KPGA Network News: E-Edition

Kaiser Permanente of Georgia Health Plans Again Ranked #1 in the State by NCQA

Image contains NCQA logo

Once again, our health plans – powered by Permanente medicine – are rated the best in Georgia for overall treatment, prevention, and patient experience by the National Committee for Quality Assurance's (NCQA) Health Insurance Plan Ratings 2024 for Commercial/Medicare/Medicaid.

Our Commercial HMO plan received a 4-star rating, and our Medicare received a 4.5-stars rating – both earning the highest rating in Georgia and maintaining the results from 2023.

"To be recognized by NCQA as a leader in quality is an accomplishment we can all be proud of," said Kim Phelps, vice president, Quality. "It's a direct reflection of your dedication and commitment in providing innovative, equitable care to our members."

NCQA classifies plans into scores from 1-to-5 stars in 0.5 increments – a system like CMS' 5-Star Quality Rating System. Along with an overall rating, plans are also rated on patient experience, prevention and equity, and treatment. In 2024, the organization analyzed more than 1,000 plans (commercial, Medicare, and Medicaid).

Referrals and Authorizations-Online Only in 2025

In the first quarter of 2025, Kaiser Permanente will require all referrals/authorizations to be submitted electronically. We will no longer accept faxes or calls unless it is a case of an urgent issue.

1. **Streamlined Referral/Authorization Process**: Online Affiliate simplifies the process of submitting referrals and authorization requests. Providers can easily create and submit these requests electronically, reducing the need for manual paperwork and phone calls. Online Affiliate is part of the broader KP HealthConnect™ system, which integrates various functionalities and information. This integration ensures that providers have a seamless experience when accessing and submitting referrals and authorization requests.
2. **Improved Efficiency**: By using Online Affiliate, providers can quickly access and submit necessary information, leading to faster processing times. This efficiency helps in reducing delays and improving patient care.
3. **Enhanced Communication**: The platform allows for better communication between providers and Kaiser Permanente. Providers can receive real-time updates on the status of their referrals and authorization requests, ensuring they are always informed.
4. **Access to Comprehensive Information**: Providers can access detailed patient information, including medical records and claim statuses, through Online Affiliate. This access helps in making informed decisions and providing better care to patients.
5. **Training and Support**: Kaiser Permanente offers training resources to help providers transition to using Online Affiliate. This support ensures that providers are comfortable and proficient in using the system, leading to a smoother workflow. Please call the Kaiser Permanente QRM Intake Services department at 404-364-7320 or 800-221-2412 (toll-free) for assistance.

Updates to the Target Review List

The Target Review List was updated and is effective October 1st, 2024. All procedures or services found on the targeted review list require authorization or medical necessity review by QRM. Please submit complete supporting clinical information with all requests. Look for the new version online: https://healthy.kaiserpermanente.org/georgia/community-providers/authorizations#targeted-review-list.

Incorrect Demographics

New address? New billing address? New provider? If your information is incorrect, your claims may not pay correctly.

Help us reduce provider and member frustration by:

- Making sure your demographic information is up to date
- Responding to outreach by your network manager
- Letting us know of changes in advance.

Please let your network manager know, or contact us with any demographic changes as soon as possible: KPGA-PDM@kp.org.

Image of finger pointing to screen that says Directory.

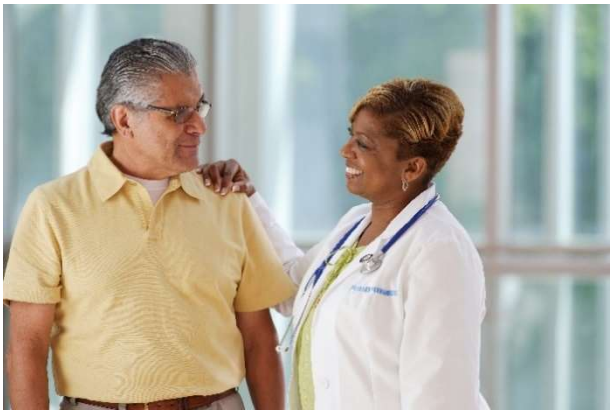

Image shows a provider with her hand on a patient's shoulder.

Changes to Dual Special Needs (DSNP) Plan Design in 2025

In 2025, KP will offer a new DSNP plan designed for Medicare Advantage members with full Medicaid coverage as well as QMB beneficiaries. Per the provider handbook, please remember that providers may not collect cost sharing from or balance bill members with full Medicaid coverage. Medicaid may assist with Medicare cost shares, depending on member eligibility. Claims should be submitted to the KP Medicare plan first. After KP Medicare's payment, any remaining balance should be sent to Medicaid. Please verify each beneficiary's eligibility and consult the relevant Medicare and Medicaid resources for accurate billing and cost-sharing application.

Appointment Access Reminder: Per the Provider Manual, you must maintain the following standards for appointment access:

- Emergency care: must be seen immediately or referred to ER, as appropriate.
- Urgent complaint: same day, or within 24 hours of member's request.
- Regular or Routine Care: within 14 days of member's request.
- Preventive routine care: within four (4) weeks of member's request.

