Playbook

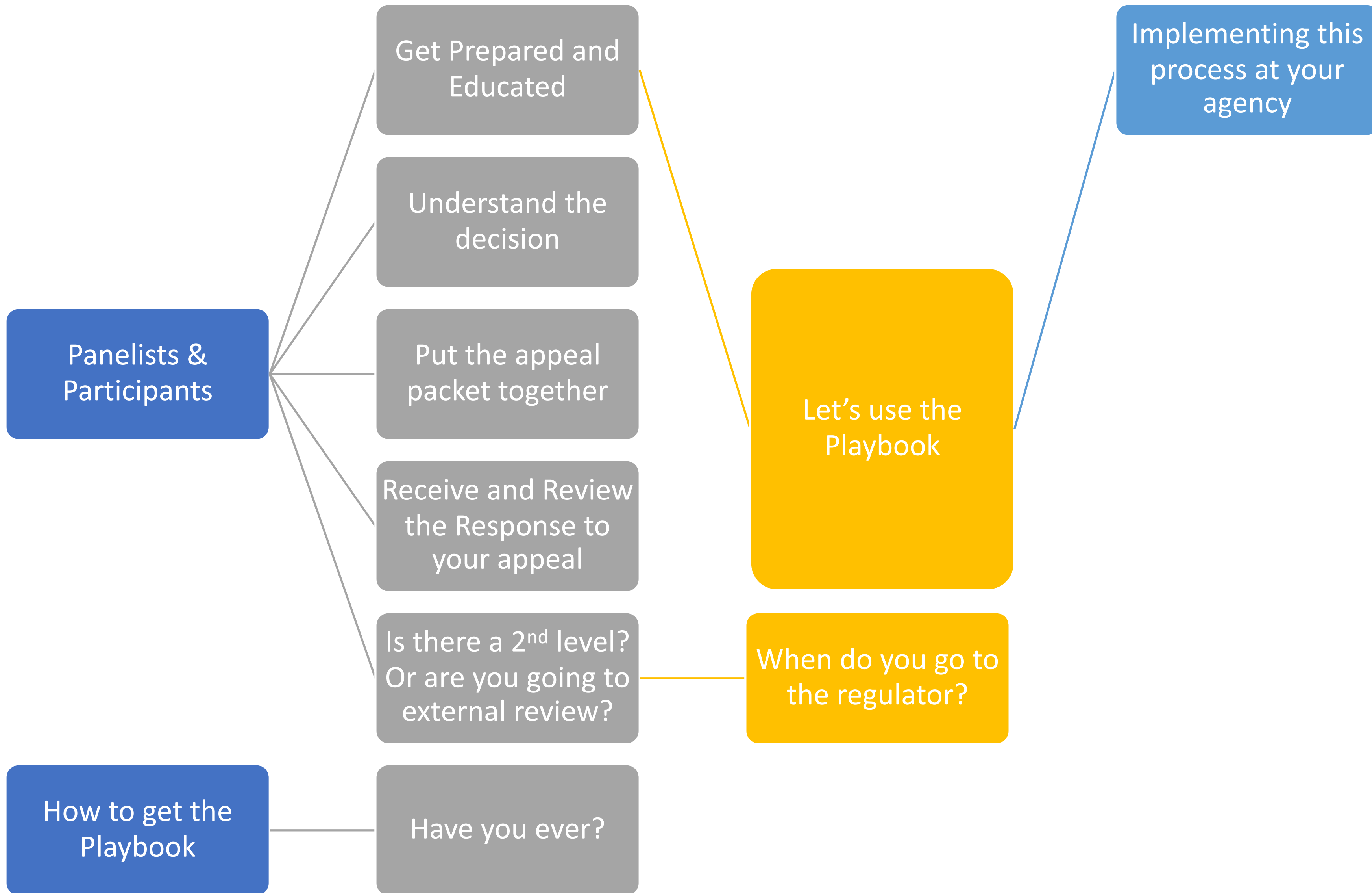
~~The Musical~~

A Workshop

Friday, October 13, 2022

The Playbook Team

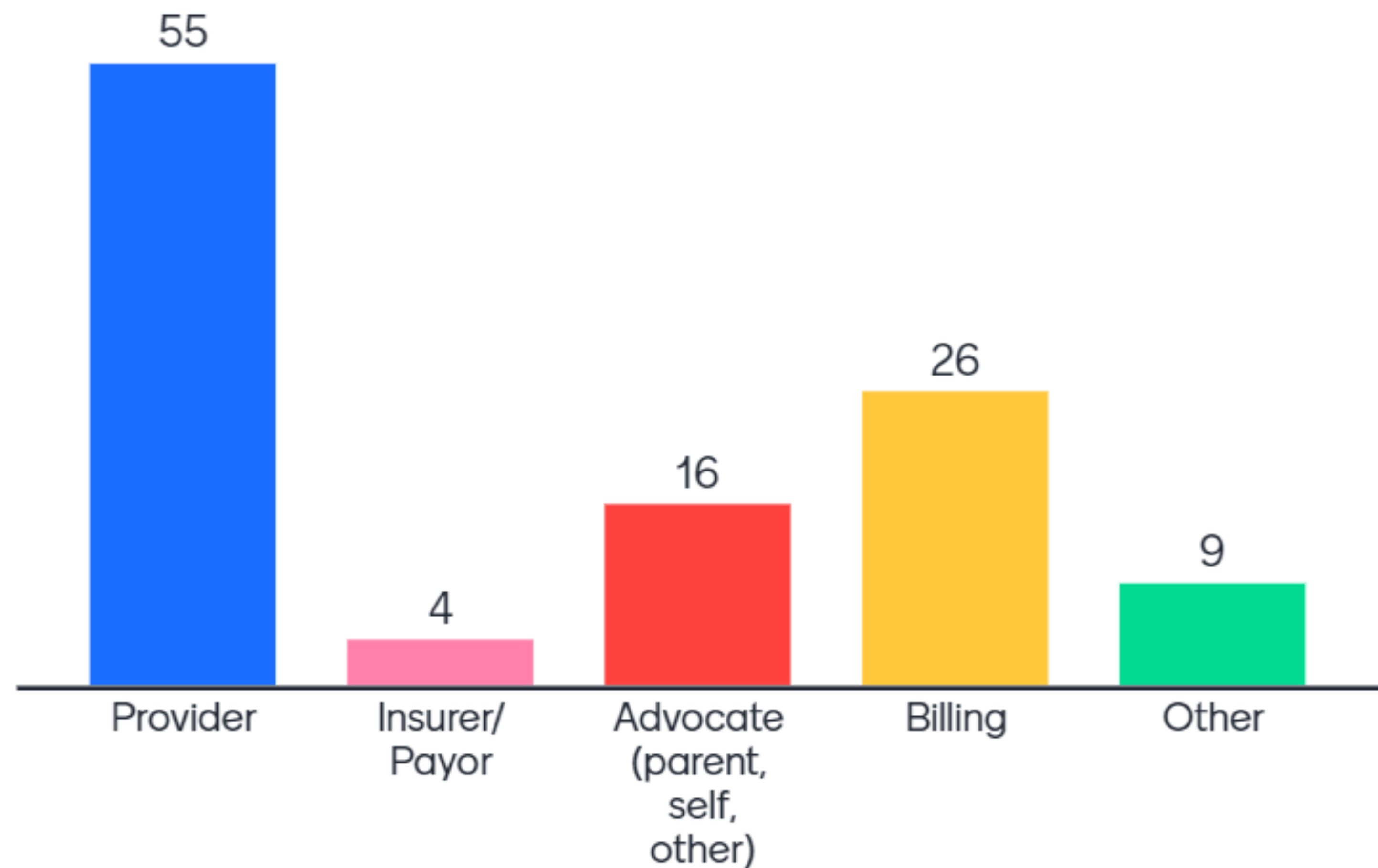
Welcome & Agenda



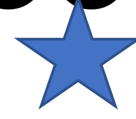
Who we are…

- Amie Perl, MBA, Senior VP of Operations, Little Leaves Behavioral Services
- Katie Dzurec, Esq., Regulatory and Policy Engagement Specialist for Regulatory Insurance Advisors, LLC.
- Karen Fessel, Dr.PH, Executive Director and Founder, Mental Health and Autism Insurance Project
- Tracy Guiou, Ph.D., President and CEO, Catalpa, Health Consultant, Bierman Autism Centers
- 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

Who are you?



How to get the Playbook



Download it, it’s free!!!

Have you ever?

- Have you submitted an appeal?
- Have you ever gone to external review?
- Have you ever contacted a regulator?
- Used a lawyer?
- Requested a peer-to-peer review?
- Changed a clinical recommendation because of a peer-to-peer conversation?

“Anything but a yes, is a no.”

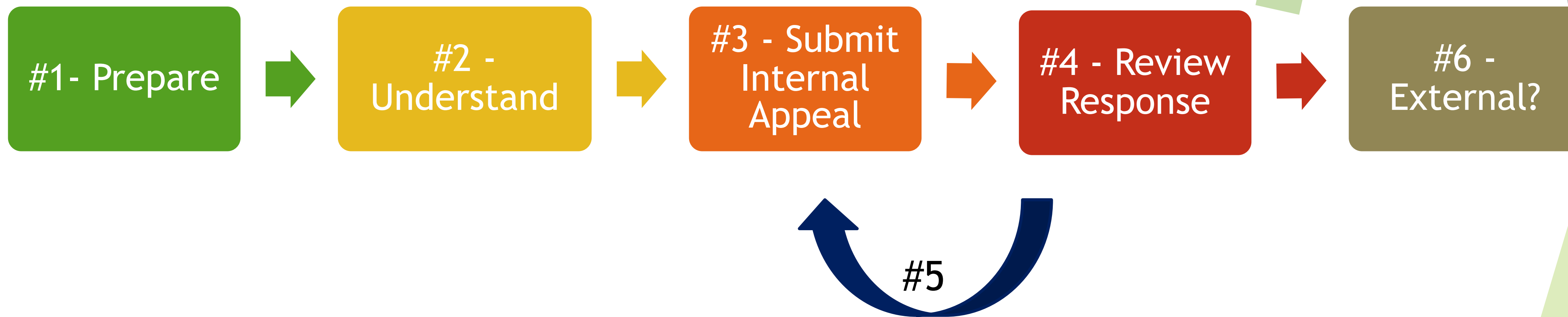
- Feda Almaliti

- Anything that differs from the request is an <u>Adverse Determination</u>
  - Dosage, setting, duration, goals, MUE
- By law, Adverse Determinations MUST be provided in writing
- The reason must be included
- The written determination must be provided within the specified timeline

You just got “not a yes”

… now what??

Appeal: How To (Process)



Watch for violations

Involve “community helpers” as needed

See pg. 1

Get the determination in writing.

- Was the determination made within the applicable timeframe?
- Did you have to fight to get the determination in writing?

Review the entire letter

- What options are given for follow-up?
