

# Autism Spectrum Disorder

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[Instructions for Use](#)

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## Federal/State Mandated Regulations

California Health and Safety Code Sections 1374.72 and 1374.73 mandate coverage of pervasive developmental disorders, including autism, and behavioral health treatment, e.g., applied behavioral analysis.

### California Health and Safety Code (HSC) Section 1374.72

[https://leginfo.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=1374.72.&lawCode=HSC](https://leginfo.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.72.&lawCode=HSC)

- (a) (1) Every health care service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).
- (2) For purposes of this section, “mental health and substance use disorders” means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.
- (3) (A) For purposes of this section, “medically necessary treatment of a mental health or substance use disorder” means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
- (i) In accordance with the generally accepted standards of mental health and substance use disorder care.
  - (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.
  - (iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.
- (B) This paragraph does not limit in any way the independent medical review rights of an enrollee or subscriber under this chapter.
- (4) For purposes of this section, “health care provider” means any of the following:
- (A) A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
  - (B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.

- (C) A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.
  - (D) An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
  - (E) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
  - (F) A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
  - (G) A registered psychological associate, as described in Section 2913 of the Business and Professions Code.
  - (H) A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.
- (5) For purposes of this section, “generally accepted standards of mental health and substance use disorder care” has the same meaning as defined in paragraph (1) of subdivision (f) of Section 1374.721.
  - (6) A health care service plan shall not limit benefits or coverage for mental health and substance use disorders to short-term or acute treatment.
  - (7) All medical necessity determinations by the health care service plan concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of Section 1374.721. This paragraph does not deprive an enrollee of the other protections of this chapter, including, but not limited to, grievances, appeals, independent medical review, discharge, transfer, and continuity of care.
  - (8) A health care service plan that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the plan’s subsequent rescission, cancellation, or modification of the enrollee’s or subscriber’s contract, or the plan’s subsequent determination that it did not make an accurate determination of the enrollee’s or subscriber’s eligibility. This section shall not be construed to expand or alter the benefits available to the enrollee or subscriber under a plan.
- (b) The benefits that shall be covered pursuant to this section shall include, but not be limited to, the following:
    - (1) Basic health care services, as defined in subdivision (b) of Section 1345.
    - (2) Intermediate services, including the full range of levels of care, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.
    - (3) Prescription drugs, if the plan contract includes coverage for prescription drugs.
  - (c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, all of the following patient financial responsibilities:
    - (1) Maximum annual and lifetime benefits, if not prohibited by applicable law.
    - (2) Copayments and coinsurance.
    - (3) Individual and family deductibles.
    - (4) Out-of-pocket maximums.
  - (d) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary followup services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to “arrange coverage to ensure the delivery of medically necessary out-of-network services” includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.
  - (e) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.
  - (f)
    - (1) For the purpose of compliance with this section, a health care service plan may provide coverage for all or part of the mental health and substance use disorder services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.
    - (2) A health care service plan shall provide the mental health and substance use disorder coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans, provided that all appropriate mental health or substance use disorder services are actually available within those geographic service areas within timeliness standards.

- (3) Notwithstanding any other law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing, provided that these practices are consistent with Section 1374.76 of this code, and Section 2052 of the Business and Professions Code.
- (g) This section shall not be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter.
- (h) A health care service plan shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.
- (i) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.
- (Amended by Stats. 2024, Ch. 497, Sec. 91. (SB 1526) Effective January 1, 2025.)*

## **California Health and Safety Code (HSC) Section 1374.73**

***Effective Jan. 1, 2026***

[Bill Text: CA AB951 | 2025-2026 | Regular Session | Introduced | LegiScan](#)

### **Section 1**

Section 1374.73 of the Health and Safety Code is amended to read:

#### ***Section 1374.73***

- (a) (1) Every health care service plan contract that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 1374.72.
- (2) Notwithstanding paragraph (1), as of the date that the proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health plans will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).
- (3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
- (4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.
- (b) Every health care service plan subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health care service plan is not prevented from selectively contracting with providers within these requirements.
- (c) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2026, shall not require an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a rediagnosis to maintain coverage for behavioral health treatment for pervasive developmental disorder or autism.
- (2) This subdivision does not prohibit or restrict a treating provider from reevaluating an enrollee for purposes of determining the appropriate treatment. The treatment plan shall be made available to the health care service plan upon request.
- (3) This subdivision does not prohibit a treating provider from prescribing a rediagnosis at the discretion of the physician licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.
- (4) A health care service plan shall not discontinue or delay existing treatment while waiting for a rediagnosis to be completed.
- (5) This subdivision does not prohibit a health care service plan from requiring utilization review. For the purpose of this section, utilization review is distinct from a rediagnosis.
- (d) For the purposes of this section, the following definitions shall apply:
- (1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent

practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

- (A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.
  - (B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
    - (i) A qualified autism service provider.
    - (ii) A qualified autism service professional supervised by the qualified autism service provider.
    - (iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.
  - (C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
    - (i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.
    - (ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
    - (iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
    - (iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
  - (D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, daycare, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.
- (2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 1374.72.
- (3) "Qualified autism service provider" means either of the following:
- (A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.
  - (B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.
- (4) "Qualified autism service professional" means an individual who meets all of the following criteria:
- (A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
  - (B) Is supervised by a qualified autism service provider.
  - (C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
  - (D) Is either of the following:
    - (i) A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
    - (ii) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.
  - (E)
    - (i) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
    - (ii) If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.

- (F) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.
- (5) “Qualified autism service paraprofessional” means an unlicensed and uncertified individual who meets all of the following criteria:
  - (A) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
  - (B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
  - (C) Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
  - (D) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
  - (E) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.
- (6) “Rediagnosis” means a subsequent undertaking by any method, device, or procedure, whether gratuitous or not, to ascertain or establish if a person is suffering from a physical or mental health disorder, pursuant to Section 2038 of the Business and Professions Code. “Rediagnosis” also means prescription of a subsequent diagnosis of pervasive developmental disorders or autism to ascertain or establish if a person is suffering from a pervasive developmental disorder or autism.
- (7) “Utilization review” means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code before, after, or concurrent with the provision of medical treatment services. “Utilization review” refers to an evaluation of existing treatment to ensure an enrollee receives the proper care at the proper time.
- (e) This section shall not apply to the following:
  - (1) A specialized health care service plan that does not deliver mental health or behavioral health services to enrollees.
  - (2) A health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).
- (f) This section does not limit the obligation to provide services under Section 1374.72.
- (g) As provided in Section 1374.72 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

## Section 2

Section 10144.51 of the Insurance Code is amended to read:

### **Section 10144.51**

- (a) (1) Every health insurance policy shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 10144.5.
- (2) Notwithstanding paragraph (1), as of the date that *the* proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).
- (3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
- (4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.
- (b) Pursuant to Article 6 (commencing with Section 2240) of Subchapter 2 of Chapter 5 of Title 10 of the California Code of Regulations, every health insurer subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health insurer is not prevented from selectively contracting with providers within these requirements.

- (c) (1) A health insurance policy issued, amended, or renewed on or after January 1, 2026, shall not require an insured previously diagnosed with pervasive developmental disorder or autism to receive a rediagnosis to maintain coverage for behavioral health treatment for pervasive developmental disorder or autism.
- (2) This subdivision does not prohibit or restrict a treating provider from reevaluating an insured for purposes of determining the appropriate treatment. The treatment plan shall be made available to the insurer upon request.
- (3) This subdivision does not prohibit a treating provider from prescribing a rediagnosis at the discretion of the physician licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.
- (4) A health insurer shall not discontinue or delay existing treatment while waiting for a rediagnosis to be completed.
- (5) This subdivision does not prohibit a health insurer from requiring utilization review. For the purpose of this section, utilization review is distinct from a rediagnosis.
- (d) For the purposes of this section, the following definitions shall apply:
  - (1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:
    - (A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.
    - (B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
      - (i) A qualified autism service provider.
      - (ii) A qualified autism service professional supervised by the qualified autism service provider.
      - (iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.
    - (C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
      - (i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.
      - (ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
      - (iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
      - (iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
    - (D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, daycare, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the insurer upon request.
  - (2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 10144.5.
  - (3) "Qualified autism service provider" means either of the following:
    - (A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.
    - (B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.
  - (4) "Qualified autism service professional" means an individual who meets all of the following criteria:
    - (A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
    - (B) Is supervised by a qualified autism service provider.
    - (C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.

