ABA Insurance Denials: What to do when insurance says NO!

Karen Fessel, MHAIP

Michele Silcox and Emily Roche, ABA Billing

Mental Health & Autism Insurance Project

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Meet the Presenters:

Mental Health and Autism Insurance Project

Karen Fessel

ABA Therapy Billing and Insurance Services

Michele Silcox and Emily Roche

Karen Fessel, Executive Director

- Doctorate in Public Health
- Parent of 23 year old with ASD
- Founded Mental Health & Autism Insurance Project after winning an appeal for coverage for speech, OT and social skills

Mental Health &
Autism Insurance Project

Who We Are and What We Do

- Non-profit public charity
- Formed by parents coming together and realizing that health care systems were not providing adequate care for ASDs.
- Mission: To help families, professionals, and people with ASDs conditions get necessary health services through insurance, so that they can reach their full potential.
- Expanded to include Mental health. We do some work with folks with other disabilities, depending on the situation.

Services that We Offer

Mental Health & Autism Insurance Project

- Free initial consult to families and providers on how to handle denials.
- Appeal writing, IMR requests, follow up on unpaid claims, regulatory intervention, sliding scale program.
- Updates on changes in laws impacting our families through our quarterly newsletter and website: www.mhautism.org
- Educating legislators and regulators on our families' needs
- Educating families, physicians, and other professionals through community based workshops on how to work with insurance.

Michele Silcox, CEO/Owner
Emily Roche, Director of Services

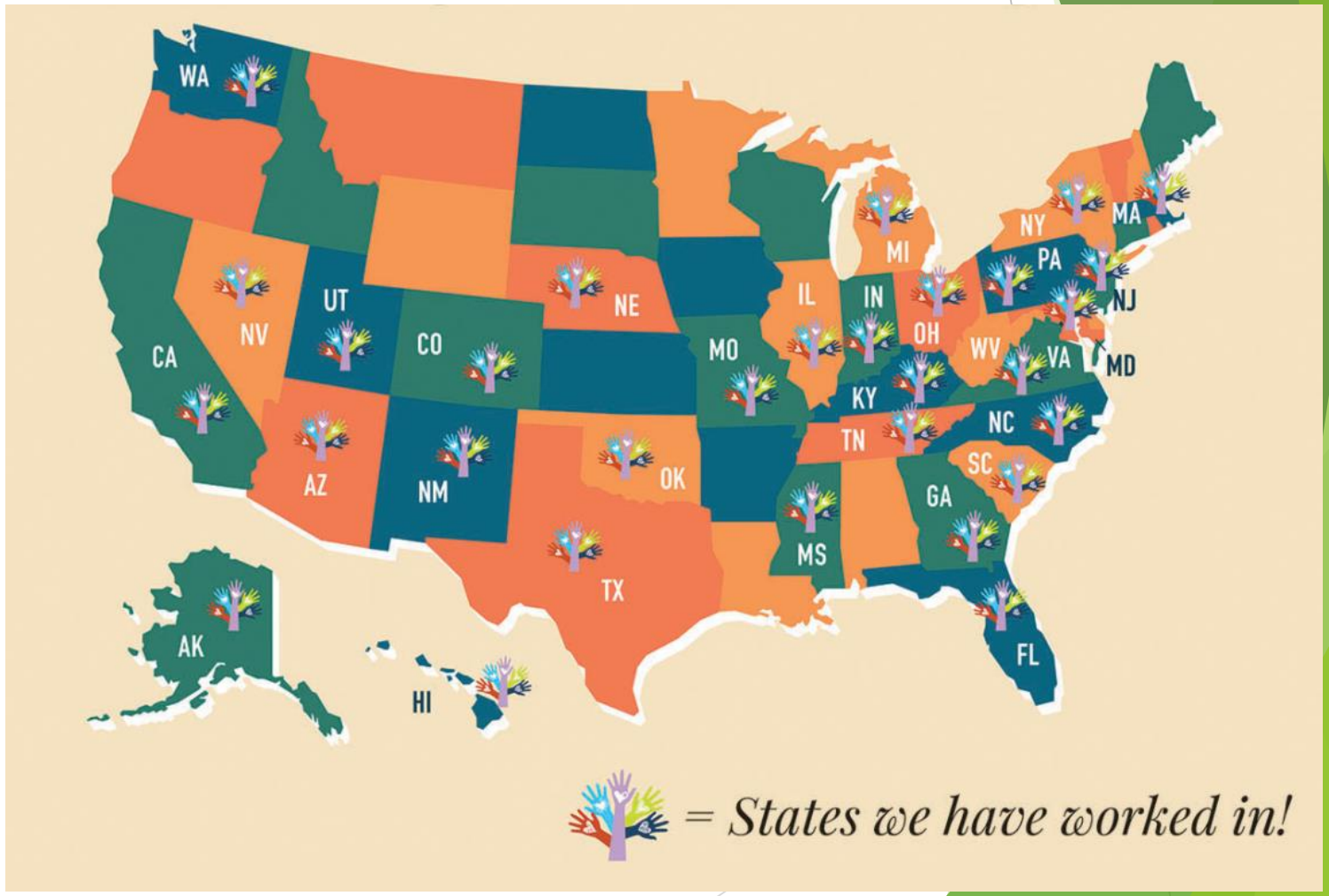
- Michele started billing for ABA in 2009
- Started ABA Therapy Billing and Insurance Services in 2012
- Accounting and Software background

- Emily started in ABA services in 2012
- Focus on authorizations, contracts, and appeals
- Joined company in 2016

ABA Therapy Billing & Insurance

- Our Services:
- Consulting/Training
- Billing and Revenue
- Case Management
- Credentialing and Contracting

- www.ababilling.net



But What Happens When they Say NO??

- Many ABA providers are now in-network with insurance, and have learned to do pre and ongoing authorizations, peer-to-peer reviews, and bill insurance.
- This is a HUGE achievement, we've come a long way in a short time!
- But what do we do when they say NO?
- This workshop will help to shed some light on the world of denials, appeals, and the external review process.

Topics for Today's Workshop

- Quick Insurance Basics
- Basics of Appeals
- Billing and Claims Denial Issues
- Authorizations and Peer Reviews
- Obtaining a Written Denial
- Different Types of Denials
- Cases: Examples of Appeals
- More Tools to Fight Denials
- Wrap-Up

Quick Insurance Basics

Insurance Coverage for ABA Therapy

- Self Funded (ERISA) vs. Fully Funded (Large Group Plans)
  - Small Group or Individual Plans may not be subject to state mandates
  - Can also carve out State Employees (AK, ME, NH, SD)
- Federal Employee Health Benefits (FEHB)
  - As of 1/1/17, FEHB plans require coverage for ABA
- Individual Plans and the Health Insurance Marketplace
- TRICARE
- Affordable Care Act: no waiting period, no high risk pools, co-pays count toward out of pocket maximum, child-only plans available on exchanges

- Great Resource: https://www.autismspeaks.org/state-initiatives

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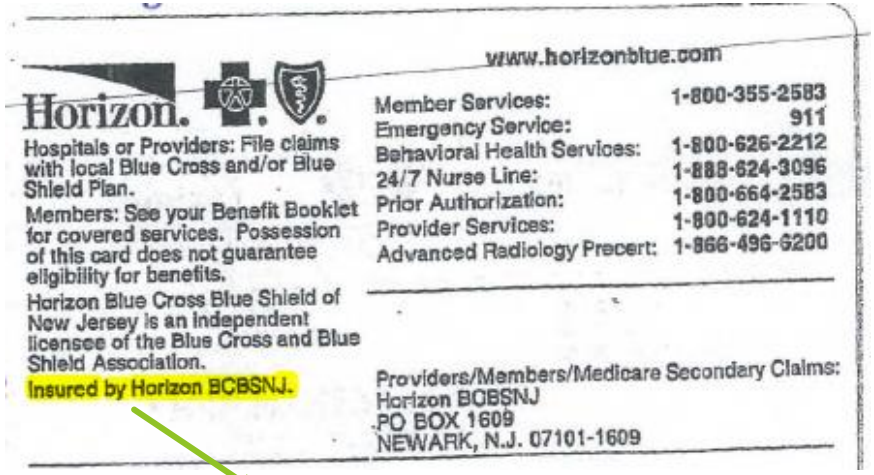
How to tell: Self-Funded or Fully Funded?

