CareSource

MEDICAL POLICY STATEMENT
Nevada Medicaid

Policy Name & Number	Date Effective
Applied Behavior Analysis for Autism Spectrum Disorder-NV MCD-MM-1846	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.

Table of Contents

A. Subject 2
B. Background 2
C. Definitions 4
D. Policy 4
E. Conditions Of Coverage 10
F. Related Policies/Rules 10
G. Review/Revision History 11
H. References 11

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 varies widely in severity and symptoms, depending on the developmental level and chronological age of the individual. ASD is characterized by specific developmental deficits that affect socialization, communication, academic and personal functioning. Individuals are typically diagnosed before entering grade school, and symptoms are noticed across multiple contexts, including social reciprocity, nonverbal communicative behaviors, and 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 ASD symptoms, maximizing learning, facilitating social integration, and improving quality of life for the member and family/caregiver(s). 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 and other disorders, including Fetal Alcohol Spectrum Disorders.

ABA is based on the science of behavior, which was founded on 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 in that it should always be adapted to the needs of each individual, 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.

Severity levels for ASD are divided into 2 domains, social communication and restricted, repetitive behaviors:

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,	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/ repetitive behaviors markedly interfere with functioning in all spheres.

	and minimal response to social overtures from others.	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. Although additional studies are necessary, a 2012 meta-analysis of five 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 in a public or private school system, research supports the use of group therapy for school readiness and improved social skills. Training must be an integral component of the management of the underlying disorder and include clearly defined goals, teach desired behaviors, provide prompting for 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).

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), reviewed at a minimum of once a year for eligible children. 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 most recently amended the IDEA through Public Law 114-95, Every Student Succeeds Act, in December 2015.

CareSource follows guidance from the Division of Health Care Financing and Policy (DHCFP), particularly the *Medicaid Services Manual* (*MSM*) and Nevada regulations. Any guidance from the State of Nevada supersedes this policy.

C. Definitions

- **Applied Behavior Analysis (ABA)** – The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
- **Caregiver/Family Training** – Therapist teaches parents/caregivers to implement methods utilized in a clinical setting into other environments, such as the home or 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 (eg, antecedents, consequences, setting events and motivating operations), 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 a provider/practitioner compliant with Nevada statutes with approved supervision, as applicable, including the following (not an all-inclusive list):
  - Board Certified Assistant Behavior Analyst (BCaBA)
  - Board-Certified Behavior Analyst (BCBA)
  - Board Certified Behavior Analyst - Doctoral (BCBA-D)
  - Registered Behavior Technician (RBT)
- **Standardized Diagnostic Assessment Tools** – Direct assessment, evidence-based tools designed to assist with identification of symptoms and criteria for a diagnosis or disorder.
- **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.
  - BCaBA services must be supervised by a BCBA, BCBA-D, or a licensed psychologist who has tested in ABA and is certified by the American Board of Professional Psychology in Behavioral and Cognitive Psychology.
- **Treatment Plan** – A written document describing presenting behavior problem(s) and behavioral goals and interventions selected to alter behavior based on information gathered from in-person assessments, review of records 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 initially with a baseline and then, again, 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 is a medical necessary treatment for any age for conditions recognized as medically necessary (ie, Autism Spectrum Disorder, Fetal Alcohol Spectrum Disorder [FASD], other developmental diagnosis). Members under age 21 will be evaluated in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage authority benefit plan.
C. Treatment goals and intensity will be based on individual needs and progress in treatment with a focus on remediation of symptoms based on clinical standards.
D. The member's treatment record (eg, plans of care, treatment plans, behavior support plans, functional assessments) must be completed by the provider or practitioner, signed by the parent or legal guardian (if minor age) or by the member if applicable, and submitted to CareSource prior to claim submission. Claims will not be accepted without accompanying, signed treatment documentation.
E. Services are to be provided in the least restrictive, most normative setting possible, including a medical professional clinic/office, a community environment or in the member's home.

II. Covered Services

The DHCFP recognizes 2 types of ABA treatment models: focused and comprehensive. More information about key characteristics to be demonstrated throughout assessment and treatment can be found in Section 3704 of the *MSM*.