Referrals and Authorizations

- For all services that require a referral or authorization you must have a valid referral/authorization **prior** to providing services.
- If a referral/authorization is not received prior to rendering services, your claim will be denied, and the member will be held harmless.
- **Kaiser Permanente will not provide retro referrals/authorizations. Please refer to the provider manual for additional information.**

Image shows two people walking with a basket of apples.

Reminder: Please use Online Affiliate for referrals, authorizations, claims, appeals, disputes, inquiries, EOPs, responding to requests for information (RFI), and uploading claims supporting documents. Please do not use faxes for provider appeals/disputes.

Provider Manual Changes for 2025

Please refer to the Provider Manual posted on Online Affiliate, accessible from kp.org/providers/ga, to review all changes and determine impact to your practice.

Throughout, Self-Funded / Level Funded Customer Service # is 1-866-800-1486

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5.17 Electronic Data Interchange (EDI)
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No changes beyond customer service number

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No changes beyond customer service number

Section 8: Quality
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Section 9: Compliance
Section 9 Compliance
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9.3 Provider and Vendor Code of Conduct
9.4 Reporting Compliance Concerns, Compliance Hotline
9.8 Fraud, Waste and Abuse

Pilot Program: Automated Provider Demographic Data Attestations

New for 2025, Kaiser Permanente will be testing a pilot program where your demographics will be sent via online affiliate so you can attest to the accuracy or alert us of any changes all in one convenient location. This will not be available for all groups until later in 2025, but we hope it will make the directory verification process easier on you and your office. How to documents and a video guide will be posted to http://kp.org/providers/ga in December.

Targeted Review List (QRM) Updates

All procedures on the Target Review List **must be authorized prior to rendering services**, or the procedure will not be covered. Please see http://kp.org/providers/ga for more information regarding the Target Review List.

Medications Requiring Prior Authorization

Kaiser Permanente periodically updates the QRM List of Medications following P&T meetings which occur on the even months (i.e. February, April, etc.) of the year. Please be sure to review the list carefully.

The QRM List of Medications (Targeted Review List) is on our Provider Website at http://providers.kp.org/ga. As a reminder, failure to obtain authorization prior to providing the medications listed will result in a denial of coverage. Please note affected members will be notified of this change.

New QRM PA Medications Effective 5.08.2024

- Vanflyta (quizartinib)
- Vowst (fecal microbiota spores)

New QRM PA Medications Effective 7.10.2024

- Augytro (repotrectinib)
- Brenzavvy (bexagliflozin)
- Lamzede (velmanase alfa-tycv)
- Lantidra (donislecel-jujn)
- Qalsody (tofersen)
- Rezlidhia (olutasidenib)
- Rivfloza (nedosiran)
- Rystiggo (rozanolixizumab-noli)
- Spevigo (spesolimab-sbzo)
- Xphozah (tenapanor)
- Zurzuvae (zuranolone)

Image of a doctor giving a prescription to a patient.

New QRM PA Medications Effective 10.9.2024

- Pegfilgrastim products

QRM PA Criteria Updates Effective 5.8.2024

- Arcalyst (rilonacept)
- Balversa (erdafitinib)
- Cabenuva (cabotegravir and rilpivirine)
- Dupixent (dupilumab)
- Emflaza (deflazacort)
- Enzyme Replacement Therapies
  - Cerezyme (imiglucerase)
  - Elelyso (taliglucerase alfa)
  - Vpriv (velaglucerase alfa)
- Forteo (teriparatide)
- Jaypirca (pirtobrutinib)
- Keveyis (dichlorphenamide)
- Nubeqa (darolutamide)
- Prolia (denosumab)
- Vocabria (cabotegravir)
- Xhance (fluticasone)
- Xolair (omalizumab)
- Zorvye (roflumilast)

QRM PA Criteria Updates Effective 6.12.2024

- Adalimumab products
- Briuvmi (ublituximab)
- Lynparza (olaparib)
- Nexletol/Nexlizet (bempedoic acid/bempedoic acid-ezetimibe)
- Ocrevus (ocrelizumab)
- Otezla (apremilast)
- Praluent (alirocumab)
- Repatha (evolocumab)
- Rituxan (rituximab)
- Tysabri (natalizumab)

CONTINUED ON NEXT PAGE

Targeted Review List (QRM) Updates
Medications Requiring Prior Authorization (Cont.)

