

MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL

POLICY TITLE: Autism Spectrum Disorders

POLICY STATEMENT:

The purpose of this document is to inform decision-making regarding the use of Applied Behavior Analysis (ABA) to treat medically necessary conditions so as to develop, maintain, or restore, to the maximum extent practicable, the functioning of individuals with Autism Spectrum Disorder (ASD) in ways that are both efficacious and cost effective.

This document applies to eligible individuals who meet the clinical criteria and who have coverage under the scope and limitations of their benefit package. Services which are medically appropriate or indicated may not be approved for coverage based on exclusions and limitations of the benefit package. This policy applies only to:

- Appendix A - Member contracts with applicable benefits that are subject to Wis. Stat. §632.895 (12m); or
- Appendix B - Member contracts with applicable benefits that are subject to Iowa HF 215 (LSB 1738HV (5) 87); or
- Appendix C - Member contracts with applicable benefits that are subject to Illinois Public Act 95-1005 (215 ILCS 356z.14).

DEFINITIONS:

Autism Spectrum Disorder (ASD) is a neurodevelopment disorder characterized by impaired social communication and interaction and atypical interests and behavioral patterns. ASD may be accompanied by other conditions, such as epilepsy and cognitive impairment. There is a DSM-V diagnosis of Autism Spectrum Disorder (ICD-10/ F84.0; F84.3 – F84.9) obtained by an appropriate provider (i.e. licensed psychologist/psychiatrist, physician, or other health care professional qualified to diagnose mental health conditions within their scope of practice).

"Behavioral" means interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.

"Therapy" means services, treatments, and strategies prescribed by a treating physician and provided by a qualified provider to improve the insured's condition or to achieve social, cognitive, communicative, self-care or behavioral goals that are clearly defined within the insured's treatment plan.

Applied Behavior Analysis (ABA) may be defined as: a scientifically supported model of treatment to remediate the functional impairments typically found in people with Autism Spectrum Disorder (ASD). It is a time-limited treatment that should result in progressive, measurable gains in functioning on a standardized measure.

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Intensive level services must be evidence-based, behavioral therapies provided to a child between the ages of 2 and 9 by a qualified health care provider. Early Intensive Behavioral Interventions incorporate principles of ABA but differ in methods and settings. Programs that are intensive range from 15 to 40 hours per week.

- State of Wisconsin intensive levels of service are limited to 4 cumulative years and will be calculated by counting number of hours. Minimum treatment hours (on average) is 20 hours per week. 20 hours x 52 weeks is 1040 hours. 1040 hours x 4 (years) is 4160 hours.

Non-intensive level services must be evidence-based therapies. A person with an autism spectrum disorder does not need to have previously received intensive-level services to qualify for non-intensive-level services.

PROCEDURE:

Requests for Autism Spectrum Disorder are reviewed on a case by case basis. Treatment of autism spectrum disorders is covered when ALL of the following are met:

1. The Member has a definitive diagnosis of an Autism Spectrum Disorder from a licensed clinician experienced in the diagnosis and treatment of autism; and
2. The diagnostic evaluation includes, without limitation, behavioral and cognitive evaluation, prenatal (if known) and perinatal history, developmental history and medical screening for comorbid medical issues; and
3. From initial evaluation through the entire course of treatment, ALL of the following apply:
 - a. Documentation supports the position that therapy will achieve functional gains beyond those expected as a result of growth and maturation, with clear evidence that symptoms are resulting in substantial impairment in daily functioning; and
 - b. There is a clear treatment plan with measurable goals that address the signs and symptoms of the illness; and
 - c. There isn't a less intensive or more appropriate level of service which can be safely and effectively provided; and
 - d. Treatment planning and medical record documentation reflects an appropriate level of Parent(s) and/or Guardian(s) involvement in the training of behavioral techniques and support for the generalization of treatment goals to the Member's environment; and
 - e. Requesting practitioner affirms that the planning and execution of the ABA course of care is consistent with nationally recognized treatment standards for the condition such as those set forth by the American Academy of Pediatrics; and
 - f. Applied Behavior Analysis, (ABA), services are provided by a person professionally certified by the national Behavior Analyst Certification Board or are performed under the supervision of a person professionally certified by the national Behavior Analyst Certification Board.
4. Coverage for the treatment of autism is subject to determinations of medical necessity following evidence based medical necessity guidelines from MAHP's current vendor. Coverage

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may be denied for a certain treatment if the treatment is not medically necessary or does not result in improved clinical status.

