MEDICAL POLICY

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Medical Policy Title	**Applied Behavior Analysis**
Policy Number	**3.01.11**
Current Effective Date	**February 18, 2027**
Next Review Date	**September 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the individual's subscriber contract language are considered first in the determination of a covered service.
(Link to Product Disclaimer)

POLICY STATEMENT(S)

I. A behavior identification assessment for applied behavior analysis (ABA) is considered **medically appropriate** when **ALL** the following are documented:

A. The individual has an established diagnosis of autism spectrum disorder (ASD) made by a licensed physician, licensed psychologist, or other qualified diagnostician acting within their scope of practice and using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) criteria;

B. The behavior identification assessment is conducted by a qualified behavior analyst (e.g., Licensed Behavior Analyst [LBA], Board-Certified Behavior Analyst [BCBA]);

C. The behavior identification assessment is performed for **either** of the following:

1. Initial assessment, prior to initiation of ABA services, to accomplish **all** the following:

a. Establish baseline levels of functioning across relevant domains;

b. Identify target behaviors/skills;

c. Identify functional impairment(s); **and**

d. Support the development of an individualized treatment plan;

or

2. Reassessment, while receiving ABA services**,** for **any** of the following:

a. For re-evaluation of current levels of functioning;

b. To develop, update, or modify the treatment plan;

c. When the prior prescription/referral for ABA services is more than 2 years old; **or**

d. Conducted as clinically indicated (e.g., worsening or emergence of challenging behaviors, lack of measurable progress, change in settings [environment, caregiver, treatment]) based on ongoing evaluation of the individual's response to treatment.

II. ABA services are considered **medically appropriate** for an established diagnosis of ASD (as

defined in Policy Statement I) when **ALL** the following are met:

A. A prescription or referral for ABA services has been provided by a qualified licensed healthcare provider (e.g., physician, psychologist, psychiatric nurse practitioner, pediatric nurse practitioner, or physician assistant);

B. ABA services are directed, monitored, and supervised by a qualified behavior analyst, including services delivered by paraprofessionals;

C. The behavior identification assessment documents the need for ABA services for **either** of the following:

   1. For an initial request for ABA services, objective baseline data demonstrate functional impairment in **at least one (1)** of the following domains:

      a. Communication;

      b. Social interaction;

      c. Adaptive functioning;

      d. Behavioral functioning; **or**

   2. For continued ABA services, objective documentation demonstrates **all** the following:

      a. The individual continues to demonstrate functional impairments requiring ABA services;

      b. Current objective data, including graphic representation, demonstrates measurable and sustained progress toward treatment goals;

      c. Data and clinical assessment support the continued need for service, including maintenance of acquired skills; **and**

      d. ABA intervention has not resulted in worsening of target behavior(s) or deterioration in functioning;

D. An individualized treatment plan developed by a qualified behavior analyst (LBA/BCBA) includes **all** the following:

   1. Clearly defined, measurable goals and objectives targeting applicable domains based on the assessment findings;

   2. Criteria for service transition and discharge of services (e.g., fading, reduction of service intensity);

   3. Description of the planned ABA service delivery, based on individual needs, including **all** the following:

      a. Provider type (BCBA/LBA, BCaBA/CBAA, RBT/behavior technician);

      b. Treatment intensity (hours per week), duration, frequency, and setting;

      c. Service delivery model (e.g., 1:1, group, family guidance); **and**

d. Service modality (in-person, telehealth, hybrid);

i. For telehealth services **only**: the treatment plan documents **all** the following:

a) A qualified behavior analyst has determined, based on clinical assessment, that telehealth delivery is appropriate based on individual characteristics (e.g., age, developmental level, behavioral presentation);

b) Description of and rationale for which services will be delivered via telehealth versus in-person;

c) Required environmental and technological supports are in place (e.g., secure connection, caregiver support, privacy); **and**

d) Parent/caregiver is available and actively engaged in all telehealth sessions to facilitate service delivery (e.g., parent-mediated intervention, caregiver coaching, and implementation of the treatment plan).

