CareSource

MEDICAL POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Applied Behavior Analysis for Autism Spectrum Disorder-OH MCD-MM-0028	09/01/2026
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 Medical Policy Statements may be superseded by federal and state laws and regulations, as applicable.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 Therapy 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 characterized by specific developmental deficits that affect socialization, communication, academic and personal functioning. Diagnoses typically occur before entering grade school, and symptoms are present 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.

Currently, there is no cure for ASD, nor is there any single treatment for the disorder. The diagnosis may be managed through a combination of therapies, including behavioral, cognitive, pharmacological, and educational interventions with a goal of minimizing the severity of symptoms, maximizing learning, facilitating social integration, and improving quality of life. Applied behavior analysis (ABA), one such therapy, may be provided in centers or at home and provides evidence-based practice for treatment.

ABA focuses on understanding behavior functioning and interaction with the environment, aiming to improve human conditions through behavior change. It is a flexible treatment adapted to individual needs, teaching useful and generalizable skills, involving individual, group and family training. Qualified practitioners oversee ABA programs and must meet state registration, certification or licensure requirements. Clinical decisions regarding telehealth delivery should consider individual needs, strengths, preferred service modalities, caregiver availability and environmental support.

Social skills instruction is an important component of management of ASD. A 2012 meta-analysis of 5 randomized trials (196 participants) found 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 showed benefits of group cognitive behavioral treatment in adolescents. As children near entry in public/private school systems, research supports the use of group therapy for school readiness and improved social skills. Training must include clearly defined goals, teach desired behaviors, prompt the natural display of desired behaviors, provide reinforcement of demonstrated behaviors and include practice of desired behaviors with goals of generalizability outside the therapeutic setting (eg, impairments in social-emotional reciprocity, restrictive or obsessional interests, aggressive behaviors).

The public school system becomes responsible for the provision of services and education at school-age with services outlined in an individualized education program (IEP) and reviewed annually. ASD services do not include education services available through programs funded under 20 US Code Chapter 3, section 1400 of the Individuals

with Disabilities Education Act (IDEA), which was reauthorized in 2004 and amended through Public Law 114-95, Every Student Succeeds Act, in December 2015.

CareSource follows the Ohio Administrative and Revised Code (OAC, ORC) and Ohio Department of Medicaid (ODM) guidelines for ABA services, based on a *DSM-5-TR* diagnosis.

C. Definitions

- **Caregiver/Family Training** – Parents/caregivers learn to implement methods utilized in a clinical setting in other environments (eg, home, community) to maximize member outcomes by furthering the generalization of skills and reinforcing methods being taught to the member in other sessions.
- **Functional Assessment** – The determination of underlying function or purpose of behavior to develop an effective treatment plan, including a variety of systematic, information gathering techniques regarding factors influencing behavior occurrence, such as interview, indirect assessment, direct observation, descriptive assessment, experimental analysis, and systematic manipulation of environmental variables to demonstrate a relationship between an event and targeted behavior.
- **Independent Practitioner** – All ABA services must be provided by provider/practitioner compliant with ORC 4783.02 with approved supervision.
- **Standardized Diagnostic Assessment Tools** – Direct assessment, evidence-based tools designed for identification of symptoms and criteria for diagnosing.
- **Supervision** – Directing, training, and assessing individuals providing ABA services with responsibilities in accordance with the appliable State board and OAC 4783-6-02 and in adherence with supervision plans as defined in OAC 4783-3-01.
- **Treatment Plan** – A written document describing presenting behavior problem(s) and goals and interventions selected to alter behavior based on in-person assessments, records review from other professionals, direct observation and clinical interview data, including an estimate of the length of time and/or number of sessions anticipated to achieve goals and specific statements about the measurement of progress toward achieving goals.

D. Policy

I. General Guidelines

A. Medical necessity review is required for all ABA services initially with a baseline and then every 6 months. Medical review must be submitted with appropriate documentation as indicated in this policy and align with the State's definition of medical necessity that includes that treatment is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.

B. 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.

C. Members under the age of 21 will be assessed. 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. Documentation: CareSource must receive documentation that confirms
      1. Definitive, primary ASD diagnosis made by 1 of the following upon evaluation:
         a. child and adolescent psychiatrist
         b. psychologist
         c. child neurologist
         d. developmental pediatrician
      2. Standardized diagnostic assessment tools considered multidisciplinary evaluations, including
         a. Autism Diagnostic Observation Schedule (ADOS)
         b. Autism Diagnostic Interview Revised (ADI-R)
         c. Childhood Autism Rating Scale, 2nd edit. (CARS-2)
      3. Written documentation (eg, provider letter) describing *DSM* symptoms present in the past year requiring treatment if the submitted diagnostic evaluation was completed more than 24 months from date of 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. Initial Behavior Assessment: Before services are provided, an initial behavior identification assessment will be performed by a BCBA, if available, and a treatment plan developed. Generally, behavior assessments are not to exceed 6-10 hours every 6 months, unless additional justification is provided.
   C. Initial Treatment Plan: An initial ABA treatment plan individualized to the member and caregiver/family needs, values, priorities and circumstances for member goals and parent/caregiver training will be developed by the member, family/caregiver, and provider, must be signed by the parent/guardian and BCBA, and must include the following:
      1. biopsychosocial information, including, but not limited to
         a. current family structure and any major life changes
         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 individualized education plans (IEP) or 504 plans
            NOTE: IEP/504 information must be provided for consideration of services.
         e. history of ABA services, including service dates and progress notes
         f. all behavioral health diagnoses and services, including any hospitalizations

   g. other services received by member (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
2. rationale for ABA services, including
   a. history with symptom intensity and duration, including how 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, frequency for services
3. goals related to core deficits must include the following:
   a. be outcome driven, performance-based and individualized measures 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 plan of care, 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 member and caregiver/family in treatment **OR** documentation detailing barriers to family/ caregiver participation and how those barriers are being actively addressed
   d. goals that define how improvement will be noted, frequency (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** of 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

