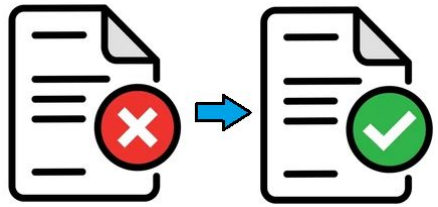
behavioral INNOVATIONS

Dr. Mirella Petersen, DHA, MISM
VP, Payor Strategy & Government Affairs



Autism Law Summit

2026

From Denial to Approval:

Building a High-Performing Appeals Process

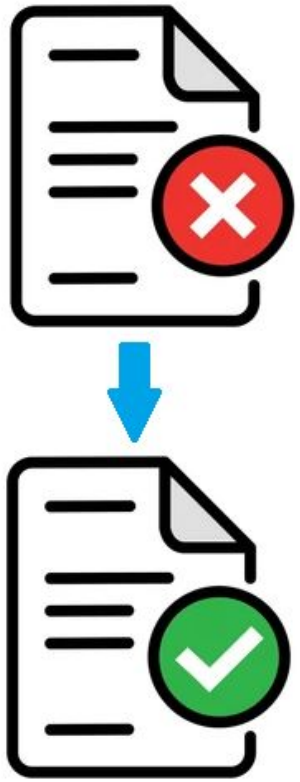
Bloom Behavior Therapy, LLC

Parity Healthcare

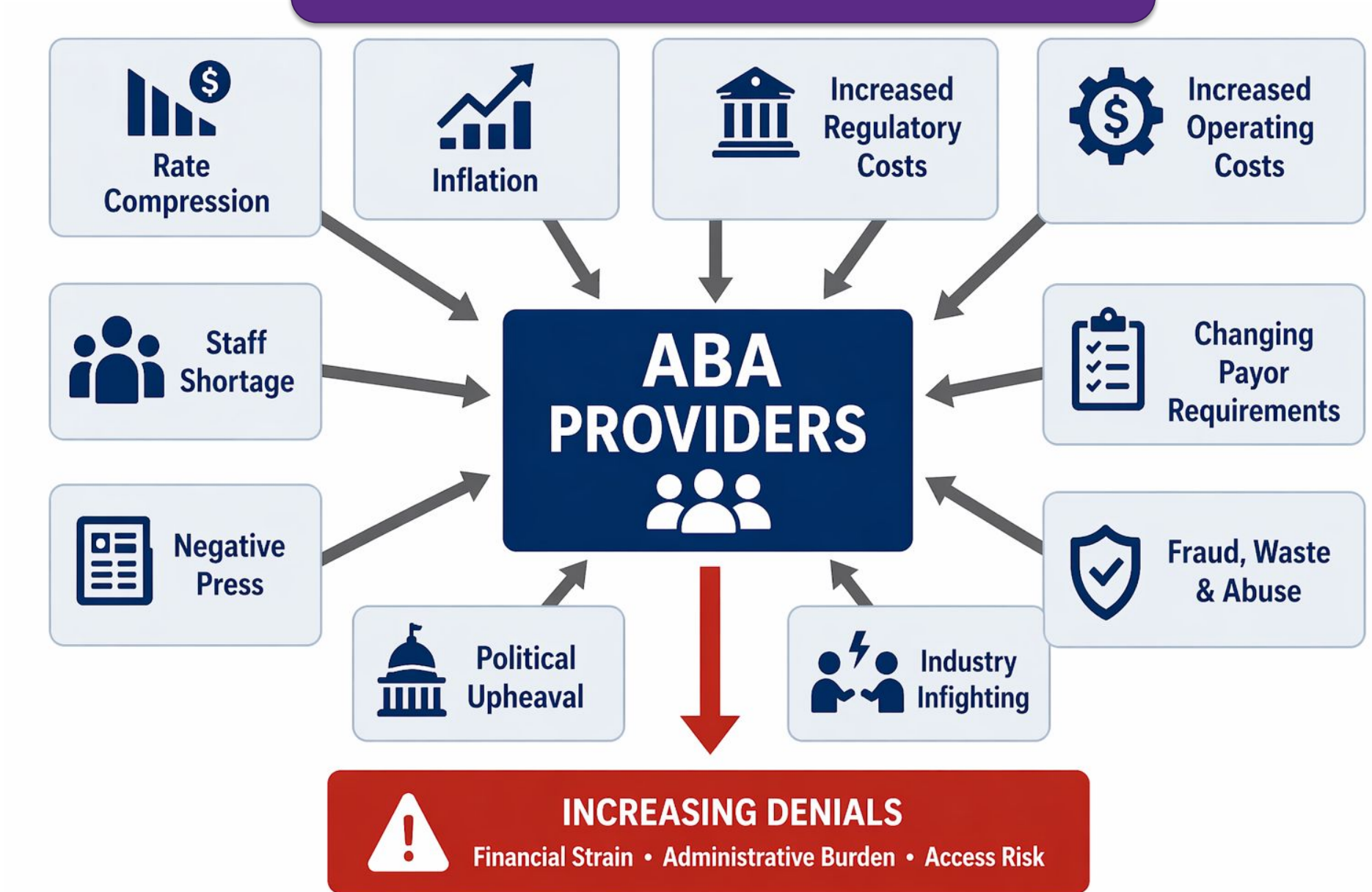
T.J. Couey, Chief Operating Officer, Owner & Co-Founder

Session Overview

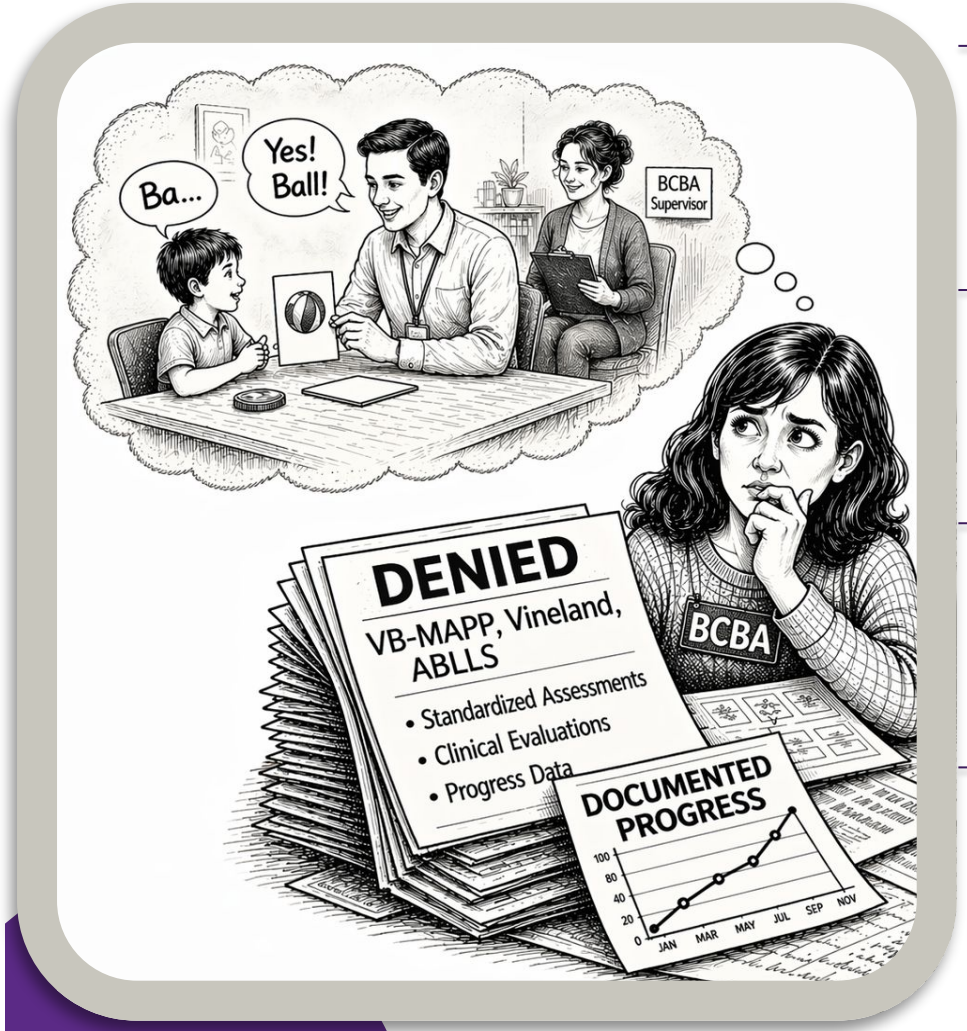
- **Current Climate: Factors contributing to increased denials.**
- **Why It Matters: Denials impact on access & sustainability.**
- **Know the Rules: Regs and denial patterns.**
- **Better Appeals: Faster, stronger outcomes.**
- **Learn & Improve: Practical, real-world insights.**



