The Council of Autism Service Providers

Insurance Coverage for Severe Behavior at Any Age

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CEO, The Council of Autism Service Providers

May 2021

CASP
The Council of Autism Service Providers

How Big is the Problem?

- About 16 million people in the US have a developmental disability, and about 12.5% (2 million) display destructive behavior.
- Largest cause of institutionalization in the U.S.

What Exactly is the Problem?

"The sad irony is that getting reimbursed for services for a child with severe destructive behavior is more complex and challenging than treating the child's behavior."

Wayne Fisher, BCBA-D, Children's Specialized Hospital-Rutgers University Center for Autism, Research, Education, and Services

"Getting coverage for severe behavior treatment should in some respects be easier than getting reimbursed for other autism interventions."

Dan Unumb, J.D., President, Autism Legal Resource Center

Is the problem the lack of coverage or the lack of available treatment professionals/centers?

What Resources Exist?

Intensive Center-Based or Residential Treatment Programs for Adolescents or Adults with Autism in the United States

- Alpine Learning Group – New Jersey -- www.alpinelearninggroup.org
- BSTN: Behavioral Services of Tennessee -- www.bstn.org
- Center for Applied Behavior Analysis – California -- www.centerforaba.com
- Devereaux Advanced Behavioral Health – Colorado, Connecticut, Florida, Massachusetts, New York, Pennsylvania -- www.devereux.org
- Eden II Programs – New Jersey -- eden2.org
- Elijah – New York - www.elija.org
- Erik's Ranch – Montana, Minnesota -- www.eriksranch.org
- Evergreen Center – Massachusetts -- www.evergreenctr.org/autism
- Kendall Center / Therapeutic Pathways – California -- www.tpathways.org
- Kennedy Krieger Institute – Maryland -- www.kennedykrieger.org/patient-care/patient-care-centers/center-autism-and-related-disorders
- Laurel Heights Hospital – Georgia -- laurelheightshospital.com/treatment-and-services/residential-treatment/
- LittleStar ABA Therapy – Indiana -- www.littlestaraba.org
- May Institute – Massachusetts -- www.mayinstitute.org
- Melmark – Massachusetts -- www.melmarkne.org
- Munroe Meyer Institute – Nebraska -- unmc.edu/mmi/departments/casd/index.html
- New England Center for Children – Massachusetts -- www.necc.org
- University of Iowa – Iowa -- uichildrens.org/medical-services/autism
- Virginia Institute of Autism – Virginia -- www.viaschool.org

CPT Codes for Severe Behavior

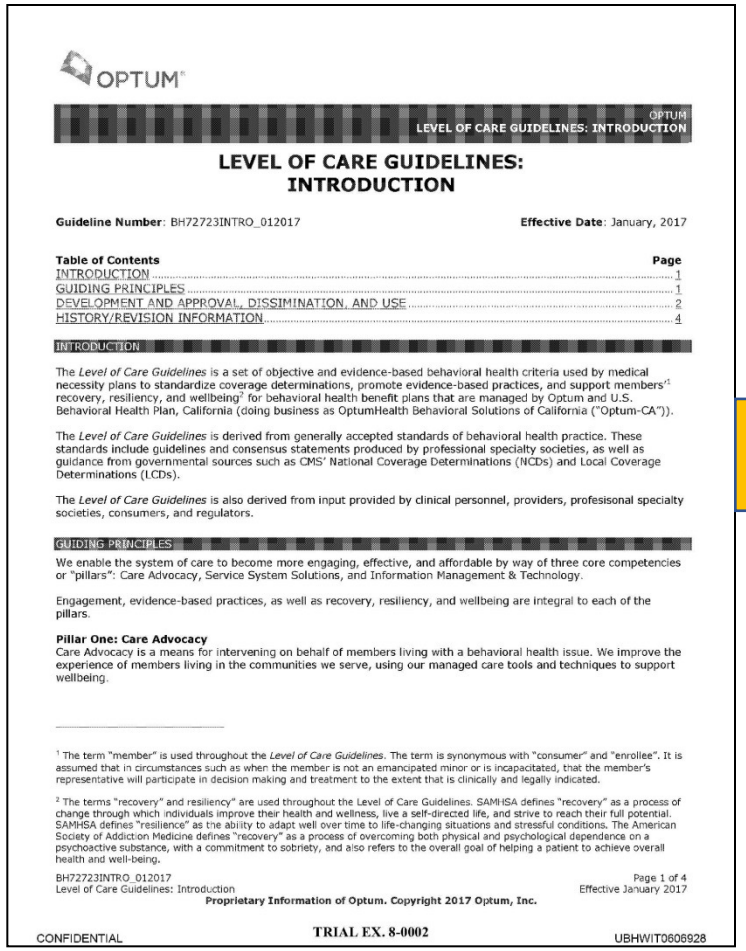
Behavior Identification Supporting Assessment (0362T).

