


The Health Insurance Mandated Autism Treatment (HIMAT) 2011 Seminar



AUTISMSOCIETY
Improving the Lives of All Affected by Autism Colorado

JFK Partners
Promoting Families, Health and Development




Understanding Colorado Coverage: HIMAT Overview Intersection with other Funding Sources

Presented by The Autism Society of Colorado
September 13, 2011

Jill Rose Tappert, Esq. (inactive license status)
Director of Private Insurance Policy

An Overview of Health Insurance Mandated Autism Treatment



Jill Rose Tappert, Esq. (inactive license status)
Director of Private Insurance Policy



HIMAT – Roadmap

1. The Forest
2. Who Has Coverage
3. What Treatments – General Requirements
4. What Treatments – Treatment Limits
5. What Treatments – Seven Categories of Treatments
6. What Treatments – Provider Requirements
7. What Treatments – Five Autism Services Providers
8. Process
9. Resources

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The Forest

HIMAT is a STATE Law

The Forest

Bill
Senate Bill 09-244

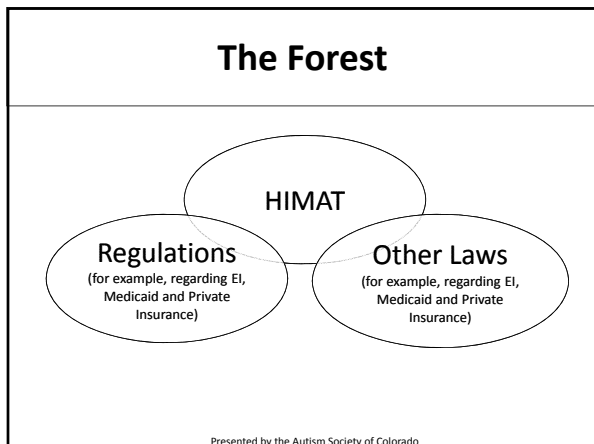
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Law = Statute
CRS §10-16-104(1.4) or
HIMAT

➔

Code
Title 10 = Insurance
Article 16 = Health Care Coverage
Part 104 = Mandatory Coverage
Section 1.4 = Autism Spectrum
Disorders

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WHO Has Coverage?

Children from birth through 18 years of age with certain private group health insurance

Health Benefit Plans that Must Comply with HIMAT (this list is not exhaustive):

- If a private health insurance card is marked with "CO-DOI", in most circumstances, the group health benefit plan is required to comply with HIMAT
- Colorado Group Insurance Policies
- Insured Employment Retirement Income Security Act (ERISA) Plans that purchase Colorado Group Insurance Policies – "fully insured"
- Colorado State Employee Plans
- Note that CoverColorado has elected to provide coverage similar to HIMAT

Health Benefit Plans that May Not Have to Comply with HIMAT (this list is not exhaustive):

- "Self-funded" ERISA Plans
- Group Insurance Policies issued to companies headquartered in another state, even if employees reside in Colorado
- Individual Plans and Self-funded Church Plans
- Note that the legislature stated that CHP+ will not be expanded, at this time, to include coverage similar to that under HIMAT

WHAT Treatments?

7 Treatment Categories are specifically covered by HIMAT

- ASD defined as Autistic Disorder, Asperger's Disorder and Atypical Autism as PDD-NOS (as defined at time of diagnosis, DSM currently being revised)

Treatments must be appropriate, effective or efficient – statute says the 7 Treatments Categories are appropriate, effective or efficient

Treatments must be medically necessary – statute says the 7 Treatment Categories are not experimental or investigational

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WHAT Treatments? Treatment Limits

Benefits are subject to the general terms of the policy (co-pays, deductibles, caps, etc.), but are otherwise unlimited, except:

- Applied Behavior Analysis (ABA) **only** – the plan may limit benefits as follows:
 - 0 through 8 -- \$34k per year
 - 9 through 18 -- \$12k per year

By reference to another statute (section 1.7 regarding congenital defects), ST, PT and OT are unlimited and not subject to the typical caps on those treatments

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WHAT Treatments? 7 Categories