Current Climate



Clinician Perspective



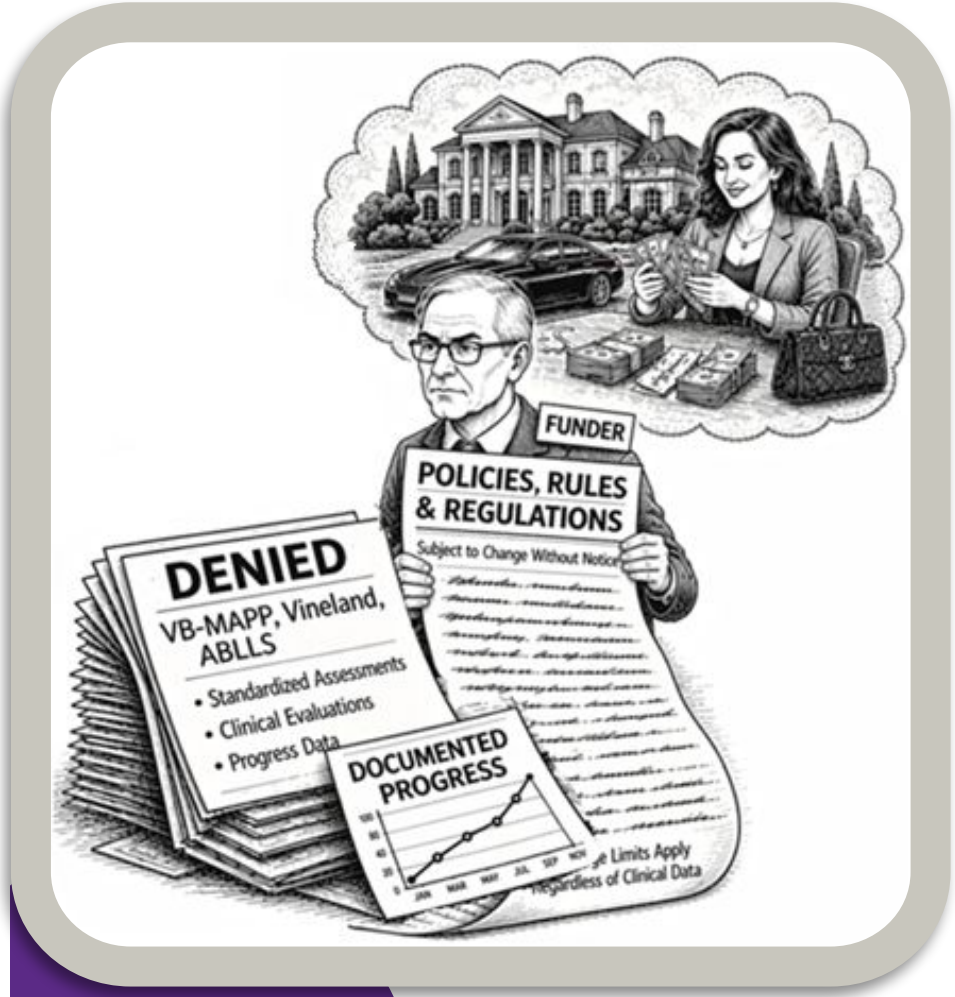
Clinicians feel responsible for getting a child's care approved.

Clinicians lack context regarding external factors and appeal rights.

Denial rationale is unclear and often unrelated to Tx Plan deficiencies.

The skillset for getting an appeal approved is not inherently clinical.

Funder Perspective



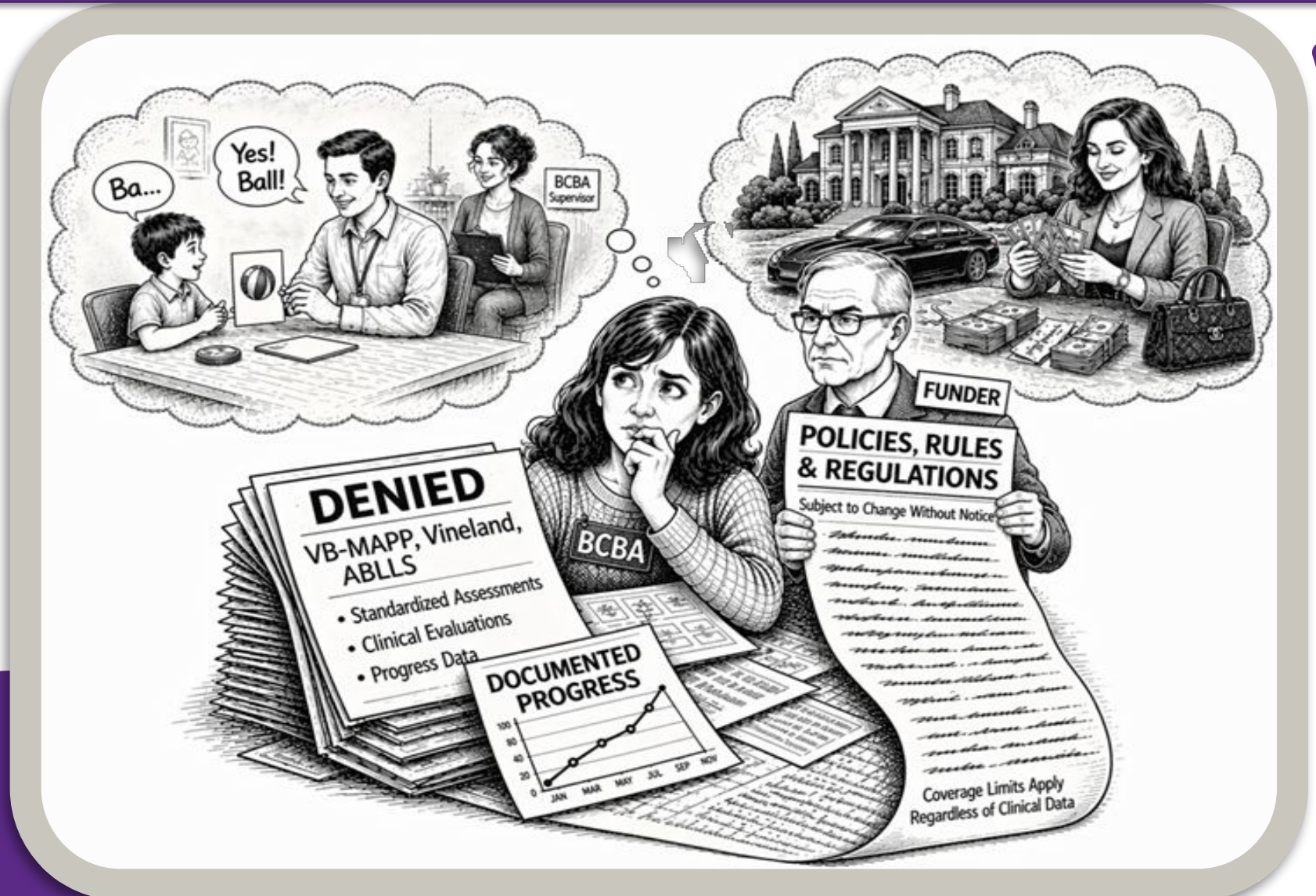
Costs for ABA services have risen exponentially over recent years and budgets are being scrutinized.