- This code is used when two or more technicians, working under the direction of a qualified healthcare professional, implement one or more protocols the professional developed to assess the patient's severe destructive behavior. This code has four required components:
  - (a) the billing qualified healthcare professional must be onsite during the procedure;
  - (b) the professional directs a team of two or more technicians to conduct the procedure;
  - (c) the code is used exclusively with patients who display destructive behavior; and
  - (d) the procedure must be implemented in an environment that is customized to the patient's specific topographies of severe destructive behavior.
- Although the professional must be onsite during the procedure, the professional does not have to be face-to-face with the patient during the procedure. However, the professional must be able to respond immediately if the patient displays behavior that the technicians cannot safely manage. Finally, a customized environment is one that will ensure that professionals and technicians can maintain the safety of the patient, others, and the environment while implementing the procedure. The professional should conduct an assessment to evaluate a patient's safety risk, to determine the appropriateness of the target treatment environment, to identify any modifications to the treatment environment needed to maintain safety, and to describe session termination criteria. A customized environment for patients whose severe destructive behavior is likely to cause harm to the patient, others, or the environment likely is one that has padded treatment rooms and uniquely trained staff who regularly assess and treat severe destructive behavior. By contrast, patients whose destructive behavior does not pose a significant risk likely can be treated in the classroom or in the home, depending on the needed modifications (see Betz & Fisher, 2011 for a discussion of managing potential risks during a functional analysis).

CPT Codes for Severe Behavior

- *Temporary, Category III Codes*
- **Adaptive Behavior Treatment by Protocol (0373T).** This code is used when two or more technicians, working under the direction of a qualified healthcare professional, implement one or more protocols the professional developed to treat the patient's destructive behavior. As described for code 0362T, a professional who is on site and available must direct the service, at least two technicians must implement the service, the service is for patients with destructive behavior, and the professional and technicians conduct the services in a customized environment. The professional should conduct the same safety assessment described above.

Wit v. United Healthcare



OPTUM

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LEVEL OF CARE GUIDELINES: INTRODUCTION

LEVEL OF CARE GUIDELINES: INTRODUCTION

Guideline Number: BH72723INTRO_012017 **Effective Date**: January, 2017

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INTRODUCTION

The *Level of Care Guidelines* is a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members'[1] recovery, resiliency, and wellbeing[2] for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California ("Optum-CA")).

The *Level of Care Guidelines* is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

The *Level of Care Guidelines* is also derived from input provided by clinical personnel, providers, profesisonal specialty societies, consumers, and regulators.

GUIDING PRINCIPLES

We enable the system of care to become more engaging, effective, and affordable by way of three core competencies or "pillars": Care Advocacy, Service System Solutions, and Information Management & Technology.

Engagement, evidence-based practices, as well as recovery, resiliency, and wellbeing are integral to each of the pillars.

Pillar One: Care Advocacy
Care Advocacy is a means for intervening on behalf of members living with a behavioral health issue. We improve the experience of members living in the communities we serve, using our managed care tools and techniques to support wellbeing.

[1] The term "member" is used throughout the *Level of Care Guidelines*. The term is synonymous with "consumer" and "enrollee". It is assumed that in circumstances such as when the member is not an emancipated minor or is incapacitated, that the member's representative will participate in decision making and treatment to the extent that is clinically and legally indicated.

[2] The terms "recovery" and resiliency" are used throughout the Level of Care Guidelines. SAMHSA defines "recovery" as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA defines "resilience" as the ability to adapt well over time to life-changing situations and stressful conditions. The American Society of Addiction Medicine defines "recovery" as a process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety, and also refers to the overall goal of helping a patient to achieve overall health and well-being.

Coverage for Residential Care, Intensive Outpatient Care, Outpatient Care under Plan terms

- Claim was that UBH violated its fiduciary duty and wrongfully denied claims by using its own guidelines instead of generally accepted standards of care.