QRM PA Criteria Updates Effective 7.10.2024

- Abecma (idecabtagene vicleucel)
- Afrezza (inhaled insulin)
- Attention-deficit/hyperactivity disorder (ADHD) Stimulants
- Bafiertam (monomethyl fumarate)
- Bimzelx (bimekizumab)
- Breyanzi (lisocabtagene maraleucel)
- Cabenuva (cabotegravir and rilpivirine)
- Carvykti (ciltacabtagene autoleucel)
- Cholbam (cholic acid)
- DPP-4 Inhibitors
- Doptelet (avatrombopag)
- Enbrel (etanercept)
- Evenity (romosozumab)
- Evkeeza (evinacumab)
- Fasenra (benralizumab)
- GLP-1 Receptor Agonists (GLP-1 RAs) for Cardiovascular and Type 2 Diabetes Mellitus Indications
- GLP-1 RAs + SGLT2 Inhibitor Combination Therapy
- Human C1 Esterase Inhibitors (Cinryze, Haegarda)
- Iclusig (ponatinib)
- Ilumya (tildrakizumab)
- Kerendia (finerenone)

Effective 7.10.2024 (continued)

- Leqvio (inclisiran)
- Metformin ER Formulations
- Mounjaro (tirzepatide)
- Nexletol (bempedoic acid)/ Nexlizet (bempedoic acid-ezetimibe)
- Orkambi (lumacaftor and ivacaftor)
- Praluent (alirocumab)
- Prolia (denosumab)
- Repatha (evolocumab)
- Rhopressa/Rocklatan (netarsudil/netarsudil-latanoprost)
- Rukobia (fostemsavir)
- Siliq (brodalumab)
- SGLT-2 Inhibitors
- Skyrizi (risankizumab)
- Stelara (ustekinumab)
- Sunlenca (lenacapavir)
- Takhzyro (lanadelumab-flyo)
- Taltz (ixekizumab)
- Tremfya (guselkumab)
- Vascepa (icosapent ethyl)
- Verquvo (vericiguat)
- Voxzogo (vosoritide)
- Vocabria (cabotegravir)
- Vumerity (diroximel fumarate)

Medicare Part D Benefit Coverage – Product Additions/ Removals/ Changes
During the year, Kaiser Permanente may make changes to our Medicare Part D Formulary (Drug List).

Prior to each effective date, affected members who were prescribed the drugs listed below will be grandfathered, meaning members will continue to receive the removed product under their Part D benefit, except for members who have been converted to the generic alternatives.

EFFECTIVE DATE	BRAND DRUG REMOVED	BRAND DRUG CURRENT TIER	GENERIC EQUIVALENT REPLACEMENT	GENERIC TIER
6/1/2024	RECTIV OINT 0.4 %	Tier 4	NITROGLYCERIN OINT 0.4 %	Tier 4

Updates to KP's Preferred Basal Insulin
Effective now, insulin glargine-yfgn (AKA Lantus) is the preferred basal insulin instead of Humulin N. For new insulin starts, **prescribe insulin glargine-yfgn.** It offers the following:

- Generic cost share
- No peak lasts up to 24 hours.
- Available in a pen or vial. With vial, use BD 6 mm short insulin syringes. With pen, use BD Nano 2nd Gen 4 mm pen needles.

Please see the attached policy regarding ABA Therapy criteria. Reminder, other policies, resources, and criteria documents can be found in the Clinical Library here: https://cl.kp.org/ga/home.html

ga.provider-relations@kp.org (404)-364-4934

KAISER PERMANENTE®

Georgia Region

Review Criteria

DEPARTMENT **Quality Resource Management**		CRITERIA NUMBER	1
SECTION **Utilization Management**		EFFECTIVE DATE	07/01/2022
TITLE **ABA Therapy criteria**		REVIEW DATES	06/30/22 2/14/23
		REVISION DATE	3/7/23
POLICY TYPE **New X** **Reviewed** **Revised**		PAGE NUMBER	1 of 15

OVERVIEW:

This medical necessity criteria is used to review and make benefit decisions for ABA service requests for members with the diagnosis of Autism Spectrum Disorder (ASD). Treatments other than ABA do not fall under the scope of this policy; these services include but are not limited to treatments that are considered to be investigational/experimental, such as Cognitive Training, Auditory Integration Therapy, Facilitated Communication; Higashi Schools/Daily Life, Individual Support Program, LEAP, SPELL, Waldon, Hanen, Early Bird, Bright Start, Social Stories, Gentle Teaching, Response Teaching Curriculum and Developmental Intervention Mode, Holding Therapy, Movement Therapy, Music Therapy, Pet Therapy, Psychoanalysis, Son-Rise Program, Scotopic Sensitivity Training, Sensory Integration Training, Neurotherapy (EEG biofeedback).

ASD is a medical, neurobiological, developmental disorder, characterized by Core Deficit areas: persistent deficits in social communication and social interaction across multiple contexts, AND restricted, repetitive patterns of behavior, interests, and activities. Diagnostic and Statistical Manual fifth edition (DSM-5) requires all of these symptoms to be present in early development, and further specifies clinically significant impairment in social, occupational, or other important areas of current function.

ABA is the behavioral treatment approach most commonly used with children with ASD. The defining characteristics of ABA are applied, behavioral, analytic, technological, conceptually systematic, effective, and capable of appropriately generalized outcomes. ABA involves a structured environment, predictable routines, individualized treatment, transition and aftercare planning, and significant family involvement. ABA attempts to increase skills related to behavioral deficits and reduce behavioral excesses including eliminating barriers to learning. Behavioral deficits may occur in the areas of communication, social, and adaptive skills, but are possible in other areas as well. Examples of deficits may include: a lack of expressive language, inability to request items or actions, limited eye contact with others, and inability to engage in age-appropriate self-help skills such as tooth brushing or dressing. Examples of behavioral excesses may include, but are not limited to: physical aggression, property destruction, elopement, self-stimulatory behavior, self-injurious behavior, and vocal stereotypy.