- Why does it matter? Many state regulators will intervene if there is a problem.
- If the problems are systemic, the health plan can be fined. For a list of regulators by state: http://www.naic.org/state_web_map.htm
- Self-funded plans are minimally regulated by the Employment Benefits Security Administration of the Department of Labor: https://www.dol.gov/agencies/ebsa
- Some states and some companies include information on the card:



- INSURED BY = Fully funded or state regulated.

Plan Manual

PLAN MANUAL: AKA **Detailed Summary Plan Description** (self insured/self-funded plans) (large private companies) or

Evidence (or Certificate) of Coverage Manual (State Regulated/Fully Funded, Medicaid)

- If you are helping the family with an appeal, it is a good idea to request this. Explains rules around appeal, filing claims, what is covered, etc.

Medicaid, CHP+, and TEFRA

- Medicaid: administered at the state level, but overseen by federal rules
  - Directive from Federal CMS in 2014 stated that all states “should” cover ABA under Medicaid
  - Some states moved quickly (CA), and other states moved slowly (NY)
  - Other states were even sued, which has proven to be powerful case law
  - Medicaid State Plan vs. EPSDT (Early Periodic Screening, Diagnosis, and Treatment)

- What is TEFRA (also called Katie Beckett)?
  - Every state has a financial threshold at which people qualify for Medicaid based on income
  - TEFRA is a state law where the income requirements can be waived and a family/individual can qualify based on need, usually due to a disability or certain diagnoses
  - Thus, a family with a child with autism may be able to obtain Medicaid even if their income is higher than the financial threshold

Insurance: Continued Challenges

- Settings (who should pay in each setting – school, community, day care)
- Funders fighting over whether ABA is educational or medical
- Still see some even try to call ABA experimental
- Who qualified to receive ABA – diagnosis, age, etc.
- How much ABA should be covered
- How do other services intersect?
- Varied requirements for who qualified to provide services (RBT, Licensure)
  - Setting quality standards is a success! But, we still have a wide range of differences

Basics of Appeals

Steps for Appeals

- Appeals Process and Deadlines
- First Appeal:
  - Be prepared to go for it! Common mistake is waiting too long.
  - Need to get family involved
  - Quickest response occurs when member (parent) submits appeal
  - Goal is to “get it out the door quickly”
  - Pay attention to appeal deadline. Can be as short as 60 days! Often up to 180 days.
  - Be sure your provider rep is aware of issue – send in writing to rep
  - Follow up to confirm appeal was received, ask if they give a “case #” or “appeal ID”
- Secondary Appeal:
  - Occurs if initial appeal is denied
  - Will again have deadline for secondary appeal
  - Need to add all supporting documentation (cannot add for external appeal

Tips for Writing the Appeal

- Include all demographic information
- Be sure to use information that you have been documenting
  - Dates of each action, reference numbers, names of reviewers
- Include copies of documents
  - Treatment plan, session notes if needed (possibly in billing denials), diagnostic report and physician referral, authorizations, etc.
- Supporting documentation
  - Research articles, white papers from APBA, documents/guidelines from BACB, especially if the insurance reviewer has tried quoting items like this
- Refer to any sections of your contract that are being violated
- Be concise and clear. Use child's name. Always circle back to the need for medically necessary treatment. Highlight any negative impact of delay/reduction in services.

External Appeal, DOI Complaint

- External Appeal (more details later in presentation!)
  - Last Appeal: Should be 3rd party reviewer
  - Watch again for deadline

- Options beyond the insurance company?
  - File complaint with Division of Insurance (fully funded insurance)
  - Go directly to employer (self funded insurance)
  - Collaborate with local groups that might have voice with insurance companies – local ABA chapter, legal resource center, etc.
  - Move forward with an attorney

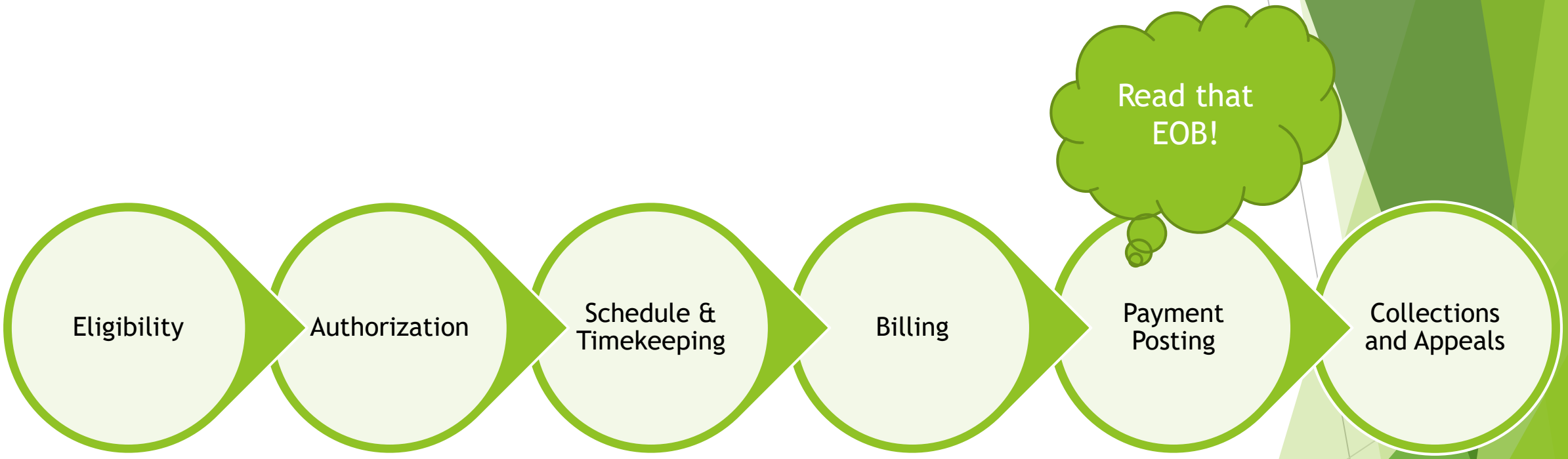
Two Types of Appeals

- Clinical/Medical Necessity
  - Usually occurs at time of request for authorization
  - Insurance may try to deny or reduce the number of hours requested
  - Could also try to dictate services: location, goals, parent training, etc

- Billing/Claims Processing
  - Denials or incorrect processing after claims are submitted
  - Review EOBs (Explanation of Benefits) carefully to determine results
  - ABA claims have a large number of incorrect claims processing "reasons"
  - Best first step is **understanding the denial** - reprocess, corrected claims, appeals, etc.

Billing and Claims Denial Issues

Insurance Billing and Collections Process



Billing Denials

- Understand how to decipher your EOB!
  - What if claims deny? Pay less than expected?
  - Incorrect processing? Incorrect billing?
  - Accurate denial and uncollectible? Such as missing timely filing!
  - Incorrect billing = did team schedule correctly?

- Accurate billing can result in 90% of claims paid
  - Now, track and collect the other 10%

First, Use Best Practices

- Work toward accurate billing and best practices before claims are submitted
  - This will help prevent corrected claims or issues that grow into denials and appeals
- What process are you using to schedule sessions and enter codes?
  - To track authorized amounts and utilization?
- What are your payroll deadlines?
- Timely Filing
  - Be sure to save all documentation if faxing or mailing claims.
  - Were claims sent to the correct place

Claims Processing Errors

- Claims may just process wrong
  - Multiple times!
- Or, payment may be delayed – are you checking insurance portals for claims in process?

- Common Denials:
- Two locations in one day
  - Process/denied as a duplicate
- Patient Responsibility
  - Co-pays or co-insurance applied incorrectly
- Processed out of network, when you are in network
- Single Case Agreements

Case #1: What do you see?

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE
02/14/18	11	0367THO	3.0	111.00		40.00				
02/14/18	11	0366THO	1.0	37.00						

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE
02/14/18	12	0365THN	3.0	75.00		40.00				
02/14/18	12	0364THN	1.0	25.00						

- These lines are from one EOB, happened to be split onto 2 pages.
- Same date of services with two locations in one day. Both locations paid!
- But, two copays applied on one day.