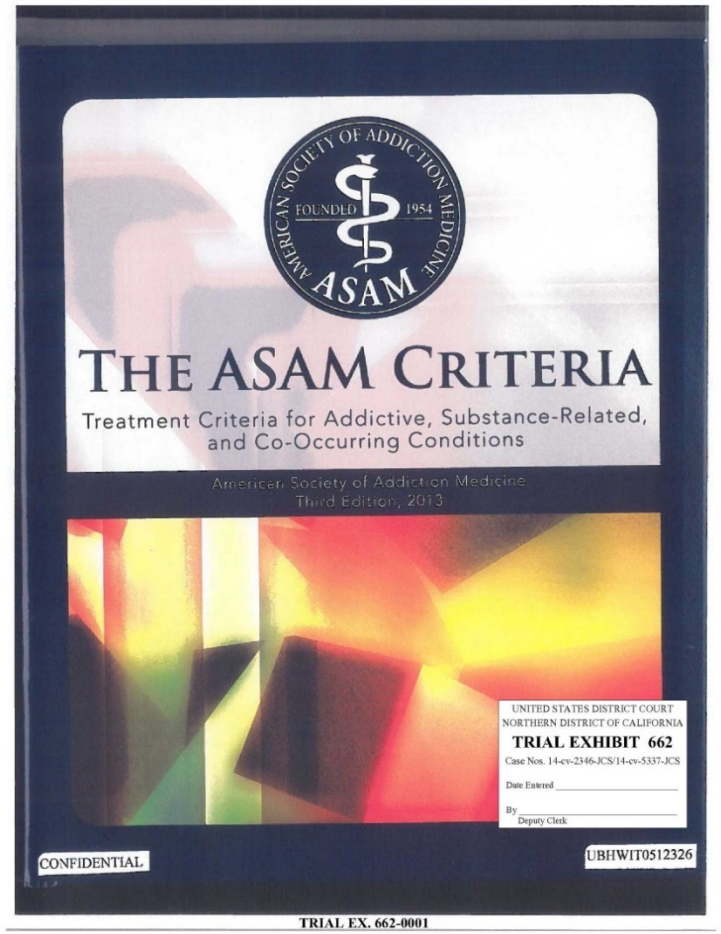
Two Key Questions in Wit

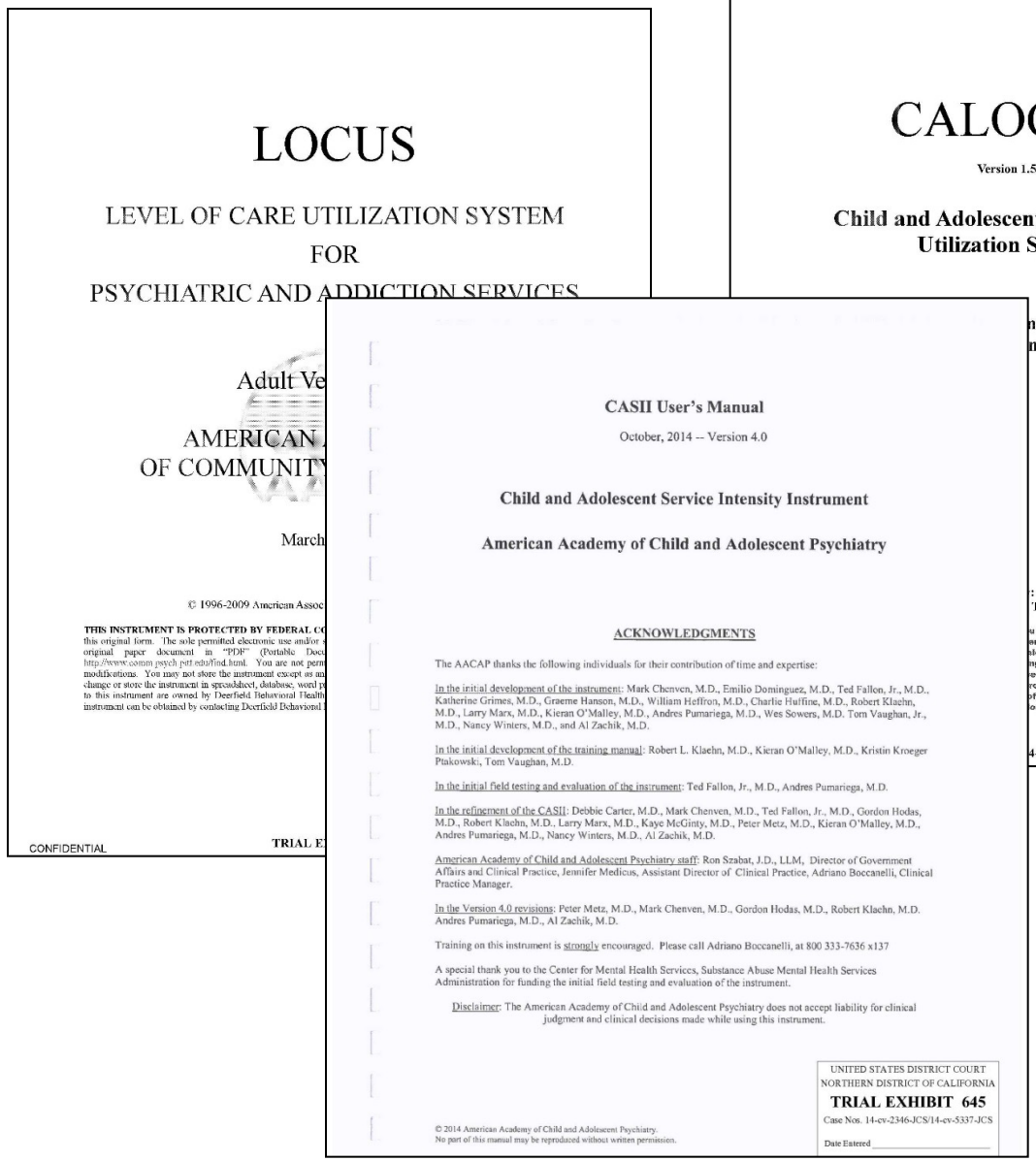
- What are "generally accepted standards of care"?