- Are there specific forms that have to be used?

Follow the instructions

- They are required to be in the letter and in the SPD

See pg. 1

Determine type of coverage and applicable law

See pp. 1-2

Self-Funded

Department of Labor

- Provided through work?
- "Claims Administrator"
- State mandates will likely not apply

Fully-insured

State Insurance Department

- State mandates apply

Medicaid

CMS & State Medicaid agency

Other Government

Federal Employee

ChampVA

Medicare

Appeal timelines may vary.
Applicable law varies.

Step 2: Understand the decision

See pg. 2

- If the decision is hard to understand, there's probably a violation.

Not enough information

- When saying "this does not meet our medical necessity guidelines" are they telling you what those guidelines are?

NQTL Analysis!!!

Decision does not align with GASC

- What guidelines are they using to make the decision?
- How are they applying those guidelines?

NQTL Analysis!!!

Unpredictable responses

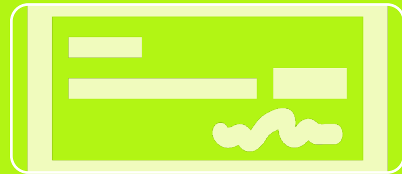
- How is this not completely arbitrary?

NQTL

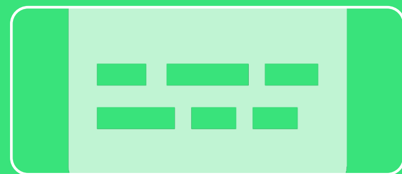
Step 3: Compile and submit the appeal packet

See pg. 3

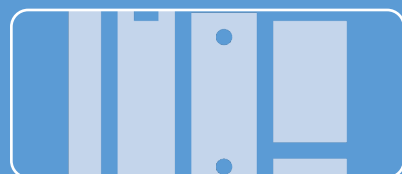
Insurer's appeal form


Authorized representative form, assignment of benefits

Appeal letter


MHPAEA disclosure request form

Copies of original authorization submission and adverse determination


Relevant literature/evidence, letters of support from other professionals

The Appeal Letter

Introduction

Patient information (name, plan ID, diagnosis)	Who you are (i.e., authorized rep)

Denial vs. Approval

What was the reason given for the denial?	What is the clinical support for approval? (e.g., why is it medically necessary? How do it meet guidelines?)

