Insurance Coverage for ABA in Texas

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About the Presenters

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Today’s Discussion

- Texas legislation related to ASD
- Becoming an in-network provider
- Verifying benefits & Pre-authorization
- Submitting insurance claims & appeals process
- Legal considerations
- Other considerations
- Perspectives coming from different backgrounds
- Implications on the future of our field
Texas State Mandates

- **Texas Autism Insurance Reform Law**
  - [http://www.autismspeaks.org/advocacy/state/texas](http://www.autismspeaks.org/advocacy/state/texas)
  - **HB1919 (2007)** requires insurance to provide coverage of medically necessary autism therapies to children with autism ages 3 to 5 years old.
  - **HB 451 (1/2010)** expanded this age cap to less than 10 years old. Unlimited coverage from diagnosis until 10th birthday.
  - **SB 1484 (9/2013)** eliminated age cap; added annual cap of $36,000 per year for children 10 and above (diagnosed before age 10).
Fully Insured versus Self Insured Policies

- **Fully insured**: employer pays a per-employee premium to an insurance company, and the insurance company assumes the risk of providing health coverage for insured events.

- **Self insured**: instead of purchasing health insurance from an insurance company and paying the insurer a per-employee premium, the employer acts as its own insurer.
  - Basically uses the money that it would have paid the insurance company and instead directly pays health care claims to providers. Self-insured plans often contract with an insurance company or other third party.
The Affordable Care Act and Texas


- For individual or small group policies, including through Texas' marketplace, will applied behavior analysis (ABA) be covered?

- Yes. Insurers that offer new coverage to individuals and small businesses are expected to cover ABA beginning in 2014.
Experiences from Texana Center
Kate Johnson-Patagoc
Texana Children’s Center for Autism

- Serving Children from age of diagnosis – 21
- Funding Sources: private pay, private insurance, DARS grant, 1115 Medicaid Waiver, TEA, School Contracts
- ABA treatment
  - Comprehensive: 15 to 32 hours per week of intensive intervention with BCBA or paraprofessional
  - Targeted: 2-4 hours per week with BCBA
- Served 63 children last year; currently serving 58 children (43 receive greater than 15 hrs per week of treatment)
- 36 children (62%) currently funded by private insurance.
Disclaimer: I am NOT the expert on insurance I am only speaking about my experience

- Texana is currently an in-network provider for:
  - United Behavioral Health/Optum Health
  - Cigna
  - Blue Cross Blue Shield
  - Tricare
  - Magellan
  - Humana/LifeSynch
Becoming an In-Network Provider

1. Obtain a NPI Number
2. Apply to an insurance company
3. Obtain a CAQH Provider ID
4. Complete credentialing process
5. Negotiate rates and secure a contract
6. Sign contract
7. Prepare for billing

*The entire process can take between 90-180 days per provider*
National Provider Identifier (NPI)

What is an NPI?
- A unique 10-digit ID issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).
- It is the required identifier for Medicare services, and is used by other payers, including commercial healthcare insurers.

Why do you need one?
- All individual HIPAA covered healthcare providers or organizations must obtain an NPI for use in all HIPAA standard transactions, even if a billing agency prepares the transaction.
- NPI is permanent and remains with the provider regardless of job or location.
- Generally recommended that both the individual provider and the organization both have NPI number. Depending on the provider, you may be asked for the agency’s NPI or the individual provider’s.
National Provider Identifier (NPI)

- How do you obtain an NPI?
  - Taxonomy Code for Behavior Analysts: 103K00000X
    - Behavior Analyst is a practitioner who specializes in analysis of behavior problems and development of appropriate intervention and treatment plans. A Behavior Analyst may work independently or with a team of professionals. Behavior Analysts often specialize in a particular area such as autism, developmental disabilities, mental health, geriatrics, or head trauma.
What is CAQH?
- A not-for-profit collaborative alliance of the nation’s leading health plans and networks.
- The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs.

What is a CAQH Provider ID?
- Unique number assigned to each provider
- Listed on the Universal Provider Database
- Each provider will have to re-attest about every 90 days.

Why is a CAQH Provider ID required?
- CAQH is an important part of the credentialing process.
- This involves the collection and verification of data from the provider regarding his/her education, training, experience, practice history, location, disclosure of any issues impacting the ability to provide care, and other background information.
Note: Before beginning the credentialing process, you must first apply to become an in-network provider with an insurance company.

After submitting the initial application, the insurance company will make an inquiry to the CAQH.

If no records are found, then you will be invited by CAQH to complete the credentialing process.

