

VBH-PA Frequently Asked Questions for ACT 62

Knowing if Act 62 Benefits may apply:

Q. What qualifies the client to be ACT 62 eligible?

A. See the attached flow sheet entitled “Does the PA Autism Insurance Act apply to my child?”

Q. Why are some kids with both primary insurance and a diagnosis on the autism spectrum not ACT 62 eligible?

A. See the attached Act 62 flow sheet entitled “Does the PA Autism Insurance Act apply to my child?”

Q. How do we check to see if the client has a primary insurance?

A. The easiest way to check to see if a member has a primary insurance is to ask the family. This should be done regularly.
Primary insurances can also be verified through the PROMISe system.

Q. How do we find out the effective date and the renewal date of the primary insurance?

A. The most accurate way for providers to find out the effective date and renewal dates on policies is to either ask the family to contact the employer or contact the primary insurance carrier about each child.

Q. How often should providers verify benefits?

A. Providers should verify benefits every time a service is provided to ensure that no changes have occurred.

Q. If the primary insurance carrier is from another state, can the client be ACT 62 eligible?

A. It’s possible. The provider should always verify the member’s primary insurance benefits.

Q. Is the cap \$36, 000 a year for all primary insurances?

A. If Act 62 applies to the child, and the primary insurance is paying for services, then the current cap is \$36,000 per year.

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Navigating the VBH-PA system regarding clients with Act 62 coverage:

Q. What information is needed by VBH-PA if the client has a diagnosis on the autism spectrum, and has private insurance coverage?

A. VBH-PA must immediately know the Group Plan Renewal Date, as well as if ACT 62 is applicable in the specific situation.

Q. If Act 62 is not applicable under the client's private insurance benefit plan, what do I need to do to ensure consistent reimbursement from VBH-PA?

A. If there is no coverage under ACT 62, the provider must forward documentation of the reason from the primary insurance carrier or from the employer to VBH-PA. This information can be submitted to the Customer Service Fax at 724-744-6379 or via "Submit an Inquiry" accessed through ProviderConnect.

Q. If Act 62 is applicable under the client's benefit plan, what do I need to do to ensure consistent reimbursement from VBH-PA?

A. If there is coverage under ACT 62, the provider must bill the private insurance plan. If there is a co-insurance, deductible, or co-pay due, these claims should then be submitted to VBH as the secondary payor. VBH is responsible for any co-insurance, deductible, or co-pay until the member reaches the \$36,000 cap.

Q. Can I submit the completed ACT 62 fax coversheet to Customer Service for use as documentation?

A. Yes, Customer Service will accept the ACT 62 fax coversheet as long as it provides the adequate information needed for claims processing.

Q. If the primary insurance is paying for services, does the provider still need to send a packet to VBH?

A. Yes; see below. The provider will receive an acknowledgement letter from VBH-PA.

Q. What is in a completed packet for a child with ACT 62 coverage?

A. There are 2 packets for an Act 62 child. The first packet is a standard packet that gets faxed to the CAFS Coordinator and the County.

The second packet contains the Act 62 fax coversheet, the plan of care and any insurance verification documentation and should be faxed to Christina Bowman at 724-744-6557. The second packet is required for all counties except for Fayette County.

Q. Where can you find the ACT 62 fax cover sheet?

A. Act 62 fax cover sheet is located on the VBH-PA website at www.vbh-pa.com

VBH-PA Frequently Asked Questions for ACT 62

Q. Who is responsible for the VBH fax coversheet for an initial case, for a child with Act 62 coverage?

A. The provider should fax the Act 62 fax coversheet into VBH-PA once they have verified member's benefits.

Q. If Act 62 applies does the evaluation still need to be sent to VBH?

A. Yes. The evaluation should be sent to VBH-PA within the 7 business day time frame.

Q. Will an authorization letter be sent out to providers when a child is ACT 62 eligible?

A. Providers will receive an acknowledgement letter from VBH indicating that we have received the information and that services are authorized using a class that is not able to be billed. The service classes for children whose services are covered by a primary insurance are:

- YT5 TSS in school
- YT6 TSS in home/community
- MT2 Mobile Therapy
- BS2 BSC

Q. How will we know when the client has met their cap on the primary insurance, so that VBH will begin covering services?