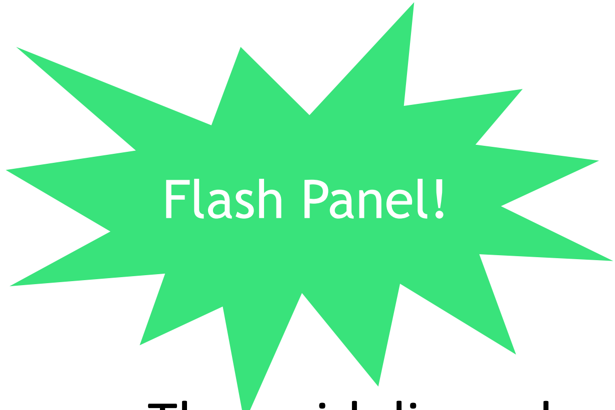
Possible violations of law or contract terms

MHPAEA violations, applicable mandates, essential health benefits, discrimination	Provider manual, SPD, policies

{Statement that continued care is being sought}

Conclusion – Summary of why denial is inappropriate and restatement of request

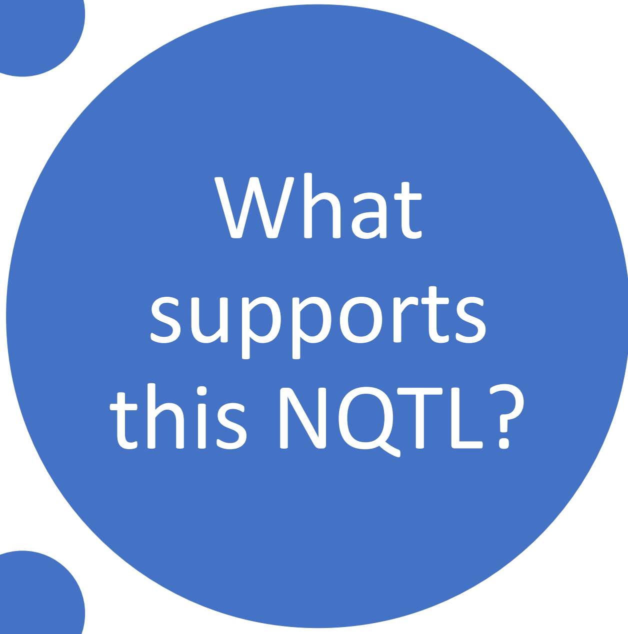
MHPAEA-spotting

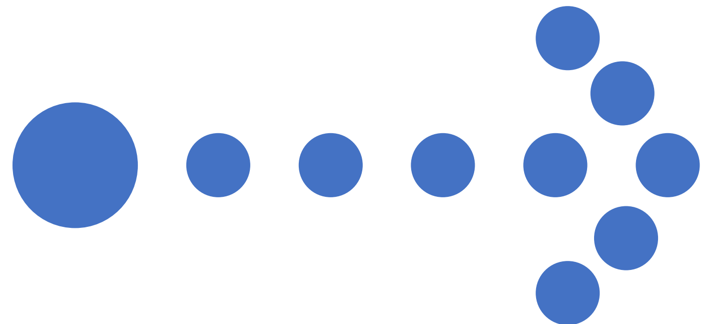


The guidelines don't support the hours requested

PA required because it's subject to fraud

We don't see likelihood of improvement





BTW: What's an NQTL?
Do you know?
Do your colleagues know?

What was the most common MHPAEA issue last year?

- Report to Congress 2022:
  - "Exclusion based on … likelihood of improvement, or functional progress"
  - Progress not considered for substantially all med/surg tx
- Most state laws include language about "maximizing functioning of individual"
- Medical necessity standards are typically based on benefit vs risk

Not enough / too much progress

Statement	Counter
• Won’t ever catch up to peers	• Tx objective is to maximize individual outcomes
• Didn’t make full-years' gains on standardized test	• Unrealistic expectation
• Deficits not severe enough to warrant tx	• Deficits require tx regardless of severity
• Fade plan or discharge requirements	• Cannot require in reports, must be individualized
• Met all goals – no need for continued therapy	• Other deficits likely exist
• Too much progress	• Quick responder, significant upside potential
• Too little progress	• Slow responders can still make meaningful medically necessary gains

Do not be afraid to flag a MHPAEA concern for further analysis

MHPAEA Disclosure Request

- Health plans must disclose, upon request, how they are complying with MHPAEA by providing the information and processes used for developing the limitations they place on coverage.

What is required?

- MHPAEA offers consumer protections against discrimination, and products that continue to discriminate based on Mental Health or Substance Use Disorder treatment status are not supposed to be sold. This disclosure should provide basic information about a company's compliance with MHPAEA.

Why it's important?

- MHPAEA Disclosure Template (available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template-draft-revised.pdf)

How do I request the disclosure?

How do I submit my parity disclosure request?

- Include with appeal
- Send to plan at appeal address
- Send to plan at address listed in SPD

What if I need help with the request or the response?

- Reach out to regulator, especially if no response after 30 days
- Reach out to an advocacy group (Kennedy Forum: www.dontdenyme.org)

Clinical evidence & literature

The Playbook does not tell you what evidence to use.

A mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice

Know what evidence you are relying on and why

There are CASP guidelines and other accepted standards of practice regarding ABA – why is yours better?

Step 4:

Receive the Response

Review the Response

Decide what happens next

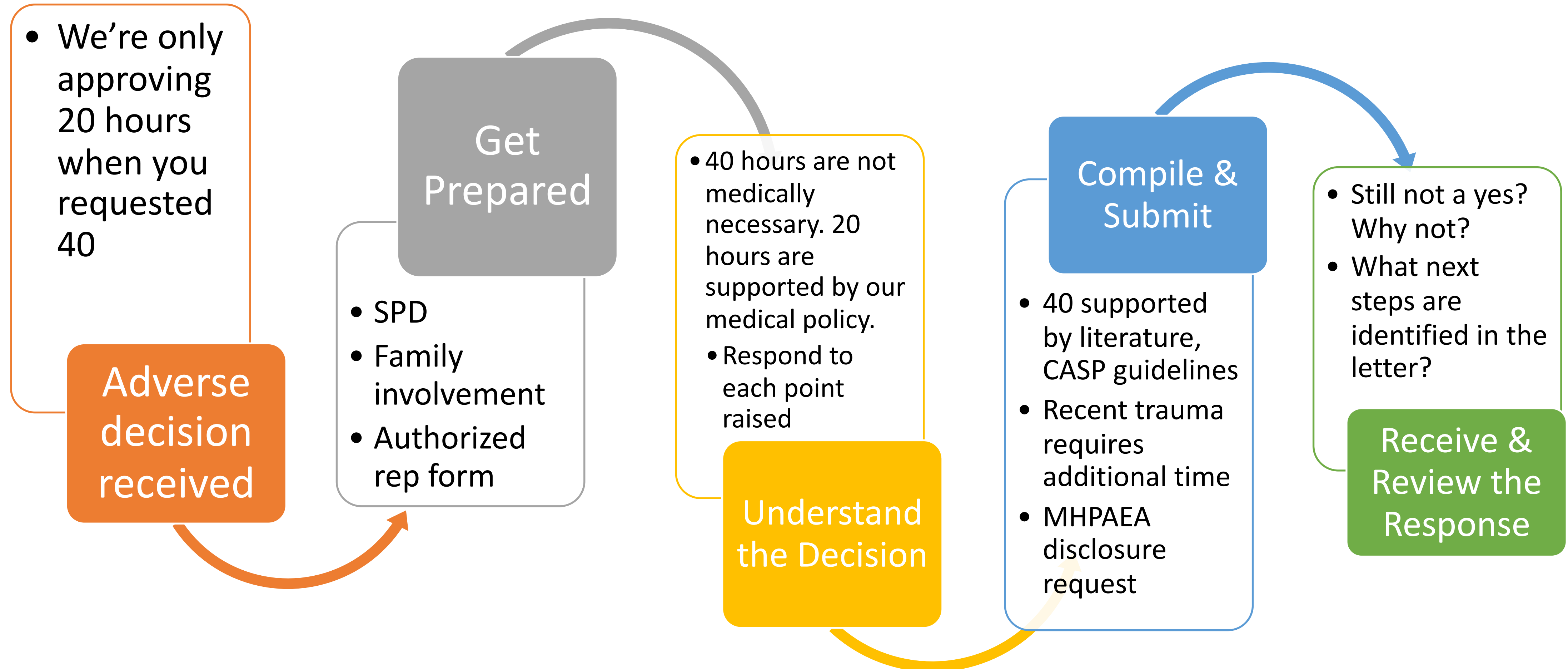
- 2nd level appeal? External Review?

See pg. 3

To appeal or not to appeal?

- What's the outcome beyond getting more hours?
  - Will this help show a trend to regulators?
  - Will this create overall systemic change?
  - How motivated is the family?
- What are the business considerations?
  - Do you keep providing services during the appeal?
    - Can you/your agency afford it?
    - What if the adverse benefit determination is upheld?
  - Is the juice worth the squeeze?
- DO NOT change your recommendation based on this decision.

Scenario 1: Fewer hours approved than requested



Adverse decision received

- Did you get it in writing?
- Did you have to fight to get it?
- Does it include instructions for next steps?
  - Peer-to-peer requirements?
  - Appeal rights and how to do it
  - How many levels of appeal?
  - When do you get to go to external review?
  - What medical necessity criteria were used?

Get Prepared

Audience Participation, please!

- Where do you get the SPD?
- What designation form do you use?
- What does the family want to do?
- Is there an appeal FORM?
  - Is it required?

Understand the Decision

Why is the company not saying yes?

- 40 hours are not medically necessary for this individual. Our reviewers used InterQual/MCG guidelines and determined that 40 hours are not medically necessary. As stated in the Member Benefits Booklet, services will only be approved if they meet the medical necessity criteria.

What do you see?
InterQual/MCG, **this** individual
Medical necessity
Member Benefits Booklet

What do you see?

That’s what goes in the letter

- Please provide the InterQual/MCG criteria used (as referenced in your letter) and how the reviewer applied each element to this case.
- The Member Benefits Booklet defines “medically necessary” as … which we followed when making our request. Specifically, we …
- Is **this** individual getting the same treatment as a prior individual who has different needs?

Write

- In a letter dated September xxxx (see Ex. G), BCBS notified our offices that the *medically necessary* prescribed treatment for the client was partially denied, citing that "ABA does not meet the necessary criteria for the following reasons: The provider is requesting approximately xx hours of treatment per week. The requested hours of treatment are not medically indicated given the member's level of functioning and stated difficulties." Another letter, dated March xxxx, stated that, "…additional visits are deemed not medically-necessary and thus are excluded from coverage, in accordance with the member's health benefits plan" (see Ex. O). The provider strongly disagrees with that determination as anything less than the medically-necessary prescribed dosage of treatment will likely jeopardize his ability to gain maximum function. *All* of the requested hours are *medically necessary* and appropriate.

Write – use research to support your rationale

- These findings are of particular importance when considering the client's unique and individualized circumstances. Granpeesheh et al.'s (2009) results add strength to the generally accepted rule that *early* intervention is a critical factor when considering treatment for children with ASD. Given that the client is a young child with ASD, and is, by definition, developmentally delayed, it is the provider's ethical and professional duty to implement a behavioral intervention that aims to increase his rate of development to be greater than that of his typically developing peers. Sadly, if the gap between his developmental age and chronological age increases, remediation of the core symptoms of ASD will become increasingly unlikely (Howard, Sparkman Cohen, Green, &. Stanislaw, 2005). Granpeesheh et al. (2009) provides further evidence by showing that, per unit of time, behavioral interventions produce more efficient acquisition of skills for younger children with ASD, thus accentuating the critical need for intense (40 hours per week or more) and early (younger than seven years of age) intervention.

Write – address their medical necessity guidelines

- BCBS's adoption and implementation of MCG Guidelines is improper and inappropriate.
  - Although the denial letter states that a number of sources have been used to determine MCG Guidelines and that "all" policies are available for viewing on the BCBS website, only one source (Volkmar et al., 2014) is found on the website.
  - The MCG Guidelines seem to be loosely based on this journal article, but some of the BCBS criteria to determine medical necessity differ from the authors' clearly stated recommendations.
  - BCBS's use of *some* of the authors' recommendations in making a checklist where *all* of their criteria must be met to determine medical necessity does not indicate that consideration is being made on a "case-by-case basis," and, thus, violates MHPAEA.
  - Several items in the MCG requirements have been satisfied although the denial letter states that they are "not met." Other items have been determined to be "not met," although BCBS's rationale is subjective or based on circular reasoning.