III. Continuation of ABA
Requests for continuation of ABA services are to be submitted every 6 months. If services stopped or were terminated for any reason for a temporary length of time (eg, cancelled over summer break after school year ends, vacation or visitation with

a noncustodial parent, a change in school hours), additional authorizations should be submitted as continuations. CareSource will not process those requests as initial requests. Documentation must meet **EITHER** A.-C. **OR** D.

A. A definitive diagnosis of ASD persists along with continued demonstration of 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 mode(s) of measurement utilized for baseline measurements
    2. a plan to transition services in intensity over time
C. Parent/caregiver(s) are involved and making progress in development of behavioral interventions.
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 of ABA therapy should occur when any of 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 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 be actively working on at least 1 unmet goal. ABA services must include documentation of the following:

A. understanding and agreement to comply with the requirements of treatment

B. how the parents/caregivers will be trained in skills that can be generalized to the home and other environments
C. methods by which the parents/caregivers will demonstrate trained skills
D. barriers to parent involvement and plans to address (eg, are treatment goals addressed when treatment professionals are not present, overall skill abilities)
E. time involvement, including materials or meetings occurring on a routine basis

VI. Telehealth

Parent/caregiver training and supervision may be provided by telehealth. 1:1 ABA services may be provided via telehealth in instances deemed medically necessary with supporting documentation that provides a plan for the provision of service delivery. Telehealth services must be appropriate for the individual member and not used as the primary method of treatment.

Providers utilizing telehealth must make consistent decisions with best available evidence and clinical consensus. Rationale must consider assessed needs, strengths, preferences and available resources of members/caregivers. The same professional ethics governing in-person care must be followed, including interstate licensure, state regulations, member or caregiver discomfort with technology and technology limitations. Providers must identify protocols for clinical appropriateness, ensure therapeutic benefit and ensure competence for delivering care via telehealth. Peer reviewed studies provides guidance on appropriate screeners/questionnaires in the determination of telehealth services for.

VII. Exclusions

Reimbursement for the following services or activities is not permitted:

A. any services not documented in the treatment plan
B. behavioral methods or modes considered experimental
C. education-related services or activities described under IDEA
D. vocational services or those available through programs funded under Section 110 of the Rehabilitation Act of 1973
E. components of adult day care programs
F. treatment solely for the benefit of the family, caregiver, or therapist
G. treatment focused on recreational activities or in nonconventional settings, even if provided by licensed providers (eg, wilderness camps, ranch programs)
H. treatment worsening symptoms, prompting member regression or not part of core symptoms or ASD
I. treatment unexpected to cause measurable, functional improvement or improvement is not documented
J. duplicative therapy services addressing the same behavioral goals using the same behavioral goals using the same techniques as the treatment plan, including services under an IEP
K. services provided by family or household members or custodial care not requiring trained or professional ABA staff

L. shadowing, paraprofessional, companion services, personal training or life coaching in any setting
M. services more costly than an alternative service(s) as likely to produce equivalent diagnostic or therapeutic results for the member

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. Program Integrity will be engaged for an annual review of data.

II. CareSource reserves the right to request supervision documentation, particularly related to telehealth services.

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	
Date Revised	01/27/2020	Added program attributes, definitions of provider types and ABA; title change; clarified PAd services; changed NP to healthcare provider trained in ASD; added IV, willingness to participate, description of poc, ages; clarified provider requirements; added ASD diagnosis, home school/IEP, doc requirements, type of ASD treatment program with PA; revised continuation of ABA therapy requirements. Added AFLS, ESDM and PEAK-DT assessments & section on ABA transition to school, revised discontinuation criteria & exclusions; removed PA checklist.
	01/25/2021	Clarified telehealth, moved doc requirements to Medical Records Doc for Practitioners; removed transition to school section; updated school section& RBT supervision; updated definitions & ABA criteria.
	08/04/2021	Removed PA language. III.B.1. Primary diagnosis by a qualified practitioner. Added to section 5. F.02: Removed old section M. to sec. DIII 5.g. added ABA services must include parent/family training. Edited Sec. V. Removed VII. A
	03/30/2022	E-voted ODM changes Sec. B. 1 and 2
	01/04/2023	Consolidated information into Sec. IV. Initial ABA Treatment Plan. Added Sec. V.J. Parent/Caregiver Involvement. Updated references.
	04/12/2023	Reorganized policy & updated definitions. Removed 1:1 telehealth ABA exclusion. Removed I under Exclusions.
	03/13/2024	Annual review. Added VII-X. Merged AD policy info to Cond of Coverage section. Updated H. Approved at Committee.
	09/25/2024	Added background, D.I.D, IX.E., E.IV. Updated references. Approved at Committee.
	10/23/2024	Removed parent signature as requirement per ODM. Approved at Committee.

	03/26/2025 02/11/2026	Removed VII.A.3. and B.7. Approved at Committee. Annual review. Removed payment information – PY-1638. Simplified background. Added Note: in II.A.3., C.1 & C.3. Added (III) continuations will not be processed as initials. Approved at Committee.
Date Effective	09/01/2026	
Date Archived		

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