At an initial assessment, target symptoms are identified, and a Vineland Adaptive Behavior Scale is completed. **Submission of an initial ABA assessment (ABLLS-R, AFLS, VB-MAPP, EFL) is required prior to authorization of a treatment plan**. A treatment plan is developed that identifies the core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and achieve individualized goals. **Treatment plans are reviewed for medical necessity (defined below) twice annually** to allow re-assessment and to document treatment progress.

A Functional Behavioral Assessment (FBA) may also be a part of any assessment. An FBA consists of

a. Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity)
b. History of the problematic behavior (long-term and recent)
c. Antecedent analysis (setting, people, time of day, events) d. Consequence analysis e. Impression and analysis of the function of the problematic behavior Medical Necessity Medical necessity is defined in the controlling specific health plan and/or group documents.

COVERAGE GUIDELINES: INITIAL SERVICE REQUEST:

KPGA may authorize ABA services for ASD only if criteria 1 through 3 are met:

Comprehensive Diagnostic Evaluation

1. Neurodevelopmental Evaluation (including detailed developmental history, developmental and cognitive scores noted) **resulting in diagnosis of Autism Spectrum Disorder (ASD).**
    a. Must have been completed or updated within the past 3 years
2. Recommendation for ABA treatment made as a result of above evaluation (either internally or at an Approved Autism Evaluation Center (AAEC)).
3. Member is below age 21 years.

ABA TREATMENT ASSESSMENT:

KPGA may authorize an ABA services assessment only if all of the following criteria are met:

1. Numbers 1-3 above.
2. Hours requested are not more than what is required to complete the treatment assessment **(max 5 hours/20 units CPT code 97151).**
3. Additional clinical rationale required for more than 5 hours (20 units) of assessment codes 97151 and 97152 **combined**. Note Standardized psychological testing services are billed with specific psychological testing AMA-CPT code by eligible providers.

KAISER PERMANENTE®
Georgia Region

Review Criteria

DEPARTMENT	CRITERIA NUMBER	1
QUALITY RESOURCE MANAGEMENT		
TITLE	PAGE NUMBER	Page 3 of 14
ABA Therapy criteria		

INITIAL/ONGOING ABA SERVICE TREATMENT REQUEST:

KPGA may authorize the initiation of ABA services for ASD only if all of the following criteria are met:

1. Diagnostic Criteria as set forth in the current DSM are met;
2. The ABA services do not duplicate services that directly support academic achievement goals that may be included in the member's educational setting or the academic goals encompassed in the member's Individualized Education Plan (IEP)/Individualized Service Plan (ISP).
3. The ABA services recommended do not duplicate services provided or available to the member by other medical or behavioral health professionals. Examples include but are not limited to behavioral health treatment such as individual, group, and family therapies; occupational, physical, and speech therapies
4. ABA services are not a substitute for non-treatment services addressing environmental factors, including shadow, para-professional, support, interpersonal or companion services in any setting.
5. Approved treatment goals and clinical documentation must be focused on active ASD core symptoms, substantial deficits that inhibit daily functioning, and clinically significant aberrant behaviors. This includes a plan for stimulus and response generalization in novel contexts.
6. When there is a history of ABA treatment, the provider reviews the previous ABA treatment record to determine that there is a reasonable expectation that a member has the capacity to learn and generalize skills to assist in his or her independence and functional improvements.
7. For comprehensive treatment, the requested ABA services are focused on reducing the gap between the member's chronological and developmental ages such that the member is able to develop or restore function to the maximum extent practical OR for focused treatment, the requested ABA services are designed to reduce the burden of selected targeted symptoms on the member, family and other significant people in the environment, and to target increases in appropriate alternative behaviors.
8. Treatment intensity does not exceed the member's functional ability to participate and/or is not for the convenience of the patient, caregiver, treating provider or other professional.
9. Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan and must reflect the member's, caregiver's, and provider's availability to participate in treatment.
10. Treatment occurs in the setting(s) where target behaviors are occurring and/or where treatment is likely to have an impact on target behaviors.
11. A complete medical record is submitted by the Board-Certified Behavior Analyst (BCBA)/Licensed Behavioral Analyst (LBA) to include:

a. All initial assessments performed by the BCBA/LBA and must utilize direct observation. Preferred skills assessments must be developmentally and age appropriate and include non-standardized assessments such as the Vineland, ABLLS, VB-MAPP, and any other developmental measurements employed. Only those portions of assessments that address core deficits of autism are reimbursable; this excludes assessments or portions of assessments that cover academic, speech, vocational deficits, etc. Please note that standardized adaptive behavior assessment tools are not accepted as skills assessment tools.
b. Individualized treatment plan with clinically significant and measurable goals that clearly address the active symptoms and signs of the member's core deficits of ASD.
c. Goals should be written with measurable criteria such that they can be reasonably achieved within six months.
d. Goals should include documentation of core symptoms of ASD in the treatment plan, date of treatment introduction, measured baseline/present level of performance of targeted goal, objective present level of behavior, mastery criteria, estimated date of mastery, and a specific plan for generalization of skills;
e. Functional Behavior Assessment to address targeted problematic behaviors with operational definition and provide data to measure progress, as clinically indicated;
f. Documentation of treatment participants, procedures and setting;
g. Coordination of care with member's other treating providers to communicate pertinent medical and/or behavioral health information.