Fraud, Waste and Abuse are occurring, and negative press has created increased scrutiny.

Many funders aren't sufficiently educated on appropriate guardrails around ABA benefits.

Funders rules frequently do not align with approving generally accepted standards of care.

Competing Realities




ENDLESS HURDLES
☑ DIAGNOSIS
☑ ASSESSMENT
☑ AUTHORIZATION
☑ APPEAL
☑ INDEPENDENT REVIEW
STILL DENIED
I LOVE MY MOM
LOVE
FIGHTING FOR HIS FUTURE
ABA SERVICES DENIED
INSURANCE COVERAGE FOR ABA THERAPY
This request for coverage has been denied.
ABA WAITLIST: 6-12 MONTHS+
293.75
MONTHLY BILLS
• RENT
• UTILITIES
• GROCERIES
• GAS
$
COPAYS

The Appeal Investment

Provide access to appropriate levels of care

Alleviate burden on clinical staff

Shape funder behavior for future clients

Support clients and families



HEALTHCARE PLAN REGULATORY & RULES DECISION TREE

Medicaid Plan

Regulators

Centers for Medicare & Medicaid Services (CMS)

Dept. of Health and Human Services (HHS)

State Medicaid Agency (SMA) / State Dept. of Health

State Attorney General's Office — Enforcement

Relevant Rules

EPSDT | ACA | ADA | MHPAEA | CMS ASD | ACA EHB | Section 504 | IDEA †

Commercial Plan

Self-Funded
(ERISA)

Regulators

Department of Labor (DOL)

Dept. of Health and Human Services (HHS)

Relevant Rules

MHPAEA | NQTL requirements | ACA §2713 preventive care | ACA EHB benchmark | ADA (Title I) | ACA §1557 nondiscrimination | ERISA §502

State autism insurance mandates do not apply.
ERISA preempts state insurance law.

Fully Funded
(State-Regulated)

Regulators

Dept. of Insurance (DOI)

Relevant Rules

ACA EHB | ACA nondiscrimination | MHPAEA | ADA (Title III) | HIPAA | Federal claims / appeal rules | State autism mandates

† **IDEA** — Education statute (school-based services / IEPs); included because Medicaid funding may overlap with IDEA-related service delivery.

HEALTHCARE PLAN APPEAL STEPS

Medicaid Plan

Internal Appeal

State Fair Hearing

Judicial Review *(optional)*

- EPSDT entitlement is critical for ABA services
- Complaints go to the State Attorney General's office

Commercial – Self-Funded
(ERISA)

Internal Appeal (Level 1)

Internal Appeal (Level 2)

External Review (IRO)

Federal Court (ERISA)

- Complaints go to the US Department of Labor
- Level 2 may not be required; can be pursued in tandem with External Review
- External Review & DOL Complaints can be filed at same time as Internal Appeal
- **State mandates (e.g., autism laws) do NOT apply**
- Decision Window: ~30–60 days

Commercial – Fully Funded
(State-Regulated)

Internal Appeal (Level 1)

Internal Appeal (Level 2)

External Review (State IRO)

DOI Complaint / Litigation

- External Review / DOI Complaints can occur at same time as Internal Appeal (Level 2)
- DOI Complaint is separate from appeal process and may be expedited
- Individual state laws apply
- Timelines for External Review / DOI = typically 45 days

Appeal pathways reflect federal minimum standards. State-specific rules, plan documents, and applicable mandates may alter timelines or available remedies.

Medicaid Rules and Regs (Part 1)

Provider determines Expedited Review timeline:
"Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the [...] ***provider indicates*** *[...] that taking the time for a standard resolution* ***could seriously jeopardize the enrollee's [...] mental health, or ability to attain, maintain, or regain maximum function.*** *" (42 CFR § 438.410)*

What must be covered:
*"...**any** medical or remedial services (provided in a facility, a home, or other setting) **recommended** by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level" (*40 U.S.C 1396d(a)(13)(C))

MCO Medical Necessity Criteria Cannot Be More Restrictive than the States'
*"**Is no more restrictive than that used in the State Medicaid program**, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures" (42 CFR 438.210(a)(5)(i))*

Federal law preempts:
"If federal and state law conflict, federal law and regulation preempts." (2025 Kentucky MCO MCA 22.2)

Medicaid Rules and Regs (Part 2)

Compliance Requirement with CMS Guidance

"*"It is the intent of the parties to this Contract that the Contract be interpreted in a manner* ***consistent with all Applicable Law, as well as the obligations imposed on the State, the Agency, and/or the MCO under the Iowa State Plan under Title XIX of the Social Security Act Medical Assistance Program*** *("State Plan"), CMS Approved waivers under the State Plan, and* ***federal guidance****, as well as any and all future amendments, changes, and additions to the State Plan, approved waivers, or federal guidance as of the effective date of such change.*" (Iowa TotalCare Contract - 1.2 Contract Purpose - Contract Compliance with Federal Laws and Guidance)

EPSDT prohibits requiring a specific diagnosis:

"States should avoid requiring an EPSDT-eligible child to have a specific behavioral health diagnosis for the provision of services, as screenings may identify symptoms that require attention but do not meet diagnostic criteria" (CMS SHO#24-005)

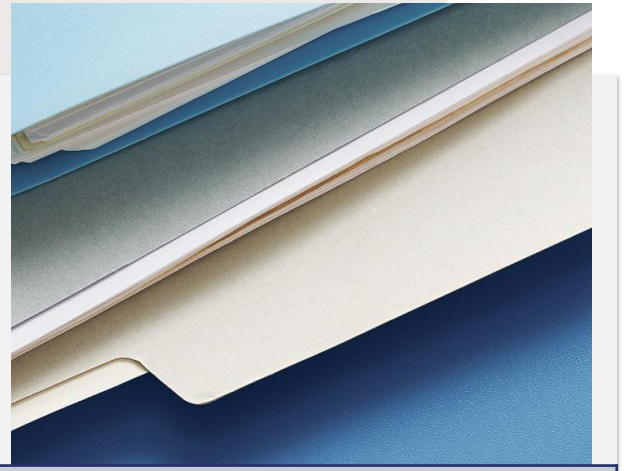
Commercial Rules and Regs

Provider determines Expedited Review timeline:
"In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act."
(29 C.F.R. § 2560.503-1(l))

Full and Fair Review:
*"(iv) **Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant** relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination."*
"
(29 C.F.R. § 2560.503-1(h)(2))

Required Expertise:
"Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment … the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;"
29 C.F.R. § 2560.503-1(h)(3)(iii)

