The Authorization and Appeals Playbook

Agenda

- The Playbook History
- The Playbook: What and Why
- Basic things we all need to know
  - Regulators
  - Utilization Management
  - MHPAEA

- How to get the Playbook … it’s free!
- What the Playbook doesn’t cover

Today's Playbook panelists

- Amie Perl, MBA, Senior VP of Operations, Little Leaves Behavioral Services
- Katie Dzurec, Esq., Regulatory and Policy Engagement Specialist for Regulatory Insurance Advisors, LLC
- Tracy Guiou, Ph.D., President and CEO, Catalpa, Health Consultant, Bierman Autism Centers
- Karen Fessel, Dr.PH, Executive Director and Founder, Mental Health and Autism Insurance Project
- Kristin Jacobson, MBA, Founder & Executive Director Autism Deserves Equal Coverage Foundation
- Emily Roche, MHA, Vice President Revenue Cycle and Contracting, Bierman Autism Centers
- Christa Stevens, JD, MAT, Director of Government Affairs, Autism Speaks

The Playbook: A history

- Despite having coverage for treatment, individuals with ASD still face barriers to care, mostly via denied authorization requests
- Many (most?) providers are not confident in how to respond to denials or best advocate for our clients
  - Detrimental to both clients and the field of ABA
  - Providers are frustrated and exhausted – it feels like David v. Goliath!
- A group of dedicated providers, advocates, and regulators spent over a year working together to build a tool for the community
  - By last year's summit, we had a word document ready for review but not distribution

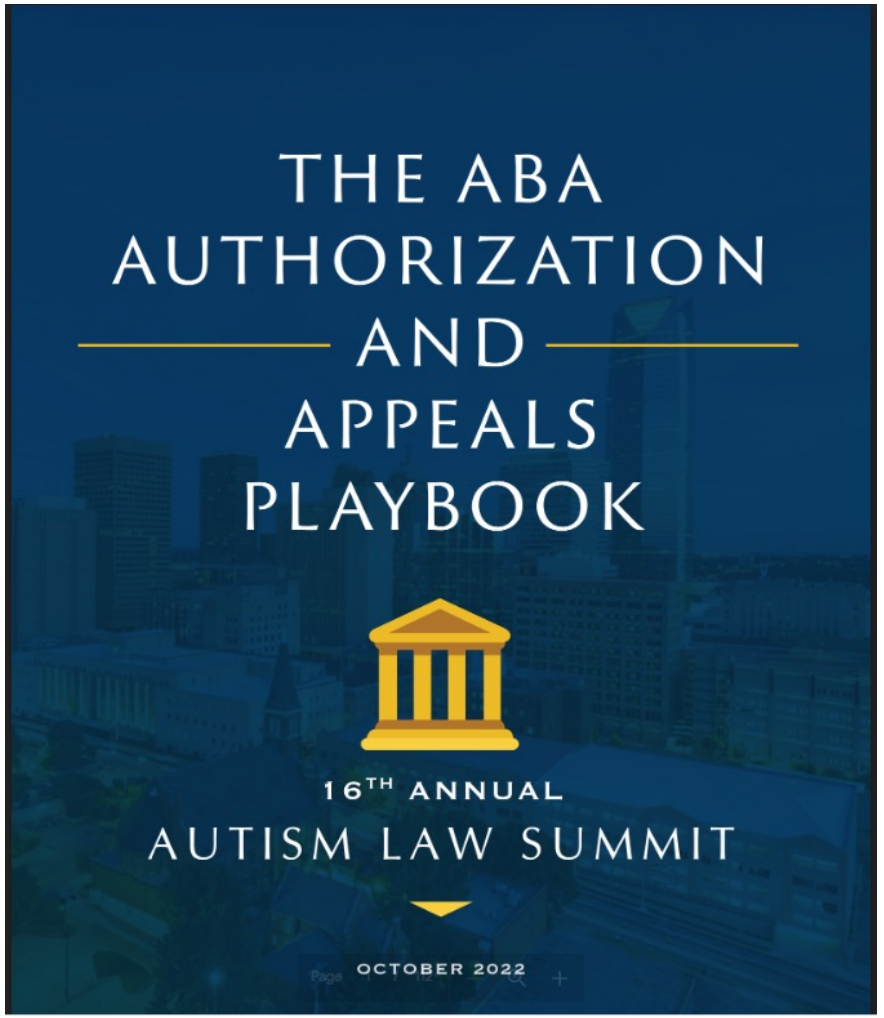
The Playbook Team

The Playbook today…

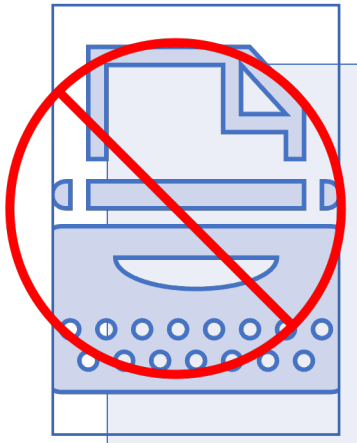
A 4-page checklist to combat medical necessity denials

Another 100 pages of detail!