12. Direct line therapy services are provided by a line therapist, Registered Behavior Technician (RBT), or Board-Certified Assistant Behavior Analyst (BCaBA), Board Certified Behavior Analyst (BCBA)/Licensed Assistant Behavior Analyst (LABA), supervised by a BCBA/LBA or BCBA-D/Doctoral level LBA or provided in a manner consistent with the controlling state mandate. In selected circumstances, KPGA will consider direct 1:1 services provider by a BCBA/LBA or a BCBA-D/Doctoral level LBA.
13. **Telehealth/ Telemedicine is not an approved method of service delivery for direct ABA services** (e.g., 97153, 97154, 0373t). Telehealth/ Telemedicine for parent education (e.g., 97156 and 97157) and direct supervision activities (e.g., 97155) can be covered if allowed as an eligible telehealth/ telemedicine service under the member benefit plan. It is recommended that telehealth/ telemedicine service delivery be combined with face-to-face service delivery of direct supervision activities.
14. The treatment plan must include a plan to support the member's ability to generalize skills across stimuli, contexts and individuals, via caregiver training or an appropriate alternative.

Provider should be able to demonstrate how operational control will be transferred to caregivers.

15. Although not required for the initial service request, transition and aftercare planning should begin during the early phases of treatment.

ONGOING ABA SERVICE TREATMENT REQUEST ONLY:

1. On concurrent review, the current ABA treatment demonstrates significant improvement and clinically significant progress to develop or restore the function of the member.
    a. Significant improvement is mastery of a minimum of 50 percent of stated goals found in the submitted treatment plan. KPGA may request further psychological testing be obtained to clarify limited/lack of treatment response. Adaptive behavior, cognitive and/or language testing must show evidence of measurable functional improvement, as opposed to declining or plateaued scores.
        i. For members who do not master 50 percent of stated goals and/or fail to demonstrate measurable and substantial evidence toward developing or restoring the maximum function of the member, the treatment plan should clearly address the barriers to treatment success.
    b. There is reasonable expectations of mastery of proposed goals within the requested six-month treatment period and that achievement of goals will assist in the member's independence and functional improvements.
    c. If six-month goals are continued into the next treatment plan, these goals must be connected to long term goals that are clinically significant and with a reasonable expectation of mastery. When the mastery criteria have been modified to meet an incremental short-term objective, the overall goal is considered to be "continued".
    d. There is a reasonable expectation that a member is able to, or demonstrates the capacity to, acquire and develop clinically significant generalized skills to assist in his or her independence and functional improvements to reduce the need for custodial, respite, interpersonal or paraprofessional care or other support services,
    e. If the member does not demonstrate significant improvement or progress achieving goals for successive authorization periods, benefit coverage of ABA services may be reduced or denied.
2. The treatment plan for generalization of skills includes either:
    a. A plan for caregiver training that includes assessment of the caregivers' skills, measurable goals for skill acquisition and monitoring of the caregivers' use of skills. Generalization of skills should be assessed during parent/caregiver training to ensure

the member can demonstrate skill with caregivers in the natural environment during non-therapeutic times. Documentation may be requested to assess the caregivers' ability to implement treatment plan procedures and recommendations to evaluate the following areas.

i. Member's ability to demonstrate the use of replacement skills and/or reductions in aberrant behavior in natural settings.
ii. Family/caregivers' ability to successfully prompt and teach skills and effectively utilize behavior reduction strategies.
iii. The BCBA/LBA clinician can assess treatment effectiveness during non-therapeutic times.

b. An alternative plan if caregiver participation does not result in generalization of skills.

3. Transition and aftercare planning should:
    1. Begin during the early phases of treatment and will change over time based upon response to treatment and presented needs.
    2. Focus on the skills and supports required for the member for transitioning toward their natural environment as appropriate to their realistic developmental abilities.
    3. Identify appropriate services and supports for the time period following ABA treatment.
    4. Include a planning process and documentation with active involvement and collaboration with a multidisciplinary team to include caregivers.
    5. Long term outcomes must be developed specifically for the individual with ASD, be functional in nature, and focus on skills needed in current and future environments.
4. Realistic expectations should be set with current treatment plan goals connecting to long term outcomes. Additional clinical rationale required for more than 5 hours (20 units) for six months reassessments. Please refer to Guidelines for Treatment Record Documentation section of KPGA's Provider Manual for standards on client file documentation. KPGA will review requests for ABA treatment benefit coverage based upon clinical information submitted by the provider. State mandates and the controlling health plan may have benefit limitation and exclusions not listed in this medical policy.

