ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE CREATING A RULE

To create Ins 3.36, Wis. Adm. Code,

Relating to treatment of autism spectrum disorders.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   ss. 600.01, 628.34 (12), 632.895 (12m) Stats.

2. **Statutory authority:**

   ss. 600.01 (2), 601.41 (3), 601.42, 628.34 (12), 632.895 (12m), Stats.

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

The statutes all relate to the commissioner's authority to promulgate rules regulating the business of insurance as it relates to disability insurance products. Specifically, s. 632.895 (12m) (f), Wis. Stats., requires the commissioner to define "intensive-level services," "nonintensive-level services," "paraprofessional," and "qualified" for purposes of providing services under this subsection. The statute further authorizes that the commissioner may promulgate rules governing the interpretation or administration of this subsection.

4. **Related statutes or rules:**

There are no other statutes or rules that mandate services for autism spectrum disorders. This rule creates a new section to implement the newly created mandate pursuant to 2009 Wis. Act 28.

5. **The plain language analysis and summary of the proposed rule:**

Under 2009 Wisconsin Act 28, the Commissioner is required pursuant to s. 632.895 (12m), Stats., to define four terms: intensive-level services, non-intensive-level services, qualified, and paraprofessionals; and may draft rules that relate to the interpretation or administration of this section. During the pendency of the proposed rule, 2009 Wis. Act 282

was enacted adding licensed behavior analysts to the list of persons able to provide services pursuant to s. 632.895 (12m) (b), Wis. Stats.

To ensure clear understanding of current provider qualifications and treatment options for autism spectrum disorders, the Commissioner established the Autism Working Group. The work group was charged with advising the Commissioner on definitions for the four required terms and making recommendations on how the statute should be implemented. The group was composed of parents, providers, insurers, legislators and advocates. Administrators of the Waiver program at the Department of Health Services also participated. The group met every other week beginning June 23rd, 2009 until September 10th, 2009 and continues meeting on a quarterly basis.

The Waiver program was used as a baseline to discuss the implementation of the new mandate. Current literature on autism spectrum disorders and information from other states was presented to the working group for review and consideration. Because the research and literature in the realm of autism treatments is rapidly evolving, the working group recommended defining “evidence-based” and “behavioral” rather than creating a list of approved therapies that could readily become outdated.

The proposed rule includes definitions of intensive-level evidence-based behavioral therapy and nonintensive-level evidence-based therapy. Based upon current research, the rule limits intensive-level services to children aged 2 to 9 as this period of time has shown to be the optimum time for gains for individuals diagnosed with autism spectrum disorders. Building from the waiver program, the working group developed a comprehensive regulation.

The proposed rule differentiates between treatment providers for intensive versus nonintensive-level services. For a psychiatrist, psychologist, behavior analyst, social worker certified or licensed to practice psychotherapy or a professional working under the supervision of an outpatient mental health clinic to be considered qualified to provide intensive-level

services, the rule delineates a combination of education, training and experience with individuals diagnosed with autism spectrum disorders.

In recognition that some current waiver providers might not be able to meet licensure or certification requirements, the proposed rule includes provisions to permit individuals who are currently providing services through the department's waiver program to be deemed qualified for up to two years for continuity of care. Also the rule permits insurers and self-funded plans to contract with these individuals who are experienced but may not meet the qualifications for providing intensive or nonintensive services.

A current, valid state-issued license or certificate is necessary in order for a psychiatrist, psychologist, behavior analyst, social worker certified or licensed to practice psychotherapy, speech pathologist, or occupational therapist to be qualified to provide nonintensive-level services or to implement an intensive-level treatment plan. For a person who is a qualified professional working under the supervision of an outpatient mental health clinic, the clinic shall be certified under s. 51.038, Stats., in order for the professional to provide nonintensive-level services or to implement an intensive-level treatment plan developed by a qualified intensive-level provider.

