Navigating Health Insurance

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DIFP
Department of Insurance, Financial Institutions & Professional Registration

Audience: December 9, 2011

House Bill 1311

- Effective for policies issued, delivered, continued or renewed on or after 1/1/2011
- Insurance coverage of autism and applied behavior analysis therapy Statute 376.1224 RSMo.
- Licensure of applied behavior analysts Statutes 337.300 to 337.345 RSMo.

Insurance Coverage Requirements

- Diagnosis and treatment of ASD
- Applied Behavior Analysis
  - Through 18 years of age
  - Up to $40,000 of therapy per calendar year
    - ➢ adjusted for inflation every 3 years
    - ➢ more therapy can be covered if medically necessary

Treatments for ASD

- Psychiatric care
- Psychological care
- Habilitative or rehabilitative care
- Therapeutic care
- Pharmacy care

Consumer Protections

- Health plans are prohibited from:
  - Refusing to sell or renew coverage because of ASD
  - Using non-ASD or ABA costs to meet the $40,000 benefit
  - Applying the age and benefit limits for ABA to other ASD benefits
  - Limiting the number of visits to avoid paying the full $40,000
  - Applying coinsurance or copayments or prior authorization that is substantially greater for ASD/ABA

What plans are covered by the law?

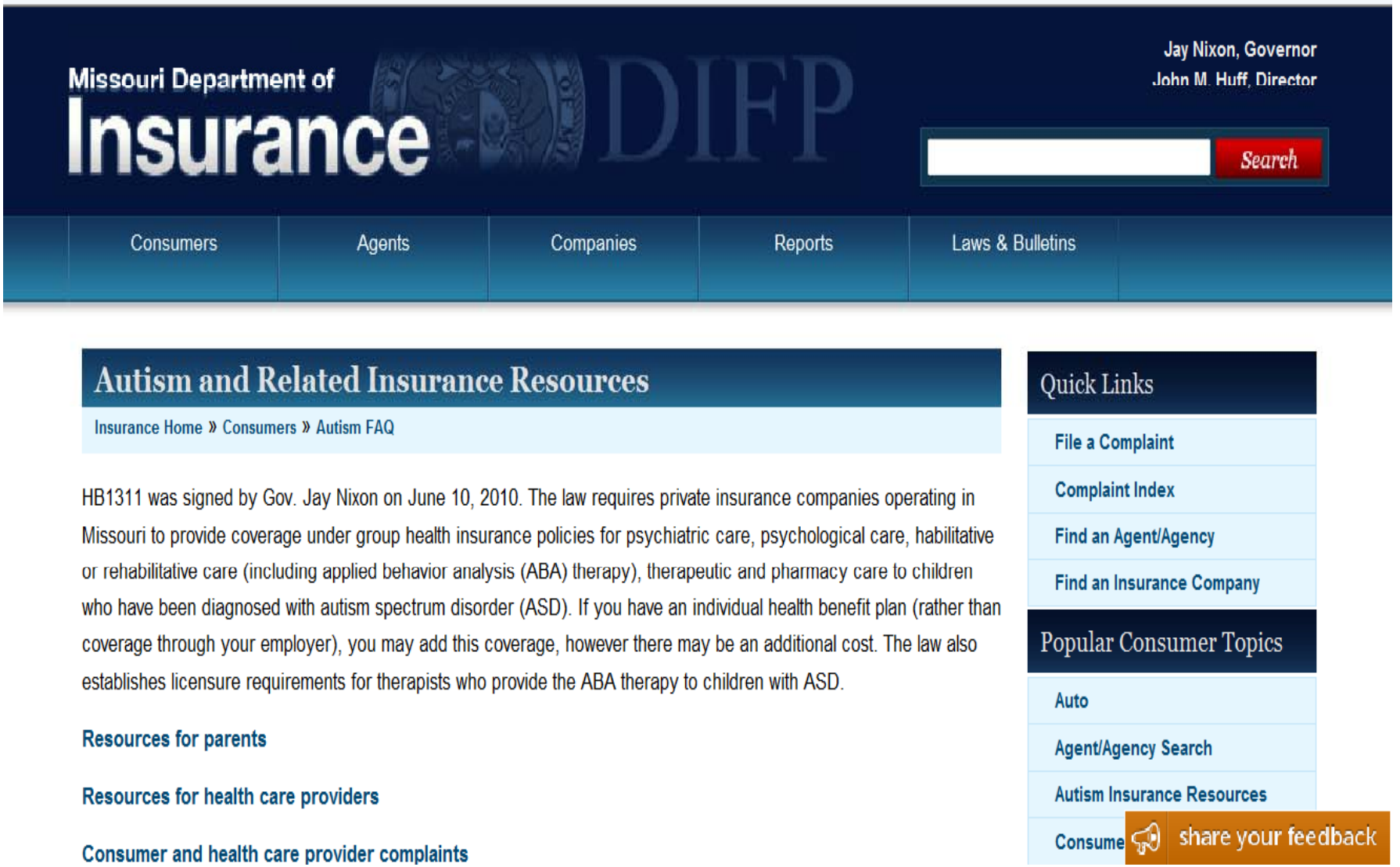
- All small group or large group health insurance plans written in Missouri
- *All small group or large group health insurance plans written in other states but insuring Missouri residents**
- *All self-insured governmental plans (defined by USC Section 1002(32) **
- *All self-insured group arrangements or multiple employer welfare arrangements, to the extent not pre-empted by federal law**
- *All self-insured school district plans**

Which ones are not?