When Reviewing Your EOB……

01/30/18	[redacted]	50.00	$74.90	$0.00	$75.10	$50.00	$24.90	$24.90 AB
01/30/18								
01/30/18		5.00	$37.45	$0.00	$37.55	$0.00	$37.45	$37.45
01/30/18								
01/30/18		2.50	$32.00	$0.00	$10.50	$0.00	$32.00	$32.00
01/30/18								
01/30/18		2.50	$32.00	$0.00	$10.50	$0.00	$32.00	$32.00
01/30/18								
02/01/18		2.50	$160.00	$0.00	$52.50	$50.00	$110.00	$110.00 BC
02/01/18								
02/01/18		2.50	$32.00	$0.00	$10.50	$0.00	$32.00	$32.00
02/01/18								
CLAIM		65.00	$368.35	$0.00	$196.65	$100.00	$268.35	$268.35

A-A COPAY OF $50.00 WAS REQUIRED. (Y647)
B-THERE IS A SUBSCRIBER COPAYMENT FOR THIS SERVICE. (Z189)
C-A COPAY OF $50.00 WAS REQUIRED. (Y647)

- This client has a $25 co-pay for ABA.

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Case #1: Co-pays Applied Incorrectly

- Options:
- Call to reprocess if co-pays are applied per session rather than per day.
- If co-pay amount is different than expected
  - May need to review plan manual
  - May need to call again to benefits department to confirm
  - And, have the claim reprocessed

- Tip: Using a good software to track A/R is critical! Each code on each date of service can have a different result and it becomes too much to track!

Case #2: What's going on here?

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
11/16/17	12	0365T		50.00			50.00	1				0.00
11/16/17	12	0364T		25.00			25.00	1				0.00
TOTALS				**375.00**		**50.00**	**75.00**				**50.00**	**250.00**

ISSUED AMT: $250.00

Remarks:
1 - This is a duplicate claim that has already been considered for payment. 770
Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)

- Date of EOB: 12/18/17
- Let's go find what else was billed on this claim – this is the first time these DOS have been processed

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SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
11/16/17	11	0365T	2.0	50.00		25.00					25.00	25.00
11/16/17	11	0364T	1.0	25.00								25.00
TOTALS				**375.00**		**75.00**					**75.00**	**300.00**

ISSUED AMT: $300.00

Remarks:

Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)

- EOB 12/18/17
- Different place of service – two session in one day
- Same date with payment on 11/16
- Also have a co-pay withheld

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11/16/17	12	0365T		50.00			50.00	2			0.00
11/16/17	12	0364T		25.00			25.00	3		25.00	0.00
TOTALS				**375.00**			**375.00**			**25.00**	**0.00**

ISSUED AMT: **NO PAY**

Remarks:

1 - This is a duplicate claim that has already been considered for payment. 114

2 - This is a duplicate claim that has already been considered for payment. 770

3 - The member's plan provides coverage for charges that are reasonable and appropriate. This procedure exceeds the maximum number of services allowed under our guidelines for a single date of service. [U55]

Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)

- After calling, the claim has been reprocessed.
- EOB 1/15/18
- Denies again as duplicate, and for good measure, also denied for “exceeding the number of services allowed on a single date.”

Paid….but wait….

Recd: **02/15/18**

Product: **Open Choice®**

Aetna Life Insurance Company

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
01/16/18	12	0365T	5.0	125.00		25.00					25.00	100.00
01/16/18	12	0364T	1.0	25.00								25.00

- Finally pays after 3 months.
- Co-pay is withheld, which makes it two in the same day.

Case #2: Two Locations in One Day – Denied as Duplicates

- First, call to reprocess.
- For ongoing issues, may be able to file a grievance or complaint to try to stop future issues.
- Know your software:
  - Example, Central Reach does not split two locations over two claims
  - Track the response from your funding source – some will pay 0364T per SESSION others will pay it per DAY.
- If claims never process correctly, move forward with an appeal letter.

Case #3: What do you see?

Date				Billed	Allowed			Denied			Denial Reason
05/11/2017	05/11/2017	0364T	11	34.00	34.00	0.00	0.00	5.10	0.00	0.00	
05/11/2017	05/11/2017	0365T	11	374.00	374.00	0.00	0.00	56.10	0.00	0.00	
05/12/2017	05/12/2017	0364T	11	34.00	34.00	0.00	0.00	5.10	0.00	0.00	
05/12/2017	05/12/2017	0365T	11	374.00	374.00	0.00	0.00	56.10	0.00	0.00	
05/15/2017	05/15/2017	0364T	11	34.00	34.00	0.00	0.00	5.10	0.00	0.00	
05/15/2017	05/15/2017	0365T	11	374.00	34.00	0.00	0.00	5.10	340.00	340.00	066 45
05/16/2017	05/16/2017	0364T	11	34.00	34.00	0.00	0.00	5.10	0.00	0.00	
		TOTAL:		4,298.32	3,958.32	0.00	0.00	593.74	340.00	340.00	
INTEREST											
		TOTAL NET PAID									

- Just one date appears to have a single unit paid on code 0365T
- Other dates have multiple units paid.
- Almost like it was processed the same as code 0364T, which automatically denies more than one unit per day.
- Look for patterns across multiple clients – this issue actually occurred across months of claims for multiple clients.
- Now what?

Look at the Reason Code

NET AMOUNT DUE

EXPL CODES	EXPLANATION
757	Claim submitted has been divided into more than one claim record for benefit consideration.
067	This balance is the member's coinsurance responsibility.
066	This is the amount in excess of the maximum allowed amount for a participating provider. The member, therefore, is not responsible for this amount.
2	COINSURANCE AMOUNT
45	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. NOTE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL REDUCTIONS) THAT HAVE RESULTED FROM PRIOR PAYER(S) ADJUDICATION.

- Important Codes: 066
- “excess of the maximum allowed amount for a participating provider”
- What does this mean?
- Bogus denial! There is nothing in the contract, ABA guidelines, authorization, or anywhere else stating that ABA would be limited to just one hour per day.

Solution: Sent Appeals
And, went to DOI once appeals were denied.

I informed the representative that we were previously paid for the code 0365T billed with 11 units, on date of service July 27, 2017 which can be found in claim number xxxxxxxxxxx. Per previous payment, the representative sent the claim back to be reprocessed, the reference number for that call is 2017264010536. The provider was told no authorizations is needed for Applied Behavioral Analysis Therapy.

Please send claim back for reprocessing at the highest priority base on previous payment of the same code on a different claim. Code 0365T is a secondary code representing additional 30 minutes from primary code 0364T the initial 30 minute. The provider has been providing Applied Behavioral Analysis Therapy to Joe, since March 2016. Joe has been receiving six hours of therapy billing at 12 units of 0364T/0365T, if only one unit is allowed for the 0365T, Joe will only be receiving 30 minutes of Medically Necessary Therapy. This denial is an error, and should be corrected immediately.

Case #3: Claims Processing Errors

- Burden is on us to carefully review EOBs.
- Tip: Have effective and consistent cash posting processes so all lines of each claim are accounted for in your A/R tracking.
- Call to reprocess.
- If the issues is ongoing where you are always being forced to place calls, consider a grievance.
- If the claims does not pay correctly, submit an appeal.

- Tip: Write appeal “templates” for common issues so it is quick and easy to send new appeals out the door.

Case #4: What's this?

12/11/17	11	0365T		260.00			260.00	2			0.00
TOTALS				**910.00**			**910.00**			**650.00**	**0.00**

ISSUED AMT: **NO PAY**

Remarks:

1 - Charges for educational services and training are excluded from coverage under the member's plan. 772

2 - "Add-on" codes describe procedures/services that are always performed in addition to the primary procedure/service and must be listed in addition to the main CPT code. Please resubmit this claim with the appropriate primary procedure/service. 856

Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)

- This is a correct denial. Now what?

Case #4: Denial for Missing T-Code

- Solution: Submit a *corrected claim* with 1 unit of 0364T. And subtract a unit of 0365T.
- With the new CPT codes that come in “pairs,” it can be easy to lose the initial code.
- Maybe a session started a half hour late. Or, two therapists see the client. The first therapist usually is billed with 0364T. But, the session with the first therapist is cancelled.
- Have strict payroll deadlines. What if therapist number one in the scenario above, just turned in time late?
- Tip: Have a routine to “scrub” billing before sending. One of the checks and balances should be looking for missing T-codes.