The proposed rule also establishes requirements for paraprofessionals, individuals who may only provide services while working under the supervision of a psychiatrist, psychologist, behavior analyst or social worker certified or licensed to practice psychotherapy.

The rule also handles several administrative concerns. It allows insurers to deny claims they believe to be fraudulent, exclude travel time from the required hours of treatment and allocated dollars for treatment and permits dispute resolution through independent review organizations.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

Autism Treatment Acceleration Act of 2009 (S. 819, H.R. 2413) was proposed in May 2009. If passed, Section 12 will require all insurance companies to provide coverage for evidence-based, medically-necessary autism treatments and therapies. A comparison of final federal requirements and state law and regulation will be reviewed if this act is passed.

Additionally, the ''Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008'' (29 U.S.C. 1185a), requires group health plans that offer both medical and surgical benefits and mental health or substance use disorder benefits to ensure financial and treatment limitations are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan. Further, the federal law does not permit separate cost-sharing requirements that are applicable only with respect to mental health or substance-use disorder benefits.

The federal government issued interim final rules implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) on February 5, 2010. Although the interim rules do not specifically define what constitutes a mental health condition, the newly issued rules provide some guidance to states and insurers. The MHPAEA rules are first effective July 1, 2010 to newly-issued plans or upon the renewal, extension or modification on or after July 1, 2010. The MHPAEA rules require mental health benefits to be defined within the plan by the issuer in accordance with federal and state law and consistent with generally recognized independent standards of current medical practice including the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM, most current version IV, contains diagnostic criteria for "autistic disorder." Although there is no direct federal guidance that autism spectrum disorders are subject to federal parity requirements, it is the position of the Commissioner that parity for autism services does apply to group health plans with more than 50 employees based upon preliminary review of the regulations.

Wisconsin's law is broader than the federal law, as it mandates inclusion of mental health, alcohol and other substance abuse benefits. Further, Wisconsin's autism treatment

mandate applies to individual, small employer and governmental self-funded health plans in addition to group health plans with more 50 employees. The individual, small employer and governmental self-funded plans will remain subject to these mandates as they are not regulated by the federal government.

7. **Comparison of similar rules in adjacent states as found by OCI:**

Illinois: Public Act 95-1005 requires private insurers to cover autism benefits for children under 21 years of age. No rule-making accompanied this law, however, the statute does include Applied Behavioral Analysis, intervention, and modification as a part of the covered behavioral treatments. The law is subject to pre-existing condition limitations. It is also subject to denials based on medical necessity.

Iowa: A bill, SF 1, was introduced in the Iowa legislature this year but did not pass. There are no other similar laws or rules in Iowa.

Michigan: Two bills, HB 4183 and 4176, requiring autism coverage, have passed the Michigan House; however, they are not expected to reach a vote this year in the Michigan Senate. There are no other similar laws or rules in Michigan.

Minnesota: Section 62A.3094 was enacted and became effective August 1, 2009. The mandate requires coverage for the diagnosis, evaluation, assessment and medically necessary care for autism spectrum disorders including intensive evidence-based behavior therapy, behavior services, speech therapy, occupational therapy, physical therapy and medications.

8. **A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:**

The Commissioner created an advisory Autism Working Group to assist in the development of workable definitions of “intensive” and “nonintensive” level services; “qualified” providers and “paraprofessionals.” The advisory working group was comprised of providers, insurers, advocates, parents of autistic children and representatives from the Department of

Health Services familiar with the Medicaid Waiver program for autism services. The working group met seven times between June 23 and September 10, 2009, and continues to meet quarterly. This proposed rule reflects the advisory working group's recommendations.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

There are no insurers offering disability insurance or state or local governmental self-funded entities that meet the definition of a small business.

10. See the attached Private Sector Fiscal Analysis.

See attached.