A treatment must be considered medically necessary if it is reasonably expected to:

- Prevent the onset of an illness, condition, injury, disease or disability;
- Reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or
- Help an individual achieve or maintain maximum functional activity in performing daily activities.

Experimental, Investigational or Unproven

ABA is considered experimental, investigational or unproven for all non-ASD indications.

Intensive behavioral interventions other than ABA are considered experimental, investigational or unproven.

Not Medically Necessary

Services that are considered primarily educational or vocational in nature or related to academic or work performance are considered not medically necessary.

Provision of ABA treatment is considered not medically necessary when delivered to the same individual, at the same time as any other treatment modality (e.g., ABA and speech therapy, or ABA and occupational therapy).

References: Applicable State Mandates
 Other Major Health Plan Guidelines

Original: 12/2017

Reviewed: 05/2020, 02/2023

Revised: 09/2019, 07/2021, 02/2024

Appendix A – WISCONSIN

STATE OF WISCONSIN

**Frequently Asked Questions on
Mandated Coverage for Autism Services**

OFFICE OF THE COMMISSIONER OF INSURANCE

PI-234 (R 12/2017)

What is the autism mandate?

Section 632.895 (12m) (c) 1., Wis. Stat., requires insurers to cover certain treatments for individuals with autism spectrum disorders. Specifically, it requires health insurers to provide coverage of at least \$50,000 for intensive-level services per year for up to 4 years adjusted annually by the Consumer Price Index (CPI). Insurers are also required to provide coverage of at least \$25,000 per year for nonintensive-level services adjusted annually by the CPI.

Each December, the Office of the Commissioner of Insurance (OCI) includes in this publication the adjusted coverage amount for intensive and nonintensive services in accordance with s. 632.895 (12m) (c) 1., Wis. Stat., and s. Ins 3.36 (12), Wis. Adm. Code. For calendar year 2018, insurers must provide coverage of at least \$61,181 for intensive-level services and \$30,590 for nonintensive-level services. The adjusted coverage amounts are effective for newly issued policies or on the first date of a modified, extended or renewed policy or certificate after January 1, 2018.

What health care coverage does the mandate apply to?

The statute applies to:

- Group and individual disability (health) insurance policies.
- Self-insured health plans sponsored by the state, county, city, town, village, or school district providing coverage to dependents.

The statute does NOT apply to:

- Disability (health) insurance policies covering only certain specified diseases such as cancer.
- A health care plan offered by a limited service health organization or preferred provider plan which is not also a defined network plan.
- A long-term care insurance policy.
- A Medicare replacement policy or a Medicare supplement policy.
- If your employer has a self-funded health benefit plan subject to federal jurisdiction, the mandate does not apply.
- Group health plans issued in another state covering employees in Wisconsin unless at least 25% of the employees covered under the plan reside in Wisconsin.

If you are not sure whether the mandate applies to you, please contact your insurance company or health plan.

What is the scope of the mandate?

If the health insurance policy was issued in Wisconsin, then the policy must include coverage for autism treatment complying with the mandate. A policy bought in Wisconsin must still comply with the mandate even if the insured moves out of Wisconsin. However, if a resident of another state buys a policy outside of Wisconsin, the policy does not need to comply with the mandate.

How do I get health care services covered under the mandate?

1. Determine whether the mandate applies to your plan or policy.
2. Determine whether your child qualifies. To qualify, your child needs a primary diagnosis of an autism spectrum disorder. Your child must also be older than 2 years of age and younger than 9 years of age for intensive-level services.

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3. Your child must have a prescription from a physician to receive treatment.
4. The treatments must be provided by a qualified provider. Contact your insurance company for listings of qualified providers.

What services does the autism mandate require insurers to cover?

The autism mandate provides coverage for intensive-level services and nonintensive-level services.

Intensive-Level Services

Intensive-level services must be evidence-based, behavioral therapies provided to a child between the ages of 2 and 9 by a qualified health care provider. Because the evidence on autism treatments is frequently updated, please consult your insurer if you have specific questions about what services are covered.

