



## **INDIANA: Frequently Asked Questions About the Autism Insurance Reform Law**

### **What does Indiana's Autism Spectrum Disorder Insurance Mandate do?**

Broadly speaking, the insurance mandate requires insurance providers to cover treatment that is prescribed by a treating physician to an individual diagnosed with pervasive developmental disorder.

The specific terms and provisions of this law are described in more detail in this FAQ document.

### **When does the law requiring insurance companies to cover services for children with autism spectrum disorder go into effect?**

The law is currently in effect.

### **What happens if we get our insurance through a "small group" employer (50 or fewer) or through an employer that self-insures?**

The insurance mandate applies to any accident or health insurance policy issued on a large or small group basis. The law does not apply to self-insured companies.

### **Are there limits on what our private insurance is going to be required to cover?**

Dollar limits for services to treat pervasive developmental disorder that are less favorable than those applying to other physical illness are not allowed under the law. Services are limited to those prescribed by the insured's treating physician in accordance with a treatment plan. Additionally, therapies provided in the public school system cannot be covered under the mandate.

### **How does one appeal a denial of coverage or challenge noncompliance with the mandate?**

Each private insurer has an internal grievance or appeals process; if the internal appeals process is unsuccessful, one may request an external appeal. An insurance company is required to supply a covered individual with the necessary information to pursue this type of appeal.

Additionally, an individual may file a complaint with the Indiana Department of Insurance if he or she determines that an insurance provider is not complying with the mandate.

## **Covered Services**

## **What coverage is mandated by the law?**

The law does not specifically define which services must be covered. Broadly speaking, coverage is restricted to services prescribed by the individual's treating physician as laid out in a treatment plan. Generally, this coverage is limited to therapies that are commonly accepted by the medical community. These include types of behavior training, speech therapy, occupational therapy, physical therapy, and medications to address symptoms of ASD.

## **Is applied behavioral analysis (ABA) covered?**

Yes. ABA cannot be limited to a certain number of calendar days per year and must be provided year-round.

## **What is included in "pervasive developmental disorder" and will all of the Autism Spectrum diagnoses be covered?**

According to the law, pervasive developmental disorder means a neurological condition as defined by the most recent edition of the Diagnostic and Statistical Manual (DSM). These include: autistic disorder, Asperger's Syndrome, Rett Syndrome, Childhood Disintegration Disorder and Pervasive Development Disorder (Not Otherwise Specified).

## **Does Autism Spectrum Disorder (ASD) have to be the primary diagnosis for the child in order to qualify for coverage under the mandate?**

No, there is no requirement that ASD must be the "primary" diagnosis for the child to qualify for coverage.

## **Is Case Management covered?**

Case Management is not specifically listed as a mandated service.

## **Who determines what services are medically necessary?**

The patient's treating physician indicates on the treatment plan what services are necessary. It is recommended that treatment plans are limited to traditional therapies, those that are generally accepted by the medical community.

## **Will the new law require insurance companies to cover the cost of social groups? Must it be prescribed by a physician?**

The law does not include a "list" of covered services. Rather, the law requires coverage of services prescribed by the treating physician. Therefore, coverage under the bill will be determined by the insurance company based on the requirements of the law, whether the treatment is generally accepted by the medical community, whether the

treatment is medically necessary, and whether the treatment is ordered as part of the child's treatment plan by a licensed physician.

## **Private Insurance**

### **Does the mandate cover insurers selling individual policies?**

Private insurers selling individual policies must offer the individual the option to include coverage for ASDs, but this will likely only be available at additional premium costs.

### **Is an insurance company able to question my child's existing autism diagnosis?**

The law does not specifically specify whether your insurance company will be able to question your child's pre-existing diagnosis.

### **Will insurance companies be able to deny services if my child is not making "sufficient progress" or has reached a plateau in his/her progress?**

The law does not specifically address this issue but limits coverage to what is deemed necessary by the treating physician.

### **Will private insurers be developing their own medical necessity criteria?**

Private insurers will use their own medical necessity criteria. The patient's physician or psychologist indicates on the treatment plan what services are medically necessary, however there is a review process within the insurance company that may review the services ordered on the treatment plan.

### **If my insurance company denies my child's autism diagnostic or treatment services, where can I go for help?**

Families can appeal any denial or partial denial of an autism diagnostic or treatment service to your insurance company and obtain a decision on an expedited basis. If your appeal is denied by the insurance company, your family can appeal for an independent, external review. An insurance company is required to supply a covered individual with the necessary information to pursue an external appeal. If the independent external review denies your appeal, you may file a complaint with the Indiana Department of Insurance.

## **Qualified Providers and Licensing**

### **Which providers and services will be eligible for reimbursement under the Indiana Autism Insurance Mandate?**

Reimbursement is required for any mandated service provided pursuant to a autism treatment plan and which is provided by the insured's treating physician. The Care Plan by the prescribing physician must be submitted to the insurance provider. The physician can include the primary care doctor, developmental pediatrician, or psychiatrist, but you should check with your insurance provider to verify its requirements.

**How can I be sure that the health care provider has the certification or license necessary to diagnose my child's autism disorder and provide services?**

The law mandates that the treatment received is that prescribed by your child's physician. Typically the child's primary care doctor, developmental pediatrician, and psychiatrist will qualify, but you should check with your insurance company to ensure that the company recognizes the health care provider you are using as properly certified or licensed. Currently, Indiana does not have any specific certification or licensure requirements for ABA providers in particular, which is why it is important to check with your provider.

**When will licensing information for autism health care providers be available?**

Indiana does not have any specific certification or licensure requirements for autism health care providers. Licensing information may not become available.

**If my child is doing a home program, will services provided by the consultant be covered under the mandate?**

You should request that your consultant file claims directly with your insurer. Your insurer may require information regarding the credentials of the consultant and may require supervision by a psychologist. To ensure coverage, families are advised to use consultants with established credentials who work for recognized providers.

**Other Questions**

**Will representatives from commercial insurance plans participate in service plan meetings?**

The mandate does not specify whether or not representatives of the commercial insurance policies may participate in service plan meetings.

If you cannot find the question or answer you need, please contact DOI.

**What is "utilization review"?**

"Utilization review" refers to techniques used by health carriers to monitor the use of, or to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings. Some examples of techniques used include

ambulatory review, prospective review, retrospective review, second opinion, certification, concurrent review, case management or retrospective review. (Source: National Association of Insurance Commissioners)

### **What is “grievance review”?**

“Grievance review” refers to a health carrier’s internal processes for the resolution of covered persons’ complaints. The complaints may arise out of a utilization review decision or involve the availability, delivery or quality of health care services; claims payment, handling or reimbursement for health care services; or matters pertaining to the contractual relationship between a covered person or health carrier. Some states may call it an “internal appeal” process. (Source: National Association of Insurance Commissioners)