SERVICE INTENSITY CLASSIFICATION:

Comprehensive treatments range from 10 to 35 total hours of direct services weekly. However, KPGA will review each request on an individual basis for fidelity to medical necessity and approve total hours

based on the member's severity, intensity, frequency of symptoms, and response to previous and current ABA treatment. Comprehensive treatment includes direct 1:1 ABA, caregiver training, supervision and treatment planning. Comprehensive ABA treatment targets members whose treatment plans address deficits in all of the core symptoms of Autism. Appropriate examples of comprehensive treatment include early intensive behavioral intervention and treatment programs for older children with aberrant behaviors across multiple settings. This treatment level, which requires very substantial support, should initially occur in a structured setting with 1:1 staffing and should advance to a least restrictive environment and small group format. Caregiver training is an essential component of Comprehensive ABA treatment. This treatment is primarily directed to children ages 18 months to 8 years old because Comprehensive ABA treatment has been shown to be most effective with this population in current medical literature. Focused treatments range from 10 to 35 total hours of direct services per week. However, KPGA will review each request on an individual basis for fidelity to medical necessity and approve total hours based on the member's severity, intensity, frequency of symptoms, and response to previous and current ABA treatment. This treatment may include caregiver training as the only component. Focused treatment typically targets a limited number of behavior goals requiring substantial support. Behavioral targets include marked deficits in social communication skills and restricted, repetitive behavior such as difficulties coping with change. In cases of specific aberrant and/or restricted, repetitive behaviors, attention to prioritization of skills is necessary to prevent and offset exacerbation of these behaviors, and to teach new skill sets. Identified aberrant behaviors should be addressed with specific procedures outlined in a Behavior Intervention Plan. Emphasis is placed on group work and parent training to assist the member in developing and enhancing his/her participation in family and community life, and developing appropriate adaptive, social or functional skills in the least restrictive environment. Requested treatment hours outside of the range for Comprehensive or Focused treatment will require a specific clinical rationale.

HOURS TO BE AUTHORIZED:

Total authorized hours will be determined based on all of the following:

- Evaluation of the submitted ABA evaluation (ABLLS-R, AFLS, Vineland, VB-MAPP, etc.) by TSPMG Development Pediatrics Department
- The following therapy codes may be approved
    - 97151 (max 20 units for initial/re-evaluation)
    - 97152 with clinical rationale describing level of need/severe behaviors
    - 97153 – commensurate with level of need described in evaluation, age/school status of member

- 97155 (max is 20% of total treatment hours approved)
  - Concurrent billing with 97153 And 97155 will not be approved.
- 97156 (1-2 hours per week, 104-208 units per 6-month authorization)

• Provider treatment plan that identifies suitable behaviors for treatment and improves the functional ability across multiple contexts

• Severity of symptoms, including aberrant behaviors

• Continued measurable treatment gains and response to previous and current ABA treatment. Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan and must reflect the member's, caregiver's, and provider's availability to participate in treatment.

COVERAGE GUIDELINES: CONTINUED SERVICE REQUEST:

KPGA may authorize continued ABA treatment services for ASD only if all of the following criteria are met:

1. Diagnostic Criteria as set forth in the Initial Review Criteria are met
2. ABA services do not duplicate services that directly support academic achievement goals that may be included in the member's educational setting or the academic goals encompassed in the member's IEP/ISP. This includes shadow, para-professional, or companion services in any setting that are implemented to directly support academic achievement goals
3. The ABA services recommended do not duplicate services provided or available to the member by other medical or behavioral health professionals. Examples include but are not limited to behavioral health treatment such as individual, group, and family therapies; occupational, physical, and speech therapies.
4. Approved treatment goals and clinical documentation must be focused on active ASD core symptoms, substantial deficits that inhibit daily functioning, and clinically significant aberrant behavior. This includes a plan for stimulus and response generalization in novel contexts.
5. Member must show progress in generalizing skills across stimuli, contexts, and individuals, via caregiver training or an appropriate alternative. Provider should be able to demonstrate how operational control is being transferred to caregivers.
6. Adaptive Behavior Testing (such as the Vineland Adaptive Behavior Scale (VABS))annually within a 45- day period of the next scheduled concurrent review. The Vineland or other standardized psychological tests may be required on any concurrent review dependent on clinical information obtained during the course of ABA treatment.