NonIntensive-Level Services

Nonintensive-level services must be evidence-based therapies. Similar to intensive-level services, please consult your insurer if you have specific questions about what services are covered. A person with an autism spectrum disorder does not need to have previously received intensive-level services to qualify for nonintensive-level services and there are no age limitations for receipt of services.

Age Requirements

The mandate provides coverage for a child's intensive-level services starting on his or her 2nd birthday; however, a child may not begin receiving intensive-level services after their 9th birthday. There are no age requirements for nonintensive-level services. The table below summarizes the differences between intensive- and nonintensive-level services.

	Intensive-Level Services	Nonintensive-Level Services
Annual Benefit*	At least \$50,000 for services provided	At least \$25,000 for services provided
Age Requirement	Must begin after 2 years old Must begin before 9 years old	None
Time Limit	Up to 4 years cumulative years	No limit
Minimum Treatment Hours	On average, 20 hours per week	None

*Annually adjusted by CPI and posted to the OCI Web site.

How is "behavioral therapy" defined?

"Behavioral" means interactive therapies targeting observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.

"Therapy" means services, treatments, and strategies prescribed by a treating physician and provided by a qualified provider to improve the insured's condition or to achieve social, cognitive, communicative, self-care or behavioral goals clearly defined within the insured's treatment plan.

Are any of my child's other health care services covered by the mandate?

No. Only services relating to the individual's autism spectrum disorder are covered by this mandate. These services must also meet the definition of either "intensive-level services" or "nonintensive-level services."

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When does insurance coverage for intensive-level treatment end?

Intensive-level services end when any of the following occur:

- The child has received a cumulative 4 years of intensive-level services.
- The child receives services, on average, less than 20 hours a week. (The average number of hours a week is calculated over a 6-month period.)
- It is determined by the supervising professional, after consulting with a physician, less treatment is medically appropriate.

How do I transition between intensive- and nonintensive-level services?

Once the intensive-level phase has ended, your insurer will notify you your coverage has changed. The notification must say the reason for the change in coverage. Once your child begins nonintensive-level services, he or she cannot resume intensive-level services later.

When does an adult with autism need to transition from their parent's insurance?

If a child is diagnosed with an autism spectrum disorder prior to turning 18 years of age and the child's condition qualifies as a handicapping condition, the child may remain on the parent's insurance provided the parents are able to provide the insurer sufficient supporting documentation. If the parents change employers and a child with an autism spectrum disorder is over 18 years of age but less than 26 years of age, the child should be eligible for coverage under their parents' insurance until the child's 26th birthday.

My child has already received intensive-level treatment paid for by my family. How much intensive-level treatment will my child be eligible for?

Coverage for intensive-level services may last up to 4 years total. If a child previously received, on average, more than 20 hours of treatment per week, the time counts against the 4 years of intensive-level services mandated by the statute. This includes treatment time paid for by the family, other states, or covered by previous insurers.

My child receives intensive services through the mandate and needs to have surgery. They will not be able to participate in intensive treatment for a month. Can they re-start intensive treatment?

Yes. Intensive-level treatments may be delayed if the child has a significant medical condition or surgery. Treatment may also be delayed if there is a catastrophic event preventing treatment. You need to notify your insurer when these situations happen.

What happens if I disagree with my insurance company about the medical necessity of treatment under the mandate?

An insurance company cannot deny a claim under the mandate due to medical necessity. The insurer can deny a claim if it believes the treatment is not supported by evidence. If you receive a denial for this reason, you can dispute the denial through the insurer's grievance process and an independent review process.

Is the diagnosis of autism covered under the mandate?

The cost of testing to reach a diagnosis must be covered by an insurer; however, it does not come out of the funds required under the mandate for that year. Other portions of the policy typically cover the cost of diagnosis but may also include copayments or deductibles.

Do I have to use providers in my health insurance plan?

Yes, if your plan requires you to use plan providers for coverage. Some plans permit you to receive services from out-of-network providers. If your plan permits you to see out-of-network providers for other conditions in your policy,

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they must also accept claims from out-of-network providers for autism treatments. Remember, your plan may have different copayments or deductibles for out-of-network providers than for in-network providers. If the plan uses only in-network providers, they may require you to use only their providers.

You may want to consult your insurer to consider finding an in-network provider. In-network providers may be more affordable.

