MEDICAL POLICY STATEMENT
TrueCare

Policy Name & Number	Date Effective
Applied Behavior Analysis for Autism Spectrum Disorders-TrueCare-MM-1477	05/01/2026
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 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 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.

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 the human condition 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), reauthorized 2004 and most recently in 2015.

C. Definitions

- **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.
- **Practitioner** – All ABA services must be provided by providers licensed in Mississippi as a Licensed Behavior Analyst (LBA) or Licensed Assistant Behavior Analyst (LABA) under the supervision of an LBA. Behavior Technicians must be certified as Registered Behavior Technicians (RBT) and listed with the respective State Licensure Board under a supervising LBA. Licensed Psychologists may provide services if the scope of practice, training, and competence includes ABA.
- **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.

D. Policy

I. General Guidelines

A. Providers must adhere to the Mississippi Administrative Code (MAC), the Department of Mental Health's (DMH) Operational Standards document and any other published materials from Mississippi Division of Medicaid (DOM). State sources supersede information in this policy.

B. Medical necessity review is required for all ABA services initially with a baseline and then, again, every 6 months. Appropriate documentation must be submitted for review. Treatment should not be more costly than an alternative service or sequence of services as likely to produce equivalent 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. ABA services will be provided for members under the age of 21. Any conservatorship or guardianship documents should be provided to TrueCare, as applicable.

D. Treatment goals and intensity will be based on individual needs and progress in treatment with a focus on remediation of symptoms. TrueCare must have a copy of the Plan of Services and Supports (PSS) for any member receiving Intellectual/Developmental Disability (IDD) services. Information about PSS documentation can be found in the DMH *Record Guide for Mental Health, Intellectual and Developmental Disabilities, and Substance Use Disorders Community Providers Manual.*

II. Initiation of ABA Services

A. Documentation: TrueCare must receive documentation that confirms the following medical criteria:

1. definitive, primary diagnosis of ASD 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. psychologist (see definition of *practitioner* above)
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 present (ie, provider letter) 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. Behavioral Assessment: A licensed ABA practitioner will perform a behavioral assessment (BA) and develop a treatment plan before services are provided. BAs are generally 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 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, signed by the parent/caregiver and BCBA 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)
         NOTE: IEP/504 information must be provided to TrueCare.
      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 hospitalizations
      g. other services the member is 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 including the following:
   a. outcome driven, performance-based, and individualized focused on targeted symptoms, behaviors, and functional impairments
   b. based on the 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 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. 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 member progress, including an individualized, specific discharge plan
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 must be submitted for approval. Any guardianship documents must also be submitted to TrueCare, as applicable, for members 18 or older.
   2. In addition to the submitted treatment plan, the treating BCBA must include the following:
      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 training, ability and willingness to learn/use therapy techniques in the home
   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 therapy services

III. Continuation of ABA

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. Requests for continuation of ABA are submitted every 6 months, and documentation must meet **EITHER A.-C. OR D**.:

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 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.

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 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 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.

V. Parent/Caregiver Training

Training will evolve as goals are met. Parent/caregiver should be actively working 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 environments
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 where appropriate. 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 for services must make decisions consistent with best available evidence. Clinical rationale must consider assessed needs, strengths, preferences and available resources of members/caregivers. The same 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 via telehealth modalities. Peer reviewed studies provides guidance on appropriate screeners and for use in the determination of appropriate telehealth services for particular members.

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 under IDEA or focused on education outcomes
D. vocational services 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 worsening symptoms or prompting member regression
H. treatment for symptoms and behaviors not part of core symptoms diagnosis
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 techniques as the treatment plan, including services under an IEP
K. services provided by family or household members
L. care primarily custodial in nature and not requiring trained/professional ABA staff
M. shadowing, para-professional, companion services, personal training or life coaching in any setting
N. services are more costly than alternative service(s) as likely to produce equivalent diagnostic or therapeutic results for the member
O. programs or services performed in nonconventional settings or for recreation (eg, wilderness camps, ranch programs)

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. TrueCare reserves the right to request documentation, including supervision documentation and any 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	02/26/2025	New policy. Approved at Committee.
Date Revised	02/11/2026	Removed PY information – PY-1639 created. Added 'Note:' in II. Updated references. Approved at Committee.
Date Effective	05/01/2026	
Date Archived		

H. References

1. Augustyn M. Autism spectrum disorder in children and adolescents: evaluation and diagnosis. UpToDate. Accessed January 29, 2026. www.uptodate.com
2. Augustyn M. Autism spectrum disorder (ASD) in children and adolescents: terminology, epidemiology, and pathogenesis. UpToDate. Accessed January 29, 2026. www.uptodate.com
3. Augustyn M, Von Hahn E. Autism spectrum disorder in children and adolescents: clinical features. UpToDate. Accessed January 29, 2026. www.uptodate.com
4. 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
5. 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
6. 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
7. 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
8. 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
9. Definitions, 42 U.S.C. § 1396d (2019).
10. 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
11. Evidence analysis research brief: applied behavior analysis training via telehealth for caregivers of children with autism spectrum disorder. Hayes; 2022. Accessed January 29, 2026. www.evidence.hayesinc.com
12. Evidence analysis research brief: direct-to-patient applied behavior analysis telehealth for children with autism spectrum disorder. Hayes; 2022. Accessed January 29, 2026. www.evidence.hayesinc.com
13. 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
14. 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
15. Health technology assessment: comparative effectiveness review of intensive behavioral intervention for treatment of autism spectrum disorder. Hayes; 2019. Accessed January 29, 2026. www.evidence.hayesinc.com
16. 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
17. Information on autism spectrum disorder for healthcare providers. Centers for Disease Control and Prevention. Accessed January 29, 2026. www.cdc.gov
18. Licensed Behavior Analysts, MISS. CODE ANN. §§ 73-75-1 – 27 (2021).
19. 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
20. 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
21. Medicaid, MISS. ADMIN. CODE, Title 23, Parts 100, 200, 206, 208, 223, 225 (2024).

22. MeiMei L, Zenghui M. A systematic review of telehealth screening, assessment, and diagnosis of autism spectrum disorder. *Child Adol Psychiatry Mental Health*. 2022;16(79):1-15. doi:10.1186/s13034-022-00514-6
23. *Mississippi Department of Mental Health Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Community Service Providers*. Mississippi Department of Mental Health. Effective November 1, 2024. Accessed January 29, 2026. www.dmh.ms.gov
24. *Mississippi Department of Mental Health Record Guide for Mental Health, Intellectual and Developmental Disabilities, and Substance Use Disorders Community Providers.* Mississippi Department of Mental Health. Revision 2022. Accessed January 29, 2026. www.dmh.ms.gov
25. Moody CT, Laugeson EA. Social skills training in autism spectrum disorder across the lifespan. *Child Adol Psychiatric Clinics N Amer.* 2020;29(2):359-371. doi:10.1016/j.chc.2019.11.001
26. Screening, Diagnosis, and Treatment of Autism Spectrum Disorder, MISS. CODE ANN. § 83-9-26 (2015).
27. 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
28. 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/s13229023416
29. 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
30. 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
31. Weissman L. Autism spectrum disorder in children and adolescents: overview of management. UpToDate. Accessed January 29, 2026. www.uptodate.com
32. Weissman L. Autism spectrum disorder in children and adolescents: screening tools. UpToDate. Accessed January 29, 2026. www.uptodate.com
33. Weissman L. Autism spectrum disorder in children and adolescents: surveillance and screening in primary care. UpToDate. Accessed January 29, 2026. www.uptodate.com
34. 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:org/10.1037/cps0000106
35. 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