  Generally accepted standards of care are the standards that have achieved widespread acceptance among behavioral health professionals.

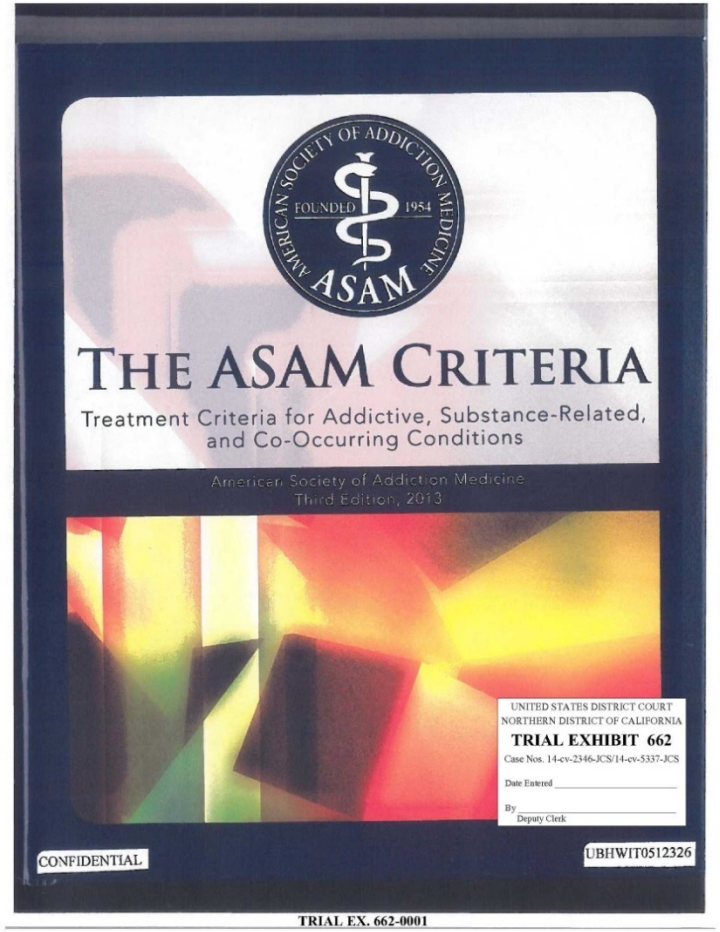
- Do generally accepted standards of care exist in the substance use disorder community?