I would like to have my child receive treatment from a provider who is not in my insurer's network of providers. Does the mandate require coverage in this situation?

No. You may be able to obtain out-of-network care through a referral from an in-network physician subject to approval by the insurer. However, as noted in the question above, you may be responsible for higher deductibles and copayments for non-network providers. If you have a dispute with your insurer about coverage, you should follow your insurer's grievance process. If the conflict is not resolved to your satisfaction or if you prefer, you may file a complaint with the Office of the Commissioner of Insurance. An online complaint form is available at <https://oci.access.wi.gov/complaints/public/>.

Do I have to get autism services prior authorized by my health insurer?

Generally, no. However, if your plan requires prior authorization for similar outpatient services, then you may be required to have autism services prior authorized. For health maintenance organizations (HMOs), you need prior authorization to receive services from out-of-network providers.

It may be beneficial to get prior authorization from your insurer because they can determine the most affordable way to provide services. It is also helpful to receive assurance the treatment will be covered.

How does payment work? Do I need to pay a deductible or other fee for my child to receive treatment?

The mandate requires certain insurance companies reimburse at least \$61,181 for intensive-level services and \$30,590 for nonintensive-level services. Reimbursement means the insurance company is responsible for paying the provider of services for providing intensive- or nonintensive-level services. Payment will be made after services are performed and a claim is submitted to the insurer. The insurer is not required to pay more than the amount mandated by the statute although the policy may provide more coverage.

An insurance company may apply deductibles, coinsurance, or copays that generally apply to other conditions covered under the policy or plan. The amount of the deductible, coinsurance or copays you (the consumer) pay is considered part of the coverage you receive. The insurer may not limit the number of treatment visits for therapies.

If a family faces a large financial burden because of high deductibles, copays, or coinsurance, can a provider reduce or waive the fees to families?

The mandate does not require a provider waive fees. Generally, providers are prohibited from reducing fees unless the total fee would impose an undue financial hardship on the individual insured.

Will insurance companies count the amount we spend on out-of-network providers toward meeting our deductible for other services?

Please consult your insurer to find out how they allocate out-of-pocket costs between different types of services in your health plan.

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The purpose of this publication is to summarize the statute and rule requiring health insurers to provide coverage for treatment of autism spectrum disorders. Please revisit the OCI Web site as these frequently asked questions may be revised and additional questions and answers added in the future for guidance and clarity.

The statute containing the autism mandate is available at <http://www.legis.state.wi.us/statutes/Stat0632.pdf>.

The rule is available at <https://oci.wi.gov/Documents/Regulation/0338fn10.pdf>.

You should contact your plan administrator to find out if your group coverage is fully insured or self-funded. You should also contact your insurer's customer service department to resolve questions regarding your coverage. If you are unable to receive a satisfactory response from your insurance company, you may file a complaint with OCI. OCI has an online complaint form available at <https://ociaccess.oci.wi.gov/complaints/public/> or you can call 1 800-263-8517 to request a complaint form be mailed to you.

If you have questions regarding this publication, please contact ocicomplaints@wisconsin.gov.

Disclaimer: This publication is intended only as a guide. It is a summary and is not intended as an OCI directive nor to interpret or address technical legal questions. Although efforts have been made to ensure this publication is current and accurate, information is subject to change on a regular basis without prior notice.

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Appendix B – IOWA

***ABA mandate does not currently apply to Iowa Small Groups**

SPECIAL HEALTH AND ACCIDENT INSURANCE COVERAGES, §514C.31514C.31 Applied behavior analysis for treatment of autism spectrum disorder — coverage.

1. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a group policy, contract, or plan providing for third-party payment or prepayment of health, medical, and surgical coverage benefits shall provide coverage benefits for applied behavior analysis provided by a practitioner to covered individuals under nineteen years of age for the treatment of autism spectrum disorder pursuant to a treatment plan if the policy, contract, or plan is either of the following:

a. A policy, contract, or plan issued by a carrier, as defined in [section 513B.2](#), to an employer who on at least fifty percent of the employer's working days during the preceding calendar year employed more than fifty full-time equivalent employees. In determining the number of full-time equivalent employees of an employer, employers who are affiliated or who are able to file a consolidated tax return for purposes of state taxation shall be considered one employer.

b. A plan established pursuant to [chapter 509A](#) for public employees other than employees of the state.