The Anatomy of an Appeal



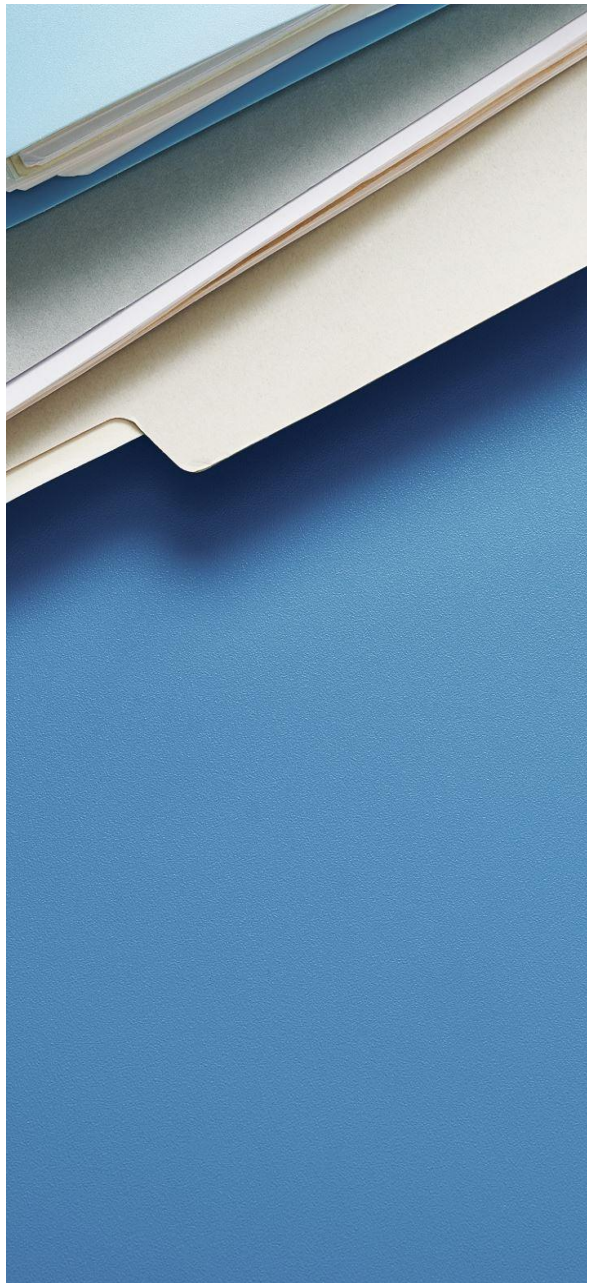
1. Member Info (including original request)
2. Denial Reason - Exact
3. Request to overturn the decision
4. Rationale for request, including Rules, Regulations and Literature
5. Risk Statement if services are delayed or denied
6. Request for all documentation used in the adverse determination decision making process

1. Member Info

APPEAL OF ADVERSE DETERMINATION

Member Name:
Member ID:
Member DOB:
Reference Number:

Original Request:



2. Denial Reason - Exact



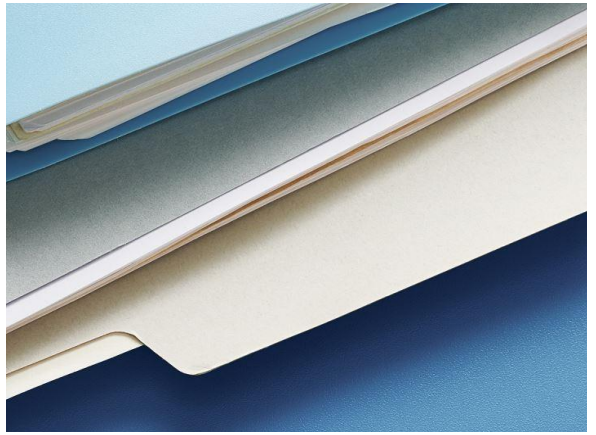
Jay Patel, MD (Medical ... ason | Utilization Management N...

Com... ...ve years ... ...nctional pr...

Rese... ...prehensive ABA for people older t... ...ved, your provider would need to show tha... ...ts comprehensive ABA for your age and condition.

CHALLENGE ACCEPTED

3. Request to Overturn

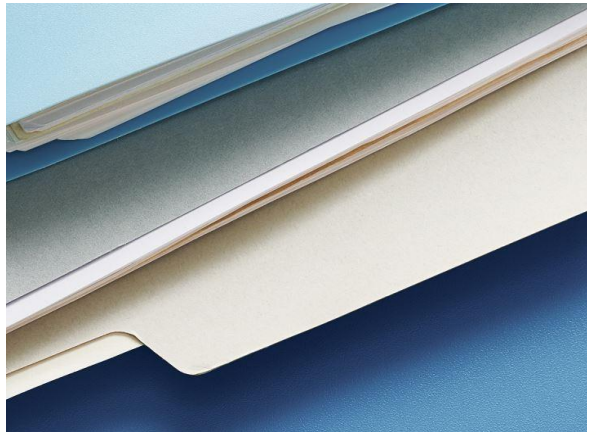


I am writing to formally request that this adverse determination be overturned.

- *The comprehensive Treatment Plan requested is medically necessary for this member.*

- *The rules and regulations governing this plan and the current peer reviewed literature do not support this adverse determination.*

4. Rationale (Regulatory)

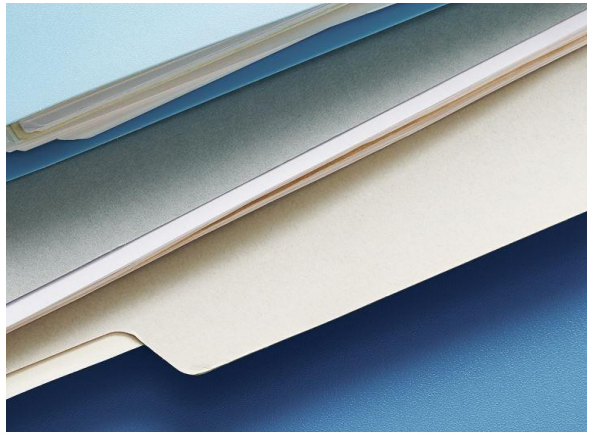


42 C.F.R. § 440.230(b) & (c)

"Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

"The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service… solely because of the diagnosis, type of illness, or condition."

4. Rationale (Literature)



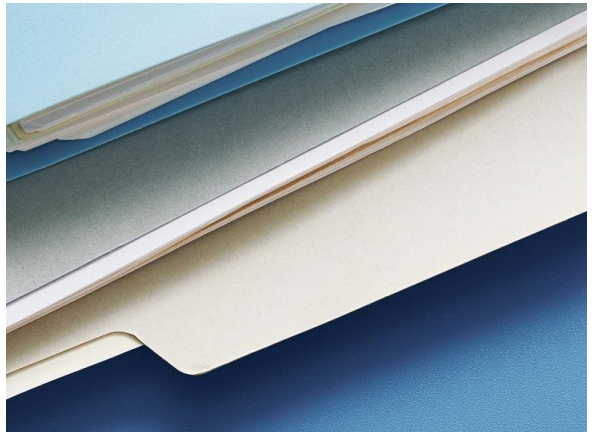
PEER REVIEWED LITERATURE TO BACK YOUR RECOMMENDATIONS

"Evidence-based practices were identified for children, youth, and young adults with autism… across a range of ages and outcomes, including adaptive, behavioral, and functional skills." **(Steinbrenner et al., 2020)**

"Behavior-analytic interventions can produce meaningful improvements in adaptive and functional skills in adolescents with autism spectrum disorder." **(Sneed et al., 2019)**

"ABA-based interventions were found to be effective across multiple domains… with improvements in cognitive, language, and adaptive behavior in school-aged children." **(Makrygianni et al., 2018)**

4. Rationale (Individualized)



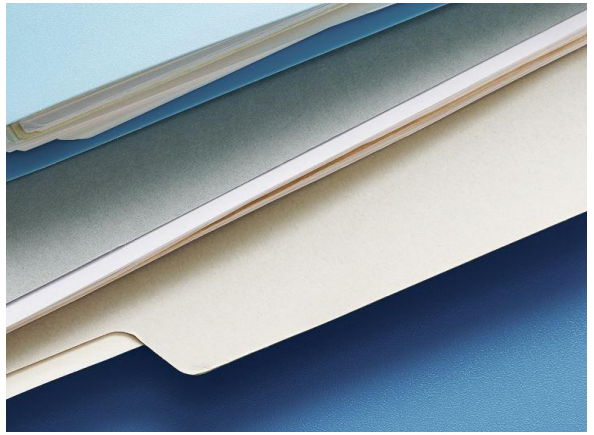
The member engages in self-injurious behavior (head-banging, hand-biting) 15–20 times per day, resulting in visible damage requiring continuous 1:1 treatment direction to maintain safety.