7. For comprehensive treatment, the requested ABA services are focused on reducing the gap between the member's chronological and developmental ages such that the member is able to develop or restore function to the maximum extent practical; OR For focused treatment the requested ABA services are designed to reduce the burden of selected targeted symptoms on the member, family and other significant people in the environment, and to target increases in appropriate alternative behaviors.
8. Treatment intensity does not exceed the member's functional ability to participate.
9. Treatment occurs in the setting(s) where target behaviors are occurring and/or where treatment is likely to have an impact on target behaviors.
10. Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan and must reflect the member's, caregiver's, and provider's availability to participate in treatment.
11. A complete medical record is submitted by the BCBA/LBA to include:
    a. Collected data, including additional non-standardized testing such as ABLLS, VBMAPP or other developmentally appropriate assessments, celebration charts, graphs, progress notes that link to interventions of specific treatment plan goals/objectives. Only those portions of assessments that address core deficits of autism are reimbursable; this excludes assessments or portions of assessments that cover academic, speech, vocational deficits, etc.
    b. Individualized treatment plan with clinically significant and measurable goals that clearly address the active symptoms and signs of the member's core deficits of ASD.
    c. Goals should be written with measurable criteria such that they can be reasonably achieved within six months.
    d. Goals should include documentation of core symptoms of ASD identified on the treatment plan, date of treatment introduction, measured baseline of targeted goal, objective present level of behavior, mastery criteria, estimated date of mastery, a specific plan for Generalization of skills, and the number of hours per week estimated to achieve each goal;
    e. Functional Behavior Assessment to address targeted problematic behaviors with operational definition and provide data to measure progress, as clinically indicated;
    f. Documentation of treatment participants, procedures and setting;
12. Direct line therapy services are provided by a line therapist, or RBT, or BCaBA/LABA, supervised by a BCBA/LBA or BCBA-D/Doctoral level LBA, or the provision of services is consistent with the controlling state mandate. In selected circumstances, KPGA will consider direct one to one services provider by a BCBA/LBA or BCBA-D/Doctoral level LBA.

13. Telehealth/ Telemedicine is not an approved method of service delivery for direct ABA services. Telehealth/ Telemedicine for parent education and direct supervision activities can be covered if allowed as an eligible telehealth/ telemedicine service under the member benefit plan. It is recommended that telehealth/ telemedicine service delivery be combined with face-to-face service delivery of direct supervision activities.

DEFINITIONS:

- Caregiver Training: Caregiver participation is a crucial part of ABA treatment and should begin at the onset of services. Provider's clinical recommendations for amount and type of caregiver training sessions should be mutually agreed upon by caregivers and provider. Caregiver participation is expected for at least 80% of agreed upon caregiver training sessions scheduled between provider and caregiver.
    - Caregiver training is defined as the education and development of caregiver-mediated ABA strategies, protocols, or techniques directed at facilitating, improving, or generalizing social interaction, skill acquisition and behavior management, to include observational measures for assurance of treatment integrity. Caregiver training is necessary to address member's appropriate generalization of skills, including activities of daily living, and to potentially decrease familial stressors by increasing member's independence.
    - Caregiver training goals submitted for each authorization period must be specific to the member's identified needs and should include goal mastery criteria, data collection and behavior management procedures if applicable, and procedures to address ABA principles such as reinforcement, prompting, fading and shaping. Each caregiver goal should include date of introduction, current performance level and a specific plan for generalization. Goals should include measurable criteria for the acquisition of specific caregiving skills.
    - It is recommended that one hour of caregiver training occurs for the first 10 hours of direct line therapy, with an additional 0.5 hours for every additional 10 hours of scheduled direct line therapy unless contraindicated or caregiver declines. Caregiver training hours should increase to a higher ratio of total direct line therapy hours if member goals address activities of daily living, as provider plans for transition to lower level of care within the next 6 months or, as member comes within one year of termination of benefits based on benefit coverage. d. If parents decline or are unable to participate in caregiver training, a generalization plan should be created to address member's skill generalization across environments and people. Should 80% not be

attainable over the course of an authorization period, a plan to increase parent participation should also be included in the request for ongoing care.

- Caregiver training does not include training of teachers, other school staff, other health professionals or other counselors or trainers in ABA techniques. However, caregiver training can include teaching caregivers how to train other professionals or people involved in the member's life.

- Clinically Significant: Clinical significance is the measurement of practical importance of the treatment effect – whether it creates a meaningful difference and has an impact that is noticeable in daily functioning.
- Core Deficits of Autism: persistent deficits in social communication and social interaction across multiple contexts AND, restricted, repetitive patterns of behavior, interests and activities.
- Functional Behavior Assessment: comprises descriptive assessment procedures designed to identify environmental events that occur just before and just after occurrences of potential target behaviors and that may influence those behaviors. That information may be gathered by interviewing the member's caregivers, having caregivers' complete checklists, rating scales, or questionnaires, and/ or observing and recording occurrences of target behaviors and environmental events in everyday situations. (AMA CPT, 2019)
- Generalization: skills acquired in one setting are applied to many contexts, stimuli, materials, people and/or settings to be practical, useful and functional for the individual. Generalized behavior change involves systematic planning and needs to be a central part of every intervention and every caregiver training strategy. When the member accomplishes generalization, this increases the likelihood of completing tasks independently.
- Interpersonal Care: interventions that do not diagnose or treat a disease, and that provide either improved communication between individuals, or a social interaction replacement
- Long-Term Objective: An objective and measurable goal that details the overall terminal mastery criteria of a skill being taught. Specifically, this terminal mastery criteria will indicate that a member can demonstrate the desired skill across people, places and time, which suggests the skill no longer requires further teaching.
- Mastery Criteria: objectively and quantitatively stated percentage, frequency or intensity and duration in which a member must display skill/behavior to be considered an acquired skill/behavior, including generalization and maintenance
- Non-standardized instruments: include, but not limited to, curriculum-referenced assessment, stimulus preference- assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual patient and behaviors. (AMA CPT, 2019)