1. Evaluation and Assessment Services (including Diagnosis; detailed requirements of diagnosis are not specified, but see the definition of "Treatment Plan" for guidance)
2. Behavior Training, Behavior Management and ABA, including consultation and supervision -- if the services are provided by an Autism Services Provider (only ABA is defined - the "use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways")
3. Habilitative or Rehabilitative Care, including "but not limited to" Occupational Therapy (OT), Speech Therapy (ST) and Physical Therapy (PT)
4. Therapeutic Care, including "but not limited to" OT, ST, PT and ABA -- if the services are provided by a speech language pathologist, registered occupational therapist, licensed physical therapist or Autism Services Provider
5. Psychological Care, including Family Counseling (direct or consultative services provided by a licensed psychologist or social worker)
6. Pharmacy Care and Medication, if covered by the health benefit plan
7. Psychiatric Care (direct or consultative services provided by a licensed psychiatrist)

WHAT TREATMENTS? Provider Requirement

2 Treatments Categories are required to be provided by an Autism Services Provider or by an OT, SLP, or PT

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WHAT TREATMENTS? Provider Requirement

If insurance plan chooses to credential only providers who meet some other standard or highest standard:

- Required to provide coverage for otherwise-qualifying treatment by all Autism Services Providers based on in-network or, if applicable, out-of-network provisions
- Correspondence between ASC and DOI (ASC letter June 4, 2010; DOI Response July 7, 2010, available at autismcolorado.org);
- Q: Can a Plan refuse to cover claims for services (either as in-network or as out-of-network) if the services are provided by an Autism Services Provider and otherwise meet all requirements of the law (for the sake of clarity, for example, if qualifying "ABA" treatment is provided by a provider who meets the criteria set forth in C.R.S. § 10-16-104(1.4)(a)(i)(C) but does not meet the criteria set forth in any other category of Autism Services Provider; in this example, the provider "has a master's degree or higher in behavioral sciences and is nationally certified as a "board certified behavior analyst" or certified by a similar nationally recognized organization"?)
- DOI Reply: If there is no other reason for denying the claims: If the provider is contracted, the claims should be covered at the in-network level of benefits. If the provider is not contracted and the policy provides out-of-network coverage, the claims should be covered at the out-of-network level of benefits.
- Network Adequacy Requirement
- Argument regarding wrongful unnecessary exhaustion of ABA cap
- Other arguments possible

WHAT Treatments? 5 Autism Service Providers

An Autism Services Provider is a person who provides direct services and is licensed, certified or registered by the applicable state licensing board or by a nationally-recognized organization and fits into one of the following categories:

Provider A (Doctorate/License/Experience):

- has a doctorate with a specialty in psychiatry, medicine or clinical psychology,
- is actively licensed by the state board of medical examiners, and
- has one year of direct experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with ASD.

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WHAT Treatments? 5 Autism Service Providers

Provider B (Doctorate/Experience):

- has a doctorate in one of the behavioral or health sciences and
- has completed one year of experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with ASD.

Provider C (Master's/BCBA):

- has a master's degree or higher in behavioral sciences and
- is nationally certified as a Board Certified Behavior Analyst (BCBA) or certified by a similar nationally-recognized organization.

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WHAT Treatments? 5 Autism Service Providers

Provider D (Master's/Related/Experience):

- has a master's degree or higher in one of the behavior or health sciences,
- is credentialed as a physical therapist, occupational therapist, or speech therapist, and
- has completed one year of direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with ASD.

Provider E (Baccalaureate/BCaBA):

- has a baccalaureate degree or higher in behavioral sciences and
- is nationally certified as a Board Certified Associate Behavior Analyst (BCaBA) or certified by a similar nationally-recognized organization.


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Process

Additional Notes on Process:

- Treatment shall be prescribed or ordered by a licensed physician or psychologist.
- "Treatment Plan" is defined - but then not required to be submitted. Expect authorization/certification requirements, and perhaps Medical Necessity review
- Treatment Plan -
 - developed by an Autism Services Provider
 - prescribed or ordered by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation
 - contain diagnosis, treatment type and frequency, anticipated outcomes as goals, and timing of an update
 - developed in accordance with medical home
- Each plan will have different processes - can be no more onerous than for other treatments.
- The authorization process is regulated the Utilization Review Regulation of the Division of Insurance.