Independent observation and treatment data show increasing SIB frequency from 6–8 to ≥12 episodes/day following reduction in service intensity, with SRS-2 scores in the severe range (T>75), indicating need for comprehensive intervention.

INDIVIDUALIZED INFORMATION FROM TREATMENT PLAN

Caregiver and teacher reports indicate SIB and behavioral dysregulation occurring daily, with Vineland-3 Adaptive Behavior Composite scores <70, preventing safe participation in home routines, classroom activities, and community settings.

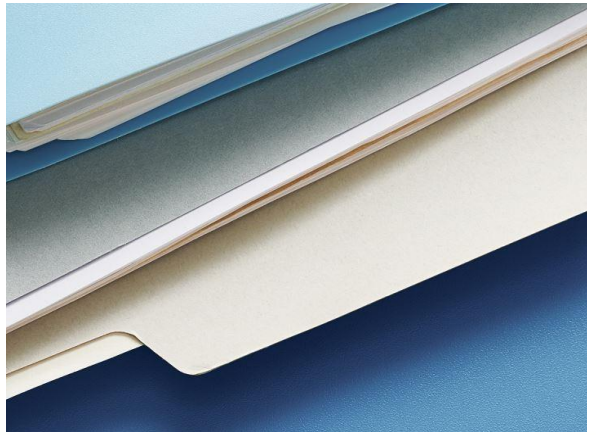
5. Risk Statement



If this adverse determination is upheld, the member faces the following risks:

- Physical harm from persistent SIB (head-banging, hand-biting)
- Behavioral escalation with reduced treatment intensity
- Increased risk of ED visits or inpatient admission
- Inability to safely access home, school, or community settings
- Loss of developmental progress and functional decline
- Unsustainable caregiver burden

6. Request for Documentation

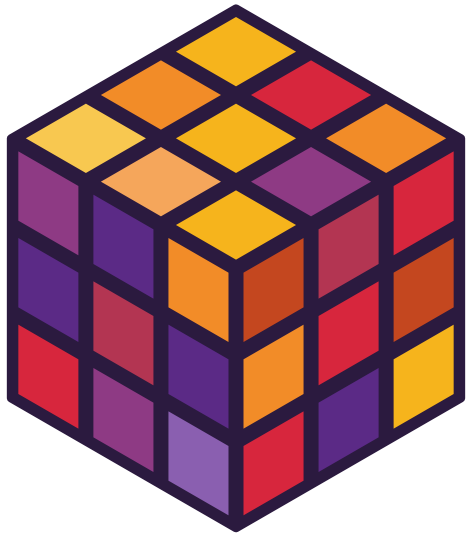


In the event the plan elects to uphold this adverse benefit determination, we respectfully request that the notice include a clear explanation of the reason for denial, including the clinical and policy basis for the decision, consistent with 42 C.F.R. § 438.404[1].

We also request access to any criteria, guidelines, policies, or supporting documentation relied upon in making this determination, to support a complete and informed review.

THE ANATOMY OF AN APPEAL

What does this look like when assembled?



Submitting Party
T.J. Couey
Parity Healthcare, LLC
123 Main Street
Anywhere, Kentucky 42000
Ph: 270-555-1212
Fx: 270-555-2121

Represented Individual
Johnny Smith
400 Main Street
Hometown, 44444
Member ID: ABCD12345

Respondent:
State Medicaid MCO
Appeals and Grievances Department
123 Big City Street
Metropolis, Kentucky 42000

04/26/2026
Incident Date: 04/26/2026
Subject: Member response to adverse determination

On 4/26/2026, we received an Adverse Benefit Determination denying medically necessary services for the treatment of Applied Behavior Analysis (ABA) for the above-referenced enrollee. This denial is improper and inconsistent with federal law, including the requirements of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate under 42 U.S.C. § 1396d(r), the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Americans with Disabilities Act (ADA), as well as applicable state statutes, regulations, and managed care contract provisions.

The accompanying documentation provides detailed explanations as to why this determination is improper and inconsistent with governing requirements. It includes specific references to the applicable provisions of the state's Managed Care Organization (MCO) contract, relevant state and federal statutes and regulations, and other controlling authorities that collectively establish the enrollee's entitlement to receive medically necessary services under Medicaid.

In accordance with these authorities, we request immediate authorization of the prescribed services to prevent further harm and to ensure compliance with federal and state Medicaid requirements.

Issues Identified

The concerns below summarize the conduct at issue in this matter. Each concern is filed as a discrete grievance, enumerated and supported in the Grievances section that follows.

1. **A standardized tool, such as InterQual or MCG was used for medical necessity determination**

Grievances

Each grievance below is a discrete regulatory filing. Payer must separately acknowledge, investigate, resolve, and log each one within the timeframes required by the respective governing statutory and regulatory laws, and must issue a per-grievance Notice of Resolution. Resolution of the underlying appeal does not resolve any individual grievance. Each grievance is independently escalatable — any grievance that is not resolved, or that is mis-resolved, will be reported to the plan's Regulatory body, discrimination and civil rights agencies (when appropriate).

1. A standardized tool, such as InterQual or MCG was used for medical necessity determination

Using a standardized screening tool such as InterQual or MCG to determine medical necessity is inappropriate because these systems are designed around generalized benchmarks rather than the unique behavioral, developmental, and environmental factors that define an individual's clinical needs. ABA treatment decisions require an individualized assessment grounded in functional analysis, direct observation, and a comprehensive evaluation of the enrollee's circumstances across settings. Standardized tools, by design, evaluate only a limited subset of criteria and do not account for the individualized treatment recommendations outlined in the Behavior Intervention Plan or the context-specific variables that influence behavior. As a result, they cannot fully assess the intensity, duration, or scope of services required for effective intervention. Utilization of these tools for a prior-authorization decision prevents reviewers from meaningfully evaluating the enrollee's unique presentation and the clinical reasoning used by the treating Board Certified Behavior Analyst. Such tools are not behavior-analytic instruments and do not measure essential components of ABA medical necessity—such as functional relations, safety considerations, skill-acquisition trajectories, or risk of regression. Substituting a standardized system for a comprehensive, individualized clinical review leads to incomplete or inaccurate conclusions and does not provide a sound clinical justification for denying, reducing, or limiting medically necessary treatment. For these reasons, we object to any adverse determination that relies on a standardized medical-necessity tool in place of a full individualized review. The following provisions apply to this issue:

Prior-authorization requires case-by-case evaluation of each child's needs individually
(CMS SHO#24-005, p.21)
> *prior authorization must be conducted on a case-by-case basis, evaluating each child's needs individually, and it must not delay the delivery of needed treatment services*

Utilization Management must adhere to EPSDT and consider individual needs
(CMS SHO#24-005)
> *MCPs must ensure that utilization management adheres to EPSDT principles and takes into consideration a particular child's needs*

Third party software used in UM decisions must comply with EPSDT requirements
(CMS SHO#24-005)
> *While many states and MCPs rely on this software to streamline the process of authorizing care, states must ensure that any software used by MCPs in this process is consistent with the EPSDT requirement to cover medically necessary care that can be covered under section 1905(a), as well as regulatory requirements for coverage and authorizations of services*

We respectfully request that you take the following actions:

1. Allow provider to file grievance on behalf of member

Parity Healthcare, LLC submits this letter on behalf of Johnny Smith (Member ID: ABCD12345), a recipient of benefits under the Plan, as their Authorized Representative. A copy of an Authorization of Representative ("AOR") is available upon request if not attached.