A. Behavior screening must be nationally accepted developmental screens. A recommended list of screen is provided by Nevada along with a link to the appropriate page in Section 3704 of the *MSM.* No reviews of medical necessity are required for behavior screens.
B. Comprehensive evaluations are discussed in *MSM* Chapter 600.
C. Behavior assessment is a comprehensive assessment that is an individualized examination establishing the presence or absence of developmental delays and/or disabilities and determining readiness for change while identifying strengths or problem areas that may affect treatment. The information collected will be used to determine appropriate interventions and treatment planning. This includes an extensive member history, including, but not limited to, the following:
    1. current medical conditions and past medical history
    2. labs and diagnostics
    3. medication history
    4. substance abuse history
    5. legal history
    6. family, educational and social history
    7. risk assessment

III. Initiation of ABA Services

All services must be reviewed for medical necessity prior to service provision.

A. Documentation: CareSource must receive documentation that confirms the following medical criteria:
   1. definitive, primary diagnosis of ASD, FASD, or other developmental diagnosis for which ABA is medically necessary and rendered according to the written orders of
      a. the physician
      b. physician's assistant (NRS 630.271)
      c. Nevada Board of Psychological Examiners
      d. advanced practitioner registered nurse (APRN)/nurse practitioner (NP)
   2. treatment regimen designed and signed by a qualified ABA provider
   3. standardized diagnostic assessment tools that are considered multidisciplinary evaluations, including
      a. Autism Diagnostic Observation Schedule, 2nd ed (ADOS-2)
      b. Childhood Autism Rating Scale, 2nd ed (CARS-2)
      c. Gilliam Autism Rating Scale, 2nd edit. (GARS-2)
      d. Fetal Alcohol Spectrum Disorders diagnostic category

      NOTE: If the Diagnostic and Statistical Manual (DSM), most current edition, criteria alone are used as the sole basis for diagnosis, the provider must submit documentation of the specific DSM criteria met.
   4. written documentation (eg, provider letter) that describes *DSM* clinical symptoms present within the past year requiring treatment if the submitted diagnostic evaluation was completed more than 24 months from date of request

B. Initial Behavior Assessment and Reassessments: A review of medical necessity is not required but are limited to 1 every 180 days, unless prior authorized. Before services are provided, an initial behavior identification assessment will be performed by a fully credentialed BCBA with state licensure, if available, and develop a treatment plan.

C. Initial Treatment Plan:

   All ABA services must be provided under a treatment plan developed and approved by a licensed psychologist, BCBA-D or BCBA, supported by a BCaBA where applicable. The licensed psychologist, BCBA-D or BCBA trains the BCaBA and RBT to implement assessment and intervention protocols with the individual and provides training and instruction to the parent/guardian and caregiver as necessary to support the implementation of the ABA treatment plan. The licensed psychologist, BCBA-D or BCBA is responsible for all aspects of clinical direction, supervision, and case management.

   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:

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 individualized education plans (IEP)
e. history of ABA services, including service dates and progress notes
f. all behavioral health diagnoses and services, including any hospitalizations
g. other services member is receiving (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 (eg, how ABA addresses current areas of need), including the following:
   a. history with symptom intensity and symptom 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 (eg, communication problems, relationship development, social and problem behaviors) must include the following:
   a. outcome driven, performance-based, and individualized measures focused on targeted symptoms, behaviors, and functional impairments that occur prior to the initiation of treatment
   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 member and caregiver/family in the implementation of treatment **OR** documentation detailing barriers to family/ caregiver participation and how those barriers are being actively addressed
   d. specific and measurable objectives to address each skill deficit and behavior excess goal
      1. delineate the baseline levels of target behaviors
      2. identify short, intermediate and long-term goals and objectives that are behaviorally defined
      3. criteria that will be used to measure achievement of behavior objectives
      4. target dates for when each goal will be mastered
4. Behavioral Intervention Plan and/or a Plan of Care (POC)
5. a plan to modify the intensity and duration of treatment over time based on the member's progress

6. coordination with other behavioral health, community members, school personnel and medical providers that includes parental or caregiver's documented consent
7. training and supervision enabling BCaBA and RBT implementation of assessment and treatment protocols
8. discharge criteria as a written component of the treatment plan at the initiation of services and updated throughout the treatment process, involving a gradual step down in services, anticipated discharge date and next level of care

IV. 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.III.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
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

V. Discontinuation of ABA Therapy

The *MSM* publishes additional guidance on discharge planning and discharge summaries, including appropriate planning protocols and summary documentation requirements. 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 two 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.