The Evidence





Court's Liability Ruling

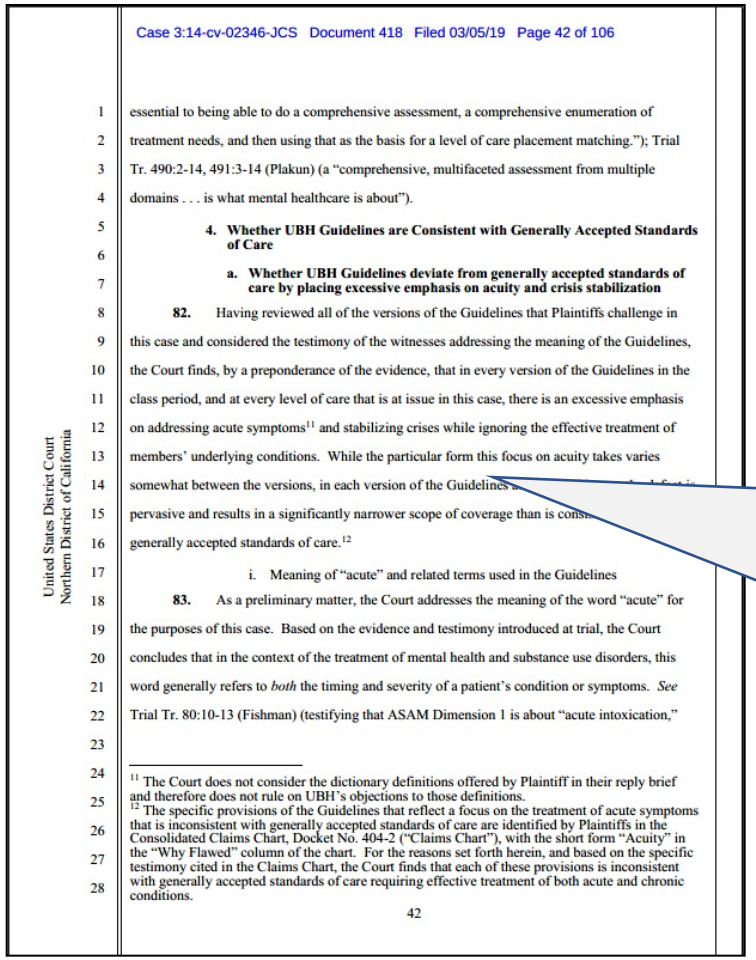


"The ASAM Criteria are the most widely accepted articulation of the generally accepted standards of care for how to conduct a comprehensive multidimensional assessment of a patient with substance related disorder, translate that into patient treatment needs and match those needs to the appropriate level of care."

Generally-Accepted Standards

- Treat the **underlying condition**, not only current symptoms
- Treat **co-occurring** conditions
- Treat at the least intensive level of care that is **safe** and **effective**
- Err on the side of **caution**
- Effective treatment includes services to **maintain function**
- Determine **duration** based on individual needs
- Take unique needs of **children/ adolescents** into account
- Make level of care decisions based on a **multidimensional assessment**

Court Ruling



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Northern District of California

essential to being able to do a comprehensive assessment, a comprehensive enumeration of treatment needs, and then using that as the basis for a level of care placement matching."); Trial Tr. 490:2-14, 491:3-14 (Plakun) (a "comprehensive, multifaceted assessment from multiple domains . . . is what mental healthcare is about").

4. Whether UBH Guidelines are Consistent with Generally Accepted Standards of Care

a. Whether UBH Guidelines deviate from generally accepted standards of care by placing excessive emphasis on acuity and crisis stabilization

82. Having reviewed all of the versions of the Guidelines that Plaintiffs challenge in this case and considered the testimony of the witnesses addressing the meaning of the Guidelines, the Court finds, by a preponderance of the evidence, that in every version of the Guidelines in the class period, and at every level of care that is at issue in this case, there is an excessive emphasis on addressing acute symptoms[11] and stabilizing crises while ignoring the effective treatment of members' underlying conditions. While the particular form this focus on acuity takes varies somewhat between the versions, in each version of the Guidelines [illegible] pervasive and results in a significantly narrower scope of coverage than is consi[illegible] generally accepted standards of care.[12]

i. Meaning of "acute" and related terms used in the Guidelines

83. As a preliminary matter, the Court addresses the meaning of the word "acute" for the purposes of this case. Based on the evidence and testimony introduced at trial, the Court concludes that in the context of the treatment of mental health and substance use disorders, this word generally refers to *both* the timing and severity of a patient's condition or symptoms. *See* Trial Tr. 80:10-13 (Fishman) (testifying that ASAM Dimension 1 is about "acute intoxication,"

[11] The Court does not consider the dictionary definitions offered by Plaintiff in their reply brief and therefore does not rule on UBH's objections to those definitions.

[12] The specific provisions of the Guidelines that reflect a focus on the treatment of acute symptoms that is inconsistent with generally accepted standards of care are identified by Plaintiffs in the Consolidated Claims Chart, Docket No. 404-2 ("Claims Chart"), with the short form "Acuity" in the "Why Flawed" column of the chart. For the reasons set forth herein, and based on the specific testimony cited in the Claims Chart, the Court finds that each of these provisions is inconsistent with generally accepted standards of care requiring effective treatment of both acute and chronic conditions.