III. ABA services are considered **not medically necessary** for **any** of the following:

A. When services are not provided by or under the supervision of a qualified behavior analyst, or providers do not meet State licensure or BACB requirements;

B. ABA services are requested without a behavior identification assessment completed by a qualified behavior analyst;

C. Documentation does not demonstrate measurable progress, without having a modified treatment plan;

D. When the treatment plan discharge criteria are met;

E. Services are duplicative of those provided under the individual's Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), or Individualized Services Plan (ISP) through the school district.

F. Parent support groups.

IV. Services are considered **investigational** for **either** of the following:

A. ABA services for all other diagnoses, including Down Syndrome, ID/IDD, and Rett Syndrome;

B. Interventions not based on ABA principles (e.g., DIR-Floortime, TEACCH).

RELATED POLICIES

Corporate Medical Policy

3.01.24 Neuropsychological and Psychological Testing

11.01.03 Experimental or Investigational Services

POLICY GUIDELINE(S)

I. Medical record documentation must be submitted for purposes of medical necessity review and determination, including but not limited to:

   A. Certification and credentials of the professional providing ABA;

   B. Documented reports of completed diagnostic psychiatric or psychological assessment(s) or other ASD diagnostic testing.

   C. Copy of the individual's Individualized Education Program (IEP) document (when applicable).

   D. Progress notes and discharge plan of the Early Intervention Program or Pre-School Special Education Program (when applicable).

   E. Requested clinical supervision hours and documentation to support the request.

   F. Copy of the behavior identification assessment and treatment plan.

II. The treatment plan and progress notes should be submitted for review at least once every 12 months or as state mandated. Documentation should demonstrate monthly updates, at a minimum. The treatment plan may be requested at any point during treatment, for review for continuity of care and/or periodic concurrent medical necessity review.

III. Coverage is not available for services stipulated in the IEP of a pre-school individual (age three to five years) or a school-age individual (ages five to 21 years) as these services are provided by the individual's school district and are considered free care or a government program.

   A. When applicable, an IEP should be completed through the school district before a request for coverage is submitted to the Health Plan.

   B. If a child is home-schooled, an assessment by the school district should be completed prior to submitting a request to the Health Plan for coverage. Requests for home-schooled children outside New York State will be reviewed on an individual basis, in accordance with regulations of the state in which the individual resides.

   C. ABA services denied by the school district, including summer services, and not covered in a child's IEP, will be reviewed by the Health Plan for medical necessity in accordance with individual's subscriber contract.

   D. Interim summer programs are provided by school districts for children whose diagnoses are severe enough to exhibit the need for a structured learning environment of 12 months' duration, to maintain developmental levels. For pre-school children, summer instruction must be available for those whose disabilities are severe enough to exhibit the need for a structured learning environment of 12 months' duration, to prevent substantial regression.

DESCRIPTION

Multiple treatments are available for ASD, commonly categorized as behavioral, developmental, educational, social-relational, pharmacological, psychological, and complementary/alternative approaches (CDC, 2024)

Applied Behavior Analysis (ABA)

ABA is an evidence-based treatment approach grounded in principles of behavior analysis that uses objective measurement and data-driven decision-making to increase adaptive behaviors and reduce behaviors that interfere with learning and functioning. Published evidence demonstrates that ABA can improve cognitive functioning, language, adaptive behavior, and social skills in children with ASD. ABA-based interventions have been studied in other developmental conditions, including Down syndrome and intellectual disability; however, the evidence for these populations is limited.

ABA interventions range from structured, adult-directed approaches (e.g., discrete trial training) to naturalistic interventions implemented within play, daily routines, and natural environments (e.g., pivotal response training). Early intensive behavioral intervention (EIBI), grounded in the principles of ABA, is among the most well-established treatment approaches for young children with ASD and is characterized by intensive (20–40 hours per week) and long-term (1–4 years) intervention. Treatment intensity should be individualized based on clinical need, and the evidence regarding optimal dosage continues to evolve.

ABA programs are individualized, intensive, and traditionally delivered in a one-to-one, face-to-face format. Services may be delivered in various settings (e.g., home, clinic, school, community) and modalities (e.g., in-person, telehealth, hybrid) based on individual clinical needs.

Provider Licensure and Certification

All providers must meet applicable State licensure requirements and/or Behavior Analyst Certification Board (BACB) standards, including associated education and training requirements. All providers must practice within the scope permitted by those standards.