11. A description of the Effect on Small Business:

This rule will have little or no effect on small businesses

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: **http://oci.wi.gov/ocirules.htm**

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 10th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

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Web site: **http://oci.wi.gov/ocirules.htm**

The rule changes are:

SECTION 1. Ins 3.36 is created to read:

Ins 3.36 **(1) APPLICABILITY.** (a) This section applies to disability insurance policies as defined in s. 632.895 (1) (a), Stats., except as provided in s. 632.895 (12m) (e), Stats., and self-insured health plans sponsored by the state, county, city, town, village, or school district.

(b) For a disability insurance policy covering employees who are affected by a collective bargaining agreement the coverage under this section first applies as follows:

1. If the collective bargaining agreement contains provisions consistent with s. 632.895 (12m), Stats., coverage under this section first applies the earliest of any of the following: the date the disability insurance policy is issued or renewed on or after November 1, 2009, or the date the self-insured health plan is established, modified, extended or renewed on or after November 1, 2009.

2. If the collective bargaining agreement contains provisions inconsistent with s. 632.895 (12m), Stats., the coverage under this section first applies on the date the health benefit plan is first issued or renewed or a self-insured health plan is first established, modified, extended, or renewed on or after the earlier of the date the collectively bargained agreement expires, or the date the collectively bargained agreement is modified, extended or renewed.

(2) DEFINITIONS. In addition to the definitions in s. 632.895 (12m) (a), Stats., in this section:

(a) “Behavior analyst” means a person certified by the Behavior Analyst Certification Board, Inc., or successor organization as a board-certified behavior analyst and has been granted a license under s. 440.312, Stats., to engage in the practice of behavior analysis.

(b)“Behavioral” means interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning

utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.

(c) “Department” means the Wisconsin department of health services.

(d) “Efficacious treatment” or “efficacious strategy” means treatment or strategies designed to address cognitive, social or behavioral conditions associated with autism spectrum disorders; to sustain and maximize gains made during intensive-level services; or to improve an individual with autism spectrum disorder’s condition.

(e) “Evidence-based therapy” means therapy, service and treatment that is based upon medical and scientific evidence as described at s. 632.835 (3m) 1., 2. (intro.), and 2. a., Stats., and s. Ins 18.10 (4), is determined to be an efficacious treatment or strategy and is prescribed to improve the insured’s condition or to achieve social, cognitive, communicative, self-care or behavioral goals that are clearly defined within the insured’s treatment plan.

(f) “Intensive-level service” means evidence-based behavioral therapies that are directly based on, and related to, an insured’s therapeutic goals and skills as prescribed by a physician familiar with the insured. Intensive-level service may include evidence-based speech therapy and occupational therapy provided by a qualified therapist when such therapy is based on, or related to, an insured’s therapeutic goals and skills, and is concomitant with evidence-based behavioral therapy.

(g) “Qualified intensive-level professional” means an individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in s. DHS 35.03 (9g), and who has completed at least 2080 hours of training, education and experience including all of the following:

1. Fifteen hundred hours supervised training involving direct one-on-one work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models.

2. Supervised experience with all of the following:

a. Working with families as part of a treatment team and ensuring treatment compliance.

b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.

c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.

d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.

e. Designing and implementing progressive treatment programs for individuals with autism spectrum disorders.

3. Academic coursework from a regionally-accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

(h) “Qualified intensive-level provider” means an individual identified in s. 632.895 (12m) (b) 1. to 4., Stats., acting within the scope of a currently valid state-issued license for psychiatry, psychology or behavior analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy, who provides evidence-based behavioral therapy in accordance with this section and s. 632.895 (12m) (a) 3., Stats., and who has completed at least 2080 hours of training, education and experience which includes all of the following:

1. Fifteen hundred hours supervised training involving direct one-on-one work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models.

2. Supervised experience with all of the following:

a. Working with families as the primary provider and ensuring treatment compliance.

b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.

c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.

d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.

e. Designing and implementing progressive treatment programs for individuals with autism spectrum disorders.