You must be invited. You can’t go on to CAQH and upload your information; you need to be invited by an insurance company who can generate you a CAQH number. Only then can you go to CAQH, complete the application.

https://upd.caqh.org/oas/
Example: United Behavioral Health/Optum Health

1. www.ubhonline.com
3. Complete Board Certified Behavior Analyst / Agency Network Participation Request Form for each provider.
4. Internal credentialing process
   a. UBH will gather CAQH information from UPD
5. Negotiate rates
6. Enter into a Letter of Agreement
   a. Approximately 90 days
7. Complete audit
   a. Can include: Facility site audit, ABA Record Review, and Supplemental ABA Tool
8. Sign contract
Verification of Coverage

- Person needs to retain a copy of insurance policy from your employer for the current year
- When calling an insurance provider:
  - Introduce yourself and write down the name of the person that you are speaking with.
  - Record a contact phone number as well as the time and date that the phone call was made.
  - Document all correspondence
  - Have Name, phone number, policy ID number, and/or group number, Policy holder Information & child information
Verification of Coverage

- Are Autism Spectrum Diagnoses covered?
- Are ABA services covered?
- If you are an out of network provider, does the policy have out of network benefits?
- Is policy self insured or fully insured?
- Does policy include a deductible and out of pocket (OOP) max?
  - If so, what has been paid toward the deductible/OOP?
  - What percentage will insurance cover after the deductible is met?
  - Does the OOP include the deductible?
  - OR does the policy include a co-pay?
Verification of Coverage

- Is pre-authorization required?
  - If so, what is the phone number for pre-authorization?
  - Who will authorize these services?
  - How often will pre-authorization be required?
- What CPT or HCPC code should be used for billing?
- Verify the electronic payer ID
- Address to send claims
- *We generally call a couple times to verify the information*
Pre-Authorization

- Most insurance companies now have an “autism department” (e.g., Optum-Care Advocates) that you will be able to work with.
- Ask for the contact number for pre-authorization during the verification process.
- Call 3 weeks prior to admission to get pre-authorization.
  - Some insurance companies have a 15 day window to complete
- Most companies will authorize a certain number of hours for assessment. After assessment, you will submit an initial treatment plan. After approval, authorization codes will be given for the next 3-6 months. Before the end of this period, you will send in an updated treatment plan in order to get authorization for the next 6 months.
  - Avoid all “education language”; insurance does not pay for school
  - You will not be given notice that a revised treatment plan is due. Mark your calendars!
Billing: CPT and HCPC Codes

- **CPT: Current Procedural Terminology**
  - CPT is largely private. Registered trademark of the American Medical Association (AMA)
  - The AMA has copyright ownership and does not wish to give the codes freely.
  - The CPT code describes medical, surgical, and diagnostic services
  - Designed to communicate uniform/standardized information/coding about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes

- CPT operates in three categories:
  - Standard CPT Codes
  - CPT Codes specific for performance measurement
  - CPT Codes that are specific for emerging technology.
Billing: CPT and HCPC Codes

- **HCPCS: Healthcare Common Procedure Coding System**
  - Is a set of healthcare procedure codes based on CPT
  - The Healthcare Portability and Protection Act of 1996 (HIPPA) mandated that all healthcare claims be reported using HCPCS
  - According to HIPPA, everyone must have access to HCPCS codes.

- HCPCS operates on three separate levels:
  - Level I is the AMA’s numeric CPT coding
  - Level II consists of alphanumeric codes that include non-physician services
  - Level III codes (also known as local codes) were developed by the state Medicaid agencies, Medicare contractors, and private insurers to be used in specific jurisdictions for specific programs
Currently Each Insurance Company Decides what Codes to Use for ABA

- Samples based on Texana Experience
  - Cigna: H2016, H0046, G9012, CPT Code-90853
  - Magellan: H0032, H2019; G9012
  - BCBS: CPT Code 96152
  - Aetna: CPT Code-96152, CPT Code-98960 with Modifiers
Submitting Billing Claims

- Written: CMS 1500
  - use red and white version not black and white version; prefer typed not handwritten
  - Methods to submit: mail, fax, scan/email
- Electronic billing
  - Subscribe to free online billing systems, such as ClaimMD [http://www.claimmd.com/services.html?gclid=CJeumom_xbUCFQXnnAodfTsAVw](http://www.claimmd.com/services.html?gclid=CJeumom_xbUCFQXnnAodfTsAVw)
  - Complete online CMS1500
  - Send directly to the insurance company/payer ID
Appeal Process: Not Simple or Clear