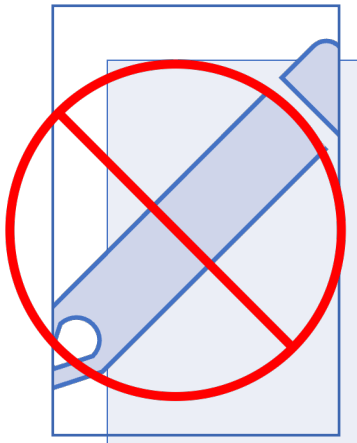
- Part I: The Basics
  - Key Term and Key Laws
- Part 2: The Playbook (How To)
  - Authorizations
  - Appeals
- Part 3: Tips and Tools
  - Checklists, Samples Documents, etc.



The Playbook is not…Clinical



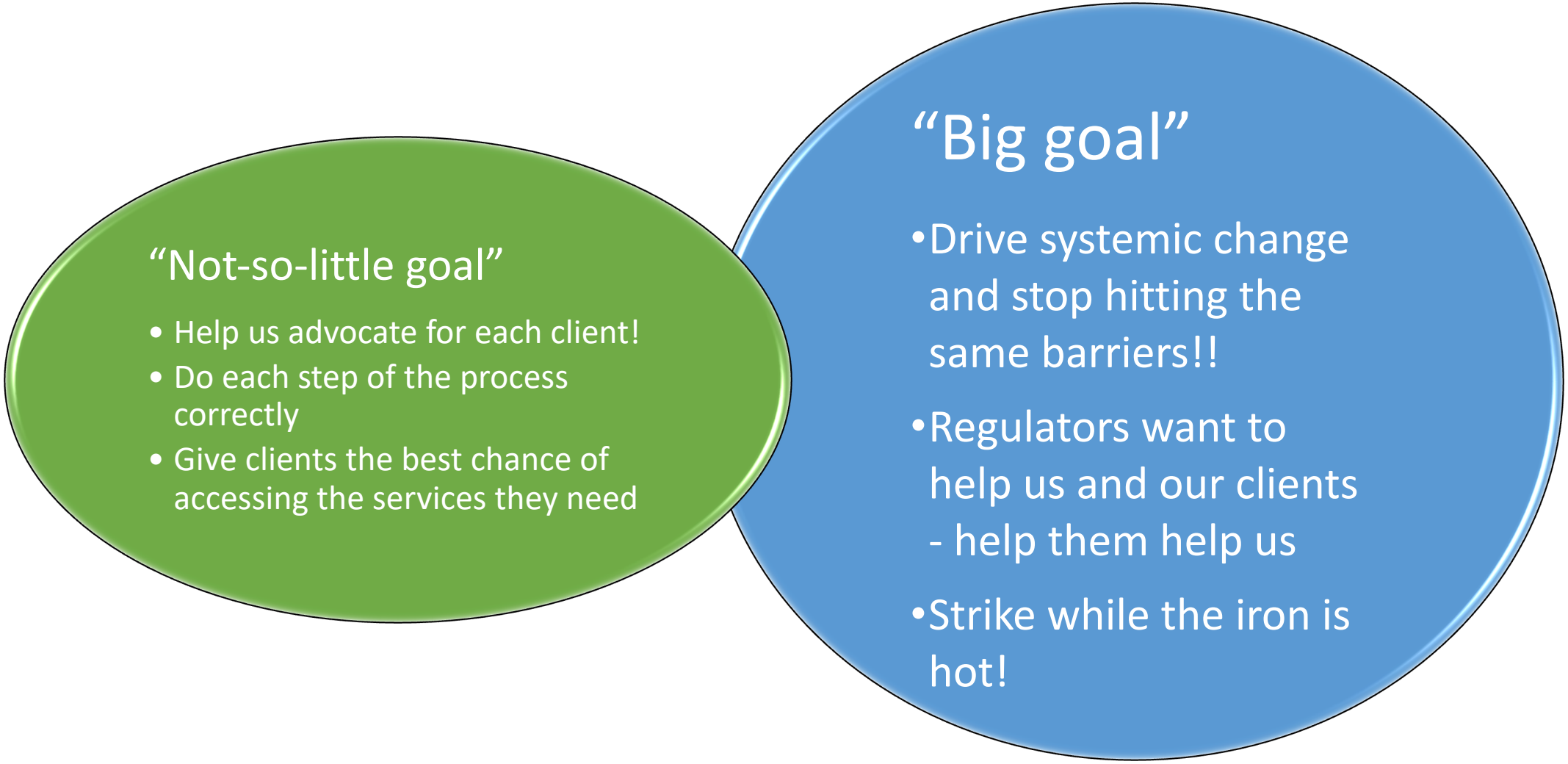
Will not tell you how to write a treatment plan