2. As used in [this section](#), unless the context otherwise requires:

a. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

b. "Autism spectrum disorder" means a complex neurodevelopmental medical disorder characterized by social impairment, communication difficulties, and restricted, repetitive, and stereotyped patterns of behavior.

c. "Practitioner" means any of the following:

(1) A physician licensed pursuant to [chapter 148](#).

(2) A psychologist licensed pursuant to [chapter 154B](#).

(3) A behavior analyst licensed pursuant to [chapter 154D](#).

d. "Treatment plan" means a plan for the treatment of an autism spectrum disorder developed by a licensed physician or licensed psychologist after a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American academy of pediatrics. "Treatment plan" includes supervisory services, subject to the provisions of [subsection 5](#).

3. *a.* The coverage for applied behavior analysis required pursuant to [this section](#) shall provide an annual maximum benefit of not less than the following:

(1) For an individual through age six, thirty-six thousand dollars per year.

(2) For an individual age seven through age thirteen, twenty-five thousand dollars per year.

(3) For an individual age fourteen through age eighteen, twelve thousand five hundred dollars per year.

b. Payments made under a group policy, contract, or plan subject to [this section](#) on behalf of a covered individual for any treatment other than applied behavior analysis shall not be applied toward the maximum benefit established under [this subsection](#).

4. Coverage required pursuant to [this section](#) may be subject to dollar limits, deductibles, copayments, or coinsurance provisions that apply to other medical and surgical services under the policy, contract, or plan, subject to the requirements of [subsection 3](#).

5. Coverage required pursuant to [this section](#) may be subject to care management provisions of the applicable policy, contract, or plan, including prior authorization, prior approval, and limits on the number of visits a covered individual may make for applied behavior analysis.

6. A carrier or plan may request a review of a treatment plan for a covered individual

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not more than once every three months during the first year of the treatment plan and not more than once every six months during every year thereafter, unless the carrier or plan and the covered individual's treating physician or psychologist execute an agreement that a more frequent review is necessary. An agreement giving a carrier or plan the right to review the treatment plan of a covered individual more frequently applies only to a particular covered individual receiving applied behavior analysis and does not apply to other individuals receiving applied behavior analysis from a practitioner. The cost of conducting a review under [this section](#) shall be paid by the carrier or plan. A carrier or plan shall not change the provisions of a treatment plan until the completion of a review of the treatment plan.

7. [This section](#) shall not be construed to limit benefits which are otherwise available to an individual under a group policy, contract, or plan.

8. [This section](#) shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

9. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance, or individual accident and sickness policies issued to individuals or to individual members of a member association.

10. [This section](#) applies to third-party provider payment contracts, policies, or plans specified in [subsection 1](#), paragraph "a" or to plans established pursuant to [chapter 509A](#) for public employees other than employees of the state, that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2018.

[2017 Acts, ch 18, §4; 2017 Acts, ch 148, §103; 2018 Acts, ch 1106, §13, 14](#)

Referred to in [§225D.1, 225D.2](#)

2018 amendment to subsection 2, paragraph c, subparagraph (3) takes effect January 1, 2019; 2018 Acts, ch 1106, §14

Subsection 2, paragraph c, subparagraph (3) amended

Appendix C – ILLINOIS

ILLINOIS INSURANCE CODE

Illinois statute, 215 ILCS 5/356z.14, provides additional mandates regarding insurance coverage for autism spectrum disorders. The following are frequently asked questions about the Illinois law.

Who Must Offer Autism Benefits that Meet the State's Additional Requirements?

All individual and group health insurance policies and HMO contracts (and voluntary health service organization contracts) must offer coverage for autism spectrum disorders. Health coverage provided to state, county, and municipal employees (and employees subject to the Schools Code (105 ILCS 5/1-1 *et seq.*)) must also provide benefits.

The Illinois Autism Coverage Law Does *Not* Apply to:

- Self-insured, non-public employers.
- Self-insured health and welfare plans, such as union plans.
- Insurance policies or trusts issued in other states.

NOTE: For HMOs, the law **does** apply to contracts written outside of Illinois if the HMO member is a resident of Illinois and the HMO has established a provider network in Illinois. To determine if your HMO coverage is required to provide treatment for autism, contact the HMO or check your certificate of coverage.