1. First Level: Make a phone call
2. Second Level: Formal Written Appeal to Appeals and Grievances Department
   - Fully insured: straightforward
   - Self insured: Show medical necessity (e.g., Doctor’s orders)
   - Ask for an appeal’s address and/or fax number; send information with a received receipt
3. Repeat steps 1 and 2 several time
4. Find name and phone number of insurance company’s president.
   - Start calling.
   - All companies will have some sort of “Presidential Appeal”
   - Send letter with supporting documentation which can include: phone logs, fax cover sheets, progress notes, data/graphs, original second level appeal and receipt, all relevant reports, doctor’s orders, etc.
Experiences from Central Texas Autism Center

Kelle Wood
Central Texas Autism Center

- It’s our 10 year anniversary!
- Serving children from diagnosis through adult
- Programs: Clinic, Home, Academy, School District Consulting
- Serve 25-30 clients per wk.- direct from BCBA’s/ BCABA’s in clinic, Behavior Techs in-home w/ 2-4 hrs. supervision/wk.
- Serve 25-30 school districts per year
- Funding: private pay, insurance, school contracts
- 78% funded through private insurance, an 20% increase from 1 year ago
Considerations

- Increased administrative costs
  - Time/ staff needed to process claims, in-house or 3rd party
  - Attorneys, insurance consultants
- Long claims processes may effect cash flow (budget enough cash on hand to handle 90-120 day processing time)
  - ABA is so new to the insurance world that we do not have standard CPT codes yet from the AMA.
  - Many insurance employees do not know how to bill/process our claims
    - Get the name and number of helpful case manager
  - Be prepared to deal with denials, partial payments, even when everything on your end was filed correctly
Texas Department of Insurance

- The **Texas Department of Insurance (TDI)** is the regulator of all Texas-based insurance companies and insurance companies that conduct business or commerce in the State of Texas.
- [http://www.tdi.texas.gov/](http://www.tdi.texas.gov/)
- For information on filing an insurance-related complaint, call the **Consumer Help Line** between 8 a.m. and 5 p.m., Central time, Monday-Friday.
  - 1-800-252-3439
- Link to the online complaint form:
  - [https://wwwapps.tdi.state.tx.us/inter/perlroot/consumer/complform/complform.html](https://wwwapps.tdi.state.tx.us/inter/perlroot/consumer/complform/complform.html)
Legal Considerations

- Get to know the Texas Department of Insurance (TDI) regulations
  - Prompt Pay Act
  - Underpayment Penalties
  - Limits on Overpayments (180 days)
  - Contracted vs. Billed Rates
    - Accounting adjusts to medical write-offs
- Clean Claims
  - Know each company's policies and procedures
Legal (Forms)

- Forms for you and your clients:
  - HIPAA Compliance
    - http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html
  - Assignment of Benefits
    - I hereby assign to ___ any insurance or other third-party Benefits available for healthcare services provided to me. I understand that ___ has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to ___, I agree to forward the Practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.
Legal (Forms)

- Verification of benefits- helpful tracking sheet
  - Are their limits to # of visits, dollar amount?
  - Deductible or co-insurance?
    - Parents will want to maximize their therapy hours to one day/ one co-pay
    - This can effect schedules/ hrs.
  - Pre-authorization needed? Prescription from MD needed/ received?
Legal (TDI)

- Parental Pre-Authorization for Medical Care
  - “For families who are ongoing patients of___, it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present during treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.”

- Patient Waiver for Non-Covered Services
  - “Your insurance does not pay for all of your healthcare costs. Some items and services are not considered “covered benefits” under your health insurance plan and as such, your insurance will not pay for these services....”
    - Ex: ARD Mtgs., Mileage

- Medical Release Waiver
  - To communicate with school, Dr.’s, other professionals, etc.
More Considerations

- Insurance companies can audit your business
  - To become a provider
  - To investigate any claims
For the Future of our Field

- **BREAKING NEWS** from the AMA!!!!!!
- Assessment codes released January 1, 2014, with an implementation date of July 1, 2014.
- Treatment codes implemented July 1, 2014, released electronically in the next month.
- Educational material and a more formal notice to precede the implementation and publication of the ABA codes in CPT 2015 codebook.
Experiences from Burkhart Center for Autism Education & Research & Texas Tech University

Wesley Dotson, Ph.D., BCBA
Considerations For the Future of our Field

- Ethical challenges for BCBA’s signing their name to work they have not personally done
- Treating in a group but filing 1:1
- Supervision by phone 1 hr./1x mo.
- Co-Treating with other professionals (SLP/OT) and mixing codes to maximize benefits
- Where there is funding, more BCBA arise
- More and newer BCBAs working independently
- Balance of Quality and Quantity
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