclusions

A. reimbursement for the following services or activities is not permitted:
   1. any services not documented in the treatment plan
   2. behavioral methods or modes considered experimental
   3. education-related services or activities described under Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. §1400 (IDEA), amended through Public Law 114-95, the Every Student Succeeds Act
   4. vocational services in nature or those available through programs funded under Section 110 of the Rehabilitation Act of 1973
   5. components of adult day care programs
   6. other duplicative therapy services received by members
B. treatment solely for the benefit of the family, caregiver or therapist or for symptoms/behaviors not part of core symptoms of ASD
C. treatment that worsens symptoms, prompts member regression or is unexpected to cause improvement
D. services provided by family or household members or custodial care not requiring trained ABA staff
E. shadowing, para-professional, or companion services in any setting
F. services more costly than an alternative service(s) likely to produce equivalent diagnostic or therapeutic result
G. any program or service performed in nonconventional settings, even if performed by a licensed provider (eg, spas/resorts, vocational or recreational settings, Outward Bound, wilderness, camp or ranch programs)

E. Conditions of Coverage

See Applied Behavior Analysis for Autism Spectrum Disorder-PY

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	Date	Action
Date Issued	06/18/2025	New policy. Benefit grid – 1/1 sessions not allowed via telehealth. Approved at Committee.
Date Revised	10/22/2025	RDM review. Added PHC to definitions. Updated D.II.A.1 & 2. Approved at Committee.
Date Effective	01/01/2026	
Date Archived		

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