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Intersection of Early Intervention, Medicaid and HIMAT


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 Director of Private Insurance Policy

Big Picture – Certain Funding Buckets for Services and Treatment for Children with ASD and DD

Early Intervention	Private Insurance	Public Insurance	Private Pay
<ul style="list-style-type: none"> Consider Funding Hierarchy (including certain private insurance and private pay) Services are "Early Intervention Services" Developmental Model Consider Cost to Family 	<ul style="list-style-type: none"> Consider what is Covered by Policy Most Colorado-regulated Group Insurance Policies (Commercial Policies) include state mandates, including HIMAT Covers Medical Treatment Consider Cost to Family (deductible, co-pays and co-insurance) 	<ul style="list-style-type: none"> Straight Medicaid Medicaid Waivers (e.g., CWA, CES, Children's HCBS) CHP+ Consider Cost to Family (deductible, co-pays and co-insurance) 	<ul style="list-style-type: none"> Consider Family Ability to Pay

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Big Picture – Certain Funding for Services and Treatment for Children with ASD and DD

Developmental Model – Early Intervention

Medical Model – Private Insurance

Medical Model – Public Insurance

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Intersection of HIMAT and Medicaid

Understand and Use the Basic Principles

- Medicaid Provider = State Plan Medicaid ("straight Medicaid") or under a waiver
- Contracted Medicaid Providers agree to accept a specific reimbursement rate

Intersection of HIMAT and Medicaid

Understand and Use the Basic Principles

If Patient is Dually-insured:

- Utilizing coverage under HIMAT – no different than other private insurance coverage
- Must bill private insurance first – private insurance is "primary"
- May bill co-pays or co-insurance or deductible to family (out of pocket) only if the medical treatment is not covered by Medicaid or that patient's waiver (note that CWA and CES include behavioral treatments) *OR*, *stated the other way*, may not bill co-pays or co-insurance or deductibles to family if the treatment is covered by Medicaid or that patient's waiver (family is "exempt")
- Medicaid does not "cover" co-pays, co-insurance or deductibles
- Medicaid will reimburse providers up to their contracted "reimbursable rate"

Intersection of HIMAT and Medicaid

<p>Example 1</p> <p>Cost of Service \$75 Dually-insured Private insurance reimburses \$50 (other \$25 is not paid for whatever reason, including co-pay, co-insurance or deductible) Medicaid contracted reimbursement rate is \$60 Treatment is covered by insurance and by Medicaid or waiver May bill Medicaid \$10 May not bill family – exempt Provider recovered their Medicaid reimbursement rate – \$50 from private insurance and \$10 from Medicaid</p>	<p>Example 2</p> <p>Cost of Service \$75 Dually-insured Private insurance reimburses \$70 (other \$5 is not paid for whatever reason, including co-pay, co-insurance or deductible) Medicaid contracted reimbursement rate is \$60 Treatment is covered by insurance and by Medicaid or waiver May not bill Medicaid May not bill family – exempt Provider recovered more than their Medicaid reimbursement rate -- \$70 from private insurance</p>
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Intersection of HIMAT and Medicaid

<p>Example 3</p> <p>Cost of Service \$75 Dually-insured Private insurance reimburses \$50 (other \$25 is not paid for whatever reason, including co-pay, co-insurance or deductible) Treatment is covered by insurance but NOT by Medicaid or waiver May bill family co-pay, co-insurance or deductible May not bill Medicaid Provider recovered \$50 from private insurance + family payment</p>	<p>Example 4</p> <p>Cost of Service \$75 Dually-insured Private insurance reimburses \$50 (other \$25 is not paid for whatever reason, including co-pay, co-insurance or deductible) Provider is not a contracted Medicaid provider May bill family co-pay, co-insurance or deductible May not bill Medicaid Provider recovered \$50 from private insurance + family payment</p>
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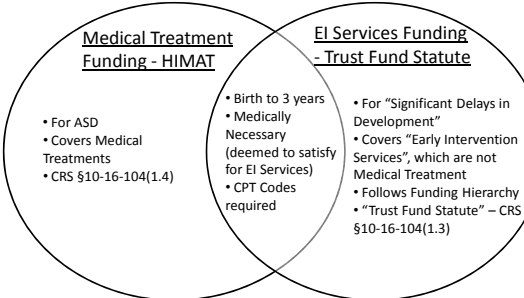
Intersection of HIMAT and Early Intervention

Pursuit of EI Services and coverage for Medical Treatment under HIMAT is not common, **yet**

- Perhaps only five instances within largest CCBs
- Expected to increase: more information + lower diagnosis age (average in Colorado is currently over 5 years old)



Intersection of HIMAT and Early Intervention



Medical Treatment Funding - HIMAT

- For ASD
- Covers Medical Treatments
- CRS §10-16-104(1.4)