The following provisions apply:

Filing requirements
(42 C.F.R. § 438.402(c)(1))
> *"... a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee."*

MCO Grievance Procedures
(42 U.S.C 1396u-2(4))
> *"Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this subchapter, **or a provider on behalf of such an enrollee**, may challenge the denial of coverage of or payment for such assistance."*

Common Denials Types

These are the denial types we see most often.

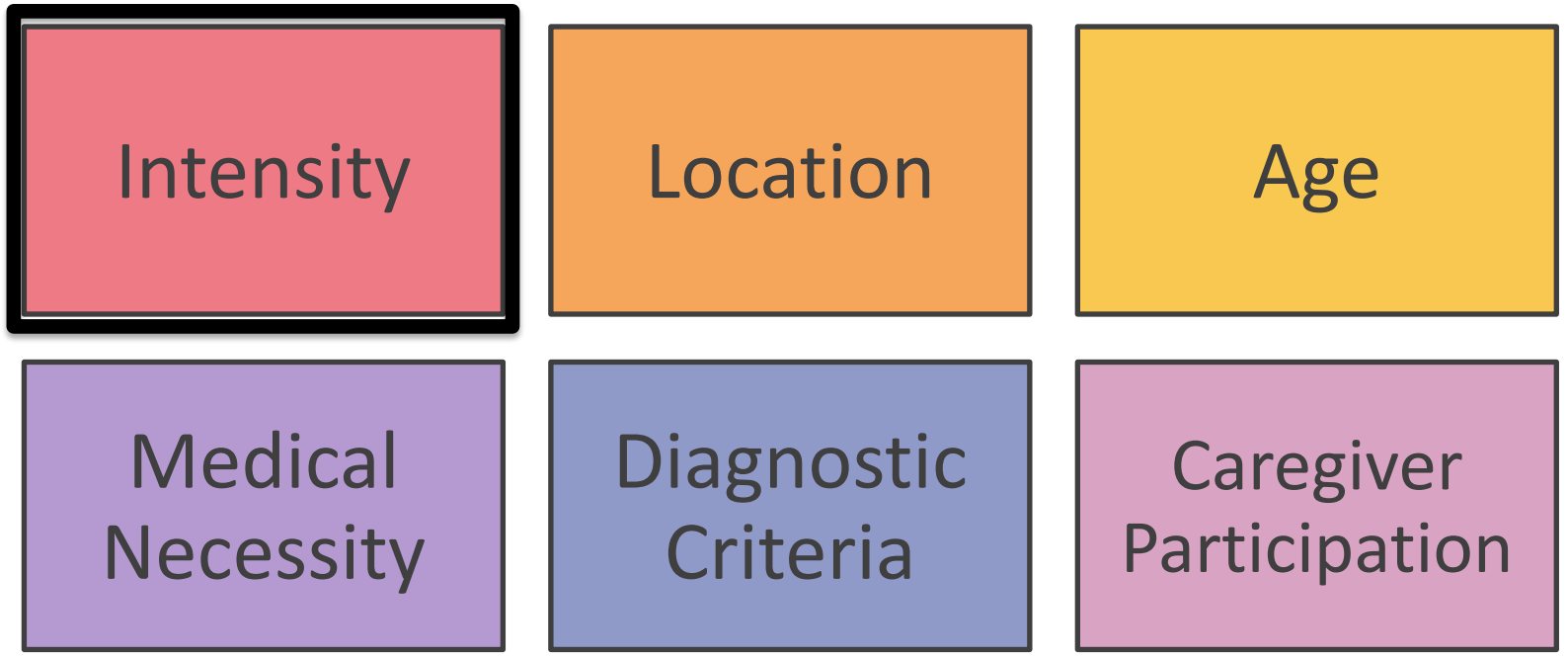
Now we are seeing more denials tied to **telehealth** and **service settings**.

Intensity	Location	Age
Medical Necessity	Diagnostic Criteria	Caregiver Participation

Intensity Denials

"Intervention intensity should be individualized based on the learner's needs and response to treatment, rather than predetermined limits." **(Smith, 2010)**

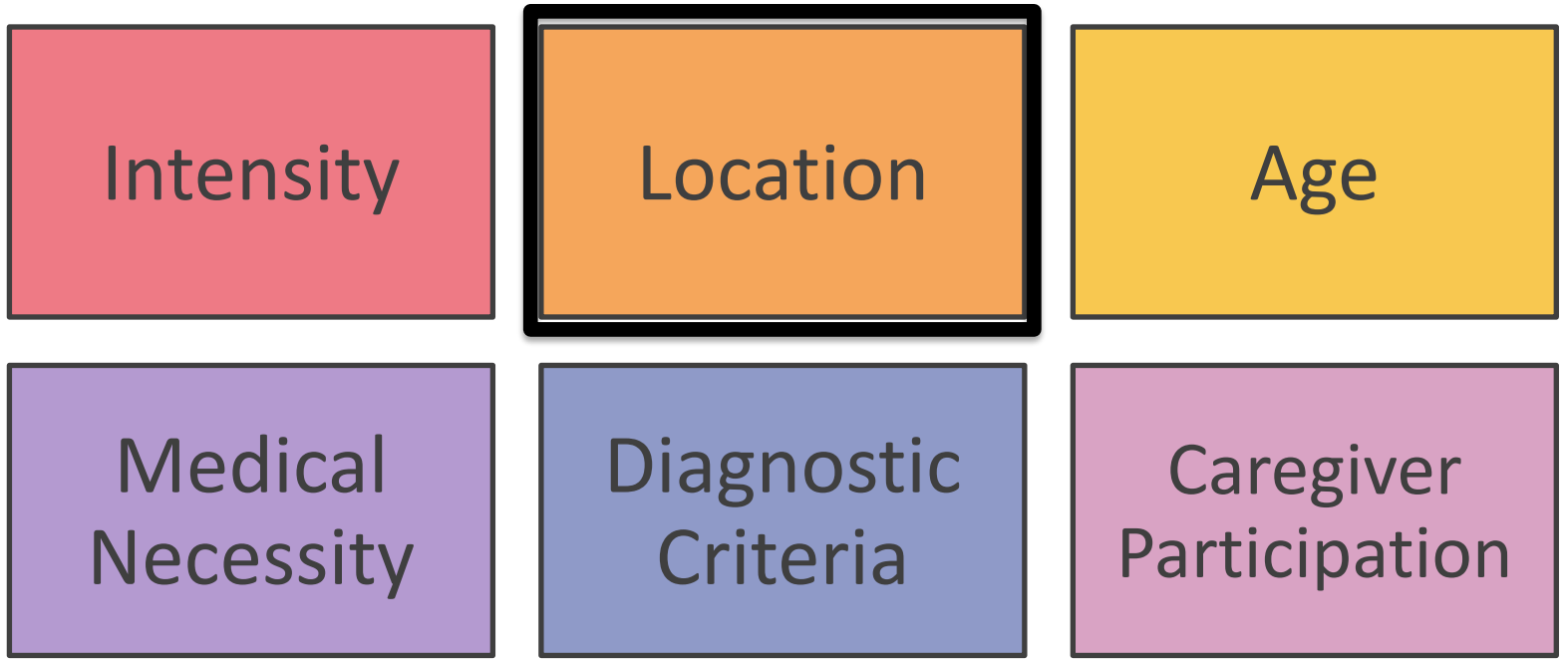
"More intensive intervention is associated with greater gains, particularly for individuals with more significant impairments." **(Eldevik et al., 2009)**