The Behavior Analyst Certification Board (BACB) establishes professional standards for the education, training, certification, and practice of behavior analysts. According to the BACB (2026), Board Certified Behavior Analysts (BCBAs) are required to complete graduate-level coursework in behavior analysis, supervised fieldwork, and pass a national certification examination. Assistant-level providers (e.g., Board Certified Assistant Behavior Analysts [BCaBAs]) and paraprofessionals (e.g., Registered Behavior Technicians [RBTs]) must meet defined training and competency requirements and provide services under the supervision of a qualified behavior analyst. These standards support the delivery of ABA services within defined scopes of practice and supervision requirements.

A qualified behavior analyst (LBA or BCBA) is responsible for all clinical aspects of ABA services, including behavioral assessment, treatment planning, and ongoing clinical supervision of service delivery.

Assistant-level behavior analysts (Certified Behavior Analyst Assistant [CBAA] or Board-Certified Assistant Behavior Analyst [BCaBA]) may assist in the delivery of ABA services, including participation in assessments, treatment implementation, and data review, only under the direction and supervision of a qualified behavior analyst. They may not practice independently or have primary responsibility for assessment or treatment planning.

Paraprofessionals (e.g., Registered Behavior Technician [RBT], Behavior Technicians [BT]) may

provide direct, protocol-driven ABA services under the direction and supervision of a qualified behavior analyst. This role is limited to implementing treatment plans and collecting data as directed. They may not practice independently, including performing behavioral assessment, functional analysis, diagnosis, or modification of treatment plans.

Naturalistic Developmental Behavioral Interventions (NDBIs)

NDBIs integrate principles of applied behavioral analysis with developmental approaches. NDBIs use behavioral teaching strategies to promote developmentally appropriate skills within natural environments, such as play and routine activities. These interventions are typically delivered in natural settings, incorporate child-initiated interactions, and utilize naturally occurring reinforcement. NDBIs emphasize social communication, engagement, and skill acquisition within the context of typical developmental processes.

The Early Start Denver Model (ESDM) is a naturalistic developmental behavioral intervention that integrates developmental and applied behavior analytic principles.. ESDM uses play-based, child-initiated interactions and measurable outcomes to improve language, play, social communication, and adaptive behavior. Parents and therapists use play, social exchanges, and shared attention in natural settings to improve language, social, and learning skills.

Developmental and Educational Interventions

Developmental relationship-focused interventions emphasize caregiver responsiveness and child-initiated interaction to support social communication and development. These models typically rely on nondirective, play-based strategies rather than behavior-analytic procedures. Examples include:

- DIRFloortime (Developmental, Individual-differences, and Relationship-based), also known as Floortime, focuses on following the child's led to promote increasingly complex social interaction.
- Relationship Development Intervention (RDI), which targets social and emotional development within relationships by increasing motivation, interest, and abilities to participate in shared social interactions.

Educational approaches use structured teaching strategies, environmental modifications, and visual supports to facilitate learning, independence, and skill acquisition in educational settings. Examples include:

- Treatment and Education of Autistic and Related Communication- Handicapped Children (TEACCH), which uses structured classroom strategies based on learning strengths and needs to increase independence, communication, and predictability, often within a classroom setting.
- Learning Experiences and Alternative Programs for Preschoolers and their Parents (LEAP), a comprehensive treatment model for preschool-aged children in inclusive settings. LEAP blends principles of ABA with special and general education teaching techniques to support social interaction.

SUPPORTIVE LITERATURE

Autism Spectrum Disorder (ASD)

Although ABA may be utilized across the lifespan, the strongest evidence base is in children and adolescents with ASD. Randomized controlled trials, systematic reviews and meta-analyses support the efficacy of ABA in intellectual functioning, language development, adaptive behavior, and daily living skills in children with ASD (Virues-Ortega 2010; Linstead 2017; Reichow 2018).

For adults with ASD, the evidence base for ABA is more limited. Bishop-Fitzpatrick et al (2013) conducted a systematic review of psychosocial interventions for adults with ASD. Of 1,217 studies reviewed, only 13 met inclusion criteria. The majority were single-case studies or non-randomized controlled trials, and most focused on ABA or social cognition training. Effects were largely positive (d=0.14–3.59); however, the quantity and quality of included studies was limited.