EI Services Funding - Trust Fund Statute

- Birth to 3 years
- Medically Necessary (deemed to satisfy for EI Services)
- CPT Codes required

- For "Significant Delays in Development"
- Covers "Early Intervention Services", which are not Medical Treatment
- Follows Funding Hierarchy
- "Trust Fund Statute" – CRS §10-16-104(1.3)

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Intersection of HIMAT and Early Intervention

Family can pursue coverage for Medical Treatment under HIMAT and EI Services simultaneously, in parallel tracks

- Distinguish between Medical Treatment and EI Services (not a new concept -- analogies to other disorders and to pre-HIMAT)
- Activities/strategies can look the same and target the same challenges, but consider, for example:
 - EI's primary goal to assist family in interactions/assistance with child versus medical 1:1 activities with child
 - Natural settings versus clinic setting
- Cautions:
 - Not yet standard practice – consider need for advocacy with insurance (HIMAT states that EI Services shall supplement but not duplicate treatment covered under HIMAT)
 - Consider significant coordination requirements – does family handle coordination or does Case Manager assist or lead that effort?
 - Should Medical Treatments only be written as "other services" on the IFSP or should they be listed and crossed out (the trust fund limits on insurance company obligations do not apply to treatment/services that are not pursuant to an IFSP)?

Resources

Autism Society of Colorado, autismcolorado.org, (720) 214-0794

- Call for Information and Referral
- Go to Website for General Overview Document (website to be updated soon)
- Coming Soon: Strategies to Obtain Coverage under ERISA Self-Funded Plans and Other Private Insurance not Subject to HIMAT


Family Voices of Colorado, familyvoicesco.org, (303) 733-3000

Colorado Division of Insurance, dora.state.co.us/insurance, (303) 894-7490


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Credentialing under HIMAT

(successes, challenges, and tips)



DAVE HATFIELD, PH.D, BCBA-D
LICENSED CLINICAL
PSYCHOLOGIST



This is not legal advice and should not be regarded as such. Seek legal counsel when developing your own procedures, policies, and tools.

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Topics

- Optimal credentialing process
- Actual credentialing process
 - Varies by provider report, but...
- Survey sampling the issue
 - *Overview on natural environment approaches if time allows*

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Who must be credentialed?

- *Do I letter!*
- Doctorate/License/Experience
 - doctorate in psychiatry, medicine or clinical psychology; actively licensed; experience in behavioral therapies that are consistent with best practice.
- Doctorate/Experience
 - doctorate in behavioral or health sciences; one year of experience in behavioral therapies that are consistent with with best practice.

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- BCBA
 - or certified by a similar nationally-recognized organization; masters min.
- Masters/Related/Experience
 - credentialed as PT, OT, ST; one year of direct supervised experience.
- BCaBA
 - or certified by a similar nationally-recognized organization; bachelors min;
 - must work under BCBA supervision.

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What about line staff?

- Bill does not require nor prohibit line staff from providing services under supervision.
- Up to the Insurance company to decide if, when, how they may provide.

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Optimal model

General process--who's been through this already?

- Call to see if network full
 - Network adequacy law—if network inadequate, consumers...
 - How would families know?
 - ✦ Insurer posted or requested info
 - ✦ Ask your insurer to initiate credentialing for your current provider

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- Ask if they use CAQH or State's Universal Provider Application
 - Law says they have to and may also use supplementals (C.R.S. § 25-1-108.7)
 - Designed to cut down on unnecessary time and hence imbedded expense of the process for consumers (and providers?)
- ✦ CAQH--Council for Affordable Quality Healthcare (www.caqh.org)

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- Request packet and complete
 - Give CAQH access or send copy of this or the State's Universal application
- Wait 60-180 days...seriously!
- Receive notification letter, and if positive, a contract to review soon after
 - Fees: set by contract so if you sign it, you're obligated to accept

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- Review contract
 - Lots of hidden clauses
- Negotiate fees if needed
 - Note, this means your not credentialed yet. You can accept then negotiate, but very little leverage if you ever had it at all...
- Sign, copy, send and wait for them to execute and send back to you

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Now you are credentialed

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Actual model

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Varies tremendously by provider, with larger companies with out of state presence or use of national billing company fairing much better than most.

Steps:

- Call to see if network full
 - 'not needing any more providers...'
 - True? licensed but not trained to do ABA?
 - Families often report they can't find list of providers or anyone in network in their area; providers can't request list to check
 - Cost of in network vs. out of network?