VI. Parent/Caregiver Training

The parent/guardian must be present during all provider training and supervisory visits that occur during home-based services. A parent/guardian may designate an authorized representative 18 years of age or older to participate in the parent/ guardian's absence during home-based services. 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 by signing the treatment plan or plan or care, including participation in treatment hours, keeping schedule appointments, and informing the provider within 24 hours if an appointment needs rescheduled
B. how the parents/caregivers will be trained in skills that can be generalized to the home and other environments, including methods by which the parents and/or caregivers will demonstrate trained skills
C. barriers to parent involvement and plans to address (eg, are treatment goals addressed when treatment professionals are not present, overall skill abilities)
D. time involvement, including materials or meetings occurring on a routine basis
E. participation in discussion during supervisory visits and training

VII. Telehealth

Providers utilizing telehealth for the delivery of services must make decisions that are 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, including interstate licensure challenges, state regulatory issues, member or caregiver discomfort with technology, technology limitations, and cultural acceptance of virtual visits. Providers must identify protocols for clinical appropriateness (eg, risk assessment, safety planning, patient/caregiver characteristics), ensure therapeutic benefit for recipients, and ensure provider competence of delivering care via telehealth modalities. 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.

VIII. Exclusions

A. reimbursement for the following services or activities is not permitted:
    1. any services not documented in the treatment plan or not meeting medical

necessity requirements
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

B. treatment solely for the benefit of the family, caregiver, or therapist, reimbursement of the parent/guardian for participation in treatment planning or services rendered by the parent/guardian
C. treatment focused on recreational, educational or vocational outcomes
D. treatment worsening symptoms or prompting member regression
E. treatment for symptoms and behaviors not part of core symptoms of ASD
F. goals focused on academic targets
G. treatment unexpected to cause measurable, functional improvement or improvement is not documented
H. duplicative therapy services addressing the same behavioral goals using the same techniques as the treatment plan, including services under an IEP, or care coordination and/or treatment planning billed independently of direct service
I. care primarily custodial in nature and not requiring trained/professional ABA staff
J. shadowing, para-professional, or companion services in any setting
K. personal training, life coaching, respite services, child care, or phone consultation
L. services more costly than an alternative service(s), which are likely to produce equivalent diagnostic or therapeutic results for the member
M. 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), including equine therapy and hippotherapy

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 – Reimbursement Policy
Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	08/13/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
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. 28th ed. Updated March 14, 2024. Accessed August 1, 2025. www.careweb.careguidelines.com
3. Augustyn M. Autism spectrum disorder in children and adolescents: evaluation and diagnosis. UpToDate. Updated July 7, 2025. Accessed August 1, 2025. www.uptodate.com
4. Augustyn M. Autism spectrum disorder (ASD) in children and adolescents: terminology, epidemiology, and pathogenesis. UpToDate. Updated August 19, 2024. Accessed August 1, 2025. www.uptodate.com
5. Augustyn M, Von Hahn E. Autism spectrum disorder in children and and adolescents: clinical features. UpToDate. Updated May 6, 2025. Accessed August 1, 2025. www.uptodate.com
6. Autism spectrum disorder. American Academy of Pediatrics. Updated April 5, 2023. Accessed August 1, 2025. www.aap.org
7. Autism spectrum disorder in young children: screening. U.S. Preventive Services Task Force; 2016. Accessed August 1, 2025. www.uspreventiveservicestaskforce.org
8. Autism Spectrum Disorders: M-7075. MCG. 28th ed. Updated March 14, 2024. Accessed August 1, 2025. www.careweb.careguidelines.com
9. Autism Spectrum Disorders: B-012-HC. MCG. 28th ed. Updated March 14, 2024. Accessed August 1, 2025. www.careweb.careguidelines.com
10. Autism Spectrum Disorders, Child or Adolescent: B-019-IP. MCG. 28th ed. Updated March 14, 2024. Accessed August 1, 2025. www.careweb.careguidelines.com
11. Autism Spectrum Disorders, Outpatient Care: B-012-AOP. MCG. 28th ed. Updated March 14, 2024. Accessed August 1, 2025. www.careweb.careguidelines.com
12. *BACB Newsletter*. Behavior Analyst Certification Board; September 2023. Accessed August 1, 2025. www.bacb.com
13. *BACB Newsletter: Introducing the 2026 RBT Examination and Certification Requirements*. Behavior Analyst Certification Board; December 2023. Accessed August 1, 2025. www.bacb.com
14. Bak M, Plavnick J, Dueñas A, et al. The use of automated data collection in applied behavior analytic research: a systematic review. *Behavior Analysis: Res Practice.* 2021;21(4), 376–405. https://doi.org/10.1037/bar0000228