- (D) Is either of the following:
  - (i) A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
  - (ii) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.
- (E) (i) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
- (ii) If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.
- (F) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.
- (5) "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
  - (A) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
  - (B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
  - (C) Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
  - (D) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
  - (E) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.
- (6) "Rediagnosis" means a subsequent undertaking by any method, device, or procedure, whether gratuitous or not, to ascertain or establish if a person is suffering from a physical or mental health disorder, pursuant to Section 2038 of the Business and Professions Code. "Rediagnosis" also means prescription of a subsequent diagnosis of pervasive developmental disorders or autism to ascertain or establish if a person is suffering from a pervasive developmental disorder or autism.
- (7) "Utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code before, after, or concurrent with the provision of medical treatment services. "Utilization review" refers to an evaluation of existing treatment to ensure an enrollee receives the proper care at the proper time.
- (e) This section shall not apply to the following:
  - (1) A specialized health insurance policy that does not cover mental health or behavioral health services or an accident only, accident-only, specified disease, hospital indemnity, or Medicare supplement policy.
  - (2) A health insurance policy in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).
- (f) This section does not limit the obligation to provide services under Section 10144.5.
- (g) As provided in Section 10144.5 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

### **Section 3**

No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

***Effective Jan. 1, 2024 until Dec. 31, 2025***

[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=1374.73&lawCode=HSC](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.73&lawCode=HSC)

- (a) (1) Every health care service plan contract that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 1374.72.
- (2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health plans will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).
- (3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
- (4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.
- (b) Every health care service plan subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health care service plan is not prevented from selectively contracting with providers within these requirements.
- (c) For the purposes of this section, the following definitions shall apply:
  - (1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:
    - (A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.
    - (B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
      - (i) A qualified autism service provider.
      - (ii) A qualified autism service professional supervised and employed by the qualified autism service provider.
      - (iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.
    - (C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
      - (i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.
      - (ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
      - (iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
      - (iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
    - (D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.
  - (2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 1374.72.
  - (3) "Qualified autism service provider" means either of the following:
    - (A) A person who, is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, who is nationally certified.
    - (B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the

Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

- (4) “Qualified autism service professional” means an individual who meets all of the following criteria:
- (A) Provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
  - (B) Is supervised by a qualified autism service provider.
  - (C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
  - (D) Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
  - (E) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
  - (F) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.
- (5) “Qualified autism service paraprofessional” means an unlicensed and uncertified individual who meets all of the following criteria:
- (A) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
  - (B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
  - (C) Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
  - (D) Has adequate education, training, and experience, as certified by a qualified autism service provider.
  - (E) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.
- (d) This section shall not apply to the following:
- (1) A specialized health care service plan that does not deliver mental health or behavioral health services to enrollees.
  - (2) A health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).
- (e) This section does not limit the obligation to provide services under Section 1374.72.
- (f) As provided in Section 1374.72 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

## **California Welfare and Institutions Code Section 4686.2, Applied Behavioral Analysis (“ABA”) Therapy**

[https://leginfo.ca.gov/faces/codes\\_displaySection.xhtml?lawCode=WIC&sectionNum=4686.2](https://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=4686.2).