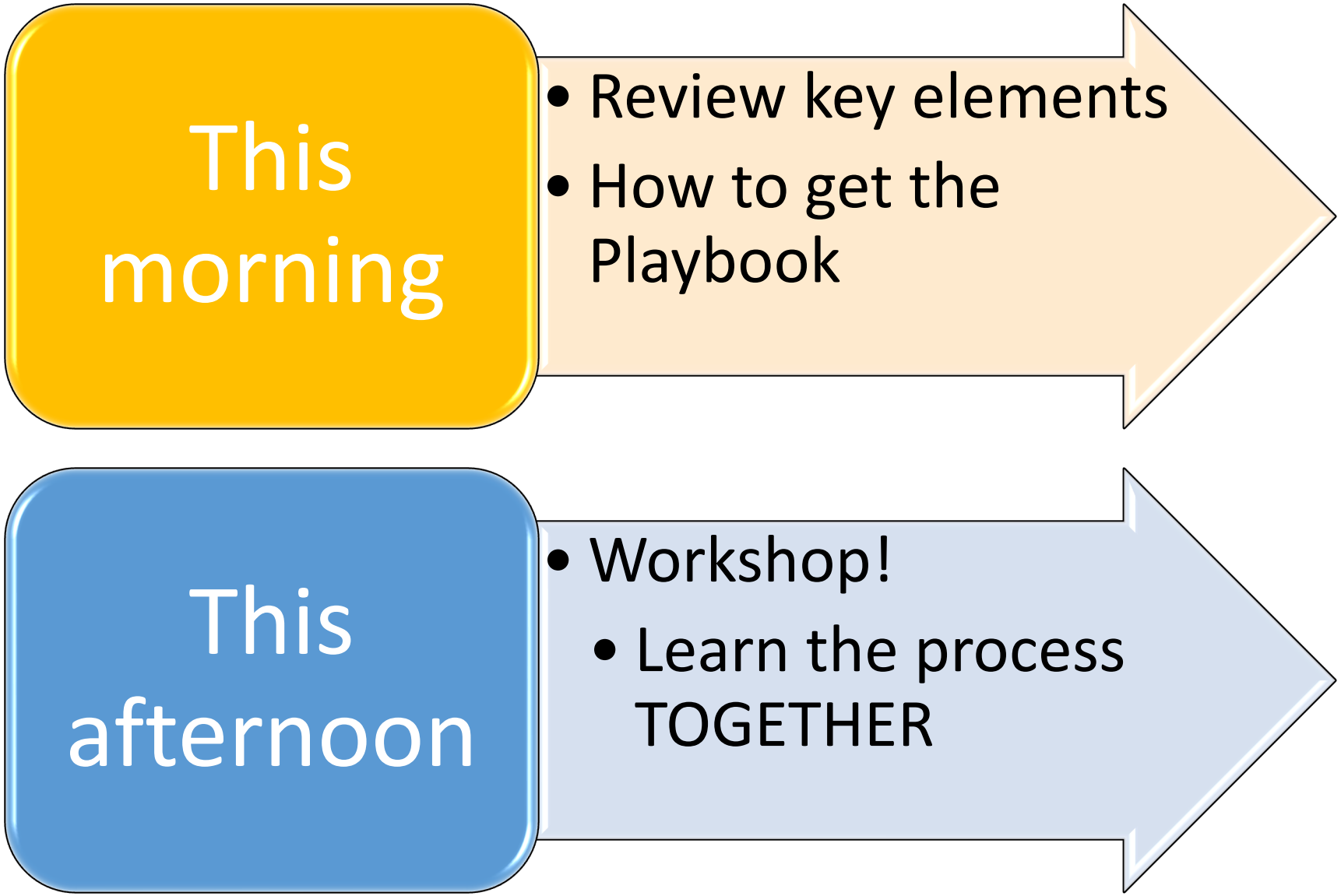


Will not tell you how to clinically refute common denials

It’s all about the process!

