Securing 100% of Recommended Treatment Hours from Your Health Plan

By Julie Kornack
Director of Public Policy
Center for Autism and Related Disorders, Inc.
J.Kornack@centerforautism.com

Accessing the Coverage You Need

Some internal health plan data show that as many as 95% of eligible insureds aren't accessing their benefits for autism treatment. Oftentimes, parents who have health plans that include coverage for autism treatment encounter barriers when they try to use that coverage. One of the most common barriers is the health plan's determination that the services being sought aren't medically necessary.

Defining Medical Necessity

Most states do not define medical necessity in statute, so health plans develop extensive descriptions of what they view as medically necessary treatment. Many of their definitions of medical necessity have no scientific basis and may even violate controlling law. For example, a health plan's arbitrary treatment limitations when applied to autism treatment likely violate the Federal Mental Health Parity and Addiction Equity Act (MHPAEA).

Medically necessary treatment is any treatment that is necessary for the purpose of preventing, ameliorating, evaluating, diagnosing, or treating an illness, injury, disability, or disease in accordance with generally accepted standards of medical practice. **A health care provider's determination of what treatment is medically necessary should not be influenced by a health plan's definition of medical necessity but should be based on the provider's expertise.**

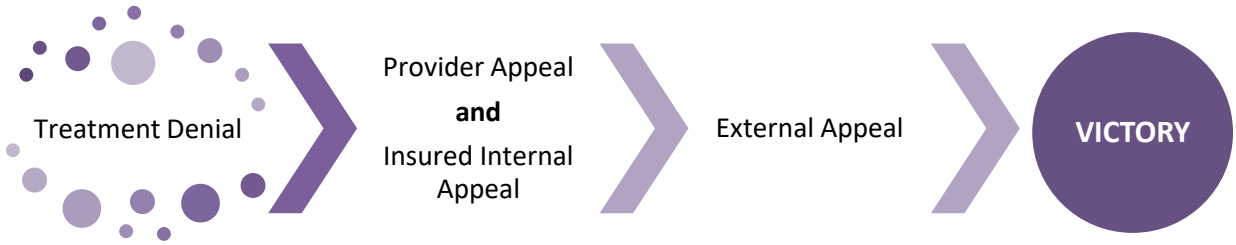
Reducing Treatment Hours

Treatment hours should never be reduced because a funding source won't authorize them. That is, a health care provider's determination of the services that are medically necessary to treat a patient should not be negotiable based on the policies, guidelines, or determinations of a health plan. Would a doctor prescribe two chemotherapy sessions to treat cancer when three are required just because the health plan is of the opinion that two chemotherapy sessions are sufficient? Of course not! A health care provider's recommendation should never change to accommodate a health plan.

Appealing a Health Plan's Denial of Services

Sometimes, health plans deny all requested treatment; more often, though, they deny a portion of the requested treatment. For example, a health care provider may seek authorization for 30 hours a week of

applied behavior analysis (ABA), and the health plan may authorize only 20 hours of treatment. *Every* denial of coverage based on lack of medical necessity – whether partial or complete -- is required to be accompanied by a description of how the insured and the health care provider can appeal that denial. Appeals are typically a three-step process:



Internal Appeal: As soon as an insured receives a complete or partial denial of services, both the health care provider requesting the medically necessary treatment and the insured need to contact the health plan to begin the appeals process. Typically, the process for the provider will be different than the process for the insured. The exact steps to take are included in the health plan's denial, so read it carefully. Remember, the provider's appeal and the insured's appeal happen at the same time. In most cases, health plans have 30 days to respond to an appeal, although insureds can request an expedited appeal if the health plan's denial puts its insured at risk.

External Appeal: Thirty days after an insured initiates the internal appeal, s/he can take the next step in the appeals process. For state-regulated plans, this means the insured can file an application for an **independent medical review** through the state. Self-funded plans may include a "second level appeal" before the insured can request an external review. External appeals should include specific details about challenging behaviors and developmental delays, so the reviewer understands the medical necessity of the requested services. If possible, include research articles that demonstrate the effectiveness of the requested treatment. Many reviewers do not have any background in autism treatment, so take time to explain the potential offered by the treatment and the harm caused by the lack of treatment. CARD works with its families to complete these appeals, and many advocacy groups have volunteers who can help with this process.

Seeking Other Funding Sources

If you lose the appeal or do not have insurance coverage that includes autism treatment benefits, you may live in a state where you can purchase an individual policy through the state marketplace (often referred to as "Obamacare").

Each state offers either a **state-based marketplace**, a **federally-facilitated marketplace**, or a **state-federal partnership marketplace** that acts as the **marketplace** where you can purchase insurance. If you live in one of the 29 states listed below or in Washington, D.C., then your state offers coverage for autism treatment through its marketplace.

States Offering Coverage for Autism Treatment through ACA Marketplace

Alaska	Louisiana	New Mexico
Arizona	Maine	New York
Arkansas	Maryland	Ohio
California	Massachusetts	Oregon
Colorado	Michigan	Texas
Connecticut	Missouri	Vermont
Delaware	Montana	Washington
Illinois	Nevada	Washington, DC
Indiana	New Hampshire	West Virginia
Kentucky	New Jersey	Wisconsin

Please send your comments or questions to Julie Kornack at J.Kornack@centerforautism.com.