The Arc Indiana

ABA Autism Treatment Health Insurance Appeal Tips

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First Level Appeals – Prevention is the Best Medicine

Health insurance covers medical/clinical services. Only medical/clinical programming should be written into an Applied Behavior Analysis (ABA) care plan that is submitted to insurance for reimbursement.

It is important to remember that the state mandate in Indiana for medical insurance to cover autism services does *not* apply to educational services provided in public, private or home-schooling programs. If a child is using ABA therapy to fulfill educational requirements, these services must be negotiated with the public school district as part of the IEP process, or parents must fund this part of the program as private or home-school program fees.

Medical ABA can be provided in public, private or homeschooling settings, so long as the medical ABA is addressing treatment – not academic goals. See below for more information.

ABA therapy providers should review any autism or ABA clinical practice guidelines that the client's insurance uses to do medical reviews. Are they reasonable? Are they below the community standard of care (per BACB and CASP guidelines, psychology and pediatric society guidelines)? If the insurer guidelines seem beneath the standard of care, contact provider and parent/patient advocacy organizations for information.

What is Medical/Clinical?

Examples, not exhaustive

- Services that are needed to address the core deficits, impairments and signs and symptoms of autism.
- Cognitive, functional communication, pragmatic communication, life skills, pre-vocational skills, pre-academic skills, fine and gross motor skills.
- Skills necessary to catch up to the typical developmental trajectory.
- Transition services to step down to full natural environment without clinical support (Phase out of intensive intervention for best outcome cases in to full time school placement, for example).

What is Educational?

Examples, not exhaustive

- Services that fulfill core curriculum or state curriculum requirements.
- Hours spent in on-line public school instructional sessions focused on subject matter content, not treating behavioral issues that impede participation.
- Services that are primarily to teach subject matter, such as subject matter tutoring.

A service is NOT "educational" simply because it uses some of the tools that may also be used in school settings, such as books, or a computer or calculator. The issue is the primary goal of the intervention.

Just because a service MAY be available in a school setting under IDEA does not necessarily mean that it is outside of clinical/medical services and cannot be part of the clinical program. IDEA only covers services that are needed to *access* a free appropriate public education (FAPE), in the least restrictive environment (LRE), and that are needed in the education program to *accommodate* the child's disability. IDEA does NOT require schools to TREAT disabling medical conditions. Nor is it designed to be the ONLY source or necessarily the PRIMARY source of intervention for a disabling condition.

Providers should ensure that their care plans and conduct follow behavior analytic society guidelines in general and the behavior analytic guidelines for health plan coverage for autism services in particular. These are available through the Behavior Analyst Certification Board (BACB) and Council of Autism Services Providers (CASP).

Children may do "braided" or "blended" programs where part of the day is spent in public, private or home school and part of the day is spent in therapy. When a child cannot attend a full school day due to medical reasons, a letter documenting the need for medical release from a full school day in order to pursue medically necessary therapy should be obtained and updated as needed, or at least annually. Many children who have finished intensive programming and are in focused programming do these types of braided or blended programs. Children transitioning from intensive therapy to full school programming may also do these types of braided or blended programs.

In recent years, some insurers have sought to impose a variety of "crack down" measures based on an apparent perception that providers are engaged in inappropriate practices. Such carrier actions risk interfering with proper clinical judgment and risk access to medically necessary care. Therefore, providers should take care to do nothing that would give support to such "crack down" measures.

Some Provider Dos and Don'ts

Providers should ensure that care plans are backed up with research and data, and make sure to keep up with the latest research. If appropriate, attach a copy of particularly pertinent research and data to the care plan.

Programmatic decisions should ultimately be driven by the needs of the child, and not administrative concerns or conveniences. For example, for ABA, it is generally accepted that not all children need full time therapy programs. Based on this, some insurers are cracking down on the use of full time programs, punishing the children who need them, and the providers who are utilizing them appropriately. Typically, an ABA provider would be expected to have a mix of full time and part time programs at varying front-line hours and would not have a policy that all children will have full time programs. Providers who focus their practice solely on children who require full time intensive intervention should make that clear in organizational materials and each plan should be supported on a child-by-child basis. Insurer perceptions that some providers are telling parents that they should "by-pass the school system and get insurance to pay for full time ABA" are not helpful and should not be reinforced.