15. *Board Certified Behavior Analyst Handbook*. Behavior Analyst Certification Board. Updated December 2023. Accessed August 1, 2025. www.bacb.com
16. *Board Certified Assistant Behavior Analyst Handbook*. Behavior Analyst Certification Board. Updated December 2023. Accessed August 1, 2025. www.bacb.com
17. 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
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, I: common clinical challenges of patients with mental health or behavioral emergencies. *Pediatr.* 2016;138(3):e20161570. doi:10.1542/peds.2016-1570
19. 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
20. 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
21. *Ethics Code for Behavior Analysts*. Behavior Analyst Certification Board; 2020. Updated January 1, 2023. Accessed August 1, 2025. www.bacb.com
22. Evidence Analysis Research Brief: Applied Behavior Analysis Training Via Telehealth for Caregivers of Children with Autism Spectrum Disorder. Hayes; 2022. Accessed August 1, 2025. www.evidence.hayesinc.com
23. Evidence Analysis Research Brief: Direct-To-Patient Applied Behavior Analysis Telehealth for Children with Autism Spectrum Disorder. Hayes; 2022. Accessed August 1, 2025. www.evidence.hayesinc.com
24. 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
25. Health Technology Assessment: Comparative Effectiveness Review of Intensive Behavioral Intervention for Treatment of Autism Spectrum Disorder. Hayes; 2019. Accessed August 1, 2025. www.evidence.hayesinc.com
26. 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:10.1542/2019-3447
27. Information on autism spectrum disorder for healthcare providers. Centers for Disease Control and Prevention (CDC). Accessed August 1, 2025. www.cdc.gov
28. 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/s10803-020-04839-z
29. 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
30. 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/cps0000117
31. *Medicaid Services Manual.* Nevada Division of Health Care Financing and Policy. Updated April 1, 2024. Accessed August 1, 2025. www.dhcfp.nv.gov
32. *Registered Behavior Technician Handbook*. Behavior Analyst Certification Board. Updated December 2023. Accessed Augst 1, 2025. www.bacb.com
33. 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
34. 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
35. Weissman L. Autism spectrum disorders in children and adolescents: behavioral and educational interventions. UpToDate. Updated July 8, 2025. Accessed August 1, 2025. www.uptodate.com
36. Weissman L. Autism spectrum disorder in children and adolescents: overview of management. UpToDate. Updated July 8, 2025. Accessed August 1, 2025. www.uptodate.com
37. Weissman L. Autism spectrum disorder in children and adolescents: pharmacologic interventions. UpToDate. Updated October 8, 2024. Accessed August 1, 2025. www.uptodate.com
38. Weissman L. Autism spectrum disorder in children and adolescents: screening tools. UpToDate. Updated January 24, 2024. Accessed August 1, 2025. www.uptodate.com
39. Weissman L. Autism spectrum disorder in children and adolescents: surveillance and screening in primary care. UpToDate. Updated November 5, 2024. Accessed August 1, 2025. www.uptodate.com
40. Weissman L, Harris H. Autism spectrum disorder in children and adolescents: complementary and alternative therapies. UpToDate. Updated July 31, 2025. Accessed August 1, 2025. www.uptodate.com
41. 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 metaanalysis. *Clin Psychol*. 2022;29(4):400-414. doi:10.1037/cps0000106
42. 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