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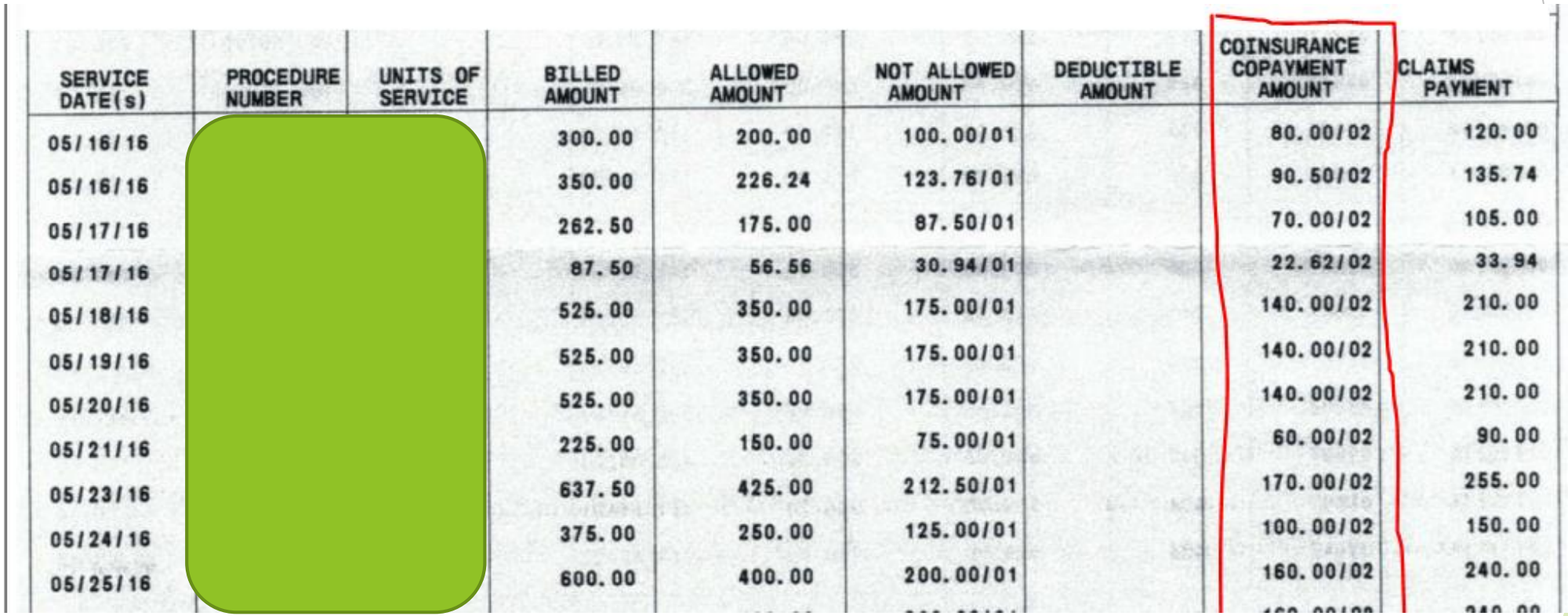
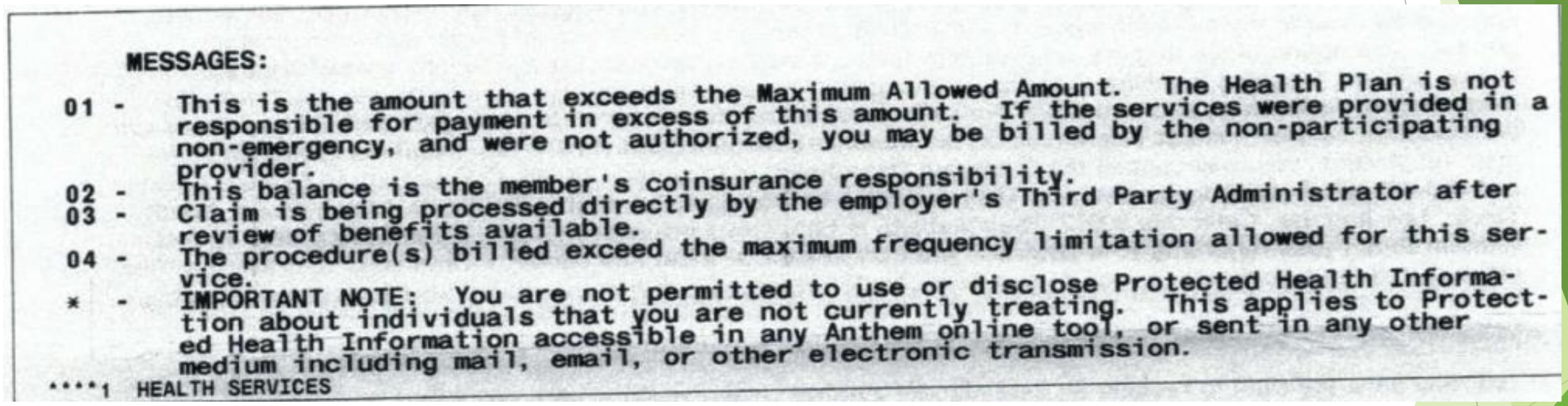
Case #5: Last one!



SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
05/16/16			300.00	200.00	100.00/01		80.00/02	120.00
05/16/16			350.00	226.24	123.76/01		90.50/02	135.74
05/17/16			262.50	175.00	87.50/01		70.00/02	105.00
05/17/16			87.50	56.56	30.94/01		22.62/02	33.94
05/18/16			525.00	350.00	175.00/01		140.00/02	210.00
05/19/16			525.00	350.00	175.00/01		140.00/02	210.00
05/20/16			525.00	350.00	175.00/01		140.00/02	210.00
05/21/16			225.00	150.00	75.00/01		60.00/02	90.00
05/23/16			637.50	425.00	212.50/01		170.00/02	255.00
05/24/16			375.00	250.00	125.00/01		100.00/02	150.00
05/25/16			600.00	400.00	200.00/01		160.00/02	240.00

Client is supposed to have a $20 co-pay. **Previous EOBs did reflect only a $20 co-pay.** This EOB has a 40% co-insurance taken out as the patient responsibility.

Reason 02: This balance is the member's coinsurance responsibility.



MESSAGES:

01 - This is the amount that exceeds the Maximum Allowed Amount. The Health Plan is not responsible for payment in excess of this amount. If the services were provided in a non-emergency, and were not authorized, you may be billed by the non-participating provider.

02 - This balance is the member's coinsurance responsibility.

03 - Claim is being processed directly by the employer's Third Party Administrator after review of benefits available.

04 - The procedure(s) billed exceed the maximum frequency limitation allowed for this service.

* - IMPORTANT NOTE: You are not permitted to use or disclose Protected Health Information about individuals that you are not currently treating. This applies to Protected Health Information accessible in any Anthem online tool, or sent in any other medium including mail, email, or other electronic transmission.

****1 HEALTH SERVICES

What now?

What else?
That “looks like” an out of network coinsurance amount.