Location Denials

"Intervention in natural environments is critical to promote generalization and maintenance of skills." **(Stokes & Baer, 1977)**

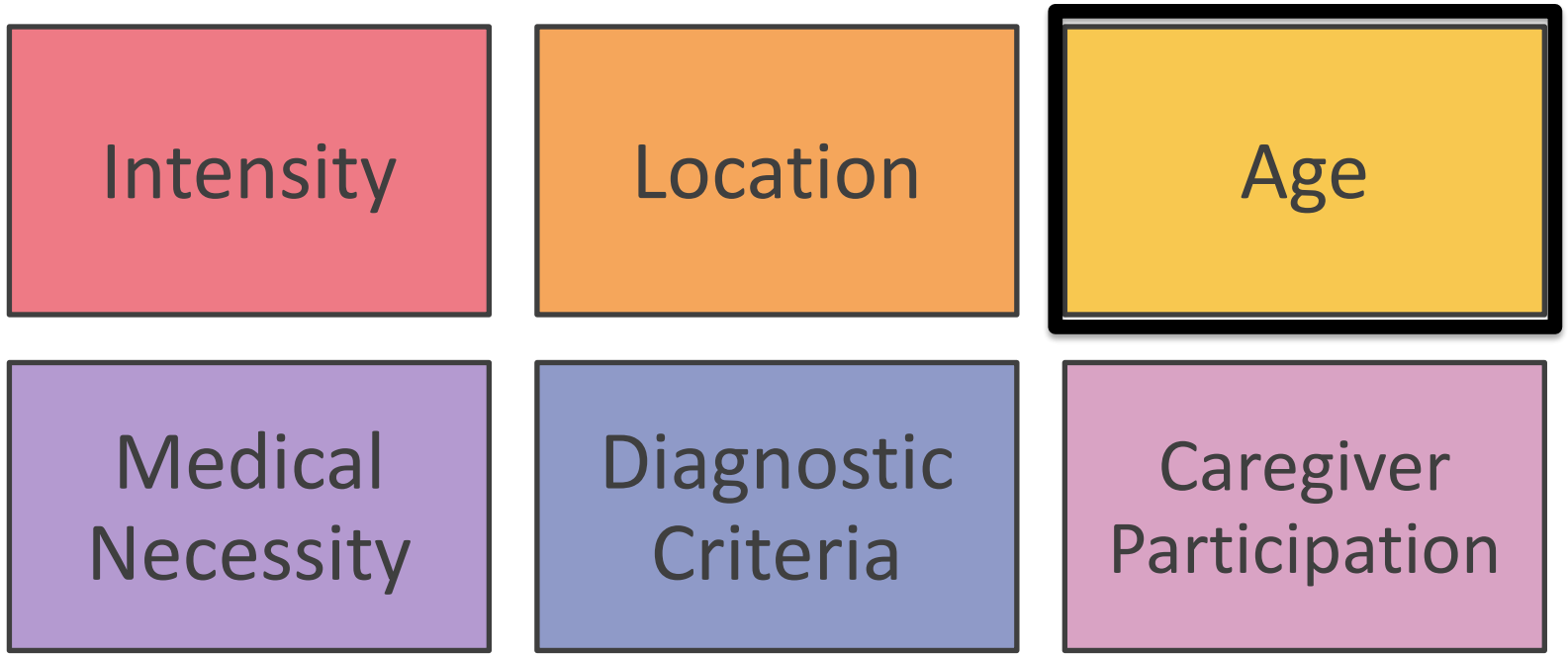
"Skills acquired in one setting often fail to generalize without systematic programming across environments." **(Koegel & Koegel, 2006)**



Age-Related Denials

"Behavioral interventions remain effective across development, including for older children and adolescents with autism." **(Steinbrenner et al., 2020)**

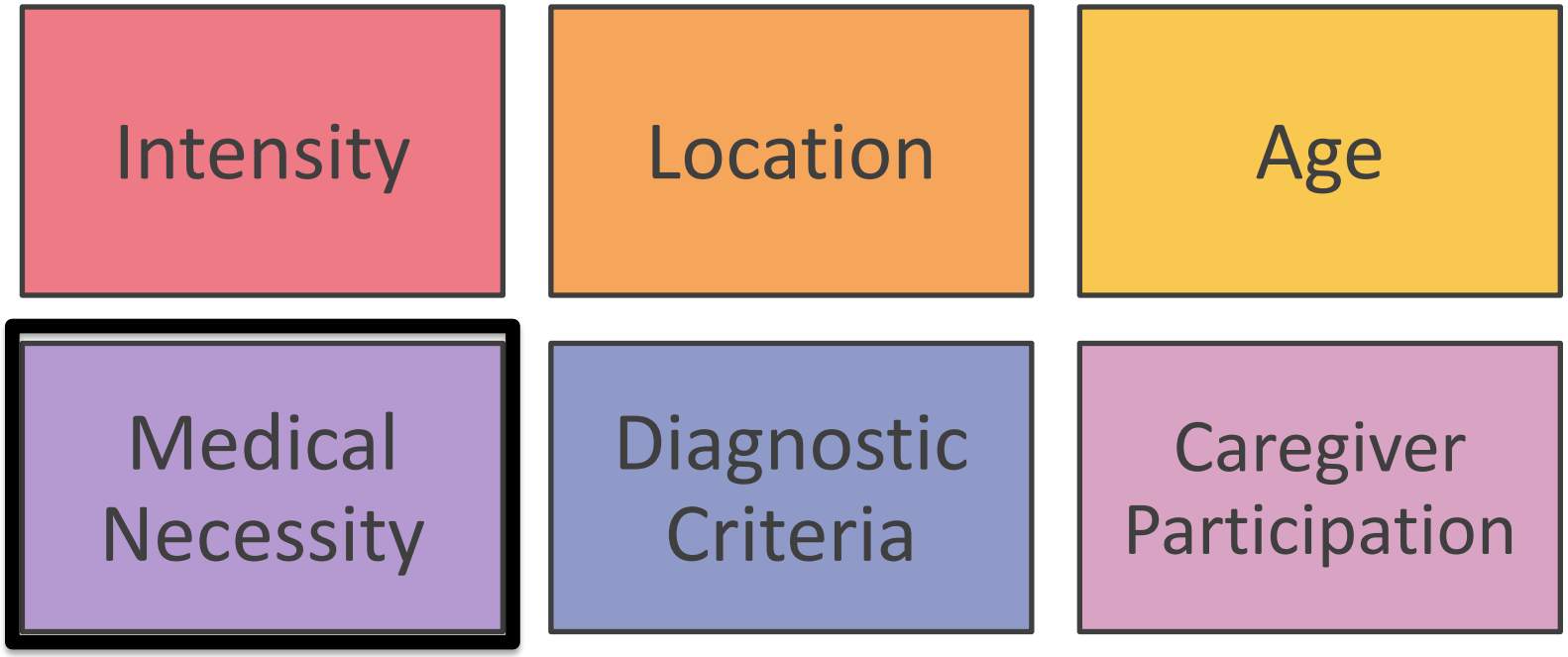
"Intervention should not be limited by age but guided by individual need and functional impairment." **(National Research Council, 2001)**