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- Ask if they use CAQH or State's Universal Provider Application
 - Most are rejecting uniform applications, stating the law only applies to providers licensed, certified by CO (which I am, but I still had to do the long form since ABA)
- Request packet and complete
 - Many refusing to credential BCBAs; 'higher safety standard than the law's minimum'—BTW, not acceptable to DoI?

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- The rest of the steps pretty much the same, except here are some tidbits from other providers:
 - Hire staff just for this task if you can afford to
 - Use national billing services (e.g., MRC billing)
 - Keep copies of everything
 - Call them constantly to check on status
 - *Know the laws and share the info with the insurance companies*

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HIMAT Survey—section on credentialing

- COCAP survey to sample HIMAT successes, N only 20

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For which insurers are you currently contracted to provide services for under HIMAT? Mark all that apply.

% of Providers Successfully Credentialed

Insurer	% of Providers Successfully Credentialed
BCBS or...	~45%
United...	~55%
PacificCare	~10%
Kaiser	~10%
Rocky Mt.	~10%
Cigna	~15%
Aetna	~25%
Value...	~10%
Coventry	~10%
MTI...	~10%
GreatWest	~10%
Cover CO	~10%
Other	~10%

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If you are providing ANY services under HIMAT, what are your credentials? Mark all that apply.

% Credentialed by Provider Type

Provider Type	% Credentialed
Licensed Psy	~25%
Other...	~15%
SLP/ST	~15%
OT	~15%
Unlicensed...	~10%
BCBA	~75%
BCaBA	~15%
Other	~5%

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Are you providing services to any families under the ABA provisions of the HIMAT law?

Are you providing services to any families under the ABA provisions of the HIMAT law?

Response	Percentage
yes	~55%
no	~45%

82% of the yes group were BCBAs

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Based on your experience, what has/have been the biggest hurdle(s) to accessing HIMAT?

Not able to get credentialed easily or with more than 1 company 35.3%

[more really cool data in the survey, just beyond the scope of this presentation...COCAP members to enjoy soon!]

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Challenges and tips

- "I have not been able to get a non BCBA contracted with YYY"
- "They are NOT credentialing new providers. [deleted text] Providers who are currently credentialed seem to be overwhelmed...we probably need many more providers under XXXX."
- "They are the hardest to please so far..just tend to send the EOB's requesting additional information every time a claim is submitted"
- "Persistence- It took daily calls on my part to get credentialed as quickly as we did."
- "Don't assume they will call you if something is missing from your application- you call them and ask if there is anything else you can do to keep the process going smoothly."

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Challenges and tips (cont.)

- “Save copies of every email, every fax, the application, any additional documentation, etc”
- “Praise them and thank them even when you really don’t want to ☺”
- “Sometimes not hearing back from them does not mean things are not going well. I had an insurance company not call or email me back for weeks and one day I got the provider acceptance packet in the mail! It was like Christmas morning ☺”
- “Insurance companies are looking for a good documentation system during their site visit.”

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COCAP

- Colorado Coalition of Autism Professionals
 - Mission: *To enhance the safe and effective delivery of services to persons with Autism Spectrum Disorders and their families through the support and education of providers, facilitation of treatment opportunities, dissemination of intervention technologies and methodologies that maximize measurable outcomes, and collaboration on policy.*
 - Membership: *To any and all autism service professionals who share our mission*
 - To learn more: cocapmembers.org

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About the presenter: disclosure statement

- I am the
 - President of Colorado Coalition of Autism Professionals
 - Chief Executive Officer and Owner of Developmental Behavioral Health, Inc.
 - ✦ developmentalbehavioralhealth.com
 - ✦ 719-527-2121
 - ✦ doctor.hatfield.dbh@gmail.com
 - Director of Behavior Support Team, The Resource Exchange
- *I am presenting my own views, and do not represent the above entities in doing so. I am not receiving financial compensation nor seeking financial considerations for this presentation. This presentation does not present legal advice. Seek legal counsel if you have questions about this law.*

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- Dr. Tyra Sellers, STE Consultants, LLC
- Nicole Frank, The Joshua School
- Dr. Keelee Burch, Trumpet Behavioral Health
- COCAP members

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Insurance Contacts for Credentialing


