304.17A-142 Coverage for autism spectrum disorders -- Limitations on coverage -- Utilization review -- Reimbursement not required.

(1) As used in this section unless the context requires otherwise:

(a) "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;

(b) "Autism services provider" means any licensed person, entity, or group that provides treatment of autism spectrum disorders;

(c) "Autism spectrum disorder" means any of the autism spectrum disorders or pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM") published by the American Psychiatric Association;

(d) "Diagnosis of autism spectrum disorders" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has any of the autism spectrum disorders, including testing tools which shall be appropriate to the presenting characteristics and age of the individual and be empirically validated for autism spectrum disorders to provide evidence that meets the criteria for autism spectrum disorder in the most recent DSM published by the American Psychiatric Association; and

(e) "Treatment for autism spectrum disorders" includes the following care for an individual diagnosed with an autism spectrum disorder:

1. Medical care services provided by a licensed physician, an advanced registered nurse practitioner, or other licensed health care provider;

2. Habilitative or rehabilitative care, including professional counseling and guidance services, therapy, and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual;

3. Pharmacy care, if covered by the plan, including medically necessary medications prescribed by a licensed physician or other health-care practitioner with prescribing authority and any medically necessary health-related services to determine the need or effectiveness of the medications;

4. Psychiatric care, including direct or consultative services, provided by a psychiatrist licensed in the state in which the psychiatrist practices;

5. Psychological care, including direct or consultative services, provided by an individual licensed by the Kentucky Board of Examiners of Psychology or by the appropriate licensing agency in the state in which the individual practices;

6. Therapeutic care services provided by licensed speech therapists, occupational therapists, or physical therapists; and

7. Applied behavior analysis prescribed or ordered by a licensed health or allied health professional.

(2) All health benefit plans issued or renewed on or after January 1, 2019, shall provide coverage for the diagnosis and treatment of autism spectrum disorders. An insurer shall not terminate coverage, or refuse to deliver, execute, issue, amend, adjust, or renew coverage, to an individual solely because the individual is diagnosed with or has received treatment for any of the autism spectrum disorders.

(3) Coverage under this section shall not be subject to any maximum annual benefit limit, including any limits on the number of visits an individual may make to an autism services provider.

(4) Coverage under this section may be subject to copayment, deductible, and coinsurance provisions of a health benefit plan that are no less favorable than those that apply to other medical services covered by the health benefit plan.

(5) This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

(6) Except for inpatient services, if an individual is receiving treatment for autism spectrum disorders:

(a) An insurer shall have the right to request a utilization review of that treatment not more than once every twelve (12) months, unless the insurer and the individual's licensed physician, licensed psychologist, or licensed psychological practitioner agree that a more frequent review is necessary. The cost of obtaining any review shall be borne by the insurer;

(b) Upon request of the reimbursing insurer, an autism services provider shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued treatment or services that are medically necessary and are resulting in improved clinical status;

(c) When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated; and

(d) The treatment plan shall contain specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed, and continually measured and that address the characteristics of the autism spectrum disorder.

(7) (a) Nothing in this section shall be construed as:

1. Limiting, replacing, or otherwise affecting any obligation to provide services to an individual under an individualized service plan or other publicly funded program; or

2. Requiring a health benefit plan to provide benefits for services that are included in an individualized family service plan, an individualized education program, an individualized service plan, or other publicly funded programs.

(b) The coverage mandated in this section shall be in addition to any services which an individual is entitled to receive under any such publicly funded programs.

(8) No reimbursement is required under this section for services, supplies, or equipment:

(a) For which the insured has no legal obligation to pay in the absence of this or like coverage;

(b) Provided to the insured by a publicly funded program;

(c) Performed by a relative of an insured for which, in the absence of any health benefits coverage, no charge would be made; and

(d) For services provided by persons who are not licensed as required by law.

Effective: January 1, 2019

History: Amended 2018 Ky. Acts ch. 86, sec. 1, effective January 1, 2019. -- Created 2010 Ky. Acts ch. 150, sec. 17, effective January 1, 2011.

Legislative Research Commission Note (1/1/2011). 2010 Ky. Acts ch. 150, sec. 17, created a new section of Subtitle 17A of KRS Chapter 304. In subsection (8) of this section there is a citation to "this section and Sections 16 and 18 of this Act." There are also two more citations to "this Act" within this subsection. It seems clear from the context and has been confirmed by the drafter that the other two citations to "this Act" in subsection (8) should also have been to "this section and Sections 16 and 18 of this Act." Sections 16, 17, and 18 of the Act are now codified as KRS 304.17A-141, 304.17A-142 and 304.17A-143. This change has been made by the Reviser of Statutes under the authority of KRS 7.136(1).