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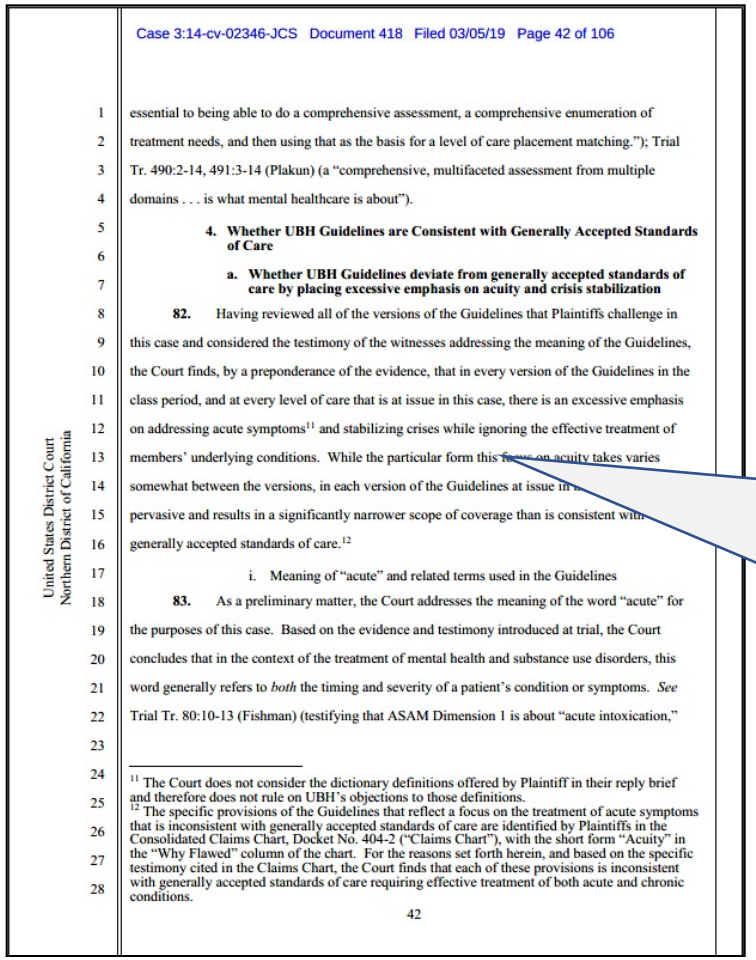
"[I]n every version of the Guidelines in the class period, and at every level of care that is at issue in this case, there is an **excessive emphasis on addressing acute symptoms** and stabilizing crises while ignoring the effective treatment of members' underlying conditions."

Court Ruling



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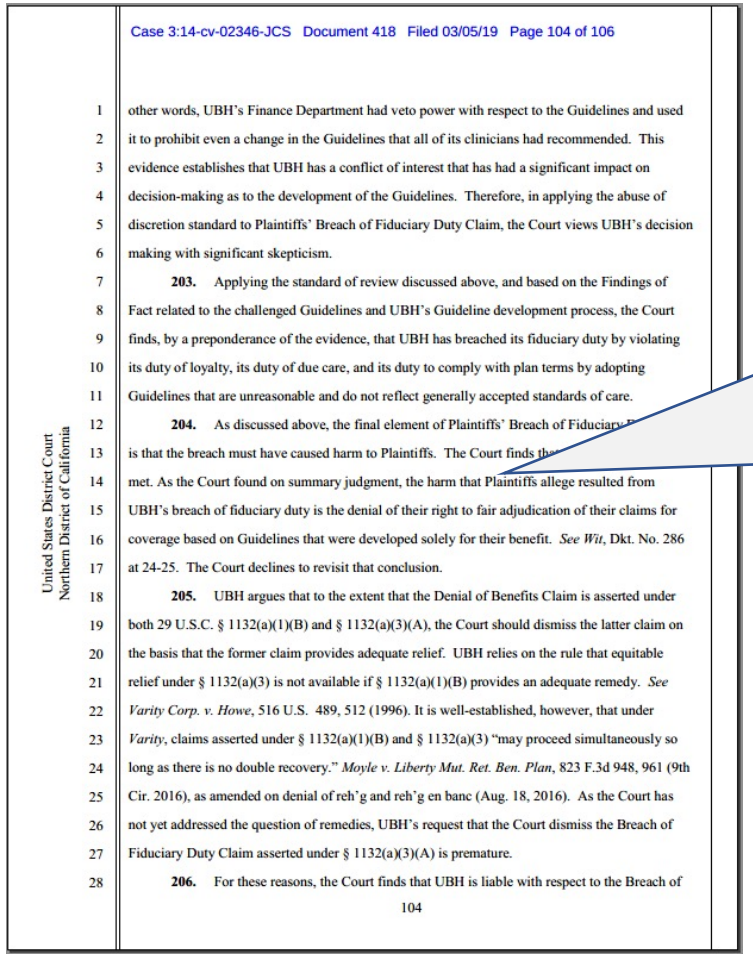
"[T]he **defect is pervasive** and results in a significantly narrower scope of coverage than is consistent with generally accepted standards of care."