Insurer	Contact	Phone	Other info
Anthem BCBS	Zanetta Jackson	303-831-2764	Fax: 303-831-5833 Zanetta.Jackson@Anthem.com
United	Marcia Ayers	951-461-0720; 619-641-8716; 951-449-2399	Fax: 619-641-8322 marcia.ayers@optumhealth.com
Humana-LifeSynch	Doreen Carpenter-Johnson	469-759-4336	
Ameriben		(866) 955-1488	
Kaiser	Kathy Bartsch	303/344-7283	
Aetna	Novella Reed-Miles	909-355-1518	Fax: 909-355-1742 Reed-Miles@aetna.com
Cigna	Alyssa Ridenour	800-687-9334	Fax: 800-687-9334 Alyssa.Ridenour@cigna.com
Kaiser/Value Options	Margaret Campbell		margaret.campbell@valuelifeoptions.com
Optum -United Behavioral Health (UBH)	Theresa Carter	Phone: 501-915-0215	Fax: 877-287-7182; Email: Theresa.Carter@optum.com ; credentialing process is also available online at www.ubhonline.com

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Natural Environment or Center-based: all depends on?

- It’s the old match patient characteristics to treatment issue!
 - Quick glimpse: We haven’t resolved it yet! We know ABA works, but not exactly the who, what, when, where match!

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- East vs. West Coast ABA
- Discrete Trials or Community Contextualism
- Behavior itself
- Ability of Child to general new skills
- Fluency building or practical use
- Language (manding)
- Age of child
- Parent Goals

- Adequacy of educational services
- Logistical items
 - Equipment
 - Travel time and expense
 - Staffing patterns and availability
 - Supervision requirements

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NUTS & BOLTS OF HEALTH COVERAGE



Heidi Loeffel, Paralegal at Ewing & Ewing

WHAT LAWS GOVERN THE HEALTH PLAN?

- State law
- Federal law
- Both??

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Why is this important?


- Some state laws like HIMAT might be preempted.
- Appeals process and procedure.
- Extra-contractual or statutory damages.
- What entities (Division of Insurance vs. Department of Labor) can help?

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ERISA

What is it?

- Employee Retirement Income Security Act of 1974.
- Federal law that governs employee benefit plans including pension plans, health plans, disability, accidental death and dismemberment plans, life insurance, etc.

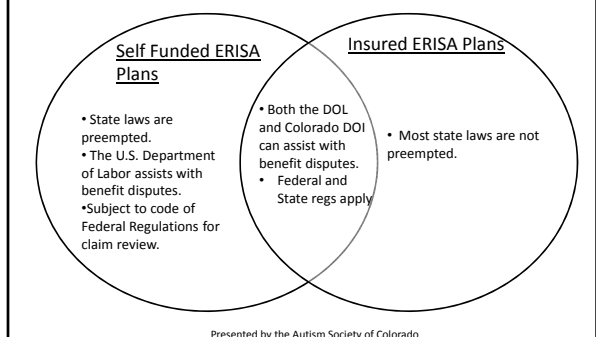


ERISA Plans

ERISA plans can be insured OR self-funded.

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Insured vs. Self-Funded ERISA Plans



ERISA Medical Appeals

Judicial review is usually limited to the "administrative record."

- Claimant **MUST** exhaust administrative remedies or is forever barred from seeking relief from the Court.
- Usually have 180 days from date of denial to request an appeal.
- There may be several levels of appeal and the right to an "external review."
- Because judicial review is usually limited to the administrative record, any and all evidence regarding the merits of the claim must be submitted to the decision-maker during the administrative appeals process.
- Most ERISA claim denials are decided under the "arbitrary and capricious" standard of review. This is BAD.
- Usually there is no trial, no jury, no testimony, no discovery.

ERISA Medical Appeals

- In-network providers usually have a provider appeals process that is separate and distinct from the appeals process for the covered person.
- If you are a provider and opt to appeal a claim determination, it is important to distinguish the two types of appeals and clarify whether you are submitting this as a provider or as a representative of the covered person.