NETWORK PROVIDER: N

FOUNDATION PHYSICIAN: N

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
05/16/16			300.00	200.00	100.00/01		80.00/02	120.00
05/16/16			350.00	226.24	123.76/01		90.50/02	135.74
05/17/16			262.50	175.00	87.50/01		70.00/02	105.00
05/17/16			87.50	56.56	30.94/01		22.62/02	33.94
05/18/16			525.00	350.00	175.00/01		140.00/02	210.00
05/19/16			525.00	350.00	175.00/01		140.00/02	210.00
05/20/16			525.00	350.00	175.00/01		140.00/02	210.00
05/21/16			225.00	150.00	75.00/01		60.00/02	90.00
05/23/16			637.50	425.00	212.50/01		170.00/02	255.00
05/24/16			375.00	250.00	125.00/01		100.00/02	150.00
05/25/16			600.00	400.00	200.00/01		160.00/02	240.00
05/26/16			600.00	400.00	200.00/01		160.00/02	240.00

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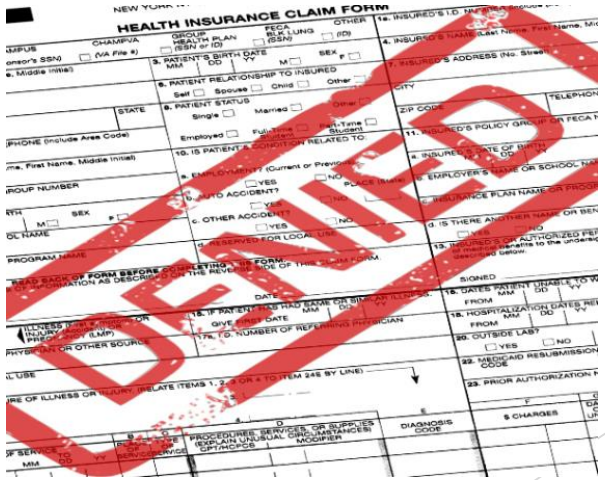
Case #5: Being Paid as Out of Network (when your in network)

- Need to identify if the group or the individual provider is being seen as out of network. In this case – it was the group.
- In this case, the provider had actually moved to a new office, which meant the service location address changed.
- No one updated the service location with all of the in network insurance contracts.
- Claims started going out with the new address.
- Claims process as out of network for the new address.
- SOLUTION:
- Go to your provider rep, request address change – WITH the date that the new address opened.
- Or, if locations overlapped and you can bill under previous address for those dates then send *corrected claim.*

Appeal vs. Corrected Claim?

- Incorrect Rendering Provider
- Incorrect use of Codes
- Rate Corrections
- Location Corrections
- Missing Modifiers
- Late time



No Denial? But, Incorrect Payment?

- Know your provider representative
- Know your contract
  - Are any terms of your contract being breached?
- Learn about state/federal laws that apply
  - Ex. Texas has a state law that timely filing is a minimum of 95 days
- File a grievance or complaint (rather than an appeal)
  - If insurance will not or has not issued an official denial
  - Provider handbook should have process for grievance listed out
  - Again, continue sending info in writing to your provider rep
- Involve families (they are the customer of the insurance company)
- Exercise your right to leave the network

Authorizations and Peer Reviews

Recommendations and MHPAEA

- What can I request? Where can it occur? How many hours?
  - Hint: You can request anything that is medically necessary for the child.
- Mental Health Parity and Addiction Equity Act: Federal Law
- MHPAEA applies to all benefits for mental health conditions
- Mental health conditions are defined by applicable state and federal law
  - Consistent with generally recognized independent standards of current medical practice such as DSM-V
  - Some states defined autism as a medical condition
  - Insurance policies must also define conditions appropriately
- Has broad application because definition focuses on the mental health condition, not the type of treatment

Requesting Hours

- Know your break down of requested hours and codes
  - Do not assume they know this for you
- ALWAYS (always!) include your RECOMMENDED number of hours
  - Err on the side of caution, do not limit the hours before you even get started
  - What if family can't schedule the full number of recommended hours?
- It is not necessary to negotiate hours, stick to your recommendation
- Insurance cannot dictate:
  - Location, parent training, goals, timeline for reducing hours or "step-down"
  - Cannot deny or reduce based on age threshold or how many years child has been in ABA treatment

Be Proactive: Train Staff

- Reviewer will start with high level picture
  - Why is child in services, what are the most significant needs, how long has s/he been in services, what are the future plans for treatment (reduction)
- Cover significant maladaptive behaviors or skill acquisition needs
- Tip: Be prepared to highlight most significant need or issues
  - Example: safety issues are major indicators for coverage (eloping into street, opening car doors, PICA, SIB)
- Important to show progress everywhere possible
- Parent Involvement
- Goals “sounding too academic”

Denials or Reduction in Hours

- Initial Review or Phone Call
  - If full authorization is not approved, ask for a peer or secondary review
  - Should occur within a week
- Reduction in hours
  - Be certain the reviewer will **issue a denial** for the difference
  - Be clear you are not “agreeing” to the decreased hours
- Full Denial
  - Letter should be issued in writing and sent to both the provider and the family

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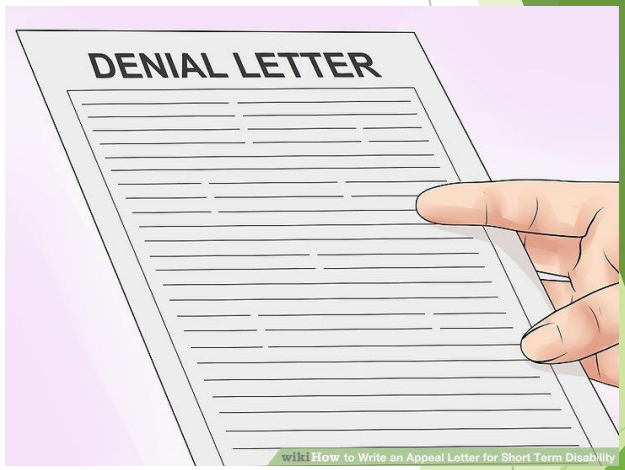
Obtaining a Written Denial

First Step to Appealing is to Obtain Written Denial

- Call to obtain pre-authorization. Sometimes comprehensive assessment with ASD dx is needed (initial), sometimes prescription from doctor.
- Be prepared to discuss clinical info on why treatment is medically needed. (Most health plans require this for ABA.)
- If they tell you pre-auth is not needed, get a tracking # to verify (if they are wrong, that tracking # will save you)



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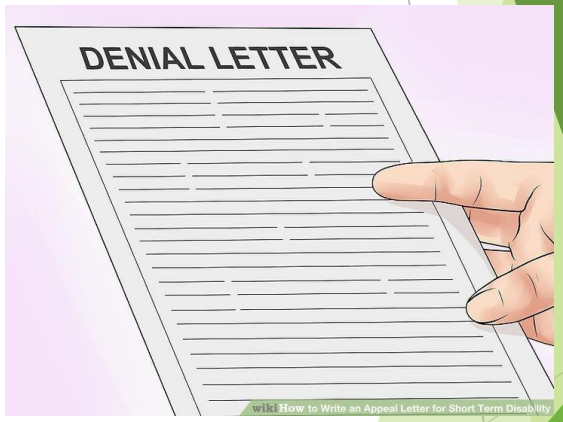
Obtaining Written Denial, 2

- When obtaining authorizations, or in “peer to peer” review, don’t let the plan change or shape your request (e.g. reduce hours, dictate setting) without getting approval from the family. If you do, you prevent the family from appealing.
- If they tell you that they are reducing hours or modifying your request, ask for both authorization (on what you agree on) and denial (of what you do not) in writing.
- Cannot make one contingent upon the other (alert regulator).
- Take notes on the reasons they tell you in the call: “He’s too old.” “She’s had ABA for five years now.” “He’s has a 150 IQ, why on earth does he need this?” It is part of the story (and probably the “real” reason).
- But you really want to see what they put in writing.



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Trouble Obtaining Written Denial?

Dispute About Hours

- File a formal grievance, explaining the problem.
- I requested 25 hours a week of ABA services for Jonny. I believe that this is what is medically necessary for reasons a, b, and c. Susie M, the care manager, told me by phone on 5/2/2017 that she could approve 15 hours a week without a problem, but she would deny anything more than that (tracking # 122222).
- I am happy to accept 15 hours a week, and I continue to disagree about the remaining ten hours. Please send an approval authorizing 15 hours a week and a denial for the remaining ten hours a week, so that we may maintain the right to appeal.

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Trouble Obtaining Written Denial, 2

Dispute About Site/Location

- I requested 40 hours a week of ABA for Jonny. He needs 25 of those hours to be administered in the greater community, including the pre-school, and 15 in the home.
- To date, he has been getting his hours at home. He has made good progress, but part of skill mastery is learning to generalize what he has learned to other environments.
- His goals also include working on social skills and building peer relationships, which can best be learned while in the natural environmental setting – which in this case is pre-school.