3. Academic coursework from a regionally-accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

(i) “Qualified paraprofessional” means an individual working under the active supervision of a qualified supervising provider, qualified intensive-level provider or qualified provider and who complies with all of the following:

1. Is at least 18 years of age.

2. Obtains a high school diploma.

3. Completes a criminal background check.

4. Obtains at least 20 hours of training that includes subjects related to autism, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid.

5. Obtains at least ten hours of training in the use of behavioral evidence-based therapy including the direct application of training techniques with an individual who has autism spectrum disorder present.

6. Receives regular, scheduled oversight by a qualified supervising provider in implementing the treatment plan for the insured.

(j) “Qualified professional” means an individual identified in s. 632.895 (12m) (b) 5., Stats., acting under the supervision of an outpatient mental health clinic certified under s. 51.038, Stats., acting within the scope of a currently valid state-issued license and who provides evidence-based therapy in accordance with this section.

(k) “Qualified provider” means an individual identified in s. 632.895 (12m) (b) 1. to 4., Stats., respectively, acting within the scope of a currently valid state-issued license for psychiatry, psychology or behavior analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy and who provides evidence-based therapy in accordance with this section.

(L) “Qualified supervising provider” means an individual who is a qualified intensive-level provider and who has completed at least 4160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

(m) “Qualified therapist” means an individual identified in s. 632.895 (12m) (b) 6. or 7., Stats., who is either a speech-language pathologist or occupational therapist acting within the scope of a currently valid state-issued license and who provides evidence-based therapy in accordance with this section, sub. (4) (e).

(n) “Supervision of an outpatient mental health clinic” for purposes of this section means an individual who meets the requirements of a qualified supervising provider and who periodically reviews all treatment plans developed by qualified professionals for insureds with autism spectrum disorders.

(o) “Waiver program” means services provided by the department through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare & Medicaid Services.

3.36 (3) Verified diagnosis. (a) Insurers and self-insured health plans shall provide coverage for services to an insured who has a primary verified diagnosis of autism spectrum

disorder made by a diagnostician skilled in testing and in the use of empirically-validated tools specific for autism spectrum disorders.

(b) Insurers and self-insured health plans shall accept as valid and provide coverage for the diagnostic testing in addition to the benefit mandated by s. 632.895 (12m), Stats. For the diagnosis to be valid for autism spectrum disorder, the testing tools shall be appropriate to the presenting characteristics and age of the insured and be empirically validated for autism spectrum disorders to provide evidence that the insured meets the criteria for autism spectrum disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Insurers and self-insured health plans may require confirmation of a primary diagnosis through completion of empirically-validated tools or tests from each of the following categories: intelligence, parent report, language skills, adaptive behavior, and direct observation of the child.

(c) An insurer and a self-insured health plan may require an insured to obtain a second opinion from a diagnostician experienced in the use of empirically-validated tools specific for autism spectrum disorders who is mutually agreeable to the insured or the insured's parent or authorized representative and to the insurer or self-insured health plan. An insurer and a self-insured health plan shall cover the cost of the second opinion and the cost of the second opinion shall be in addition to the benefit mandated by s. 632.895 (12m), Stats.

(d) Insurers and self-insured health plans may require that the assessment include both a standardized parent interview regarding current concerns and behavioral history as well as direct, structured observation of social and communicative behavior and play. The diagnostic evaluation shall also assess those factors that are not specific to autism spectrum disorders including degree of language impairment, cognitive functioning, and the presence of nonspecific behavioral disorders.

3.36 (4) Intensive-level Services. (a) *Coverage for intensive-level services*. Insurers and self-insured health plans shall provide coverage for evidence-based behavioral intensive-level therapy for an insured with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to the insured when the parent or legal guardian is present and engaged and all of the prescribed therapy is consistent with all of the following requirements:

1. Based upon a treatment plan developed by an individual who at least meets the requirements of a qualified intensive-level provider or a qualified intensive-level professional that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment, and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the insured be present and engaged in the intervention.