Court Ruling



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other words, UBH's Finance Department had veto power with respect to the Guidelines and used it to prohibit even a change in the Guidelines that all of its clinicians had recommended. This evidence establishes that UBH has a conflict of interest that has had a significant impact on decision-making as to the development of the Guidelines. Therefore, in applying the abuse of discretion standard to Plaintiffs' Breach of Fiduciary Duty Claim, the Court views UBH's decision making with significant skepticism.

203. Applying the standard of review discussed above, and based on the Findings of Fact related to the challenged Guidelines and UBH's Guideline development process, the Court finds, by a preponderance of the evidence, that UBH has breached its fiduciary duty by violating its duty of loyalty, its duty of due care, and its duty to comply with plan terms by adopting Guidelines that are unreasonable and do not reflect generally accepted standards of care.

204. As discussed above, the final element of Plaintiffs' Breach of Fiduciary D
is that the breach must have caused harm to Plaintiffs. The Court finds that
met. As the Court found on summary judgment, the harm that Plaintiffs allege resulted from UBH's breach of fiduciary duty is the denial of their right to fair adjudication of their claims for coverage based on Guidelines that were developed solely for their benefit. *See Wit*, Dkt. No. 286 at 24-25. The Court declines to revisit that conclusion.

205. UBH argues that to the extent that the Denial of Benefits Claim is asserted under both 29 U.S.C. § 1132(a)(1)(B) and § 1132(a)(3)(A), the Court should dismiss the latter claim on the basis that the former claim provides adequate relief. UBH relies on the rule that equitable relief under § 1132(a)(3) is not available if § 1132(a)(1)(B) provides an adequate remedy. *See Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996). It is well-established, however, that under *Varity*, claims asserted under § 1132(a)(1)(B) and § 1132(a)(3) "may proceed simultaneously so long as there is no double recovery." *Moyle v. Liberty Mut. Ret. Ben. Plan*, 823 F.3d 948, 961 (9th Cir. 2016), as amended on denial of reh'g and reh'g en banc (Aug. 18, 2016). As the Court has not yet addressed the question of remedies, UBH's request that the Court dismiss the Breach of Fiduciary Duty Claim asserted under § 1132(a)(3)(A) is premature.

206. For these reasons, the Court finds that UBH is liable with respect to the Breach of

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"UBH has breached its fiduciary duty by violating its duty of loyalty, its duty of due care, and its duty to comply with plan terms by adopting Guidelines that are unreasonable and do not reflect generally accepted standards of care."

Court Ruling

- UBH owed duty to administer plans solely in the interest of the participants. Promised to cover all care in accordance with generally accepted standards.
- Violated obligations by using guidelines more restrictive than generally accepted standards and prioritizing cost savings over members interests.
- Court noted multiple sources for determining generally accepted standards of care, including:
  - peer-reviewed studies;
  - consensus guidelines from professional organizations (ex., American Association of Community Psychiatrists, American Academy of Child and Adolescent Psychiatry, APA)
  - guidelines and materials distributed by government agencies (ex., CMS).

Court Ruling

- Standards adopted and used by UBH were more restrictive than generally accepted standards.
  - Generally accepted standards include services to maintain functioning and prevent deterioration.
  - Multidimensional taking into account a wide range of patient information.
  - UBH standards placed excessive emphasis on acuity and crises stabilization.
  - UBH standards pushed patients to lower of care when safe to do so even if would be less effective.
- Care should not be denied on grounds that patient not responding to treatment where patient has potential to respond to treatment.
- UBH standards failed to take into account developmental state of children.
- Financial incentives "infected" Guideline development process

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When Challenging a Denial of Care, Make Sure Appropriate Standards Were Used

- Fast-forward one year
- California Legislature
- Senate Bill 855
- September 25, 2020

SB 855 California

- 1374.721. (a) A health care service plan . . .shall base any medical necessity determination or the utilization review criteria . . .on current generally accepted standards of mental health and substance use disorder care.
- (b) In conducting utilization review . . . shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the **nonprofit professional association** for the relevant clinical specialty.
- (c) In conducting utilization review . . . shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources.

CASP The Council of Autism Service Providers

Applied Behavior Analysis Treatment of Autism: Spectrum Disorder

Practice Guidelines for Healthcare Funders and Managers

SECOND EDITION

The BACB was the original publisher of this document. This and future editions will now be published by CASP.