The Illinois statute does not change the autism-related benefits provided by public health care programs such as FamilyCare, All Kids, or the Illinois Early Intervention Program. Contact the specific program for more information about its autism coverage.

Who Is Covered?

Children under the age of 21 who have health coverage through an individual or group policy, as described above, will receive coverage for the **diagnosis** and **treatment** of autism spectrum disorders.

What Is Covered?

The law requires coverage for the diagnosis of autism spectrum disorders. For individuals diagnosed with an autism spectrum disorder, the law also requires coverage for the following treatments:

- Psychiatric care provided by a licensed psychiatrist;
- Psychological care provided by a licensed psychologist;
- Habilitative or rehabilitative care (counseling and treatment programs intended to develop, maintain, and restore the functioning of an individual, including Applied Behavioral Analysis ("ABA")); and
- Therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas:

- o Self-care and feeding
- o Pragmatic, receptive, and expressive language
- o Cognitive functioning
- o Applied behavioral analysis, intervention, and modification
- o Motor planning

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o Sensory processing

Insurance companies and HMOs are required to cover all medically necessary care prescribed by a physician, regardless of the type of provider delivering the treatment. If an individual has been diagnosed as having autism spectrum disorder, meeting the diagnostic criteria in place at the time of diagnosis, and treatment is determined medically necessary, then that individual shall remain eligible for coverage under Illinois law even if subsequent changes to the diagnostic criteria are adopted by the American Psychiatric Association. (215 ILCS 5/356z.14(h-5)).

What Are the Limits of Coverage Under the New Law?

The Illinois statute permitted insurers and HMOs to set an annual cap on autism-related benefits of \$36,000 which was increased annually for inflation. The Affordable Care Act, however, now bans annual caps on benefits for "essential benefits" such as mental health and behavioral services. For grandfathered group plans, this ban takes place upon renewal of the policy on or after January 1, 2014. However, individual grandfathered plans may still include an annual limit on autism-related services.

- The inflation-adjusted annual limit for 2014 is \$42,549.50 for individual grandfathered plans.
- The inflation adjusted annual limit for 2015 is \$43,825.99 for individual grandfathered plans.
- The inflation adjusted annual limit for 2016 is \$44,877.81 for individual grandfathered plans.

Insurance companies and HMOs must otherwise provide benefits for autism just as they do for other services, and may not impose dollar limits, deductibles, or copayments for the diagnosis or treatment of autism spectrum disorders which differ from the dollar limits, deductibles, or copayments established for other medical services covered (this is known as "parity"). Insurance companies are prohibited from limiting the number of visits to a physician or other service provider.

Is Autism Subject To Pre-Existing Condition Limitations?

Beginning January 1, 2014, the Affordable Care Act prohibits insurers in the individual and group markets (with the exception of grandfathered individual plans and transitional plans,) from imposing pre-existing condition exclusions on enrollees aged 19 or older. For enrollees under the age 19, this prohibition has been in effect since September 23, 2010.

Can Insurers Deny Claims Based on Medical Necessity?

Like coverage for other conditions, coverage for the treatment of autism is subject to insurance company determinations of medical necessity. An insurance company may deny coverage for a certain treatment if the treatment is not medically necessary or does not result in improved clinical status.

A treatment must be considered medically necessary if it is reasonably expected to:

- Prevent the onset of an illness, condition, injury, disease or disability;
- Reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or
- Help an individual achieve or maintain maximum functional activity in performing daily activities.

If an insurance company or HMO denies a claim based on an adverse determination of medical necessity, you may appeal the company's decision through its internal appeal process as

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provided in your insurance plan documentation. The company's decision must be based on a determination made by a physician with expertise in the most current and effective treatments for autism spectrum disorders. If you exhaust the company's internal appeal process and still end up with an adverse determination, then you may request an external review within four (4) months of the date of the final determination. Please note that the appeals and external review processes apply to fully insured Illinois policies, but do not apply to self-insured "grandfathered" policies under the ACA.

For information about how to request an external review and what conditions and exclusions apply, consult our External Review Fact Sheet:

http://insurance.illinois.gov/ExternalReview/Fact_sheet.pdf.

For More Information

Call Office of Consumer Health
Insurance toll free at (877) 527-9431
or visit <http://insurance.illinois.gov>