Non-ASD Diagnoses

Overall, the evidence remains insufficient to demonstrate improvement in net health outcomes necessary to support coverage for non-ASD diagnoses. Evidence is limited to single-case and small studies. While multiple professional sources acknowledge that ABA principles may benefit individuals with intellectual disability, Down syndrome, and Rett syndrome - particularly for challenging behavior and communication – there are currently no randomized controlled trials.

Neil et al (2021) conducted a meta-analysis of single-case studies evaluating ABA for individuals with Down syndrome (n= 36 studies), which demonstrated a medium overall effect, primarily in communication and challenging behavior outcomes.

Ho et al (2021) conducted a systematic review of behavior analytic interventions for young children (ages 0–8) with intellectual disability without ASD (49 studies). Despite limitations to the quality of the body of research, various behavior analytic interventions met criteria for being established interventions when used for targeting communication, adaptive, and pre-academic skills.

Naturalistic Developmental Behavioral Interventions (NDBIs)

Rogers et al (2019) conducted the largest multisite, single-blind, randomized controlled Early Start Denver Model (ESDM) trial to date, with 118 children 14 to 24 months old with ASD. A significant advantage was found only for language outcomes. No significant differences in developmental quotient, autism severity, or adaptive behavior compared to community interventions. The treatment effect of group on language outcomes was not moderated by baseline developmental quotient, autism severity, or language. The authors concluded that findings partially replicate prior language outcomes but are limited by reduced generalizability due to higher-than-typical treatment intensity and staff training, as well as participant attrition that may reflect challenges in sustaining family engagement.

Sandbank et al (2023) published an updated Project AIM systematic review and meta-analysis of controlled studies evaluating nonpharmacologic interventions for young autistic children (252 studies; n=13,304). When analyses were restricted to RCTs, NDBIs demonstrated significant effects on

adaptive behavior, language, play, social communication, and diagnostic characteristics of autism. However, when analyses were restricted to studies at lower risk of detection bias, only the effect on diagnostic characteristics of autism remained statistically significant (g=0.30, p=0.03).

Developmental and Educational Interventions

The overall evidence for developmental and educational interventions that are not based on ABA principles is limited, with insufficient high-quality data to determine their impact on net health outcomes.

Published evidence for DIR/Floortime includes small randomized trials and observational studies with methodological limitations, and systematic reviews (e.g., Solomon 2007; Pajareya 2011; Solomon 2014, Divya 2023).

Evidence for TEACCH includes meta-analyses showing small to moderate effects on social behavior and motor skills (Virues-Ortega 2013).

Sandbank et al. (2023) published an updated Project AIM systematic review and meta-analysis of controlled studies evaluating nonpharmacologic interventions for young autistic children (252 studies; n=13,304). When analyses were restricted to RCTs, developmental interventions demonstrated a significant effect on social communication (g=0.28). When analyses were further restricted to exclude caregiver- or teacher-reported outcomes, a significant effect on social communication remained.

Telehealth Services

Lindgren et al (2020) conducted a randomized controlled trial (RCT) evaluating functional communication training (FCT) delivered via telehealth for young children (ages 21–84 months) with ASD and significant problem behavior, compared to treatment as usual. A total of 38 participants completed the functional analysis and were randomized to immediate FCT (n=21) or a waitlist control group (n=17). Parents implemented FCT in their homes with real-time coaching from behavioral consultants via weekly 60-minute telehealth sessions over an average of 9 weeks (range: 3–20), with no in-person treatment component. The FCT group achieved a 98% mean reduction in problem behavior ($p<0.0001$) with a large effect size of 1.57, along with significant increases in manding and task completion, while the control group showed no significant change. All 21 participants in the immediate group achieved ≥80% behavior reduction versus 2 of 17 (12%) controls ($p<0.0001$). After the RCT, the participants in the delay group who received FCT achieved comparable reductions (95.83%), replicating the results. Treatment gains were maintained at 6-month follow-up, and parent acceptability was high (mean 6.30/7.0). Limitations include the sample size, single-site design, inability to blind participants, low minority representation (10%), narrow age range, and focus on a single ABA technique rather than comprehensive ABA services. This is the first RCT of FCT and the first randomized FCT trial conducted entirely via telehealth.

