# Navigating Insurance – What you need to know.

| *Navigation Steps* | *Explanation of Each Navigational Step* |
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| Assessment/Diagnosis - symptoms identified needing treatment | Assessment/Diagnostic can involve reviewing documentation, observations, testing tools, input from other professionals, functional behavioral assessments and skills assessment to determine functioning levels. Educational diagnosis is not valid for accessing medical treatments through insurance. |
| Health Benefits Checked for intervention coverage | Contact your employer human resource or benefits department is the best place to get this information. You can also look at your plan's Certificate of Coverage/Summary of Benefits or any riders related to autism. |
| Interventions Prescribed or Recommended, Referrals made | Behavior analysts and licensed professionals acting within the scope of their licensure/certification determine treatment dosage (hours) based on professional judgment, research, and standard of care. *ABA Treatment for Autism Spectrum Disorders - Practice Guidelines for Healthcare Funders & Managers* http://www.apbahome.net/pdf/BACB_ASD_Gdlns.pdf |
| Treatment Goals & Plans Developed | Treatment plans identify the proposed goals and objectives, locations where treatments will occur, instructional methods to be used, definition for each skill to be achieved, and describes data collection procedures. |
| Does the intervention and treatment plan meet medical necessity? | Medically necessary generally refers to treatments that ameliorate or manage symptoms, improve functioning, and/or prevent regression or deterioration. Insurers have their own definitions of medical necessity. Elements of medical necessity include evidenced based interventions or generally medically accepted treatment, goals to remediate deficits, signs and symptoms of the condition being treated, and treatment plans that specify frequency, intensity and duration of treatment that is considered to be clinically appropriate. ABA is an evidenced based interventions and generally medically accepted treatment for symptoms of autism. |
| Prior Authorization | Authorizations for ABA treatment are usually for a six-month period of time. It there is concern by the insurer if ABA is an appropriate treatment for a certain individual, then three-month authorizations may by granted. If an insurer fails to authorize all of the treatment hours requested, file an appeal. The denial letter from the insurer includes instructions. |
| Annual Deductible, Coinsurance, Co-Pays & Annual Out-of-pocket maximum | Assure you understand the out-of-pocket cost you will incur moving forward with treatment. Insurers in other states have charged coinsurance and co-pays differently. Examples of co-pay charges are per session, per day or per week. If daily co-pay and your co-pay is $20 with 3 different treatment sessions on one day, you will have a $60 co-payment on that day. Cost can add up quickly. After July 2017, Medicaid could provide secondary insurance coverage for treatments and cover co-pays. Definitions: Annual deductible means you pay the full cost, up to your deductible amount; Co-Insurance means after reaching your annual deductible, you pay a percentage of the cost of the care; Co-pays is a flat dollar amount paid at time of service, and Annual out-of-pocket maximum means if you have reached maximum and plan pays 100%. |
| Treatment Provided, Medical Coding & Claims Submission | The Association of Professional Behavior Analysts developed an amazing Crosswalk document to understand medical coding for services provided in ABA treatment. A link to the Crosswalk document is located on the Navigating Insurance page. |
| On-going Treatment Requests | Treatment duration is determined by evaluating the individual's treatment outcomes. This evaluation can be conducted prior to the conclusion of an authorization period. Some individuals will continue to demonstrate medical necessity and require continued treatment across multiple authorization periods. |
| Delays, Denials, & Appeals | If claims are reasonable, received authorization and proper therapies are denied, be sure to appeal the denial. Each insurer has an internal grievance or appeals process that should be outlined in your policy handbook or employee information. Follow the procedures outlined by the insurer for an internal review. If you lose the internal review, file for an external review. If a third-party clinical review is called upon that reviewer should be a BCBA or Board Certified Behavior Analyst who has expertise in this area. We know appeals are time consuming, but they do set precedent and can support others getting services down the road. If you are not satisfied with the appeal results, you also have the option to file a complaint with the Department of Insurance if you feel your insurer is not complying with the law. http://insurance.illinois.gov/Complaints/UnderstandComplaintProcess.html |
| Discharge Planning, Transition Planning and Continuum of Care | |
| Payment Received from Insurer to Provider | |

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