How to Appeal An Autism (Act 62) Insurance Assessment or Treatment Denial-*Fast Facts (For Private Insurance)*

- **A claim (whether pre-service or post-service) may be denied for any number of reasons. Some examples: the law does not apply to the insurance policy; the service is not medically necessary; the provider is not in the network; the service was not written in a treatment plan; and/or the treatment is experimental.**

- **The claim denial (called an adverse benefit determination) may be appealed first internally with the insurance company either on an expedited or standard (non-expedited) basis.**

- **After your insurance company completes the internal appeal, you will receive a written determination explaining the company's reasons for the decision. If you are not satisfied with the outcome, you may request an external review by an independent party, although some companies may require a second internal appeal before you are able to request an external review. Your insurance company must explain how to begin the external review process in their written determination of your internal appeal.**

- **External review is not available for all adverse benefit determinations. External review is available for adverse benefit determinations such as whether your care is medically necessary, where you receive care, what types of care are available to you, and rescissions of coverage. If your issue involves something else, external review is not available to you.**

- **External reviews are assigned to an independent review organization (IRO). Health insurance companies are required to contract with at least three (3) IROs and assign them to cases on a random or rotating basis. IROs are independent, do not work for your insurance company, and cannot receive financial incentives to side with one party over another.**

- **The decision of the IRO is final and binding on both you and the insurance company.**

- **The family (enrollee), or, with written authorization, the autism service provider or other person, may represent you in the appeal process.**

- **Keep good notes and copies of any written correspondence. Clear, complete, and detailed documentation, including names and dates, is always helpful. It can speak for you when you are not present, and it can be used to show what happened after your memory of the specific details fades.**

- **Appeals should include a cover letter with identifying information and your detailed position. You will need to specify whether you want this external appeal to be on an expedited or standard (non-expedited) basis. *See attached example.***

NOTE: The Autism Insurance Act (commonly known as Act 62) and this guidance apply to children and young adults under the age of 21 who are covered under a fully-insured health insurance policy offered or issued in Pennsylvania to a group of 51 or more employees. Act 62 generally requires that private group insurers provide $38,582 * per year for the diagnosis and treatment of an Autism Spectrum Disorder (ASD) subject to copayment, deductible, coinsurance, and other exclusions or limitations to the same extent as other medical services covered by the policy. For more details visit http://www.dhs.state.pa.us/foradults/autismservices/paautisminsuranceact62/autisminsuranceactfactsheet/index.htm

* This is the amount required for policies issued or renewed in 2017. The amount is adjusted annually; under Act 62.

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- **Clinical Justification - Documentation to explain your appeal:**
  - **Treatment plan and letter from the treating doctor or therapist explaining why the treatment should be covered**
  - **Explanation of benefits (EOB – this is the first document you receive from your insurance company that says how much of the claim is covered) and internal appeal denial determination, if applicable**
  - **Proof of child's age and insurance coverage**
  - **Proof of diagnosis of Autism Spectrum Disorder**

WHO, WHEN and HOW for Each Level and Type of ACT 62 Appeal

	STANDARD **Internal Appeal**	***EXPEDITED*** **Internal Appeal**	***STANDARD*** **External Review**	***EXPEDITED*** **External Review**
WHO	• Enrollees may represent themselves, or give written permission to provider, lawyer, or another person. • Internal review committee is established by the insurance company and includes a physician or licensed psychologist that would diagnose or treat children with ASD.		• Internal appeal determinations may be reviewed through an independent external review process by an independent review organization (IRO). • IROs consist of legal and medical experts to consider documents submitted by you and your insurance company. Some insurance companies may require a second internal appeal before you are able to request an external review.	
WHEN	**File appeal no later than six (6) months** from date of receiving a denial (adverse benefit determination) to start a standard internal appeal. The plan must make its decision within thirty (30) days for pre-service claims, and sixty (60) days if treatment has been completed.	Expedited reviews must be completed within seventy-two (72) hours of the request but can be completed more quickly if the medical condition requires more immediate action. This final decision can be delivered verbally but must be followed by a written notice within forty-eight (48) hours.	**File request for an external review within four (4) months** from date of internal appeal decision to request a standard independent external review. After an IRO is assigned, you must submit supporting documents within ten (10) business days. The IRO has **forty-five (45) days** after receiving the request to issue a written decision.	Expedited reviews must be completed within seventy-two (72) hours of the request but can be completed more quickly if the medical condition requires more immediate action. This final decision can be delivered verbally but must be followed by a written notice within forty-eight (48) hours. The decision of the IRO is final and binding against both you and the insurance company.
HOW	Enrollee, or other person, should send the insurance company a cover letter (example attached) requesting an internal appeal. See ***FAST FACTS*** for documents to include.	Enrollee, or other person, should call or send the insurance company a cover letter (example attached) requesting an expedited internal appeal. Make sure all documents (see list in **FAST FACTS**) are ready to go given the tight decision timeframe.	Your insurance company must explain how to begin the external review process in their written determination of your internal appeal.	