PROFESSIONAL GUIDELINE(S)

American Psychological Association (APA)

The APA (2017) recognizes ABA as grounded in psychological science and supported by evidence-

based practice, and affirms that the practice and supervision of ABA fall within the scope of the discipline of psychology.

American Academy of Pediatrics (AAP)

In 2020, the AAP Council on Children with Disabilities issued an updated clinical report on the identification, evaluation, and management of children with ASD into a single report (Hyman 2020). The AAP states that ABA improves cognitive functioning and language skills, with better results from more intense therapy, and recommends prompt implementation of evidence-based interventions. The AAP made the following statements related to published evidence:

- A comprehensive ABA approach for younger children, also known as early intensive behavioral intervention, is supported by a few randomized controlled trials (RCTs) and a substantial single-subject literature.
- Developmental relationship–focused interventions (Floortime and RDI) need more research to evaluate efficacy and community use.
- Educational interventions require rigorous studies and are necessary to understand the effectiveness of different models.

Council of Autism Service Providers (CASP)

In 2024, the CASP ASD Practice Guidelines (third edition) describes ABA as a data-driven, evidence-based behavioral health treatment that uses objective assessment and behavior analysis to improve health, skills, independence, and quality of life. Treatment should be based on the clinical needs of the individual and not constrained by age, noting that ABA is effective across the lifespan and that research has not established an age limit beyond which ABA is ineffective. The guidelines support service delivery through both in-person and telehealth modalities when clinically appropriate. CASP recommends a general standard of 1–2 hours of case supervision for every 10 hours of direct treatment, individualized based on patient needs, clinical complexity, and the experience of the supervising behavior analyst.

In 2021, CASP published Practice Parameters for Telehealth—Implementation of ABA, which provides guidance for designing, implementing, and operating ABA services delivered via telehealth in a broad range of clinical settings. Providers and organizations should consider the potential limitations of telehealth, including individual characteristics, caregiver availability, and features of the treatment environment.

REGULATORY STATUS

New York State (NYS) Insurance Law requires coverage for screening, diagnosis, and treatment of autism spectrum disorder (ASD). For more information on NYS Insurance Law, please refer to reference section.

CODE(S)

- Codes may not be covered under all circumstances.

- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
97148	Behavior identification-supporting assessment of harmful behavior; each 15 minutes of technician time face-to-face with a patient, requiring the following components: delivered by 2 technicians, for a patient who exhibits harmful behavior, conducted in an environment that is customized to the patient's behavior (Effective 1/1/27)
97149	Behavior identification-supporting assessment of harmful behavior; each additional technician present, each 15 minutes (List separately in addition to code for primary procedure) (Effective 1/1/27)
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes

Code	Description
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
97159	Adaptive behavior treatment of harmful behavior; each 15 minutes of technician time face-to-face with a patient, requiring the following components: delivered by 2 technicians, for a patient who exhibits harmful behavior, conducted in an environment that is customized to the patient's behavior (Effective 1/1/27)
97160	Adaptive behavior treatment of harmful behavior; each additional technician present, each 15 minutes (List separately in addition to code for primary procedure) (Effective 1/1/27)
97173	Adaptive behavior treatment with analysis, administered by physician or other qualified health care professional, face-to-face with 1 patient, each 15 minutes (Effective 1/1/27)
97180	Adaptive behavior non-face-to-face services, personally performed by a physician or other qualified health care professional, each 15 minutes, with any of the following elements, when performed: review and analysis of data and session notes on patient treatment targets, clinical decision-making regarding the need to modify treatment targets, goals, or protocols and/or making those modifications, clinical decision-making regarding the need for additional assessment and developing or modifying assessment protocols, developing discharge or transition plan, training on or reviewing treatment targets and/or revised assessment or treatment protocols with technician(s) *(Effective 1/1/27)*
0362T Termed 12/31/26	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.
0373T Termed 12/31/26	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.

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HCPCS Codes

Code	Description
Not Applicable	

ICD10 Codes

Code	Description
Multiple Codes	

REFERENCES

ABA Coding Coalition [Internet]. Reporting CPT codes for telehealth delivery of adaptive behavior (ABA) services. 2020 Apr [accessed 2026 Aug 25]. Available from: https://abacodes.org/wp-content/uploads/2020/05/ABACC-Reporting-CPT-Telehealth-Delivery.pdf

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). Washington, DC, American Psychiatric Association, 2022.