- Paraprofessional Care: services provided by unlicensed persons to help maintain behavior programs designed to allow inclusion of members in structured programs or to support independent living goals except as identified in state mandates or benefit provisions
- Present Level of Performance: objective and quantitative measures of the percentage, frequency or intensity and duration of skill/behavior prior to intervention
- Respite Care: care that provides respite for the individual's family or persons caring for the individual
- Short-Term Objective: An intermediate, objective and measurable goal that details the incremental increases a member must demonstrate in moving toward the identified Long-Term Objective.
- Standardized Assessments: include, but not limited to, behavior checklists, rating scales and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all patients. (AMA CPT, 2019) The listed assessments are not meant to be exhaustive but serve as a general guideline to quantify baseline intelligence and adaptive behaviors and when repeated, measure treatment outcomes. The autism-specific assessments assist not only in the confirmation of diagnosis but more importantly, in identifying/quantifying the severity and intensity of the baseline core ASD behaviors.
- Diagnostic Instruments/Assessments: These assessments are typically longer, in pronounced detail concerning specific deficits and/or survey a broader swath of core behaviors in autism. Reliability and validity of the instrument are defined in depth. Reliability gauges the extent to which the instrument is free from measurement errors across time, across raters, and within the test. Validity is the degree to which other evidence supports inferences drawn from the scores yielded by the instrument. This is often grouped into content, construct, and criteria related evidence. These assessments also provide a measure for severity of illness.
    - Autism Diagnostic Observation Schedule, second edition (ADOS-2), Autism Diagnostic Interview, revised (ADI-R), Social Responsiveness Scale, second edition (SRS-2), DSM-5 Checklist, Gillian Autism Rating Scale (GARS, Childhood Autism Rating Scale, second edition (CARS-2)
- Screening Measures: These are brief assessments designed to identify children who need a comprehensive evaluation secondary to risks associated with delay, disorder, or disease that will interfere with normal development. Screening measures differ from diagnostic measures in that they typically require less time and training to administer and have high rates of false positives. Results of screening measures indicate the level of risk for disability as opposed to the provision of a diagnosis. Screening measures are not appropriate standalone support for an autism diagnosis and should be followed up by an in-depth assessment. Additional acceptable

documentation includes autism specific standardized assessments, or a detailed clinical note based on the DSM-5 signs and symptoms.

- Standardized Cognitive Assessments: Leiter International Performance Scale-R, Mullen Scales of Early Learning, Bayley Scales of Infant Development, Kaufmann Assessment Battery for Children, second edition (K-ABC-II), Wechsler Preschool and Primary Scale of Intelligence, third edition (WPPSI-III), Wechsler Intelligence Scale for Children, fourth edition (WISC-IV), Test of Non-Verbal Intelligence, fourth edition (TONI-4), trac
- Curricular Assessments: These tools are developed to provide a curriculum-based individual assessment. They are criterion-refenced, as opposed to psychological testing, which is vetted, standardized and norm referenced. The latter provide a pathway to allow comparison of an individual member's score to a norm-referenced mean. Examples include Assessment of Basic Language and Learning Skills (ABLLS-R), Verbal Behavior Milestones Assessment and Placement Program (VBMAPP), PEAK Essentials For Living (EFL), Assessment of Functional Living Skills (AFLS), Vineland Adaptive Behavior Scales (VABS).

ABA may be ordered **only** by Developmental Pediatrics Clinician(s). If requests from any other providers, e.g., pediatricians, **for Applied Behavioral Analysis (ABA) to any contracted ABA vendor** , the case should be sent to the QRM MD for "soft denial" using the developed SmartPhrase that states the patient will need to be evaluated (or existing diagnosis verified) by internal qualified autism service provider first, prior to ABA approval The QRM MD will send a staff message in KP HealthConnect to the requesting PCP, and include Developmental Pediatrics Clinician and Program Coordinator (currently Dr. Jennifer Scholz, PsyD and Leslie Quackenbush, LCSW, MPH, respectively), informing them of the denial. Developmental Pediatrics team will contact the parent and determine appropriate next steps in Developmental Evaluation process. Staff message may also be sent to the developmental pool "P DEV" which goes to our Developmental Pediatrics department.

Denial Language:

Request for autism services/ABA is not approved, as it does not meet QRM criteria for medical necessity. Members must be evaluated by internal qualified autism service providers or submit diagnostic evaluation report indicating previous diagnosis of ASD, to be verified by internal providers, prior to referral for autism services. The Developmental Pediatric Department will make contact to arrange for an appointment.

Does not meet the age requirement:

Request for ABA is not approved, coverage for these services is limited to patients up through age 20. These services are not covered beyond this age. May follow up with your primary care doctor regarding this request.

Does not have the benefit for autism services:

Request for autism services at the listed vendor is not approved because this is not a covered benefit for this member's plan. May follow up with your PCP regarding this request.

Non-contracted provider –

Request for autism services at the listed vendor is not approved because this is not a contracted ABA provider. Follow up with Developmental Pediatrics Department regarding this denial.

Approval Date 06/30/22

Luke Beno, MD

Physician Program Director, Quality Resource

Management