Helpful Colorado State Laws & Regulations

- C.R.S. 10-16-106.5 – Prompt payment of claims.
- This statute says, among other things, that carriers must pay or settle claims within the time frames set forth in the statute. If clean claims are not paid or settled within the statutory time frames, the carrier must pay interest at 10% and penalties.
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Helpful Colorado State Laws & Regulations

- The Colorado Consumer Protection Standards Act for the Operation of Managed Care Plans found at C.R.S. 10-16-701 et seq.
- Network Adequacy (10-16-704(2)(a)). In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.
 - Preauthorization (10-16-704(4)). When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse. If a health carrier provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person.
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Helpful Colorado State Laws & Regulations

- Unreasonable Denial or Delay of Payment – CRS 10-3-1115 and CRS 10-3-1116. These statutes allow a claimant to bring an action in district court against an insurer to recover reasonable attorney's fees and court costs and two times the covered benefit if an insurer unreasonably denies or delays payment of a covered benefit. These statutes do not apply to all types of insurance and may be preempted by ERISA in some cases.
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Helpful Colorado State Laws & Regulations

- Colorado Division of Insurance Regulation 4-2-17. This sets forth the procedures and requirements for appeals that involve utilization review.



Health Benefit Exchanges

- Colorado's Health Benefit Exchange was created by SB11-200
 - Must offer "essential health benefits" that consist of:
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Mental health and substance abuse and behavioral health
 - Prescription drugs
 - Rehabilitative and habilitative services and devices
 - Laboratory Services
 - Preventative and wellness services and chronic disease management
 - Pediatric services
- State insurance mandates will not be required in the plans offered by the exchanges. The federal proposed regulations that will govern these plans are not yet available.

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Federal Mental Health Parity and Autism

- Requires insured and self-insured plans to provide "parity" between mental health benefits and those benefits for medical/surgical benefits.
- Does not apply to ERISA group plans with 50 or fewer employees.
- Has been used to try to defeat coverage limits for ABA autism therapy.
- To my knowledge, untested in Colorado.

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COPAYS vs. COINSURANCE

- Copays are a flat fee and usually do not count toward coinsurance or the deductible.
- Coinsurance is a percentage of the covered service and usually is paid after deductible is satisfied. Coinsurance usually counts towards the out-of-pocket maximum.

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Resources

<http://www.gpoaccess.gov/cfr/> This is a website where you can access and search the Code of Federal Regulations. ERISA claims regulation is 29 CFR 2560.503-1

http://www.state.co.us.gov_dir/leg_dir/olls/colorado_revised_statutes.htm This is a website where you can access and search the Colorado Revised Statutes.

U.S. Department of Labor: <http://www.dol.gov/> Helpful resource for ERISA, COBRA, FMLA and other federal laws. There FAQs for COBRA and ERISA are very helpful.

<http://www.kff.org/healthreform/upload/8061.pdf> Summary of the Affordable Care Act

<http://healthreform.kff.org/timeline.aspx> Timeline for implementation of the Affordable Care Act.



Eligibility and Authorization under HIMAT

Where to begin?

Travis Blevins, MS, BSOTR



Disclaimer:

- All practitioners experiences will not mirror our own. This presentation is simply a description of how we have navigated the HIMAT insurance authorizations and eligibility hurdles since the legislation past.
- It is our hope that some of these strategies and procedures for obtaining authorization and eligibility information will some how help in providing services to families in need.

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The call comes in...

- **Setting Events:**
 - A family leaving Children's hospital has just received an official diagnoses. They are confused, overwhelmed, and on information overload.
 - They have heard of the ABA and would like you to drop it by their house.
 - How do you respond? Where do we as practitioners start when we receive requests for services under HIMAT?

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Initiating services

- The first thing we tell families is to send in a copy of their insurance card front and back, along with an intake application (2-3 pages)
- The intake application focuses more on the behavioral need, and severity.
- The insurance card is necessary because even with the same carrier plans differ dramatically, and practitioner requirements may as well.
- Now you make the call...

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Initiating services

- I would recommend involving families as much as possible during the eligibility determination and moreso during the authorization phase of initiating services.
- **Eligibility determination:** simply determining whether ABA services are covered by the insurance carrier for the individual referred.
- **Authorization:** determining the scope and allowance for services once deemed eligible.
- These are two distinct phases of initiating services

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Initiating services

- Eligibility has proven to be the smoothest of the insurance interactions.
 - We use a simple form to prepare for seeking authorization, or to inform the family the insurance policy is not under the mandate, and refer to alternative funding streams. (See attachment A)

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Initiating services

Most of this information is useful if not necessary to obtain authorization. We may interview the family to gather this information, or pull it from our intake application.

The blue section occurs when you (or your billing agent) call the insurance company (the number on the back of the card).