American Psychological Association [Internet]. APA policy manual: Applied behavior analysis. 2017 [accessed 2026 Aug 25]. Available from: https://www.apa.org/about/policy/applied-behavior-analysis

Bagner DM, et al. Telehealth treatment of behavior problems in young children with developmental delay: a randomized clinical trial. JAMA Pediatr. 2023 Mar 1;177(3):231-239. Erratum in: JAMA Pediatr. 2023 Mar 1;177(3):323.

Behavior Analyst Certification Board [Internet]. About behavior analysis. No date [accessed 2026 Jun 25]. Available from: https://www.bacb.com/about-behavior-analysis/

Behavior Analyst Certification Board [Internet]. Credentials. 2026 [accessed 2026 Aug 25]. Available from: https://www.bacb.com/

Bishop-Fitzpatrick L, et al. A systematic review of psychosocial interventions for adults with autism spectrum disorders. J Autism Dev Disord. 2013 Mar;43(3):687-94.

Center for Disease Control [Internet]. Autism spectrum disorder (ASD). Treatment and intervention for autism spectrum disorder. 2024 May 16 [accessed 2026 Aug 25]. Available from: https://www.cdc.gov/autism/treatment/index.html

Colombo RA, et al. An essential service decision model for ABA providers during crisis. Behav Anal. Pract. 2020 May 22;13(2):306-311.

Council of Autism Service Providers [Internet]. Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder. Guidance for healthcare funders, regulatory bodies, service providers, and consumers. Third Edition. 2024 [accessed 2026 Aug 25]. Available from: https://www.casproviders.org/resources

Council of Autism Service Providers [Internet]. Practice parameter for telehealth-implementation of applied behavior analysis: second edition. Updated 2021 Dec 01 [accessed 2026 Aug 25]. Available

from: https://www.casproviders.org/resources

Dionne M, et al. Floor time play with a child with autism: a single-subject study. Can J Occup Ther. 2011 Jun;78(3):196-203.

Divya KY, et al. DIR/floor time in engaging autism: a systematic Review. Iran J Nurs Midwifery Res. 2023 Apr 14;28(2):132-138.

Ferguson J, et al. Telehealth as a model for providing behaviour analytic interventions to individuals with autism spectrum disorder: a systematic review. J Autism Dev Disord. 2019 Feb;49(2):582-616.

Gutstein SE. Empowering families through relationship development intervention: an important part of the biopsychosocial management of autism spectrum disorders. Ann Clin Psychiatry. 2009;21(3):174–182

Ho H, et al. A systematic review of behaviour analytic interventions for young children with intellectual disabilities. J Intellect Disabil Res. 2021 Jan;65(1):11-31. Epub 2020 Sep 24.

Hyman SL, et al.; Council on Children with Disabilities, section on developmental and behavioral pediatrics. Identification, evaluation, and management of children with autism spectrum disorder. Pediatrics. 2020 Jan;145(1):e20193447. Epub 2019 Dec 16.

Ichikawa K, et al. TEACCH-based group social skills training for children with high-functioning autism: a pilot randomized controlled trial. Biopsychosoc Med. 2013 Oct 1;7(1):14

International Council on Development and Learning (ICDL) [Internet]. Home of DIRFloortime (Floortime). No date [accessed 2026 Jun 25]. Available from: https://www.icdl.com/

Leaf JB, et al. An evaluation of a behaviorally based social skills group for individuals diagnosed with autism spectrum disorder. J Autism Dev Disord. 2017 Feb;47(2):243-259.

Lindgren S, et al. A randomized controlled trial of functional communication training via telehealth for young children with autism spectrum disorder. J Autism Dev Disord. 2020 Dec;50(12):4449-4462.

Linstead E, et al. Intensity and learning outcomes in the treatment of children with autism spectrum disorder. Behav Modif. 2017; 41(2):229–252

Lovaas OI. Behavioral treatment and normal educational and intellectual functioning in young autistic children. J Consulting Clinical Psychology. 1987;55:3-9.

Micai M, et al. Effectiveness, implementation settings, and research priorities of telemedicine-delivered interventions for children and adolescents with autism spectrum disorder: A systematic review. Neurosci Biobehav Rev. 2024 Nov;166:105875.

