

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 may be appealed first internally with the insurance company either on an expedited or standard (non-expedited) basis.
- If the internal appeal is denied, that decision may be appealed to an independent external review organization called a Certified Review Entity, or CRE. Requests for External Review are submitted first to the insurance company which in turn will notify the Pennsylvania Insurance Department. The Insurance Department then assigns the appeal to a CRE on a rotational basis. CRE decisions are appealable to court.
- 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.*
- 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

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 \$38,276 * 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 2015. The amount is adjusted annually; under Act 62.



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

	<u>STANDARD</u> Internal Appeal	<u>EXPEDITED</u> Internal Appeal	<u>STANDARD</u> External Review	<u>EXPEDITED</u> External Review
WHO	<ul style="list-style-type: none"> 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. 		<ul style="list-style-type: none"> Internal appeal denials may be appealed for an independent external review by a Certified Review Entity (CRE) assigned by the Pennsylvania Insurance Department. The CRE panel consists of an independent physician, psychologist, or sometimes a lawyer. 	
WHEN	<p>File appeal at no later than forty-five (45) days from date of claim denial to start a standard internal appeal.</p> <p>The plan must make its decision within 30 days, and must notify enrollee or designee in writing within five (5) business days of the internal committee's decision.</p>	<p>File appeal two (2) business days from date of claim denial to start an expedited internal appeal.</p> <p>A plan must conduct an expedited internal review and issue its decision within (48) hours.</p>	<p>File appeal no later than fifteen (15) days from date of internal appeal decision to request a standard independent external review.</p> <p>After a CRE is assigned, the CRE has sixty (60) days after receiving the appeal to issue a written decision.</p>	<p>File appeal two (2) business days from date of expedited internal appeal decision to start an expedited external review with a CRE.</p> <p>After a CRE is assigned, the CRE has two (2) business days to issue its decision.</p>
HOW	<p>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.</p>	<p>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.</p>	<p>Enrollee, or designee should contact the insurance company to begin the External Review process. The insurance company will notify the Pennsylvania Insurance Department of the request for external review by a CRE.</p>	