Medical Necessity Denials

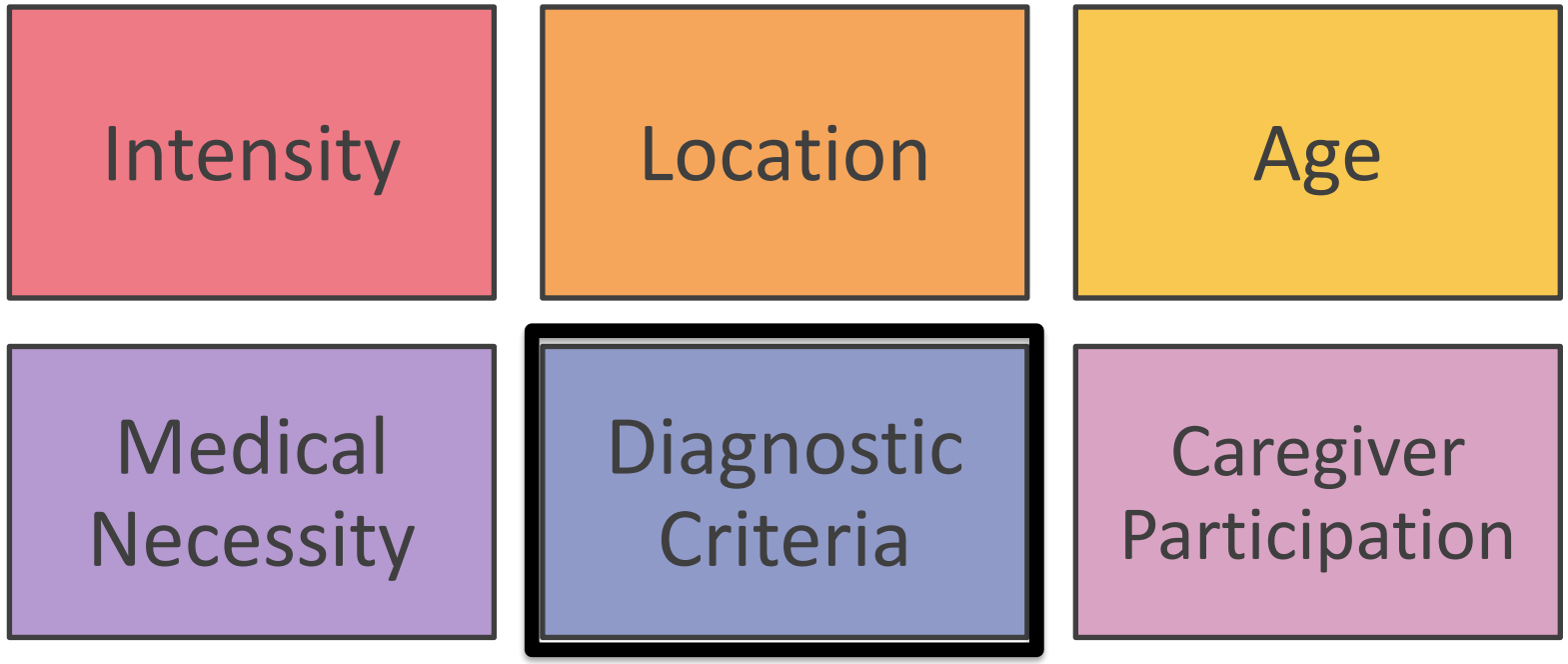
"Autism is a lifelong condition requiring ongoing intervention to address deficits in communication, behavior, and adaptive functioning." **(National Research Council, 2001)**

"Treatment should target behaviors that significantly interfere with functioning and quality of life." **(Cooper, Heron, & Heward, 2020)**



Diagnostic Denials

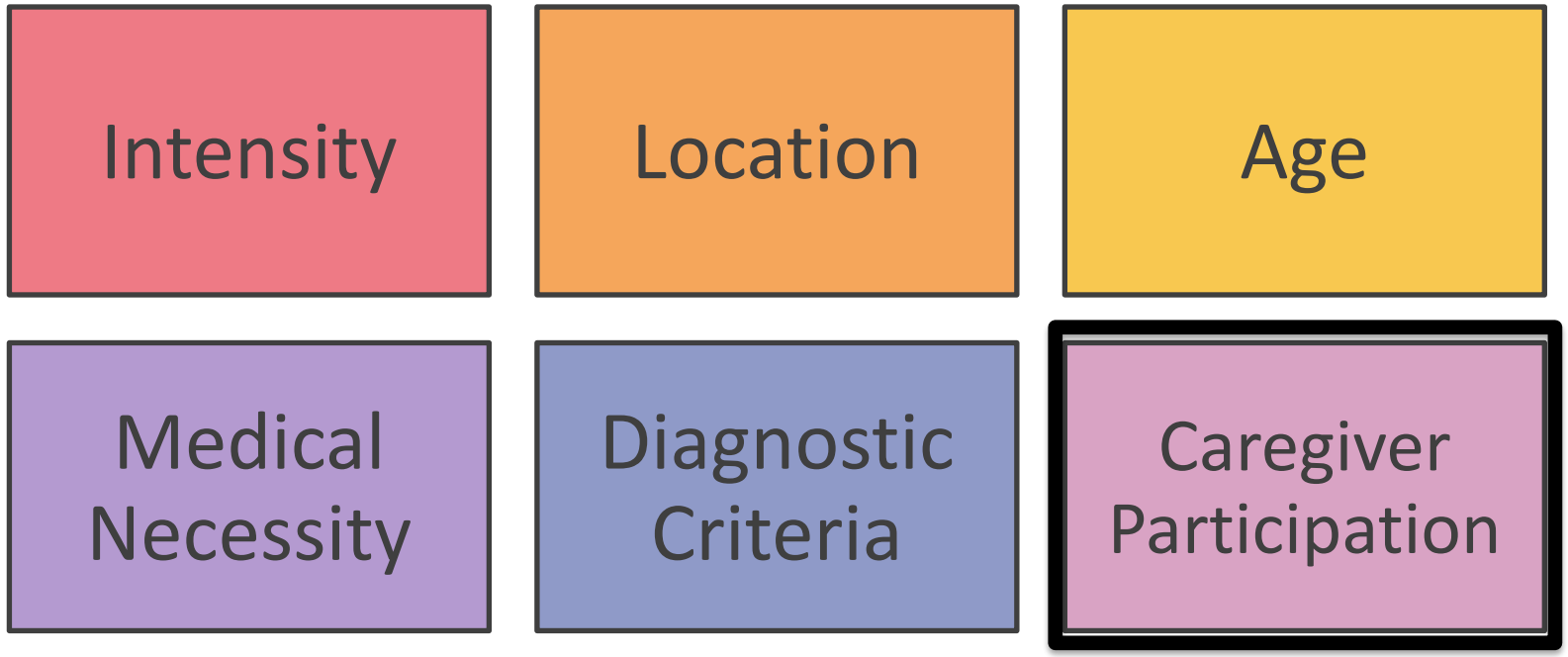
Under Early and Periodic Screening, Diagnostic and Treatment (EPSDT), coverage must be based on **medical necessity and functional impairment—not diagnostic label alone**. Services are required when necessary to **correct or ameliorate a child's condition**, regardless of whether they are explicitly listed in the state plan ***(42 U.S.C. § 1396d(r)(5))***.



Caregiver Participation Denials

"Parent involvement enhances outcomes but is not required for behavior-analytic intervention to be effective." **(Bearss et al., 2015)**

"Direct intervention can produce meaningful behavior change even when caregiver implementation is limited." **(Matson & Smith, 2008)**



Pro-Tips

- Assignment of Benefits Document in Intake Packet
- Engage the families using clear, actionable steps
- Submit External Review and Secondary Review Requests Simultaneously (where possible)
- Create an internal template to submit quickly with minimal effort
- Train and Support clinical team with an efficient, repeatable process

Pick your Battles

Prioritize	Prioritize when you will push back on a requirement and when you will comply.
Group	Group appeals by pattern and funder and focus on volume.
Strategize	Strategize individualized decisions based on your org and client needs.

THANK YOU

Questions?



Share a denial you are working on, and let’s talk it through.