Neil N, et al. A meta-analysis of single-case research on applied behavior analytic interventions for people with Down syndrome. Am J Intellect Dev Disabil. 2021 Mar 1;126(2):114-141.

New York State Senate [Internet]. Consolidated Laws of New York. Insurance. Chapter 28. Article 32, Section 3216 (25) and 3221 (17); Article 43, Section 4303 (ee). Available from https://www.nysenate.gov/legislation/laws/CONSOLIDATED [accessed 2026 Aug 25].

Nohelty K, et al. Effectiveness of telehealth direct therapy for individuals with autism spectrum disorder. Beh Analysis in Practice. 2022 Sept;15(3):643-658.

Pajareya K, et al. A pilot randomized controlled trial of DIR/Floortime parent training intervention for pre-school children with autistic spectrum disorders. Autism. 2011 Sep;15(5):563-77.

RDIconnect [Internet]. What is RDI. An introduction to RDI. 2026 [accessed 2026 Aug 25]. Available from: https://www.rdiconnect.com/about-rdi/

Reichow B, et al. Early intensive behavioral intervention (EIBI) for young children with autism spectrum disorders (ASD). Cochrane Database Syst Rev. 2018 May 9;5:CD009260.

Rogers SJ, et al. A multisite randomized controlled two-phase trial of the early start denver model compared to treatment as usual. J Am Acad Child Adolesc Psychiatry. 2019 Sep;58(9):853-865.

Rogers SJ, et al. Effects of a brief Early Start Denver Model (ESDM)-based parent intervention on toddlers at risk for autism spectrum disorders: a randomized controlled trial. J Am Acad Child Adolesc Psychiatry. 2012 Oct;51(10):1052-65.

Sandbank M, et al. Autism intervention meta-analysis of early childhood studies (Project AIM): updated systematic review and secondary analysis. BMJ. 2023 Nov 14;383:e076733.

Sandbank M, et al. Project AIM: Autism intervention meta-analysis for studies of young children. Psychol Bull. 2020 Jan;146(1):1-29. Epub 2019 Nov 25.

Solomon R, et al. Pilot study of a parent training program for young children with autism: the PLAY project home consultation program. Autism. 2007 May;11(3):205-24.

Solomon R, et al. PLAY project home consultation intervention program for young children with autism spectrum disorders: a randomized controlled trial. J Dev Behav Pediatr. 2014;35(8):475–485.

Tachibana Y, et al. Meta-analyses of individual versus group interventions for pre-school children with autism spectrum disorder (ASD). PLoS One. 2018 May 15;13(5):e0196272.

Virues-Ortega J. Applied behavior analytic intervention for Autism in early childhood: meta-analysis, meta-regression, and dose-response meta-analysis of multiple outcomes. Clinical Psychology Review. 2010;30:387-99.

Virues-Ortega J, et al. The TEACCH program for children and adults with autism: a meta-analysis of intervention studies. Clin Psychol Rev. 2013 Dec;33(8):940-953

Volkmar F, et al. Summary of the practice parameters for the assessment and treatment of children, adolescents and adults with autism and other pervasive developmental disorders. Amer Acad Child Adolescent Psychiatry. 1999;38(12):1611-6.

Yu Q, et al. Efficacy of interventions based on applied behavior analysis for autism spectrum disorder: a meta-analysis. Psychiatry Investig. 2020 May;17(5):432-443.

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Applied Behavior Analysis is not addressed in a National Coverage Determination or policy.

Psychiatry and Psychology Services (LCD L33632) [accessed 2026 Aug 25]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

10/25/12, 10/24/13, 12/11/14, 12/10/15, 12/08/16, 12/14/17, 12/13/18, 10/24/19, 10/22/20, 12/16/21, 12/22/22, 06/22/23, 06/20/24, 06/26/25, 06/18/26, 09/17/26

Date	Summary of Changes
09/17/26	• Off-cycle policy update. Policy stance was revised to align with the NYS Insurance Law for ASD only. Policy was updated with expanded criteria requirements. Updates to coding section.
06/18/26	• Annual review, policy intent unchanged.
09/02/25	• Policy code edit, removed HCPCS codes that are not ABA.
06/26/25	• Annual review, policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
10/25/12	• Original effective date