Write – address any specific denial reasons

- The denial letter states that one criterion that was not met by the providers was [a lack of] “Diagnosis of Autism Spectrum Disorder using one or more validated assessment tools (e.g., DSM-5 severity levels rating, Autism Diagnostic Observation Schedule (ADOS), Autism Diagnostic Interview (ADI-R), Childhood Rating Scale (CARS), Gilliam Autism Rating Scale (GARS) (see Ex O);” careful review of the Volkmar et al. (2014) article lists some of those same assessment tools, some different ones, and *clearly* states that “The use of such instruments supplements, but *does not replace*, informed clinical judgment” (see Ex. P). The client’s diagnosis was given by Dr. xxxxxxx Ph.D., Clinical Psychologist at the xxxxxxx Medical Center; the diagnosis was more recently verified by Dr. xxxxxxx (who also wrote a script for xxx hours per week of ABA treatment). Clearly, MCG has taken a *suggestion* given by the authors and turned it into a required criterion on their own; however, and as noted by Volkmar et al. (2014), the “informed clinical judgment” of two independent medical professionals confirms the client’s diagnosis and should be the determinants of treatment intensity and dosage, along with his treating clinicians at the Provider.

Write – address anything that violates regulations

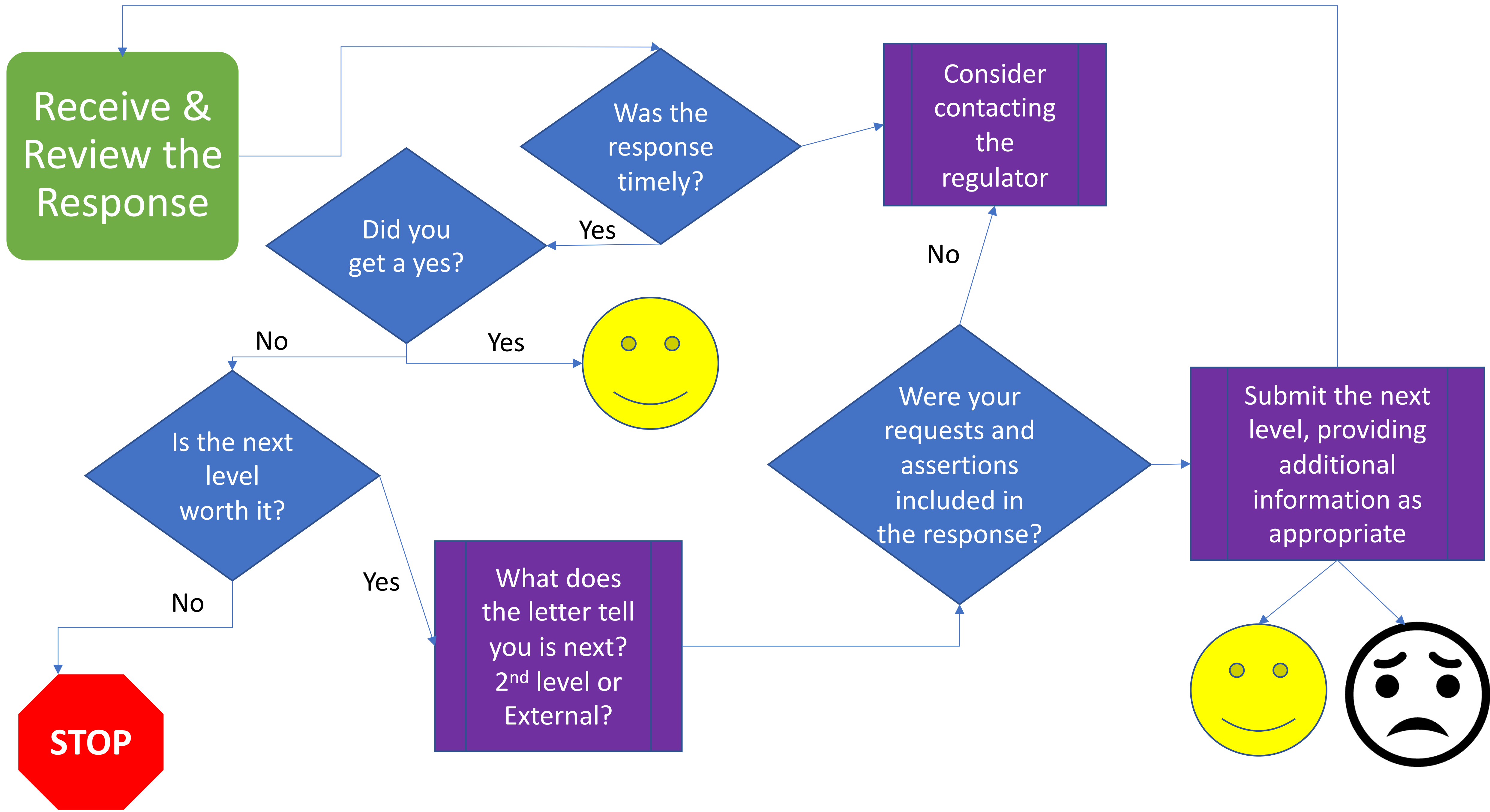
- By determining an inadequate treatment dosage based on **quantitative treatment limits (QTL)**, BCBS has violated MHPAEA and is obligated to overturn its decision.
  - Policy Guidelines stating that treatment not exceed 10 hours per week for the majority of patients functions as a quantitative treatment limit not applied to other medical/surgical conditions.
  - Policy Guidelines state that additional hours may be considered on a "case-by-case basis." However, the clinicians treating the client have provided *comprehensive and full* rationale as to why 40 hours per week is **medically-necessary;** if the information provided is not sufficient in satisfying the BCBS's requirements for unique and serious circumstances, the subjectivity and lack of specificity in making those determinations is functioning as a **non-quantitative treatment limit (NQTL**), also violating the MHPAEA.

Compile

- What does the letter require from you?
  - Appeal form?
  - Designation of provider as authorized representative?
  - Fax submission to a particular number? Mail? Portal?
- What evidence did you use to support your decision?
  - Peer reviewed articles?
  - CASP guidelines?
- MHPAEA Disclosure Request
- Copy of denial letter
- Literature review and bibliography, letters of support

