March 30, 2006

Bulletin 136

Insurance Coverage for Pervasive Developmental Disorders

This Bulletin is directed to all insurance companies that issue accident and sickness insurance policies as defined in IC 27-8-14.2-1 and to health maintenance organizations (HMOs) as defined in IC 27-13-1-19. Coverage for Pervasive Developmental Disorders (PDD) is a very complex issue. In 2001, the Indiana General Assembly passed P.L. 148-2001 adding IC 27-8-14.2 and IC 27-13-7-14.7. These provisions increased insurance coverage for persons suffering with PDD from what was available in the insurance market at that time. As is often the case, the bill that was passed contained compromises from the bills that were introduced, debated and amended. After a bill is passed and the statute is implemented it is not uncommon for interested persons to continue to dispute the meaning of the final language. The Department of Insurance is charged with implementing the provisions of Title 27. The Department must implement the statutes as they are written, giving meaning to each word of the statute. This Bulletin is intended to provide guidance to insurers and to consumers on contract language and administration of claims for the treatment of PDD as required by IC 27-8-14.2 and IC 27-13-7-14.7.

IC 27-8-14.2-4 requires that a group accident and sickness insurance policy must provide coverage for the treatment of PDD of an insured. IC 27-8-14.2-5 requires insurers that issue individual policies of accident and sickness insurance to offer to provide coverage for the treatment of PDD. And, IC 27-13-7-14.7 requires an HMO that provides basic health care services to provide services for the treatment of PDD of an enrollee. Neither insurers nor HMOs can deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, or reissue or otherwise terminate coverage on an individual solely because the individual is diagnosed with PDD.

A written treatment plan for each individual with PDD must be developed and signed by the treating physician. The treatment plan should be submitted to the insurer or HMO as soon as possible after its development to facilitate the payment of claims. If a non-physician recommends the treatment plan, it must be approved and signed by the treating physician. The Department of Insurance recognizes the insurer's or HMO's right to review the services prescribed under the treatment plan as to medical necessity. The insurer or HMO shall consult with the treating physician in its consideration of the treatment plan. Any challenge to medical necessity will be viewed as reasonable only if the review is by a specialist in the treatment of PDD. A specialist includes a clinical employee such as a medical director or PhD clinical administrator, provider or consultant of the insurer or HMO, and has specialized and current knowledge of PDD. Any challenge to medical necessity will be treated the same as any other grievance, following the grievance and appeals process as defined in IC 27-8-28, IC 27-8-29, IC 27-13-10, and IC 27-13-10.1.

The treatment plan must include all elements necessary for the insurer or HMO to appropriately pay claims. These elements include but are not limited to: a diagnosis, proposed treatment by type(s), frequency and duration of treatment(s), the anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated, and the treating physician's signature. The insurer must provide, in writing, its determination regarding coverage for the services and supplies prescribed by the treatment plan within thirty (30) days of the insurer or HMO receiving the treatment plan. The insurer or HMO shall provide specific contact information for provider or member questions and shall facilitate filing of claims. An insurer or HMO that fails to provide its determination on the treatment plan within 30 days may be subject to enforcement action under IC 27-4-1-4.5.

Recognizing that PDD is a neurological condition, services will be provided without interruption, as long as those services are consistent with the treatment plan and with medical necessity decisions. Service exclusions contained in the insurance policy or HMO contract that are inconsistent with the treatment plan will be considered invalid as to PDD. However, coverage of services may be subject to other general exclusions and limitations of the contract or benefit plan, such as coordination of benefits, participating provider requirements, services provided by family or household members, eligibility, appeals processes, and carved out services (e.g. if the employer elects not to provide pharmacy coverage for any employees). IC 27-8-14.2-4(b), IC 27-8-14.2-5(b) and IC 27-13-7-14.7(c) and (e) state that the coverage or services that must be offered "may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally" under the accident and sickness policy or contract with the health maintenance organization. This provision allows the insurer or HMO to apply dollar limits, deductibles, co-payments and coinsurance as long as the application is consistent with coverage for physical illness generally. The Department considers dollar limits and visit limits to be synonymous for the purposes of this bulletin.

It is the Department's position that behavioral therapies such as Applied Behavioral Analysis Services may not be subject to limitations that apply to therapies such as physical, occupational or speech therapy. Further, Indiana does not currently have a licensing requirement for persons who perform Applied Behavioral Analysis Services. It is, therefore, inappropriate at this time for an insurer or HMO to deny a claim based upon the fact that the provider of Applied Behavioral Analysis Services does not hold a license.

The insurer shall have the right to request an updated treatment plan not more than once every six (6) months from the treating physician to review medical necessity, unless the insurer or HMO and the provider agree that a more frequent review is necessary due to emerging clinical circumstances. The cost of obtaining an updated treatment plan at the request of the insurer or HMO shall be borne by the insurer or HMO. This review does not alter the requirements and rights described in IC 27-8-29, IC 27-13-10 and IC 27-13-10.1.

It is important for consumers to review their insurance coverage. For persons covered by individual policies, insurers are required to provide the insured with a copy of their insurance contract. For persons covered by group insurance policies or HMO contracts, the insurer or HMO is required to provide a copy of the certificate or evidence of coverage. While the insurer is not required to provide each covered person with a copy of the group insurance contract it should be made available if requested.

The insurance policies and HMO contracts affected by this Bulletin are required to be filed and approved by the Department. As guidance to the companies the Department approves the following language in its entirety:

1. Pervasive Development Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
2. Coverage for services will be provided as prescribed by the insured's treating physician in accordance with a treatment plan.
3. Any exclusion within the policy, certificate or contract that is inconsistent with the treatment plan does not apply.
4. The benefits for Pervasive Developmental Disorder will not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the accident and sickness insurance policy, certificate or HMO contract.

Any form in conflict with this Bulletin should be revised and filed with the Department. Policies, certificates, contracts, endorsements, or riders already approved for use may be used until the employer contract is amended, renewed, or terminated. However, the Department requires effective with the date of this Bulletin any insurer or HMO that is interpreting its policies more restrictively than the standards of this Bulletin shall adjudicate claims consistent with the provisions of the Bulletin. The Consumer Protection Unit of the Department encourages individuals to contact the Department with any concerns over the payment of claims. Each complaint will be reviewed individually for compliance with all applicable statutes.

INDIANA DEPARTMENT OF INSURANCE

James Atterholt, Commissioner