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Trouble Obtaining Written Denial, 3

Dispute About Site/Location

- During the UR process, I was told that if I did not accept the home setting, all treatment would be denied. I am formally requesting 15 hours a week in the home setting, which we all agree Jonny needs.
- I am also requesting 25 hours a week, to be delivered in varied community settings, including pre-school.
- If you cannot approve the request for working in the community and school settings, please issue an approval for the home based hours, and a formal denial for the remainder, so that we can appeal that which we do not agree on.

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More about Denials

- Many health plans do this already (issue two responses), but many do not.
- Required to respond in 30 days. When requesting continued care, response time is often equivalent to “expedited” status – 3 days.
- Other option: If services have been rendered, send in invoice. They are supposed to process and send EOB (**EXPLANATION** of benefits statement) for what they don’t cover. EOB is sufficient for appealing.

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What Needs to Be Included In Denial?

The Health Plan must:

- Clearly identify what service is being denied, including provider, date of service, type of service, etc.
- Tell you why they are denying the claim (cannot just say “not medically necessary”), as well as the standard or guideline used in making the determination
- Must make documents used in decision available to you upon request.
- Must instruct you on next steps, including how to initiate appeal and external review, if available.
- Disclose availability and contact information of state consumer assistance office.
- If the plan fails to adhere to the requirements, and it impedes the process, the claimant has “exhausted” the appeal and can proceed to next steps (external review or litigation).

This is all part of federal law and can be found at: Code of Federal Regulations:

CFR § 2590.715-2719

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Different Types of Denials

Types of Denials, Medical Necessity

Not Medically Necessary. Must tell you WHY!!

- Must provide guidelines or other documents used in decision, upon request. REQUEST THEM!! Use them in your appeal, or use BACB guidelines as community standard.
- Supposed to be reviewed by a physician expert within the plan or in consultation with plan.
- We sometimes look up the experts that sign the denial letters to check on autism expertise. Vitals.com lists their self-identified specialties. They will often list many mental health conditions, but sometimes do not list autism. Okay to mention in appeal.

Robert Friedman, Medical Director, Anthem
Schizophrenia, Insomnia, ADHD, Depression, Sleep Disorders

Stuart Lustig, Medical Director, Cigna:
STDs, schizophrenia, sleep disorders, insomnia, depressive disorder, PTSD, Substance Abuse, ADHD, Eating Disorders

BUT NOT AUTISM!!!!

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Types of Medical Necessity Denials

Common Reasons For Denial

- Treatment being stopped
- Hours cut back
- You have met your goals and no longer need treatment
- You have plateaued and are no longer showing benefit/progress
- You do not meet our level of care guidelines
- You are too old to benefit.
- Your cognitive abilities are too low to benefit.
- ABA in school is educational
- You have had ABA for several years.
- Services could have been provided by an in-network provider
- WHAT ELSE?????

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What is Medical Necessity?

- Multiple definitions but usually requires that treatment ameliorate or manage symptoms, improve functioning, and prevent deterioration. Some definitions also include improving quality of life, lessening pain and alleviating disability.

In characterizing medical necessity, health plans may:

- Require clinically meaningful progress for those with severe challenges
- Terminate when progress has plateaued
- Terminate abruptly without gradually fading
- Terminate when goals are met without adding additional goals
- Terminate without consideration of age expectations
- Cut back services after a few years

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Types of Denials: Administrative

- Did you call and verify benefits? Get a tracking #?
- Request plan manual from parent. Check to see if ABA is covered.
- Does the reason given for denial match what is specified in the plan manual?
- Is it consistent with your state mandate (for fully funded plans)?
- Age and hours caps, are they legal?
- Failed to use in-network provider
- Failed to obtain pre-authorization
- ABA in school is educational
- Disputes about amount paid.
- OTHER

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Administrative Denials: Errors in obtaining approval

- Error in verification of benefits or in pre-auth: GET TRACKING #
- Approval given, services started, denied retroactively
- Request phone logs and internal communication
- I've won multiple cases on this issue. Family or provider had to lay out the money. We complained to the state regulator (FL and CA).
- Regulators don't like those types of mistakes and typically will hold the plans responsible because they initially authorized.
- Is worth fighting.

Administrative Denials: Failure to Pre-authorize

- I don't advise you to try to skirt pre-authorization requirements
- However, if you are trying to remedy a problem after the fact, MANY plans have monetary penalties for failing to pre-authorize.
- Will be listed in the plan manual
- Some as low as $300 one time penalty
- Sometimes deduct half the costs off the top
- Pre-authorization requirements for outpatient therapy (ABA) may be a violation of Federal MHP, as it imposes a greater restriction on MH therapy than "substantially all" medical and surgical outpatient treatments.
- Worth submitting an appeal and letting the state regulator weigh in (if fully funded).

Age and Hour Caps, Sometimes Denied Administratively

- Quantitative violation of the Federal Mental Health Parity Act
- Federal MHPAEA should take precedence over caps in state mandates
- Many states still impose these, but will back off when so advised
- Autism Speaks has been working to get states to revise their mandates
- If you are in such a state, it is worth it to appeal.
- For self-funded plans, may need an attorney
- Recent class action: WP vs Anthem of Indiana: 20 hour age limits imposed on those over age 7, may have impact in other states and on those in self-funded plans.

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Cases: Examples of Appeals

Case 1: Appeal for Denial in a School Setting

- Eight year old boy with autism in a mainstream private school, 3rd grade class. He had been receiving ABA in the home. Due to constant verbal stimming, high distraction, and being disruptive in the class, the school was ready to expel him.
- Family contacted Kaiser and requested that some of the hours be provided in the classroom. Kaiser initially denied because "The Plan does not cover non-health care services, such as teaching social/communication skills, manners and etiquette, special education, and academic coaching, tutoring or instruction."

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Case 1: Appeal for Denial in a School Setting, Continued (2)

- We argued that teaching social communication skills addresses core deficits of autism and is covered in state mandate and through the federal MH parity act. Should be provided in natural settings, such as schools, and with peers.
- ABA is identified as a medically necessary treatment in state autism mandate, -- Kaiser characterizations are invalid.
- Child also needed 1 on 1 in order to generalize behaviors learned and mastered in the home environment to community/school environments, stay on task, and manage behavioral excesses in classroom (used data from in-class observations).

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Case 1: Appeal for Denial in a School Setting, Continued (3)

- Child was receiving academic tutoring which the family was self-funding, we included a letter from the educational expert describing the academics that she was addressing, to make clear that this was not to address academic issues.
- Parents were seeking that the same services, which had already been approved in-home, be provided in an environment that would allow him to continue to progress and generalize
- Because it was initiated privately on a small scale, we were able to include favorable data on early progress in school setting in our argument. ($ always talks)

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Case 1: Appeal for Denial in a School Setting, Continued (4)

- Unlike other treatments, ABA setting may be a key therapeutic component to ensure skill acquisition and generalization to new settings. School is where children are expected to spend bulk of waking hours, it is a natural environment, and where social facilitation can easily occur.
- Cite literature re generalizing skills and use in classroom environments. Cite policy papers and opinions from professional organizations.
- Spreckly M and Boyd R. Efficacy of applied behavioral intervention in preschool children with autism for improving cognitive, language and adaptive behavior: a systematic review and meta analysis. *J Pediatr*, 2009 (154: 3): 338-44.
- Mohammadzaheri F et al. A randomized clinical trial comparison between PRT and adult-driven ABA intervention on disruptive behaviors in public school children with autism. J Autism Dev Disord, 2015; 45(9): 2899-2907.
- Search PUBMED, check APBA white paper.

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Results of Case 1

- We requested 32 hours a week in the school setting.
- Kaiser upheld their denial (this nearly always happens, health plans rarely overturn).
- External reviewer partially overturned, and awarded 24 hours a week in the school setting.
- Family and school were satisfied with this amount of hours. Child was able to function without the 1 to 1 support during predictable schedules.
- Sometimes a competent teacher can make a huge difference, what works one year in one class may not work the next in a different class.

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Case 2: Cutting Back Hours due to Duration of Treatment

- 14 year old minimally verbal boy, Anthem cut back from 15 to 10 hours a week because “you have been receiving ABA for many years. Reports show considerable progress … Since you have progressed, the number of hours requested is more than needed to address your remaining goals…. Member will continue to step down in hours, given the length of time he has been in treatment.”
- Second denial in six months, triggered by submission of six month report.
- Anthem did not provide specific facts of medical necessity in support of their assertion.