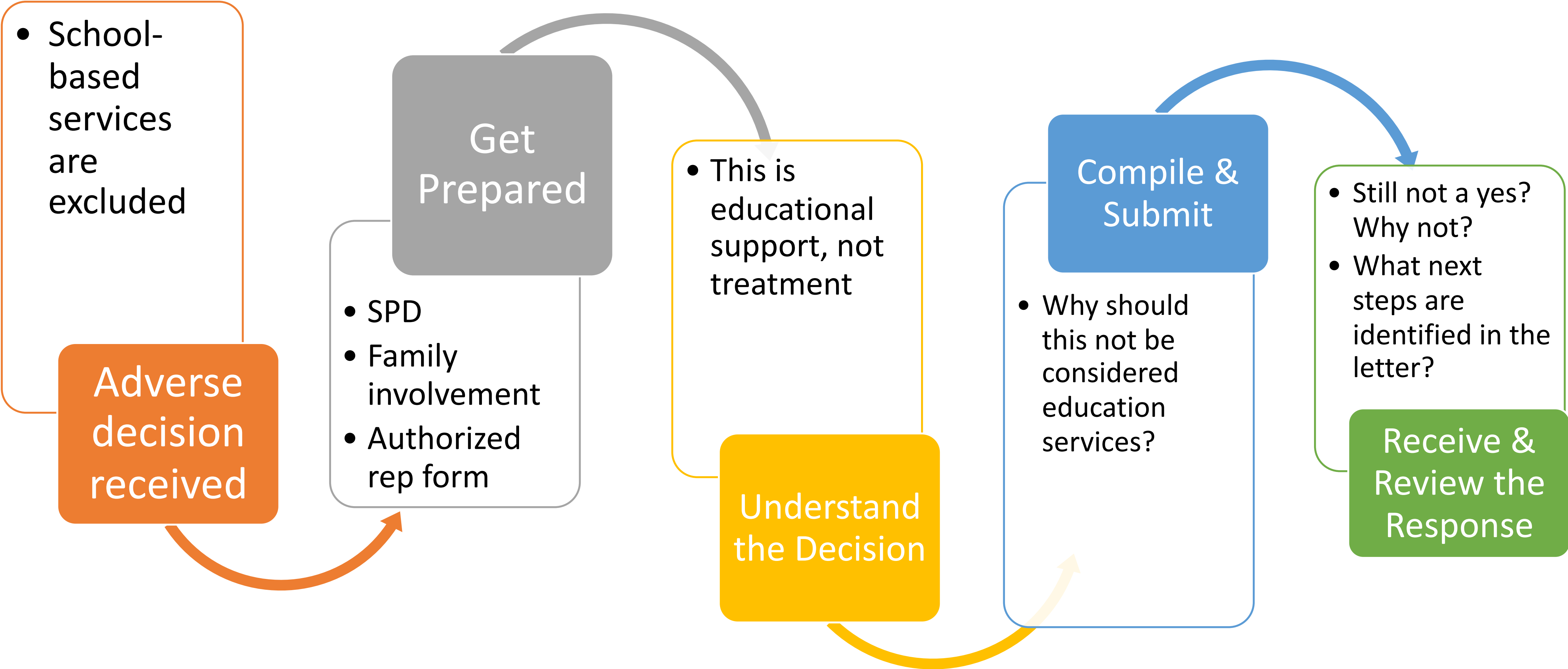
& Submit

Track and follow up!!



Receive & Review the Response
Was the response timely?
Consider contacting the regulator
Yes
Did you get a yes?
No
No
Yes
Is the next level worth it?
Were your requests and assertions included in the response?
Submit the next level, providing additional information as appropriate
Yes
No
What does the letter tell you is next? 2nd level or External?
STOP

Scenario 2: Inappropriate service location



Understand the Decision

Why is the company not saying yes?

- School-based services are educational in nature. The Member Benefit Booklet clearly states that educational services are excluded.

What do you see?
"Educational" Member Benefits Booklet Exclusion

Compile & Submit

Scenario 2: service location

- Arguments to support school-based ABA
  - Generalization necessary
  - Goals target core deficits, not academics
  - Peers needed to achieve social goals
  - Naturalistic setting, ideal for social facilitation, addressing behaviors, and basic social rules.
  - Location is necessary to achieve appropriate intensity

Compile & Submit

Scenario 2: service location

- Arguments to support school-based ABA
  - Based on individual needs
  - Supported in literature – 40 hour programs conducted across multiple settings, including school
  - Reasonable Accommodation under ADA
  - Contemplated in IDEA – insurance reimbursement to school districts
  - Categorical exclusion is MHPAEA concern

Sample letter – school-based denial

Include specifics about why important to this child

- #####
- HMO Help Center
- Re: ##### Expedited IMR request and supplemental information: #####, #####, DOB #####
- I have previously filed an IMR with the Department of Managed Health Care regarding #####'s denial of my request for medically necessary behavioral health treatment/ABA in a school setting for my son #####, who has autism. I understand the case it at Maximus for an IMR but on hold because I requested the opportunity to submit more supporting documentation.
- I would like to reiterate my request for an expedited IMR. ##### and individuals around him face an imminent health and safety risk if the intensity and location of the treatment is not immediately intensified and modified. The environment where ##### faces the most demands in in his kindergarten setting. The high demands cause more of the symptoms of his autism to be expressed and is where his maladaptive behaviors are the highest. We have long been concerned that #####s outbursts put himself, the other students and teachers at risk. Since we have filed this IMR our concerns have been validated. Last Friday January 18th, ##### bit one of his classmates. It was during a time when his ABA therapist was NOT in the classroom. In fact she had left one hour prior to the incident. While the bite was not serious and no skin was broken, it is an escalation of behaviors because treatment is not of sufficient intensity to address #####'s symptoms. We cannot risk further intensification of behaviors by waiting for a standard IMR. Further, this is strong evidence that the ABA is NOT addressing academic or educational skills but is addressing the core deficits and maladaptive behaviors due to his autism. We are requesting 35-40 hours of ABA for #####, 20 of which needs to be provided in the kindergarten classroom to address the core symptoms of #####'s autism. The classroom setting places the highest demands on ##### and therefore is the setting where he exhibits the most significant maladaptive

Sample letter – school-based denial (con't)

Include support letters Quote from them

- Please see the attached letter of medical necessity dated 1/16/2013 from #####'s neurologist Dr. ########, MD, that states the requested ABA is medically necessary, especially in the classroom setting.
- Please also find a letter attached from ##### dated 1/24/13 describing their expertise providing medical necessary ABA in a school setting and their description of how they would approach a child with #####'s deficits. As ##### states: [quotes added]
  - "Reducing maladaptive behaviors and increasing socially significant behaviors across multiple settings is medically necessary for all individuals with autism to ameliorate the symptoms of autism and optimize outcomes."
  - Further: "the vast majority of clinical studies in the medical literature demonstrating the efficacy of intensive ABA, including Ivaar Lovaas' original study, are based on ABA provided across settings, including the school setting. The school setting is critical for generalization and is often the setting where the most demands are placed on a child, resulting in more maladaptive behaviors. Based on the letter from the school Principal, this is apparently the case for #####." As his parent I can attest that this is definitely the case for #####. The principal has also stated the same in her letter attached.
- Please refer to the letter from the school Principal dates 12/31/2012 (previously attached and reattached here), clarifying that #####'s deficits are not educational or academic in nature, but rather are medical. The research confirms that the deficits and target areas for the treatment identified on her letter are core deficits of autism.

