THE NUMBER NOBODY EXPLAINS

Why one provider recommends 10 hours — and another says 30.

Few things rattle a family like getting two professional recommendations that don't agree. It usually doesn't mean someone is wrong or dishonest. It means therapy hours are a **clinical judgment built from several ingredients** — and you're allowed to ask about every one of them.

FIVE HONEST REASONS THE NUMBERS DIFFER

1 They assessed different amounts of your child.

A recommendation after a records review and one visit is built on less than one after a comprehensive assessment across settings. Ask what the number is based on — the answer tells you how much weight it deserves.

2 They practice different models.

The field's own practice guidelines describe two shapes of ABA: focused treatment — a limited set of goals, generally around 10–25 hours per week — and comprehensive treatment — many developmental domains at once, often 30–40 hours (CASP Practice Guidelines, 2nd ed., 2020). The same child can honestly land in either shape depending on which questions the plan is answering. Different models can both be legitimate; they arrive at different numbers honestly.

3 They weighed the same child differently.

Two thoughtful clinicians can see the same assessment and prioritize different goals first. This is real clinical judgment at work — and a provider should be able to explain their reasoning about your child, not recite a philosophy.

4 Sometimes the number isn't only about your child.

Capacity, staffing, scheduling, and what a payer typically authorizes can shape recommendations anywhere in healthcare — an operational reality, not a scandal. The protection isn't suspicion — it's the question: **"How did you arrive at this number for my child?"** A provider should be able to explain how the recommendation connects to your child's assessed needs, the goals, the treatment model, and the plan for reviewing it.

5 Your family's reality counts too.

Sleep, school, siblings, drive time, your own capacity. A technically ideal schedule a family can't sustain isn't ideal. Good providers treat your life as part of the clinical picture, not an obstacle to it.

> **Therapy hours are a clinical decision about one child — not a product tier, and not a default.**

QUESTIONS THAT GET YOU A REAL ANSWER

- **"How did you arrive at this number for my child specifically?"** — the single most useful question in this guide.
- **"What would make you recommend fewer hours? What would make you recommend more?"** — a clinician thinking clinically has answers to both directions.
- **"Which goals require this intensity — and what happens to them at half the hours?"**
- **"When will the number be revisited, and against what evidence?"** — hours should follow progress, not just the original authorization.
- **"If we can only sustain part of this schedule, what should we protect first?"**

WHAT TO NOTICE IN THE ANSWERS

WORTH A SECOND LOOK

- — Every child at the practice seems to get the same number
- — The recommendation exactly matches the insurance maximum, with no reasoning attached
- — Nobody can say what would change the number
- — "More is always better," full stop

GOOD SIGNS

- The number is tied to named goals for your child
- Both "what would lower it" and "what would raise it" get real answers
- A reassessment of the dose is already on the calendar
- Your family's capacity is treated as data, not resistance

A CAREFUL NOTE ON THE EVIDENCE

Here's the honest state of the research. The field's practice guidelines say dosage "will vary with each client and should reflect the goals of treatment, specific client needs, and response to treatment," with hours rising to reach goals and falling as goals are met (CASP, 2nd ed., 2020). What research has **not** settled is whether more hours reliably produce better outcomes. A 2024 meta-analysis of 144 studies found no significant association between the amount of early intervention and the size of its effects (Sandbank et al., JAMA Pediatrics). Other researchers countered with evidence they read as supporting a dosage–outcome link (Frazier et al., JAMA Pediatrics, 2025), and the original authors replied defending their analysis — so the question is genuinely debated, not settled in either direction. What that means for you: **no number is automatic — high or low**. A recommendation deserves reasoning attached to your child. That's not a courtesy. It's the standard.

Where we stand

Fathom North is being built in Oak Creek, and this question is one we're designing the organization around: **dose decisions justified per child, revisited on evidence** — with systems being built to hold us to it. That's a commitment under construction, like the building. You're welcome to hold us to both.

This guide is general educational information for families, not clinical advice about any particular child, and not a substitute for evaluation and guidance from qualified professionals. Treatment recommendations should always be discussed directly with your child's clinicians.

Sources: [1] Council of Autism Service Providers, Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines, **2nd ed. (2020)** — the historical edition quoted here (pp. 25–26: focused "generally ranges from 10-25 hours per week"; comprehensive "often involves an intensity level of 30-40 hours"; dosage individualization; dosage adjustment). CASP has since published updated guidelines: casproviders.org/asd-guidelines · [2] Sandbank M, et al. "Determining Associations Between Intervention Amount and Outcomes for Young Autistic Children: A Meta-Analysis," JAMA Pediatrics. 2024;178(8):763–773. doi:10.1001/jamapediatrics.2024.1832 · [3] Frazier TW, Chetcuti L, Uljarevic M. "Evidence That Intervention Dosage Is Associated With Better Outcomes in Autism," JAMA Pediatrics. 2025;179(1):101–102. doi:10.1001/jamapediatrics.2024.4710 · [4] Sandbank M, and colleagues, "...—Reply," JAMA Pediatrics. 2025;179(1) (PMID 39495503). Statements not tied to a cited source are professional-practice description or general parent education. · **Written by** Fathom North · **Published** August 2026 · **Updated** August 2026 · **Clinical review:** pending — this guide will be reviewed by Fathom North's founding clinical leadership when hired, and corrected if needed.