Educating providers on authorizations and appeals serves two goals




This morning
• Review key elements
• How to get the Playbook
This afternoon
• Workshop!
• Learn the process TOGETHER

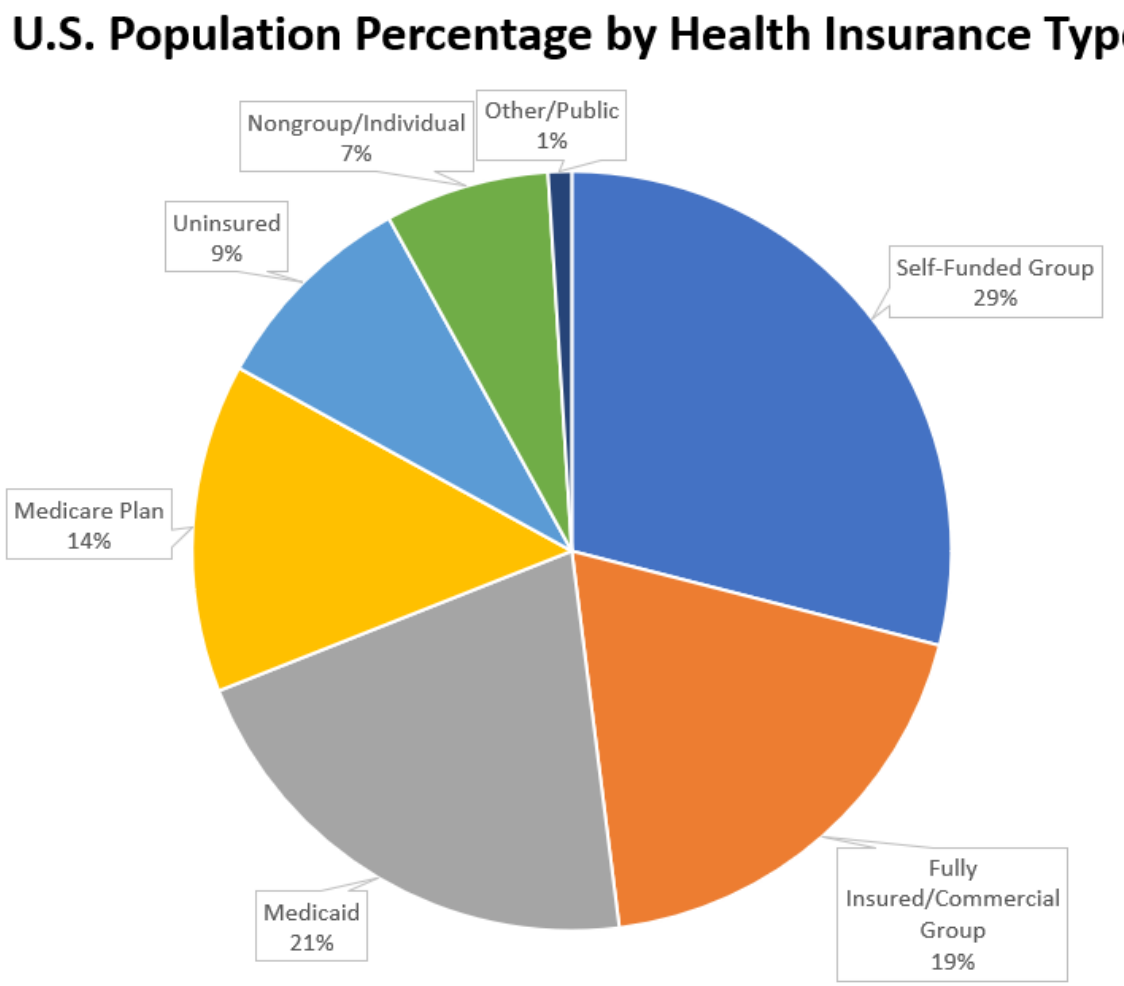
This morning

- Review key elements
- How to get the Playbook

Insurance is regulated

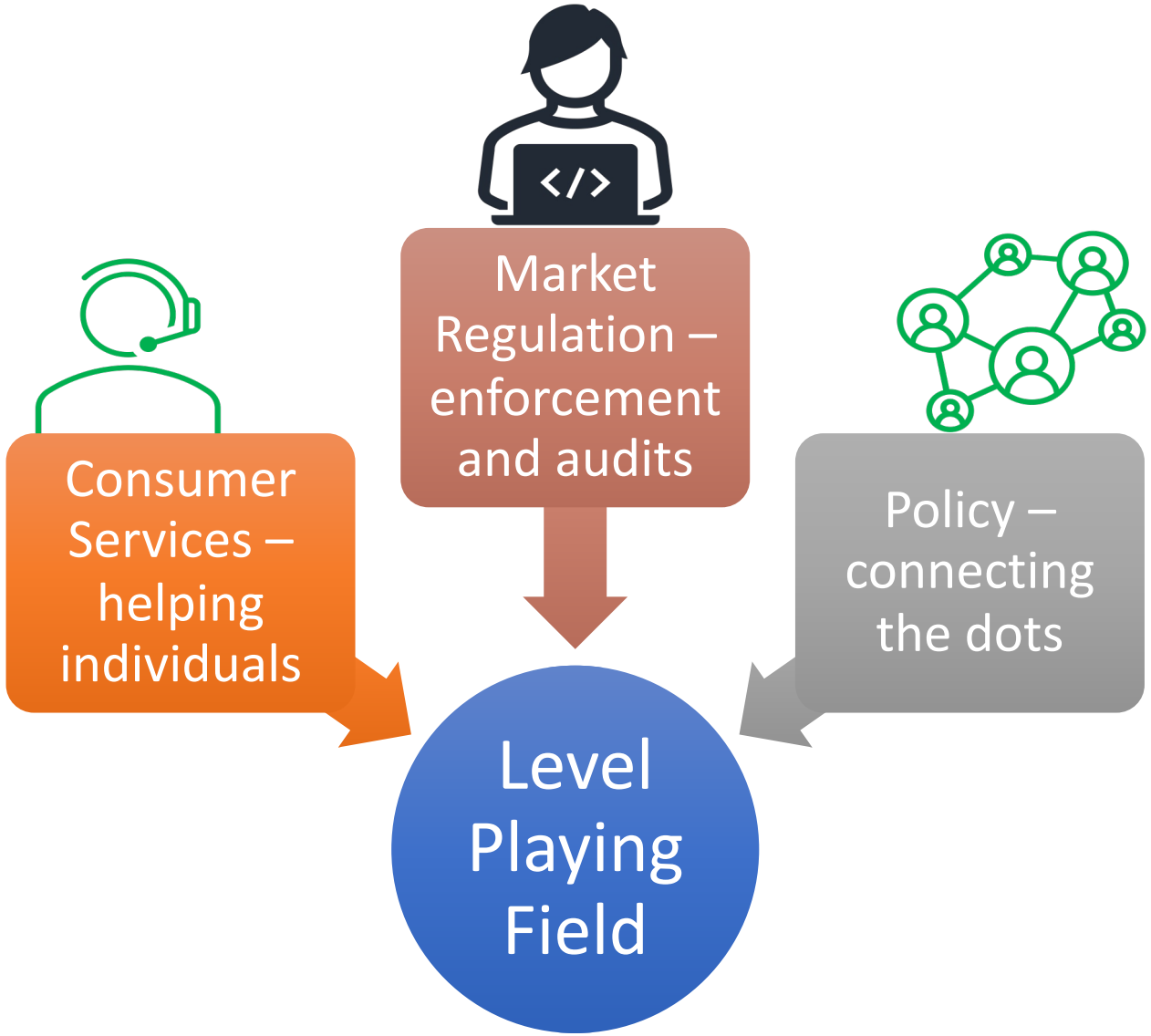
There are different types of health insurance

Different laws apply, so <u>different regulators get involved</u>



Source; Data from Kaiser Family Foundation 2019

Regulators enforce the insurance laws



Insurance is a contract

- Each insurance plan has a **Summary Plan Description (SPD), aka Certificate/Evidence of Coverage**, that includes the terms of the contract
  - Who is covered
  - How the plan works
  - What is and is not covered
  - Which services require pre-authorization
  - Claims and appeal information

- The contract is between the member/subscriber and the insurance company (or employer) – NOT the provider
  - The provider can act as an **Authorized Representative** but protections under the law are for the member

Insurance Pays For…

- **Covered Benefits** that are...
  - **Medical Necessity** which means (among other things)…
    - They align with the **Generally Accepted Standards of Care**

- Some Covered Benefits require **Authorization** which is when…
  - The insurance company evaluates the treatment to determine whether they feel it is **Medically Necessary**
  - In ABA, it usually happens before treatment begins (aka **Prior Authorization**)
  - Note: Authorization is part of a function called **Utilization Management**

Insurers and providers do not always agree

- Insurers may deny services that we request (and we believe are medically necessary) – that's called an **Adverse Determination**

- We can ask them to reconsider their decision – that's called an **Appeal**
  - **Internal appeals –** one or two levels
  - **External appeal** by an Independent Review Organization (IRO)
    - Can jump to external in the case of **Deemed Exhaustion**

- **Regulator complaints**
  - Not for when we disagree, but for when the insurers are not playing by the rules

So what are these rules?