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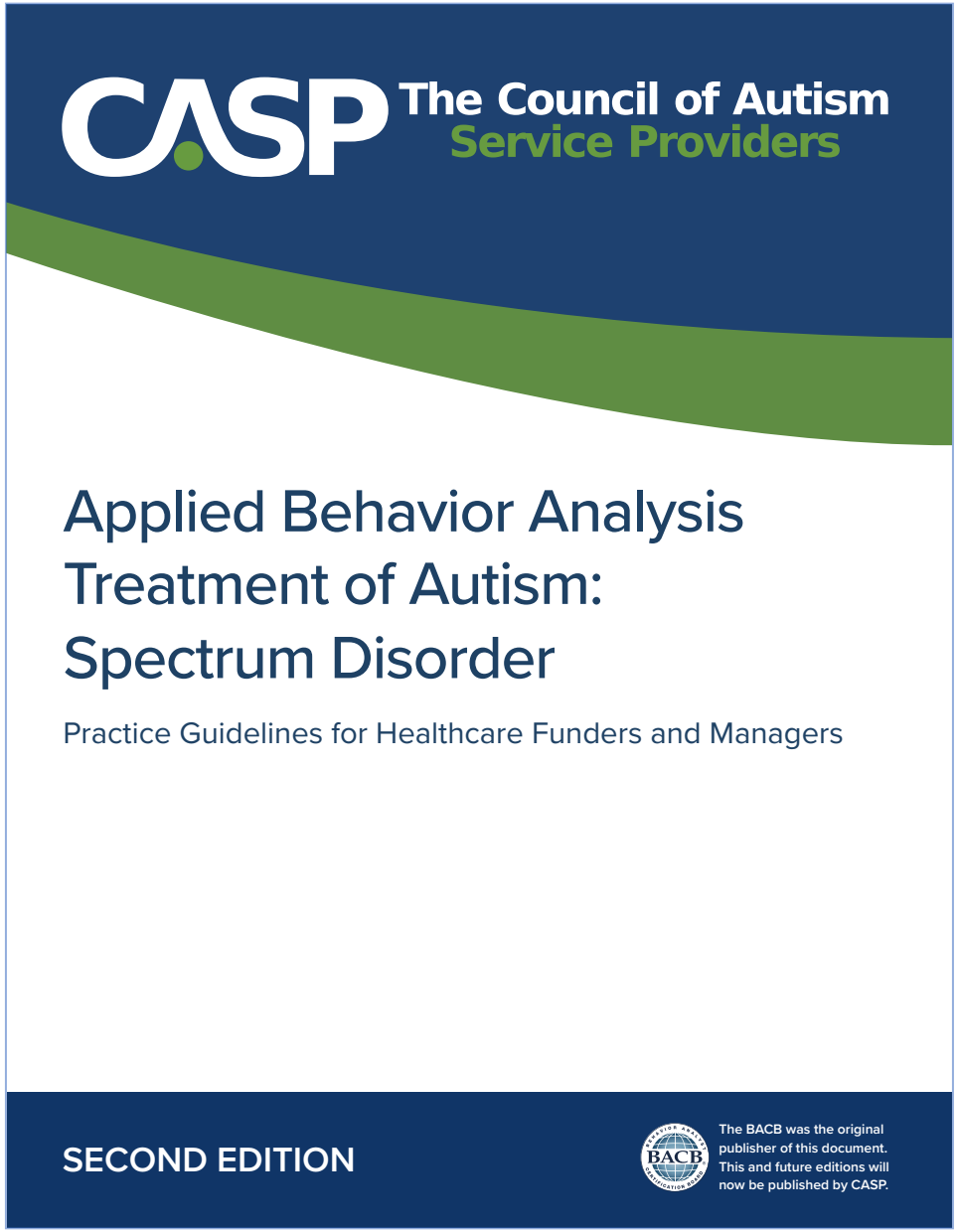

"The standards presented in this document reflect the consensus of a number of subject matter experts, but do not represent the only acceptable practice. . . .
The document is based on the best available scientific evidence and expert clinical opinion regarding the use of ABA as a behavioral health treatment for individuals diagnosed with ASD. . . . <u>These guidelines are written for healthcare funders and managers, such as insurance companies, government health programs, employers, among others.</u>
The guidelines may also be useful for consumers, service providers, and regulatory bodies."

Forthcoming Resource

- Developing a Severe Behavior Program: A Toolkit
  - Wayne Fisher, Cathleen Piazza, Ashley Fuhrman - Rutgers