- Federal health plans
- Medicaid plans (MC+ and traditional Medicaid and SCHIP)
- “non-comprehensive” medical plans:
  - Accident/sickness plans
  - Discount medical organizations
  - Short term plans
  - Hospital/surgical /limited medical plans

Bulletin

- Claim coding
  - Acknowledge and encourage usage of HCPCS H0031, H0032, H2012 and H2019
  - Publicize what codes if different
- Improper claim denials
  - No administrative denials or coverage restrictions
- Safe harbor for temporary modifications in guidelines to accommodate those already receiving treatment


Missouri Department of
Insurance
DIFP
Jay Nixon, Governor
John M. Huff, Director
Search
Consumers
Agents
Companies
Reports
Laws & Bulletins
Autism and Related Insurance Resources
Insurance Home » Consumers » Autism FAQ
HB1311 was signed by Gov. Jay Nixon on June 10, 2010. The law requires private insurance companies operating in Missouri to provide coverage under group health insurance policies for psychiatric care, psychological care, habilitative or rehabilitative care (including applied behavior analysis (ABA) therapy), therapeutic and pharmacy care to children who have been diagnosed with autism spectrum disorder (ASD). If you have an individual health benefit plan (rather than coverage through your employer), you may add this coverage, however there may be an additional cost. The law also establishes licensure requirements for therapists who provide the ABA therapy to children with ASD.
Resources for parents
Resources for health care providers
Consumer and health care provider complaints
Quick Links
File a Complaint
Complaint Index
Find an Agent/Agency
Find an Insurance Company
Popular Consumer Topics
Auto
Agent/Agency Search
Autism Insurance Resources
Consume
share your feedback

Parent Resource Center

- Glossary of common health terminology (still under development)
- Steps to ensuring insurance coverage for autism treatment
- Links to complaint information
- Links to other autism and health plan resources

Provider Resource Center

- Information on health ID cards
- Links to provider complaint information
- Links to carrier survey responses

Billing, Denials and Appeals

Do Your Homework

- Review the health ID card
- Confirm you are in the plan's network
- Make sure there is:
  - An autism diagnosis;
  - Referral from treating physician;
  - Treatment plan

Before Services are Provided

- Check DIFP Provider Resource Page
- Call the insurance company
  - Ask for information on coverage
    - Group or individual plan;
    - Fully insured or self-funded plan;
    - Where was policy issued;
  - Ask if claim should be should be submitted to health or behavioral health unit

Before Services are Provided

- Confirm what billing codes should be used
- Ask how treatment plan should be submitted; any forms?
- Ask if prior authorization is required
- Ask for case manager with autism experience if you don't get information you need

Before Services are Provided

- Document file with time, date of call and name of representative
- Submit request for prior authorization, if required
- Document file with prior authorization number
- Confirm coverage is still in place on date of service

Billing Tips

- Make sure
  - Claim is submitted timely
    - Keep documentation of submission
  - Claim is submitted to proper address and unit
  - Correct diagnosis and procedure codes are used
  - Billing units are listed correctly
    - Some codes bill in increments; some in blocks of time

Denials Can and Will Happen…

- Claims cannot be denied for being experimental or investigational or pre-existing condition
- Claims can be denied:
  - Based on a lack of medical necessity
  - Based on incorrect billing codes
  - Based on lack of prior authorization
  - Based on lack of timely filing
  - Based on lapse in coverage

When Denial is Received

- Starting July 2, 2011, when claims are denied, plans shall provide
  - The reason the claim was denied
  - Disclose rights to file an internal appeal
  - Disclose rights to request an external review if your internal appeal was unsuccessful
  - Notice of the availability of DIFP assistance

Appeal, Appeal, Appeal

- If denial is based on medical necessity
  - Appeal
  - Opportunity for full, fair review
  - Provide additional information, if any
- What appeal rights does my patient have?
  - Individual health plans – one level
  - Group health plans – two levels
- Plan has to provide response in 30 days

Other Denials

- Incorrect billing codes
  - Correct, and resubmit ASAP
- Prior authorization
- Timely filing
  - File complaint with DIFP, if documented

External Reviews

- Available after internal appeals are exhausted
- External review available for claims denied for
  - Medical necessity
  - Experimental
  - Efficacy
  - Level of care
- Final review by outside medical expert
- No cost to consumer in Missouri

External Reviews

- Access to external review process
  - Self-funded – through the plan or OPM
  - Fully insured – through DIFP
  - Plan issued in other state – through state DOI
- Time limitation
  - No time limitation for fully insured plans issued in Missouri
  - Four months for self-funded plans

External Reviews

- Eligibility determined by DIFP
- Medical records and claim file obtained
- Each party can provide supplemental information or documentation
- Reviewed by IRO and recommendation issued
- Decision is binding on patient and plan
- Most decisions received within 45 days

How Can DIFP Help?

- Fully insured plans
  - Complaints as to compliance
  - Assistance with internal appeals
  - External review process
- Self-funded plans and out of state plans
  - Informational
  - Assistance with internal appeals

Resources

- DIFP Autism – Provider Resources

http://insurance.mo.gov/consumers/autismFAQ/Autismproviderresourcecenter.php

- DIFP Missouri External Review

http://insurance.mo.gov/consumers/autismFAQ/Externalreviewprocess.php

- Healthcare.gov – Other states' resources

http://www.healthcare.gov/using-insurance/managing/consumer-help/index.html

- Healthcare.gov – Appeals

http://www.healthcare.gov/law/features/rights/appealing-decisions/

Questions