2. Implemented by qualified providers, qualified professionals or qualified therapists, or qualified paraprofessionals.

3. Provided in an environment most conducive to achieving the goals of the insured's treatment plan.

4. Implemented identified therapeutic goals developed by the team including training and consultation, participation in team meetings and active involvement of the insured's family.

5. Commenced after an insured is two years of age and before the insured is nine years of age.

6. Provided by a qualified intensive-level provider or qualified intensive-level professional who directly observes the insured at least once every two months.

(b) *Forty-eight cumulative months*. Insurers and self-insured health plans shall provide up to forty-eight months of intensive-level services. Insurers and self-insured health plans may credit against the required forty-eight months of intensive-level services any previous intensive-

level services the insured received regardless of payor. Insurers and self-insured health plans may require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the insured received for autism spectrum disorders that was provided to the insured prior to the insured attaining nine years of age. Insurers and self-insured health plans may consider any evidence-based behavioral therapy that was provided to the insured for an average of 20 or more hours per week over a continuous six-month period to be intensive-level services.

(c) *Travel*. Insurers and self-insured health plans shall not include coverage of travel time for qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals when calculating the number of hours of care provided per week and are not required to separately reimburse for travel time.

(d) *Progress assessment*. Insurers and self-insured health plans shall require that progress be assessed and documented throughout the course of treatment. Insurers and self-insured health plans may request and review the insured's treatment plan and the summary of progress on a periodic basis.

(e) *Concomitant Therapy*. Insurers and self-insured health plans shall provide coverage pursuant to s. 632.895 (12m) (c), Stats., for a qualified therapist when services are rendered concomitant with intensive-level evidence-based behavioral therapy and all of the following:

1. The qualified therapist provides evidence-based therapy to an insured who has a primary diagnosis of an autism spectrum disorder.

2. The insured is actively receiving behavioral services from a qualified intensive-level provider or qualified intensive-level professional.

3. The qualified therapist develops and implements a treatment plan consistent with their license and this section.

3.36 (5) Nonintensive-Level Services. (a) *Coverage for nonintensive-level services*. Insurers and self-insured health plans shall provide coverage for an insured with a verified diagnosis of autism spectrum disorder for nonintensive-level services that are evidence-based and that are provided to an insured by a person who is at least a qualified provider, a qualified professional, a qualified therapist or a qualified paraprofessional in either of the following conditions:

1. After the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level services treatment.

2. To an insured who has not and will not receive intensive-level services but for whom nonintensive-level services will improve the insured's condition.

(b) *Requirements for coverage*. Insurers and self-insured health plans shall provide coverage for evidence-based therapy that is consistent with all of the following requirements:

1. Based upon a treatment plan developed by an individual who minimally meets the requirements as a qualified provider, a qualified professional or a qualified therapist that includes specific evidence-based therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the insured be present and engaged in the intervention.

2. Implemented by a person who is at least a qualified provider, qualified professional, qualified therapist, or a qualified paraprofessional.

3. Provided in an environment most conducive to achieving the goals of the insured's treatment plan.

4. Implements identified therapeutic goals developed by the team including training and consultation, participation in team meetings and active involvement of the insured's family.

(c) *Services*. Insurers and self-insured health plans shall provide coverage for nonintensive-level services that may include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified therapists, or qualified paraprofessionals.

(d) *Progress assessment*. Insurers and self-insured health plans shall require that progress be assessed and documented throughout the course of treatment. Insurers and self-insured health plans may request and review the insured's treatment plan and the summary of progress on a periodic basis.

(e) *Travel*. Insurers and self-insured health plans shall not include coverage of travel time by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals when calculating the number of hours of care provided per week and are not required to separately reimburse for travel time.