- (a) Notwithstanding any other law or regulation to the contrary, any vendor who provides applied behavioral analysis (ABA) services, or intensive behavioral intervention services or both, as defined in subdivision (d), shall:
- (1) Conduct a behavioral assessment of each consumer to whom the vendor provides these services.
  - (2) Design an intervention plan that shall include the service type, number of hours needed, and recommended parent participation to achieve the consumer’s goals and objectives, as set forth in the consumer’s individual program plan (IPP) or individualized family service plan (IFSP). The intervention plan shall also set forth the frequency at which the consumer’s progress shall be evaluated and reported.
  - (3) Provide a copy of the intervention plan to the regional center for review and consideration by the planning team members.
- (b) (1) Notwithstanding any other law or regulation to the contrary, regional centers shall:
- (A) Only purchase ABA services or intensive behavioral intervention services that reflect evidence-based practices, promote positive social behaviors, and ameliorate behaviors that interfere with learning and social interactions.
  - (B) Not purchase either ABA or intensive behavioral intervention services for purposes of providing respite, day care, or school services.
  - (C) Discontinue purchasing ABA or intensive behavioral intervention services for a consumer when the consumer’s treatment goals and objectives, as described under subdivision (a), are achieved. ABA or intensive behavioral intervention services shall not be discontinued until the goals and objectives are

reviewed and updated as required in subparagraph (D) and shall be discontinued only if those updated treatment goals and objectives do not require ABA or intensive behavioral intervention services.

- (D) For each consumer, evaluate the vendor's intervention plan and number of service hours for ABA or intensive behavioral intervention no less than every six months, consistent with evidence-based practices. If necessary, the intervention plan's treatment goals and objectives shall be updated and revised.
  - (E) Not reimburse a parent for participating in a behavioral services treatment program.
  - (F) Not deny or delay the provision of ABA or intensive behavioral intervention services for a minor consumer due to the lack of parent participation. A regional center shall not adopt, implement, or have in effect any policy or practice that prohibits or substantially prohibits the purchase of ABA or intensive behavioral intervention services due to the lack of parent participation. For purposes of this section, "substantially prohibits" means any policy or practice that generally prohibits a purchase of service, but includes a process for the regional center to allow exceptions.
- (2) This subdivision shall not be construed to prohibit a regional center from highlighting the benefit of parental participation, as recommended by the intervention plan.
- (c) For purposes of this section, the following definitions shall apply:
- (1) "Applied behavioral analysis" means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors that interfere with learning and social interaction.
  - (2) "Intensive behavioral intervention" means any form of applied behavioral analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings for no more than 40 hours per week, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.
  - (3) "Evidence-based practice" means a decisionmaking process that integrates the best available scientifically rigorous research, clinical expertise, and individual's characteristics. Evidence-based practice is an approach to treatment rather than a specific treatment. Evidence-based practice promotes the collection, interpretation, integration, and continuous evaluation of valid, important, and applicable individual- or family-reported, clinically-observed, and research-supported evidence. The best available evidence, matched to consumer circumstances and preferences, is applied to ensure the quality of clinical judgments and facilitates the most cost-effective care.
  - (4) "Parent participation" may include, but shall not be limited to, the following meanings:
    - (A) Completion of group instruction on the basics of behavior intervention.
    - (B) Implementation of intervention strategies, according to the intervention plan.
    - (C) If needed, collection of data on behavioral strategies and submission of that data to the provider for incorporation into progress reports.
    - (D) Participation in any needed clinical meetings.
    - (E) Purchase of suggested behavior modification materials or community involvement if a reward system is used.

## State Market Plan Enhancements

The member may have additional mental health coverage as required by State Mental Health Parity Law through UnitedHealthcare of California or designee. Refer to the Benefit Interpretation policy titled [Inpatient and Outpatient Mental Health](#).

## Covered Benefits

**Important Note:** Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

### Notes:

- Autism services performed (OT, ST, PT or ABA) in the home setting are not "home health services" and are not subject to visit or dollar limitations, if any.
- Benefits include behavioral health treatment for autism spectrum disorders under the same terms and conditions that apply to medical conditions. Medically necessary behavioral health treatment will not be denied or unreasonably delayed:
  - Based on an asserted need for cognitive or intelligence quotient (IQ) testing;
  - On the grounds that the behavioral health treatment is an experimental or investigational services or educational;
  - or

- On the grounds that behavioral health treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity, or group when the provider or supervisor in question is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission of Certifying Agencies.
- Refer to the member's evidence of coverage (EOC)/schedule of benefits (SOB) for specific benefit information.