During Peer to Peer reviews, do not engage in a "negotiation" to diminish treatment hours in order to avoid a denial or in order to avoid an appeal - this is a race to the bottom. This reduces the community standard of care and gives the impression that providers do not stand by their own clinical judgement. This "off the record" type of negotiation with medical reviewers denies the patient their right to appeal because no denial on the reduced hours is issued.

Second Level Appeals or Medical Director Peer to Peer Phone Calls

Documenting the following will be important if your case goes to external appeal, state or federal insurance complaint processes or legal action. Document all phone calls with the insurer clinical reviewers in order to have a "paper trail" should the case go to external appeal, complaint process or legal action.

1. Ask if the call is being recorded. Your state may require you to be notified if your call is being recorded. Get the reference number for the call.
2. Questions to ask the Medical Director
    - What is your specialty? If psychiatry, what is your subspecialty or area of concentration in practice?
    - How many hours per week are you in clinical practice?
    - If not in clinical practice currently, how long have you been out of clinical practice?
    - Is at least 50% or more of your practice treating children with autism (if child) adults with autism (if adult patient)?
    - What is your specific training in ABA? From where? By whom?
    - How many ABA programs have you personally supervised?
    - How many years of experience do you have supervising BCBAs, BCaBAs and or ABA programs?

3. If the clinical reviewer is a BCBA
    - How many years have you been a BCBA?
    - How many years have you been in clinical practice (at least 50% of time clinical not administrative)?
    - How many ABA programs for persons with autism have you personally supervised?
    - Are you currently in clinical practice, what percentage of your time is clinical?
    - Do you supervise home, center, or school programs?

How to Respond to Demands for Education/IEP/ISP Information

1. Document that your client's parents are meeting their legal obligations to educate their child.
2. If applicable, (for fully funded or ACA plans) ask the reviewer to please show you the language in the Indiana Autism Mandate or in IDOI Bulletin 136 where the insurer is given the authority to use the IEP or presumed educational services to deny medically necessary services? (It is not in there; they do not have that authority from the mandate or IDOI Bulletin 136). When they cannot, re-direct to discussing clinical needs.
3. If the insurance is ERISA, FEHB, Union, other – ask to see the specific language in the policy and specific language in the clinical guidelines that addresses the use of educational information to determine medical necessity? Typically, policies discuss that "educational services" are not covered – that is NOT the same as using a patient's confidential educational information to reduce treatment, offset treatment or deny treatment as part of a medical necessity review. It may violate federal mental health parity law and non-discrimination regulations.
4. We are discussing medical treatment; let's discuss specific clinical features of this case and let me answer your specific clinical questions about this case.
5. Medical treatment is about reducing or eliminating the disabling affects of a condition and managing the condition. Let's talk about how this plan does that. This plan is not about educating the child.
6. Be vigilant against attempts to deny services because of the tools you are using, not the therapy goals or progress (e.g., the insurer concluding that a book must be educational, kicking a ball recreational, or circle time is educational or play) and be prepared to explain the role of these tools in achieving your clinical therapy goals.
7. Know your diagnostic criteria and tie treatment to the diagnostic criteria
8. Review the clinical guidelines or medical review guidelines for the plan before your call or before writing an appeal. Demonstrate how the plan's own language supports your treatment plan. Push back if the guidelines are below the accepted standards of care or include age, duration or visit caps.

Items to Document

1. Date, time of call
2. Case(s) discussed
3. Name of medical director or clinical reviewer
4. How were you treated by the clinical reviewer/medical director – document if they were hostile, rude, unwilling to listen or unprofessional, such as "bargaining" for hours of ABA, refusal to follow BACB and proper industry standards for ABA; did they give you misinformation about the mandate law, Bulletin 136, federal mental health parity law or IDEA/Article 7 requirements?
5. Document questions asked – were they clinical or trying to categorize the whole program as educational?
6. Document if any coercive statements were made – implication of losing network status, using you as an "example", threatening to take away supervision hours if you do not take reduced front line hours, etc.

Keys to Successful Appeals

1. Clinical care plan preparation – well researched, data driven, individual, clinical.
2. Abide by BACB standards, CASP guidelines for health plans.
3. Document, document, document – including medical reviewer interactions.
4. Handle all internal appeals as preparation for an external appeal or further action.
5. Maintain professional, objective stance on the issues, do not be led into emotional debates.
6. Know the applicable laws to your client's plan - mandate law and IDOI Bulletin 136, federal mental health parity law, PPACA. Get educated via national and local BCBA organizations such as APBA, CASP, INPEAT.

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