Sample letter – school-based denial (con't)

Reference clinical guidelines – include quotes

- The Clinical Treatment guidelines recently published by the Behavior Analysis Certification Board (Fall, 2012), the only NCAA accredited and only national certifying body of Board Certified Behavior Analysts, conclude that 30-40 hours of ABA is the clinical standard for an individual of #####'s age and goal profile. On page 22[1] of the guidelines, the BACB writes: "**If the goal of treatment is to bring the client's functioning to levels typical for that chronological age or maximize independence in multiple areas** (e.g., cognitive, social, adaptive)**…**
  - Comprehensive ABA requires intensive treatment, defined as 26-40 hours per week of direct treatment with adjustments based on individual client needs and response to treatment.
    - Treatment hours are most commonly in the range of 26-30 hours per week for children under 3 years of age and **30-40 hours per week for children over 3 years of age.**
  - Treatment hours do not include time spent with other professionals or family members specifically trained to extend and amplify the benefits of treatment."

Reference inadequate gains of current tx if applicable

- In addition to #######'s treatment recommendation being only half the standard of care, the December 2013 progress from ##### does not show significant progress with only 15 hours of treatment. Only goal areas of manding and eye contact have meaningful progress and there is no progress noted on reducing maladaptive behaviors. (See ##### Progress Report 12/21/12

- [1] Behavior Analyst Certification Board; Guidelines: Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorder; 2012 1-44.

Use citations

Sample letter – school-based denial (con't)

Reference literature supporting efficacy of 40 hr program over time

- For a child of #####'s age, medical literature supports an intensive program behavior intervention. The most effective intensity of treatment is 40 hours per week for 2-4 years. (Sallows and Gauptner 2005[1], American Academy of Pediatrics[2], CHDR paper. The CHDR white paper shows evidence for 30 and 40 hour per week EIBI programs is fair to good and for 20 hour per week is only fair. At only 5 years old, ##### is still in the optimal age window where his treatment outcomes can be optimized with intensive treatment. While individuals with autism certainly benefit from ABA if delivered when they are older, the ABA is more effective the younger the child. Therefore delivering anything other than the standard of care 40 hours per week of ABA therapy would likely be harmful to ##### by reducing his outcomes and potential for maximizing functioning. SB 946 requires BHT that "improves functioning to the maximum extent practicable," which certainly is the standard of care 40 hours per week. Further, it is important that #####'s maladaptive behaviors in school be resolved in his first year of formal education before the behaviors are ingrained and more difficult to reverse and before he gets behind academically because the behaviors interfere with his ability to access the curriculum. The behaviors need to be addressed now when they are only medically necessary, before they cause educational problems.
- Literature also supports that individuals with autism have difficulty generalizing skills across settings. Therefore it is important that ##### receive the intensive ABA treatment across settings to ensure generalization. The intensity should be proportional to the intensity of his maladaptive behaviors – highest at preschool, next in day care, and least at home. Therefore our request is 40 hours per week comprised of 20 hours in Kindergarten, 15 hours in day care and 5 hours at home.

Reference literature supporting difficulty generalizing

- [1] Sallows & Gauptner; Intensive Behavioral Services for Children With Autism: Four Year Outcomes and Predictors, American Journal of Mental Retardation, Vol. 110, No. 6, November, 2007, 417-438.
- [2] Scott M. Myers, Chris Plauche Johnson and the Council on Children with Disabilities, "Management of Children with Autism Spectrum Disorders", Pediatrics published online October 29, 2007; DOI: 10.1542/peds.2007-2362

Sample letter – school-based denial (con't)

Reference literature full of ABA in school settings, may be impossible to provide sufficient intensity without school site

- In all of the clinical literature, the studies showing the efficacy of 40 hours per week of ABA, the ABA is delivered across settings, including in the school setting. It is not possible to deliver 40 hours of ABA to school aged children without delivering a significant number of hours in a school setting. The 40 hour intensity is medically necessary, and a significant portion of that time being delivered on a school site is a necessary part of providing the standard of care and achieving optimal outcomes.
  - Eikeseth 2007[1] specifically compares the efficacy of behavioral (Lovaas based ABA) to an eclectic approach for individuals commencing treatment between ages 4 and 7, #####'s age. Both behavioral and eclectic treatment took place in public kindergartens and elementary schools for typically developing children (#####'s school setting). The treatment took place during all the kindergarten hours, with in individual sessions or therapy in the mainstreamed classroom. After 1 year the behavioral/ABA group showed statistically significant improvement compared to the eclectic approach in IQ, all dimensions of Vineland adaptive scales including communication, socialization, daily living, maladaptive behaviors and composite, and two sections of the Achenbach behavioral checklist, social and aggressive. The differences between the groups increase over time. The 8 hour per week ABA in school offered by ##### is akin to the eclectic approach in this study and the requested full-time 20 hours per weekABA in the school setting is akin to the behavioral group in the study. The study results clearly demonstrate that the requested behavioral approach is much more efficacious than the eclectic approach ##### if offering.

Reference efficacy greater with intensive vs eclectic

- Further, the vast majority of goals developed by ##### are social in nature and therefore need to be addressed in a social setting. For ##### this is first Kindergarten, then day care, then home.

- [1] Eikeseth et al. Outcome for Children With Autism Who Began Intensive Behavioral Treatment Between Ages 4 and 7 A Comparison Controlled Study; Bebavior Modification Vol 31, No 3, May 3007, 264-278.

Sample letter – school-based denial (con't)

Include any other violations by health plan on case, e.g., no denial letter or other damaging statements, e.g., we have no school-based programs

- .....
- Further violations by #####
- ###### has never issued a denial of services even though they have not provided the services that were requested in the location they were requested. Any expression of dissatisfaction is to be handled as a grievance. Any modification of a request is to be handled as a denial. ##### has never sent a denial refusing to provide the ABA in the school setting as requested.
- ####### cannot and has not provide the hours approved/recommended: #####'s network therapists recommended 20 hours per week of ABA. However due to scheduling availability they have been unable to provide all the hours that have been approved. Further only 8 hours are provided in the classroom, and as documented above and in previous letters, his behaviors are escalating due to insufficient treatment intensity. Given ##### cannot even provide their recommended 20 hours, there is no way they will have capacity to provide the medically necessary 35-40, and they do not have school based expertise where 20+ hours needs to be delivered for maximum efficacy..
- ##### states it does not have a school based support program – and that ##### has already made an partial exception in #####'s case. We are concerned that while his therapist who is providing the medically necessary ABA has classroom experience, ##### states it does not have such a program. Therefore ##### and the Supervisors do not have competence in ABA based in school settings and the supervisor who is running the program does not have that experience. We would like a provider that is trained and experienced in providing medically necessary ABA in school setting.

