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Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

Chapter 39 Utilization Review of Treatment for Autism and Autism Spectrum Disorders

Authority: Insurance Article, §§2-109(a)(1) and 15-835, Annotated Code of Maryland Ch. 294, §2, Acts of 2012

.01 Scope.

This chapter establishes the manner in which carriers and private review agents acting on behalf of carriers may apply utilization review criteria and impose documentation requirements regarding the treatment of children diagnosed with autism or autism spectrum disorders, when covered under a habilitative services benefit under a health benefit plan.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) “Behavioral health treatment” means professional counseling and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

(3) "Carrier" means an insurer, a nonprofit health service plan, or a health maintenance organization.

(4) “Child” means an individual who is:

(a) Younger than 19 years of age; and

(b) Diagnosed with autism or autism spectrum disorder.

(5) "Commissioner" means the Maryland Insurance Commissioner.

(6) “Habilitative services” has the meaning stated in Insurance Article, §15-835, Annotated Code of Maryland.

(7) “Health benefit plan” has the meaning stated in Insurance Article, §15-1301, Annotated Code of Maryland.

(8) "Health maintenance organization" has the meaning stated in Health-General Article, §19-701, Annotated Code of Maryland.

(9) "Insurer" has the meaning stated in Insurance Article, §1-101, Annotated Code of Maryland.

(10) "Nonprofit health service plan" means a person who has received a certificate of authority from the Commissioner to act as a nonprofit health service plan in the State.

(11) "Private review agent" has the meaning stated in Insurance Article, §15-10B-01, Annotated Code of Maryland.

(12) Psychological Care.

(a) “Psychological care” means direct or consultative services provided by a psychologist licensed in the state in which the services are provided or by a social worker licensed in the state in which in which the services are provided.

(b) “Psychological care” includes psychotherapy.

(13) “Therapeutic care” means services provided by a speech-language pathologist, occupational therapist, or physical therapist licensed in the state in which the services are provided.

(14) "Utilization review" has the meaning stated in Insurance Article, §15-10B-01, Annotated Code of Maryland.

.03 Utilization Review Criteria for Treatment of Autism and Autism Spectrum Disorders.

A. The utilization review criteria of a carrier or private review agent acting on behalf of a carrier to determine medical necessity or appropriateness may not be more restrictive for habilitative services for the treatment of autism and autism spectrum disorders than the criteria listed in this regulation.

B. The carrier’s criteria for habilitative services shall include criteria for behavioral health treatment, psychological care, and therapeutic care.

C. Utilization review criteria of a carrier or private review agent acting on behalf of a carrier may require:

(1) A comprehensive evaluation of a child by the child’s primary care provider or specialty physician identifying the need for habilitative services for the treatment of autism or autism spectrum disorder;

(2) A prescription from a child’s primary care provider or specialty physician that includes specific treatment goals; and

(3) An annual review by the prescribing primary care provider or specialty physician, in consultation with the habilitative services provider, that includes:

(a) Documentation of benefit to the child;

(b) Identification of new or continuing treatment goals; and

(c) Development of a new or continuing treatment plan.

D. A carrier or private review agent acting on behalf of a carrier may not deny coverage based solely on the number of hours of habilitative services prescribed, for:

(1) Less than or equal to 25 hours per week in the case of a child who is at least 18 months of age and who has not reached the child's sixth birthday, or

(2) Less than or equal to 10 hours per week in the case of a child who has reached the child's sixth birthday and who has not reached the child's nineteenth birthday.

(3) Notwithstanding §D(1) and (2) of this regulation, a carrier may authorize additional hours of habilitative services that are medically necessary and appropriate for the treatment of autism or autism spectrum disorders.

E. A carrier may limit payment for habilitative services to payment for services provided by individuals who are licensed, certified, or otherwise authorized under the Health Occupations Article or similar licensing, certification, or authorization requirements of another state or U.S. territory where the habilitative services are provided.

F. Location of services.

(1) A carrier may not deny payment for habilitative services if a treatment goal identifies the location of the habilitative services as the child's educational setting.

(2) Nothing in §F(1) of this regulation shall be construed to require a carrier to provide services to a child under an individualized education program or any obligation imposed on a public school by the Individuals With Disabilities Education Act, 20 U.S.C. 1400 et seq., as amended from time to time.

G. A carrier or a private review agent acting on behalf of a carrier may not deny payment for applied behavior analysis on the basis that it is experimental or investigational.

.04 Coverage for Habilitative Services.

Coverage required under this chapter may be subject to limitations in a health benefit plan relating to coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, case management provisions, and co-payments, co-insurance, and deductible amounts.

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