A. The provider needs to check with the primary insurance to determine if the cap has been met or exceeded. If the cap has been met, the provider will then resubmit to VBH-PA the complete packet along with the documentation from the primary insurance indicating that the cap has been met/exceeded. VBH will enter an authorization for the remaining time on the POC. The provider will assist the family in obtaining an evaluation and scheduling an ISPT according to the normal routine.

Q. Once the cap is met, what steps need to be taken by the provider?

A. When the provider is aware that the cap is met, they should submit the current packet to VBH-PA along with documentation from the insurance company indicating that the cap has been met or exceeded. VBH will then issue an authorization for the remainder of the plan of care.

Q. If a POC is going to expire with VBH-PA, and the child's services are still covered by a primary insurance, does the provider still need to have an ISPT meeting with VBH?

A. It is strongly suggested that the parents and provider continue to follow the normal VBH-PA authorization process, including an ISPT meeting. The purpose of this is to have a parallel authorization in place so that if the primary insurance no longer pays for the service during that time period, there is no lapse in service. VBH-PA can easily pick up the remainder of the plan of care without waiting for an additional evaluation or ISPT.

VBH-PA Frequently Asked Questions for ACT 62

Q. What should I do if a child's primary insurance changes and Act 62 now applies?

A. If you are providing services to a child whose primary insurance changes, the provider must notify VBH-PA immediately by sending in the Act 62 fax coversheet, along with a copy of the plan of care to Christina Bowman. The provider must not delay giving current information to VBH-PA.

Adjustments will be made to the current authorization and the provider will then receive an acknowledgement letter with the new service classes.

Q. What happens if their primary insurance only pays for part of the prescribed services?

A. VBH-PA will become the primary payor for the services that are not covered by the commercial insurance. VBH-PA will authorize the services not covered based on medical necessity.

Q. If a primary insurance has deductibles or co-pays will VBH-PA pay for these? Will the provider need an authorization for this?

A. Primary co-insurance, co-pays and deductibles will be paid by VBH-PA. There is no need for an authorization if the provider is only billing for deductibles/co-pays/co-insurance.

Q. What if the provider is not "in network" with the member's primary insurance? Can the provider just bill VBH-PA?

A. No. The provider must arrange to be paid for services by the primary insurance. If that is not possible, the family may need to choose a provider that is in network with the primary insurance carrier. VBH-PA is not permitted to pay for services if the provider is not participating with that member's primary insurance.

Q. What if I cannot obtain documentation related to the client's ACT 62 status from the private insurance plan?

A. VBH-PA will accept documentation from the provider on their letter head explaining the details of ACT 62 with relation to your client.

Q. If I get a claim denied by VBH requiring a documented explanation of benefits (EOB), what should I do next?

A. If the client has a diagnosis on the autism spectrum and has private insurance, VBH will deny the claim and request the primary insurance EOB. VBH-PA will assume that ACT 62 applies until informed by the provider that it does not. The provider must verify the private insurance information.

If ACT 62 benefits are available, you must work within the private insurances billing guidelines. If ACT 62 benefits are not available, you need to provide VBH with proof so that VBH-PA can continue to reimburse for services provided.

VBH-PA Frequently Asked Questions for ACT 62

Q. What if I receive an EOB from the private insurance plan that denies the ACT 62 covered services?

A. If you receive a denial from the private insurance plan for service that should be covered under ACT 62 benefits, you must contact the private insurance plan and dispute the denial. If there are ACT 62 benefits, the private insurance plan is mandated to pay for services.

Unusual Situations:

Q. If VBH-PA has sent a case for peer review resulting in different recommendation, and the primary insurance authorizes the original prescription, which amount of services does the provider give?