Sample letter – school-based denial (con't)

Reference relevant state and federal statutes with quotes and citations

- Relevant Statutes:
- California law (H&S Code1374.72/Insurance Code 101445) requires health plans provide medically necessary treatment for autism. Medical literature supports behavioral health treatment as medically necessary and the standard of care for treating autism. The letters from Dr. ##### and #####, establish that the requested treatment is medically necessary for #####. The mental health parity law (CA H&S Code 1374.72/Insurance Code 101445) states "Every health care service plan contract… shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, . . . "severe mental illnesses" shall include: . . . Pervasive developmental disorder [PDD] or autism. . ." The new autism insurance law, H&S Code 1374.73/Insurance Code 101445.1, further confirms behavior health treatment, including applied behavior analysis, must be covered for PDD or autism.
- ALL the requirements of the new autism insurance law have been met – a diagnosis of autism, a prescription from a physician, supervision by a qualified autism service provider, being part of a treatment plan with time-limited, objective measures. There is no exclusion for any type of medically necessary treatment. The prescribed treatment under dispute is designed to ameliorate the core symptoms of my child's autism. The standard under the law is to maximize the functioning of my child to the maximum extent practicable.
- The California Legislature (W&I Code 14059.5) has defined "medically necessary" as all care which is "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain." Decades of peer-reviewed literature demonstrates ABA as medically necessary and clinically effective for PDD or autism.

Sample letter – school-based denial (con't)

Consider adding justification for expedited review

- California statute and regulations clearly states that a health plan/insurer much notify an enrollee/insured in writing of any delay, denial of modification of a treatment request in a timely manner and provide information about the appeals process. H&S Code 1386 (a) (5)/Insurance Code 10123.135 (h) (3). Further, any disputed healthcare service that has been denied, delayed or modified, in whole or part due to medical necessity is subject to an independent medical review through the regulatory department H&S Code1474.30 (d) / Insurance Code 10159 (k). The IMR shall be expedited if there is an imminent and serious health threat. H&S Code 1374.31/Insurance Code 10169.1.
- According to all related medical reports, including The American Academy of Pediatrics, it is critical to begin autism intervention services immediately.[1] Any delay in services is inappropriate care and can be detrimental for the child. The Department of Managed Health Care's justification for the emergency regulations for H&S 1374.73 published by the Department of Managed Health Care in September, 2012, clearly document the severe and immediate health threat caused by the denial, delay or modification of ABA for individuals with PDD or autism. An imminent and serious health threat under the Insurance Code Section 10123.135 (h) (2) includes circumstances where denial modification or delay of treatment "could jeopardize the insured's ability to regain maximum function," which is clearly the case here. Further Justice is aggressive to others and puts them in imminent danger if his treatment is denied.
- [1] (Meyers et. al., 2007)

Sample letter – school-based denial (con't)

Attach letters, assessments, and clinical articles as appropriate

- **Attachments:**
- Medical necessity letter from ##### dated 1/16/2013
- Medical necessity letter from ##### dated 1/24/2013
- Letter from Kindergarten Principal dated _December 31st 2012
- ##### Assessment dated 11/26/12 and progress report dated 12/21/12
- Select clinical articles supporting efficacy of intensive ABA over multiple years (Behavior Analyst Certification Board Clinical Guidelines 2012), Eikeseth et al 2007; CHDR White Paper 2008; Meyers et al 2007; Sallows and Gauptner 2005)

What ifs…

Flash Panel!

- What if the company denies for "not enough parent training?"

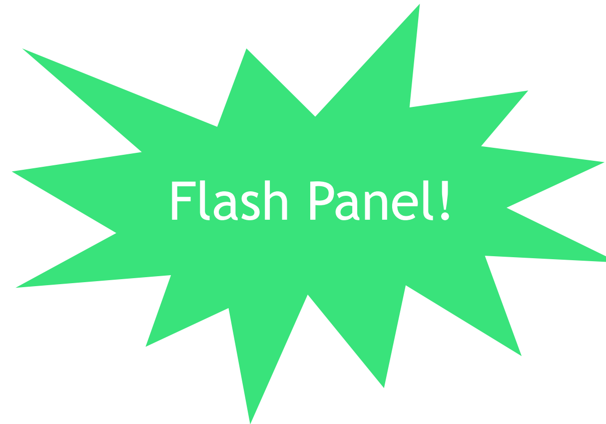
- Let's hear from an expert!

Write

While our standard treatment protocol includes twelve hours a week of data-based parent training and other involvement, we individualize our treatment plan based upon the optimal likely benefit for the child. It is widely acknowledged that parent-training in the home and community is a key component of optimum treatment outcomes. However, more than half of the published long-term outcome studies of EIBI with autism have involved center-based treatment to some extent. In many of these studies, the center-based EIBI was the only realistic service option for families who were facing multiple economic or social stresses, or are in an underserved area (urban or rural), or do not have the personal resources to continuously cope with the child's challenging behavior. In any of these situations, to force the home-based service delivery model may reduce the effectiveness, because it may be too compromised, or lead the family to forego access to treatment.

In contrast, the ABA studies in the attached bibliography show that children can still make socially important gains through center-based services, and some will make even better gains than some children in the home-based models. The long-term outcome studies all incorporated at least one phase of center-based treatment in the implementation of EIBI for at least some of the children studied. In many cases, the phase of center-based treatment consisted of the systematic ABA-based transition into a regular school program.

What ifs…



- What if the company does not allow group authorizations?
  - This impacts our ability to provide consistent treatment when people are out
- What if the regulators don’t help?
- What if the company doesn’t respond?
  - If plan does not respond to the issues you raised, in second appeal or external appeal, mention that (you are entitled to a full and fair review).
- The company’s denial process makes it impossible to bill secondary?

Make some noise!

Even if they're in state law

Look for soft caps, e.g., you're never going to get more than 20 hours, so don't bother asking for more.

Take it back…

Educate Staff

- All staff should understand the insurance environment, the definition of Medical Necessity and what the Authorization process is about

Care Alignment

- Ensure treatment plans always align with Generally Accepted Standards of Care and that clinicians are trained to conduct review calls

Appoint an appeal process manager

- This person should be notified as soon as an Adverse Determination occurs and coordinate with clinical team and family to discuss options

Give it time

- The process takes time, and it can get frustrating - internal appeals may get "lost," requests for information may be ignored. We are playing the long game.

Some resources

- https://www.autismspeaks.org/advocacy-news/importance-generally-accepted-standards-care?fbclid=IwAR2cetKLnwli1ovfsFBGZwJ5EmXbtsLiDVi30XJYEz55JEMfTnz_1cH_f-E

Time!

Thanks!