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Case 2: Cutting Back Hours due to Duration of Treatment, Continued (2)

- The CA state autism mandate requires that functioning be developed to the "maximum extent practical." There are no age or treatment duration limits in the law. Know your state mandate.
- Parity violation: treatment for chronic medical conditions are not cut back due length of treatment (we cited examples: diabetes, respiratory therapy).

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Case 2: Cutting Back Hours due to Duration of Treatment (3)

- Goals included answering “W” questions, refrain from eloping into traffic (SAFETY ISSUE), -- basic functional skills. His history demonstrated ability to learn and progress. We described in detail what he was working on.
- We described regressions which occurred when services were cutback (this is a case where NOT paying privately is sometimes helpful).
- Goal achievement should lead to the addition of more challenging goals, (not reduction in intensity) until functioning approaches same age peers.

Case 2: Cutting Back Hours due to Duration of Treatment (4)

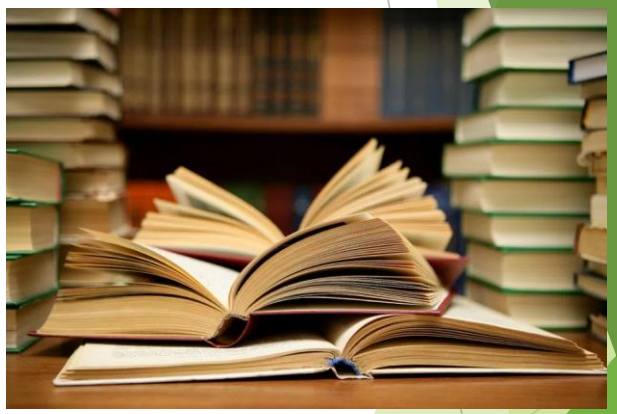
- We cited literature which showed dose-response effects of ABA, i.e, more hours contributed to better outcomes.

Linstead E, Dixon DR, French R, Granpeesheh D et al. (2016). Intensity and Learning Outcomes in the Treatment of Children with Autism Spectrum Disorder. *Behavior Modification 41(2):* 229-252

Granpeesheh D, Dixon DR, Tarbox J, Kaplan AM, and Wilke AE (2009). The effects of age and treatment intensity on behavioral intervention outcomes for child with autism spectrum disorders. *Research in Autism Spectrum Disorders (3):* 1014-1022.

- Cited literature re efficacy in teens (we need more literature on this!!)

Roth, M.E., Gillis, J.M., & Reed, F.D.D. (2014). A meta-analysis of behavioral interventions for adolescents and adults with autism spectrum disorders. *Journal of Behavioral Education, 23*, 258-286. (and articles within)



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Case 2: Cutting Back Hours due to Duration of Treatment, Continued (5)

- We appealed on an expedited basis because care was being cut back and he was regressing in the interim. We also cited emergency regulations in CA which discussed how children can sustain lasting damages by not getting treatment at critical periods of development.
- We also requested that Anthem pay in the interim until the case had been resolved, but the regulator did not allow this, likely because he had completed his six month approved "course of treatment."
- Federal law re continued care (from ACA):

"A plan.. Is required to provide continued coverage pending the outcome of an appeal… Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review." From: **CFR § 2590.715-2719 (b)(2)(iii)**

Results of Case 2

- Case was overturned in expedited appeal.
- Anthem has not attempted to cutback hours a third time.
- When clients pay out of pocket for the full amount of hours during the disputed period, and we win in IMR, nearly always the health plan must reimburse retro-actively for the disputed period. (again, $ talks)
- However, we have found that most regulators do not require that plans pay ongoing during the period of dispute going forward.
- We also always request interest, and when we win, it is awarded.

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More Tools to Fight Denials

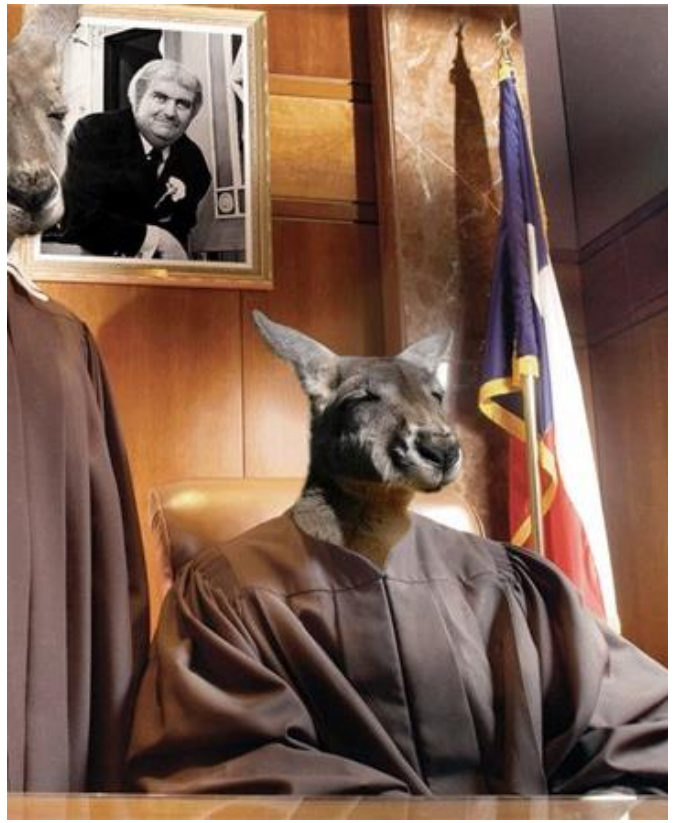
Expedited Appeals

- Standards for expedited review differ by state and plan contract (for self-insured).
- Some plans will allow the following: "Could seriously jeopardize your life, health, or ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care requested."
- Possible to argue that stopping or cutting back ABA hours will jeopardize ability to regain maximum function. Also contributes to serious regressions
- Other plans will only allow "seriously jeopardize life or health, or in severe pain."
- When you expedite, you can submit appeal and external review at the same time!!
- If your state processes external reviews directly, send in to both plan and regulator, and let state be the arbiter of whether it qualifies for expedited status.
- In CA, our regulators wrote emergency regulations which indicated that children with ASD could suffer irreparable harm if treatment was delayed. We quote from those regulations when requesting expedited appeals.

External Reviews with Fully Funded Plans

- If still denied, the next option is external review or litigation/arbitration.
- Usually available for medical necessity denials (and sometimes for procedural denials)
- External Review goes out to an agency where an unaffiliated medical expert reviews clinical files and determines if services are medically necessary.
- Has anyone had a case reviewed by a BCBA? A licensed psychologist?
- If state regulated, we will investigate the state external review process and their published rate of overturn and try to advise clients.
- States typically have different rates of overturn, some publish their rates. If your state has a low overturn rate, it might be worth meeting and discussing with your regulator.

External Reviews with Self- Funded Plans



- External reviews for self-insured plans typically are harder to win (Kangaroo court).
- Rates of overturn are not monitored.
- Paid for and contracted by the health plans, there is a direct incentive **not** to overturn.
- Arbitration and litigation: Not enough attorneys practice in this area. Many county legal aid offices have contracts with health agencies to provide legal assistance. We need more class actions. Dan Unumb will be discussing this.

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Fine Balance between Progress and Need

- Health plans want to see some progress, but also a continued need for care. They can deny for medical necessity by alleging that you've made too much progress and no longer need services, or that you have not made enough progress and are not benefitting from therapy. It is a fine balance.
- For children, making adequate progress should mean that they are approaching age appropriate milestones.
- Sometimes we will get denied in round 1 for no longer needing treatment (due to adequate progress). Denied in round 2 for not making enough progress. These types of mix-ups nearly always result in wins.