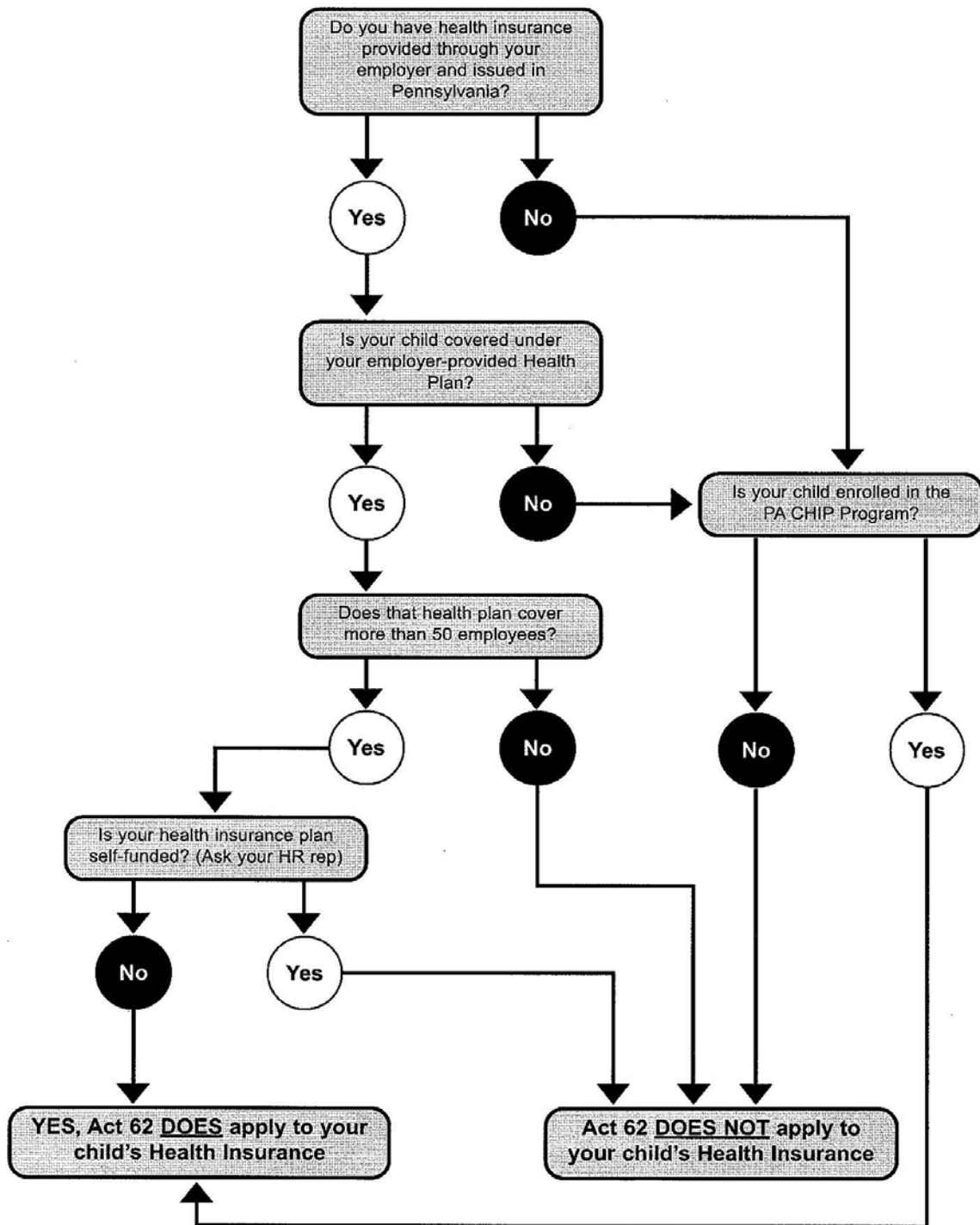
A. If the primary insurance is paying for the services, then the provider should provide the services that the primary insurance has authorized.

Q. If VBH-PA has sent a case for peer review resulting in different recommendation, and the cap is then met by the primary insurance, what happens?

A. VBH-PA will enter an authorization for services based on whatever was authorized out of peer review, grievance or DPW Fair hearing. In some circumstances, continuation rights will apply.

VBH-PA strongly encourages families to continue with the VBH-PA appeals/grievance process if they desire a different outcome than what was granted in peer review, even if the child's services are being covered by a primary insurance at the time.

Does the PA Autism Insurance Act Apply to My Child?



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