Responsibility	Services
The following services are the responsibility of the member's medical plan [IPA, PMG, or UnitedHealthcare].	<ul style="list-style-type: none"> <li>● Physical therapy, occupational therapy, and speech therapy</li> <li>● Medical specialist services (e.g., neurology)</li> <li>● Durable medical equipment (e.g., speech device)</li> <li>● Laboratory monitoring if ordered by the PCP or medical specialist</li> <li>● Prescription drugs (refer to the supplemental drug rider/benefit)</li> </ul>
The following services are the responsibility of the member's behavioral health plan [(Optum) US Behavioral Health Plan of CA or alternative behavioral health plan selected by the member's employer].	<ul style="list-style-type: none"> <li>● Applied behavioral therapy</li> <li>● Psychiatry and/or psychologist related services</li> <li>● Diagnostic testing</li> <li>● Laboratory monitoring if ordered by the behavioral health professional</li> </ul>

## Behavioral Health Treatment for Autism Spectrum Disorder

Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the extent practicable, the functioning of a member with autism spectrum disorder, and meet all of the following criteria:

- The treatment is prescribed by a licensed physician and surgeon of the California Business and Professions Code or developed by a licensed network psychologist according to the California Business and Professions Code or as authorized under California law.
- The treatment is provided under a treatment plan prescribed by a network qualified autism service provider and is administered by one of the following:
  - A network qualified autism service provider.
  - A network qualified autism service professional supervised and employed by the network qualified autism service provider.
  - A network qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
- The treatment plan must have measurable goals over a specific timeline that is developed and approved by the network qualified autism service provider for the specific member being treated. The treatment plan shall be reviewed no less than once every six months by the network qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the network qualified autism service provider does all of the following:
  - Describes the member's behavioral health impairments or developmental challenges that are to be treated.
  - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the member's progress is evaluated and reported.
  - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating autism spectrum disorder.
  - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
  - The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.
- Assessment and testing and coordination of care for autism spectrum disorder by the member's pediatrician or primary care physician (e.g., history, physical and management of medications).
- Developmental testing beyond first diagnosis is limited to medically necessary testing for medical conditions, autism spectrum disorders.
- Referral for consultation and evaluation of individuals with suspected autism spectrum disorder.
- Play therapy services are covered only when they are authorized, part of a medically necessary treatment plan, require the supervision of a licensed physical therapist or qualified autism service provider, and are provided by an authorized provider acting within the scope of his or her license or as authorized under California law.
- Medically necessary behavioral health therapy services for treatment autism spectrum disorder.

- Cognitive habilitation and rehabilitation therapy when provided as part of an authorized autism behavioral health treatment plan.
- For members who are suspected to have or have confirmed diagnosis of autism, benefits may be available through Optum Behavioral Health for treatment and evaluation.
- Autism spectrum disorder services that extend beyond the 6-month period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective without a new treatment plan (refer to the *Federal/State Mandated Regulations* section for additional information).
- Specific therapies for the treatment of suspected complex developmental and/or behavioral problems, including speech therapy.
- Coverage may also include: non- crisis mental health counseling, behavioral modification programs, psychoanalysis, and non- crisis family counseling.

Refer to the Benefit Interpretation Policies titled [Attention Deficit Hyperactivity Disorder \(ADHD\)](#), [Developmental Delay and Learning Disabilities](#), [Inpatient and Outpatient Mental Health](#), [Rehabilitation Services \(Physical, Occupational, and Speech Therapy\)](#), and [Cognitive Rehabilitation](#).

## Not Covered

- Tuition for services which are school based for children and adolescents under the individuals with Disabilities Education Act.
- Prescription drugs, unless member has the supplemental prescription benefit.

## Policy History/Revision Information

Date	Summary of Changes
12/01/2025	<p><b>Federal/State Mandated Regulations</b></p> <ul style="list-style-type: none"> <li>• Revised language pertaining to the <i>California Health and Safety Code (HSC)</i>:               <ul style="list-style-type: none"> <li>○ <i>Section 1374.72</i></li> <li>○ <i>Section 1374.73</i></li> </ul> </li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>• Archived previous policy version BIP127.M</li> </ul>

## Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.