1. State and federal Utilization Management laws regulate auth and appeals decisions

Process – must be clearly outlined in the SPD

The how

- Timelines – must meet deadlines for responses to authorization requests and appeals
- Reviewers – must be have appropriate training and expertise in the field
- Decisions – must be based on clearly established medical necessity guidelines and be consistent (similar client, similar decision)

Adverse Determinations

The why

- Must include “an explanation of the scientific or clinical judgment for the determination
- Inform how the terms of the plan apply to the claimant’s medical circumstances
- **Must be provided in writing**

2. State Level Autism Laws

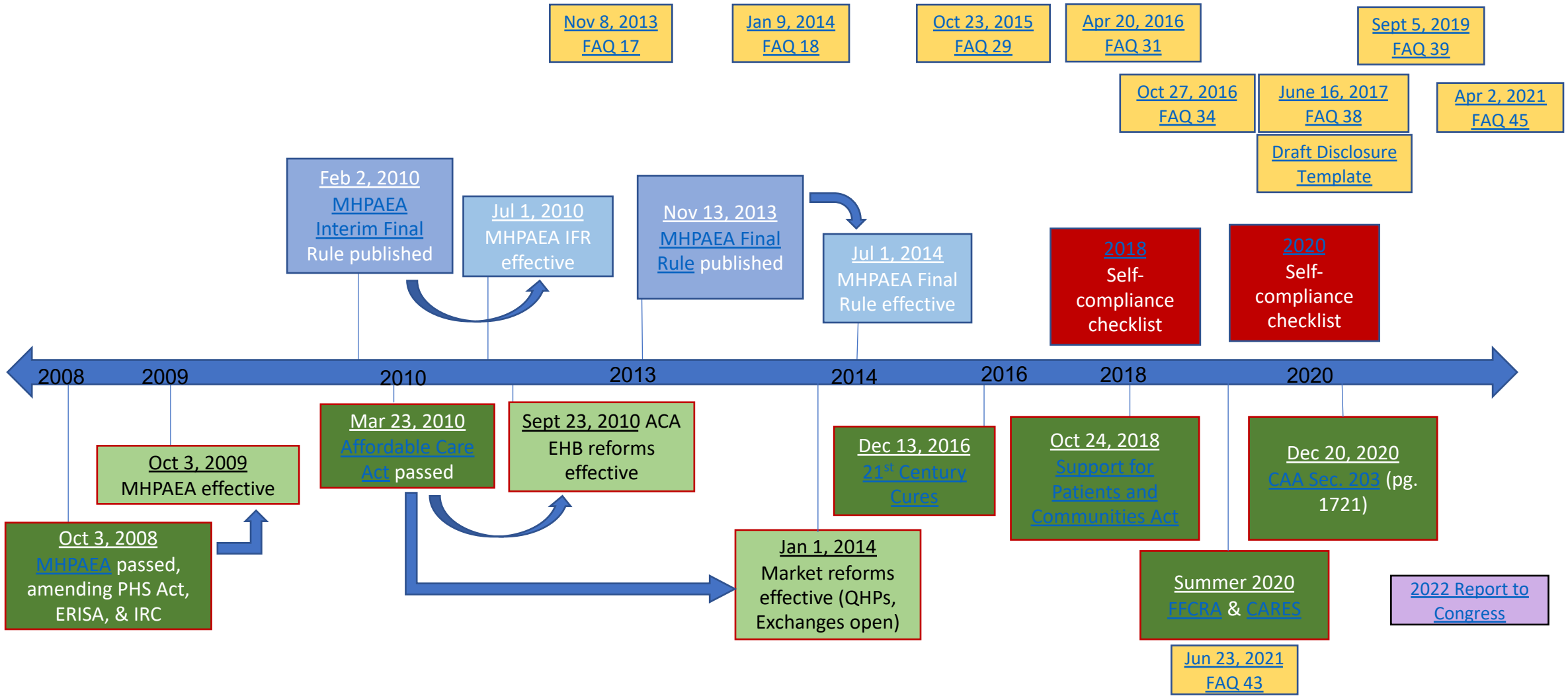
- For fully-insured plans in the state
- Know them!
- May have clauses that protect clients
  - Maryland – services cannot be denied just because they are delivered in a school
  - Treatment must be provided for “individuals with a diagnosis of ASD”, not “individuals with a diagnosis of ASD based on multi-disciplinary, comprehensive evaluation using specific tests delivered every 24 months”