Eligibility Verification Request

Client: _____ Contact: _____
 Tax ID: _____ Contact #: _____
 Patient Name: _____ DOB: _____ Age: _____
 Address: _____
 Member ID: _____ Group #: _____ Subscriber: _____
 Insurance Co: _____ Insurance Phone #: _____
 Other Insurance: _____
 Insurance Self Funded: Yes No
 Prescribing MD: _____
 DR: _____
 CPT: Practitioner's Name: _____

Billing Agent Complete

Coverage: _____ Deductible: _____
 Eligible for Therapy: _____
 Limitations: _____
 Referral #: _____ Insurance Rep: _____
 Plan Name: _____ Eligible: Yes No Pre-Auth: Yes No
 If Pre-Auth necessary, What to send: _____
 Where to send it: _____
 Additional information needed: _____

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Initiating Services

- The most important element once you determine the individual is eligible is identifying the CPT codes
- This can be a painful almost sadistic process.
- It is recommended that within your authorization form (and your provider contract) you mention that the service is approved to be funded and list the codes to submit.
- Identifying those codes can be tedious, **STICK WITH IT!** Perseverance will pay off!

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Initiating services

- Once eligibility is determined:
 - When/if: The insurance company tells you the individual is eligible for ABA services.
 - Ask for it in writing (via email or fax)
 - Ask if prior authorization is necessary, ask what is included in the authorization (most providers have this information available on their website) and where it is to be sent
 - Ask what the turnaround is for authorization (communicate this to the family)

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Initiating services

- Confirm the billing codes you will be using
- Confirm the staff that will be providing services will be funded (their credentials are funded)
- Identify if there is an annual CAP to the amount of services approved
- Identify if there is a CAP to the amount of assessment funded.
- SEE ATTACHMENT 2 for an example from United Behavioral Health.

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Initiating Services

United requests 4 things:

- 1) Release of Info
- 2) Behavior Benefit Assessment
- 3) Diagnostic Report
- 4) Treatment Plan

They will usually allow about 8 hours to conduct the assessment and develop the treatment "plan" (actually more like recommendations given the time limits)

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Initiating services

- Once eligibility is determined:
 - The road to authorization:
 - Gather information that will determine how you proceed.
 - In a single case agreement (out of network, individual service plan designed directly with the insurance provider) authorization protocols should be clearly identified.
 - In network, most large companies have authorization information online, some have a phone in hotline.
 - We use a checklist of information we have gathered to begin down the road to authorization.. SEE ATTACHMENT 3

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Initiating Services

Once we establish eligibility and benefit coverage we move toward securing authorization. We use this simple checklist to gather information that will be necessary for beginning or continuing services.

Some agencies, allow a brief assessment before formal authorization for the annual service year is funded.

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Initiating Services

- Authorization, re-authorization, pre-authorization...
- **WHEN CAN I START WORKING WITH THIS KIDDO!!!**
- Be sure and identify when the authorization begins, and make sure all services delivered occur after this date and time. Do not assume services start after you complete the authorization.
- Some agencies will require authorization prior to providing ANY services, some agencies require frequent re-authorization, and some require an assessment prior to authorization. **KNOW YOUR PROVIDER!!!** Ask these questions!

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Initiating services

- Other things to be aware of:
 - Make sure each therapist that works with the individual is either in the provider network, or you have a blanket group policy that covers all of your employees.
 - Know the re-authorization date for services, some agencies will not inform you of an expired authorization and will just deny your claims with a code you have to look up.
 - Know your rights as a provider (CSS 10-3-115) which states: "a person engaged in the business of insurance shall not unreasonably delay or deny payment of a claim for benefits owed to or on behalf of any first-party claimant"

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Initiating services

- Strategies and tactics to speed up the process:
 - Identify and work with a specific individual within the insurance agency who provides authorizations.
 - Build Rapport (I am not fluent with this, so I pay others to do it)
 - Provide verbal reinforcement when things go smoothly and cc their supervisor.
 - Most of the time, engaging in behavior that directly reduces the stress or amount of work the insurance contact engages in can facilitate more speedy processing.

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Initiating services

- More strategies to speed up the authorization process:
 - Involve the family, and possibly their employer (some employers have in-house insurance affiliates, who may be able to speed up the authorization process)
 - Process many authorizations (so SHARE info with other providers). The more authorizations for ABA treatment under HIMAT processed the better the insurance companies will get at it, and the more kids that will receive services!
 - **GOOD LUCK!!**

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