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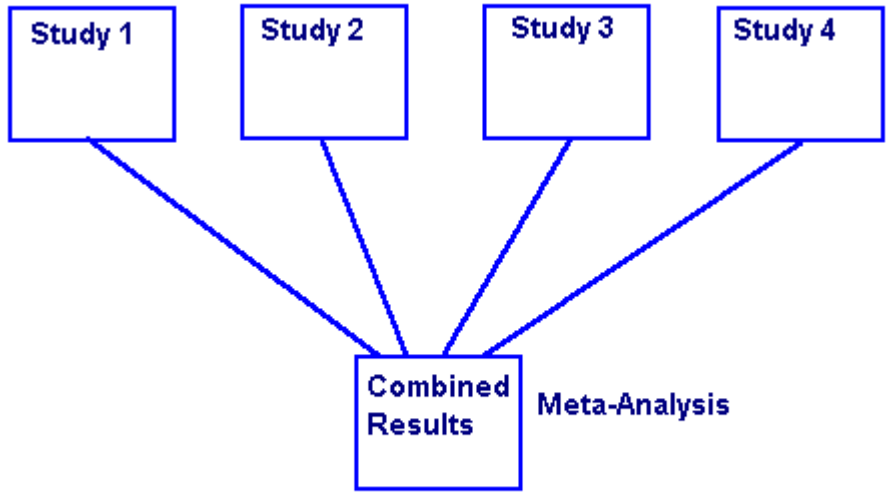
Best Available Evidence

- Definitions of Medical Necessity often include discussions of the best available evidence.
- Usually includes Meta analyses -compilation of MANY studies which examine the same problem or intervention and combine the data in such a way as to determine the size or impact of the treatment.
- Can include guidelines and consensus opinions from professional organizations.



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Best Available Evidence, 2

- Evidence for Comprehensive Intensive ABA for young children with ASD:

Eldevik, S., Hastings, R.P.,Hughes, J. C., Jahr,E., Eikeseth, S., & Cross, S. (2010). *American Journal on Intellectual and Developmental Disabilities, 115,* 381- 405

Eldevik, S., Hastings, R.P., Hughes, J.C., Jahr, E., Eikeseth, S., & Cross, S. (2009). Meta-analysis of early intensive behavioral intervention for children with autism. *Journal of Clinical Child & Adolescent Psychology*, *38,* 439-450.

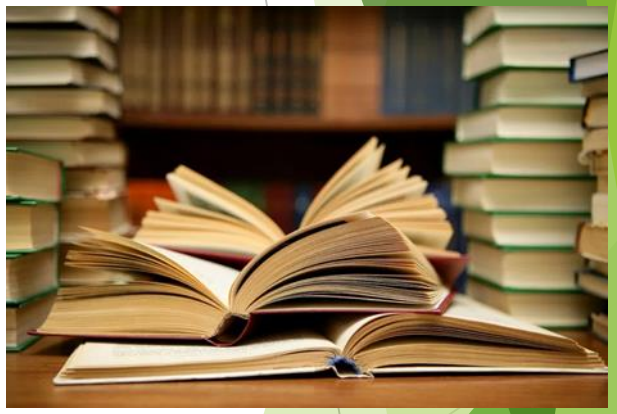
Klintwall, L., Eldevik, S., & Eikeseth, S. (2015). Narrowing the gap: Effects of intervention on developmental trajectories in autism. *Autism, 19*, 53-63.

Reichow, B. (2012). Overview of meta-analyses on early intensive behavioral intervention for young children with autism spectrum disorders. *Journal of Autism and Developmental Disorders, 42*, 512-520.

Reichow, B. & Wolery, M. (2009). Comprehensive synthesis of early intensive behavioral interventions for young children with autism based on the UCLA Young Autism Project model. *Journal of Autism and Developmental Disorders, 39,* 23-41.

Smith, T. & Iadarola, S. (2015). Evidence base update for autism spectrum disorder. *Journal of Clinical Child & Adolescent Psychology, 44*, 897-922.

Virués-Ortega, J. (2010). Applied behavior analytic intervention for autism in early childhood. *Clinical Psychology Review, 30*, 387-399.



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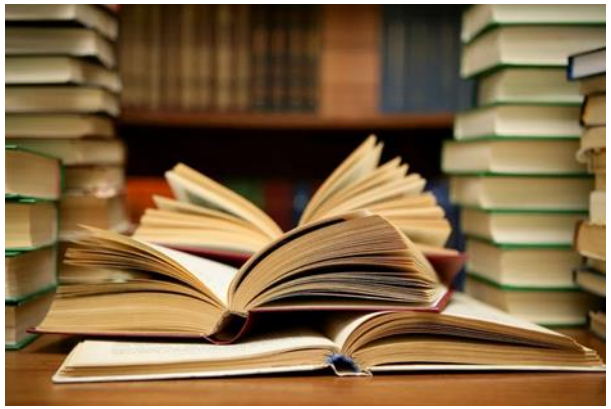
Best Available Evidence, 3

- Evidence for Focused ABA:

Wong et al. (2014) *Evidence-Based Practices for Children, Youths, and Young Adults with Autism Spectrum Disorder* – available at http://autismpdc.fpg.unc.edu/node/21

National Autism Center (2015). *Findings and Conclusions: National Standards Project, Phase 2* -- available at http://www.nationalautismcenter.org/national-standards-project/phase-2/

See upcoming White Paper from APBA: Applied Behavior Analysis: Medically Necessary Interventions for Autism Spectrum and Related Disorders



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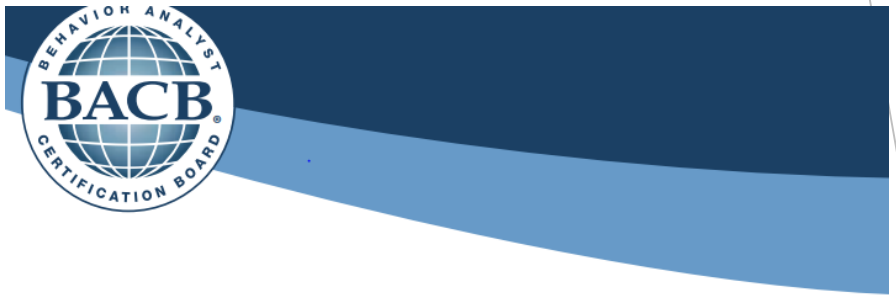
About Guidelines …

- The plans will cite their own guidelines, okay to review them and argue that the client meets their standards.
- HOWEVER: A consensus of independent subject matter experts have developed guidelines that are generally accepted in the community.
- Provides guidance on supervision/tutor ratios
- Assessment, goal formulation, measuring progress.
- Duration and intensity
- Caregiver training
- Fading, Discharge planning
- And More

Okay to cite these guidelines as community standards and include and cite in appeal



https://www.bacb.com/wp-content/uploads/2017/09/ABA_Guidelines_for_ASD.pdf

The TAKEAWAY™

- Disputes about medical necessity require time and support from clinical staff. Build it in when budgeting.
- Choose your battles carefully. If families are highly motivated, they may be able to do some of this themselves.
- Establish relationships with your state regulators. Important to discuss patterns of abuse with both peers (other providers) and regulators.
- If overturns are low in your state and regulator is not enforcing the law, have your families bring in your state legislators. They can do oversight hearings.
- News media can have impact, most health plans do not want bad publicity.
- Don’t give up!!
- It is worth the fight!
- We can help!!

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Find a Healthcare Attorney

- Every ABA agency needs a trusted attorney
- Familiar with healthcare and able to practice in your state
- Becoming in-network is a legally binding contract with the insurance company
- Health insurance is very complex with federal laws, state laws, insurance contracts, and individual family insurance policies all have regulations and guidelines
- Insurance companies are big (and have a lot of $). Don't be afraid to get some back up!
  - A few hours of time with an attorney could bring in thousands of unpaid claims and prevent future issues!

Conclusion and Questions

Resources

- Conferences:
  - APBA (April in St. Louis)
  - Autism Law Summit (September/October)
- Follow Facebook Groups
- Advocate and Collaborate
  - Connect with other agencies in your area
  - Know what is going on in your state
- ABA Treatment of ASD: Practice Guidelines for Funders (BACB)
  - https://www.bacb.com/asd-practice-document/
- APBA: http://www.apbahome.net/page/practiceguidelines

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Contact Info

- ABA Therapy Billing and Insurance Services
- www.ababilling.net
- Facebook Group: https://www.facebook.com/groups/ababillinginshelp
- info@ababilling.net

- Mental Health and Autism Insurance Project
- https://mhautism.org/
- Sign up for our newsletter!
- info@autismhealthinsurance.org

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