3. MHPAEA – what is it?

Mental Health Parity and Addiction Equity Act

- Anti-discrimination law at its core
- Addresses past practices that limited coverage for Mental Health and Substance Use Disorder Services

Legislative & Regulatory Timeline



MHPAEA – Two key elements
a) Treatment Limitations

QTL

Quantitative limits

Cost sharing, Visit limits, Max hours, MUE

NQTL

Non-quantitative limits

Med necessity criteria, parent particip., location limits

- Med/surg vs. Mental Health/Substance Abuse
- Limits are ok, but must be fair: A group health plan…may not impose a nonquantitative treatment limitation … **as written and in operation**, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification **are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification**.

MHPAEA – Two key elements
a) Treatment Limitations

FAIR

- A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition.

UNFAIR

- Med/Surg: Using medical necessity criteria based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved surg

- MH/SU: Using medical necessity criteria that do not align with Generally Accepted Standards of Care

MHPAEA – Two key elements
b) Analysis/Disclosure Requirements

- Health plan must do the analysis that shows the limitations are fair before imposing them

- 45 C.F.R. § 146.136(h)
  - Can't sell the plan if it does not comply with MHPAEA

Disclosure Requirements

Consumers' right to request the analyses conducted that show limitations meet parity requirements

- We will submit a disclosure request each time they limit treatment
- 30 days to respond

Must include specific reasons denials are made for each patient

- Again, they have to tell us WHY!

MHPAEA Report to Congress 2022

- Requested analyses from 156 plans regarding >200 unique NQTLs
  - 0 of analyses were sufficient
- Nonetheless DOL and HHS had sufficient information to evaluate 48 NQTLs from 30 plans
  - 100% were found to be violations of MHPAEA

MHPAEA Report to Congress 2022

2022 MHPAEA Report to Congress

Secretary Martin J. Walsh — **Department of Labor**

Secretary Xavier Becerra — **Department of Health & Human Services**

Secretary Janet L. Yellen Department of the Treasury

Realizing Parity, Reducing Stigma, and Raising

ummaryofRequestsandIdentificationofNon-CompliantPlansandIssuers[21]

'een April 9, 2021 and October 31, 2021, EBSA issued 156 letters to plans and issuers esting comparative analyses for 216 unique NQTLs, across 86 investigations. Of the 156 's, EBSA issued 141 to plans (7 to plans providing fully-insured coverage and 134 to plans iding self-funded coverage) and 15 to issuers. EBSA's requests sought information erning many different kinds of NQTLs. The following is a list of the most common NQTLs hich EBSA requested a comparative analysis, listed in descending order of frequency.

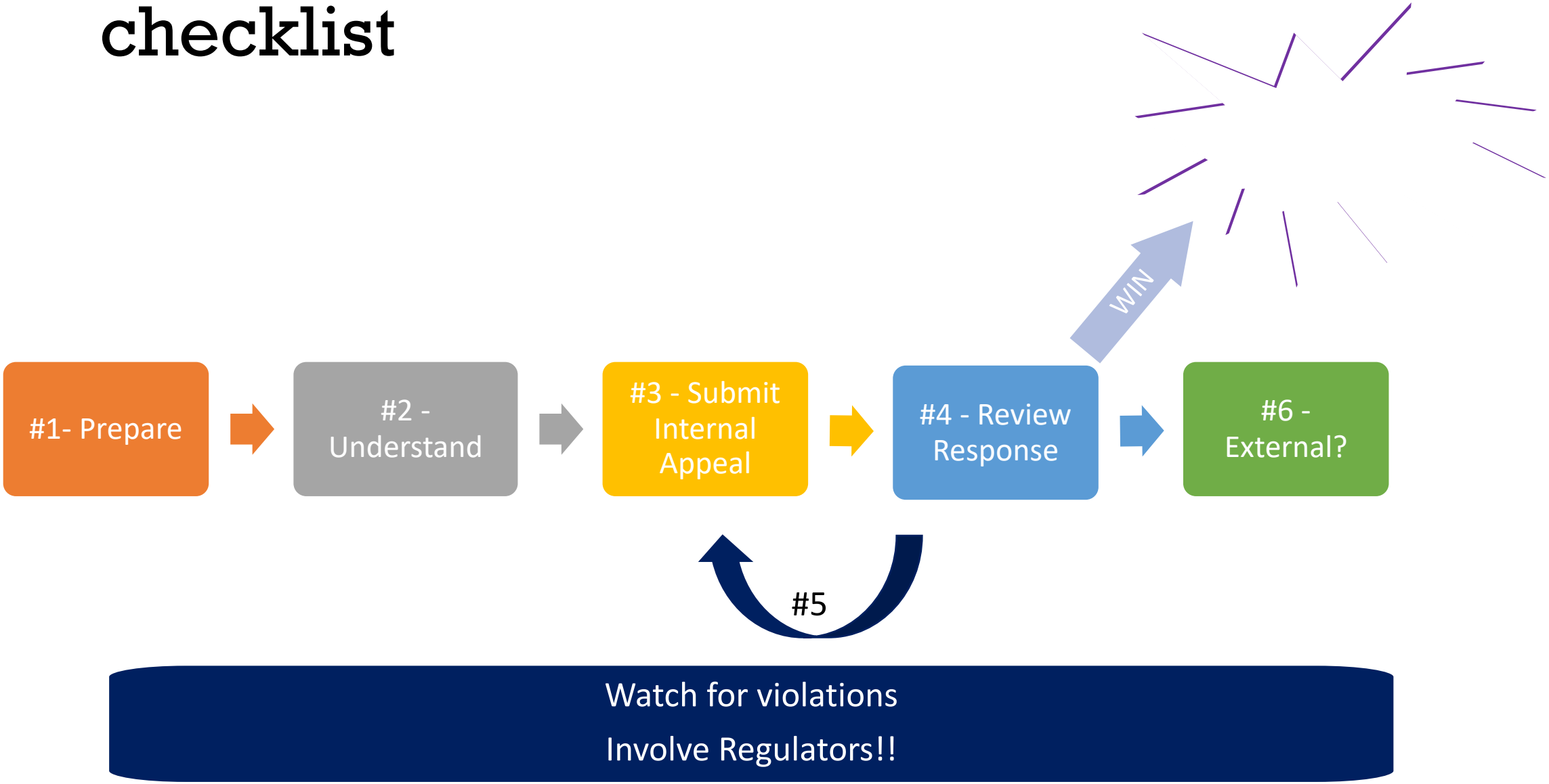
Preauthorization or precertification requirements	
Network provider admission standards	
Concurrent care review	
Limitations on applied behavior analysis or treatment for autism spectrum disorder	
Out-of-network reimbursement rates	
Treatment plan requirements	
Limitations on medication assisted treatment for opioid use disorder	
Provider qualification or billing restrictions	
Limitations on residential care or partial hospitalization programs	
Nutritional counseling limitations	
Speech therapy restrictions	
Exclusions based on chronicity or treatability of condition, likelihood of improvement, or functional progress	
Virtual or telephonic visit restrictions	
14. Fail-first or step therapy requirements	

NQTL	Number of Initial Determinations of Non- compliance for that NQTL
Limitation or exclusion of applied behavior analysis therapy or other services to treat autism spectrum disorder	9
Billing requirements – licensed MH/SUD providers can bill the plan only through specific types of other providers	7
Limitation or exclusion of medication-assisted treatment for opioid use disorder	4
Preauthorization or precertification	4
Limitation or exclusion of nutritional counseling for MH/SUD conditions	4
Provider experience requirement beyond licensure	3
Care manager or specific supervision requirement for MH/SUD	2
Exclusion or limitation on residential care or partial hospitalization to treat MH/SUD conditions	2
"Effective treatment" requirement applicable only to SUD benefits	1
Treatment plan requirement	1
Employee assistance program referral requirement	1
Exclusion of care for chronic MH/SUD conditions	1
Exclusion of speech therapy to treat MH/SUD conditions	1
Concurrent care and discharge planning requirements	1
Retrospective review	1
Maximum allowable charge and reference-based pricing	1
Other exclusion specifically targeting MH/SUD benefits eg location limits	1
Age, scope, or durational limits	1
Formulary design	1
Limit on telehealth for MH/SUD	1
Restriction on lab testing for MH/SUD	1
Total	**48**

DOL says these are NQTL and 0% of NQTL analyses were sufficient

DOL says these are MHPAEA violations 100% of NQTLs were MHPAEA violations

The Playbook provides a step-by-step checklist



It's not always sweetness and light

Regulators define "pattern" differently	• But that is why you have to keep providing data points.
It takes a long time	• But restitution can go back many years.
Sometimes the case reviewer has no idea	• But regulators can't stop it if they don't know about it. • That's where you come in.

How to get the Playbook

Download it, it’s free!!!

This afternoon

- Workshop!
  - How to do it
  - How the pieces all fit
  - Hands on and interactive!