3.36 (6) Transition to nonintensive-level services. (a) *Notice of transition by insurer*. Insurers and self-insured plans shall provide notice to the insured or the insured's authorized representative regarding change in an insured's level of treatment. The notice shall indicate the reason for transition that may include any of the following:

1. The insured has received forty-eight cumulative months of intensive-level services.

2. The insured no longer requires intensive-level services as supported by documentation from a qualified supervising provider, qualified intensive-level provider, or a qualified intensive-level professional.

3. The insured no longer receives evidence-based behavioral therapy for at least 20 hours per week over a six-month period of time.

(b) *Notice of break in service by insured*. Insurers and self-insured plans may require an insured or an insured's authorized representative to promptly notify the insurer or self-insured plan if the insured requires and qualifies for intensive-level services but the insured or the

insured's family or caregiver is unable to receive intensive-level services for an extended period of time. The insured or the insured's authorized representative shall indicate the specific reason or reasons the insured or the insured's family or caregiver is unable to comply with an intensive-level service treatment plan. Reasons for requesting intensive-level services be interrupted for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event or any other reason the insurer or self-insured plan determines to be acceptable.

(c) *Documentation*. Insurers and self-insured plans may not deny intensive-level services to an insured for failing to maintain at least 20 hours per week of evidence-based behavioral therapy over a six-month period when the insured or the insured's authorized representative complied with par. (b) or the insured or the insured's authorized representative can document that the insured failed to maintain at least 20 hours per week of evidence-based behavioral therapy due to waiting for waiver program services.

3.36 (7) Notice to Insureds. Insurers and self-insured plans shall provide written notice regarding claims submitted and processed for the treatment of autism spectrum disorders to the insured or insured's parents or authorized representative and include the total amount expended to date for the current policy year. The notice may be included with the explanation of benefits form or in a separate communication provided on a periodic basis during the course of treatment.

3.36 (8) Research that is the basis for efficacious treatment or efficacious strategies. Research designs that are sufficient to demonstrate that a treatment or strategy when used solely or in combination with other treatments or strategies, is effective in addressing the cognitive, social, and behavioral challenges associated with autism spectrum disorders demonstrates significant improvement shall include at least one of the following:

(a) Two or more high quality experimental or quasi-experimental group design studies that meet all of the following criteria:

1. A clearly defined population for whom inclusion criteria have been delineated in a reliable, valid manner.

2. Outcome measures with established reliability and construct validity.

3. Independent evaluators who are not aware of the particular treatment utilized.

(b) Five or more single subject design studies that meet all of the following criteria:

1. Studies must have been published in a peer-reviewed scientific or medical journal.

2. Studies must have been conducted by three different researchers or research groups in three different geographical locations.

3. The body of studies must have included 20 or more participants.

(c) One high quality randomized or quasi-experimental group design study that meets all of the criteria in par. (a) and three high-quality single-subject design studies that meet all of the criteria in par. (b).

3.36 (9) Disputes. An insurer's or a self-insured health plan's determination regarding diagnosis and level of service may be considered an adverse determination if the insured disagrees with the determination. The insured or the insured's authorized representative may file a grievance in accordance with s. Ins 18.03. The insured or the insured's authorized representative may seek independent review of the coverage denial determination in accordance with s. Ins 18.11.

3.36 (10) Non-required coverage. (a) *Services*. Insurers and self-insured health plans are not required to cover any of the following:

1. Acupuncture.

2. Animal-based therapy including hippotherapy.

3. Auditory integration training.

4. Chelation therapy.

5. Child care fees.

6. Cranial sacral therapy.

7. Custodial or respite care.

8. Hyperbaric oxygen therapy.

9. Special diets or supplements.

(b) *Drugs and devices*. Insurers and self-insured health plans shall not provide coverage for pharmaceuticals or durable medical equipment through s. 632.895 (12m), Stats. Coverage of pharmaceuticals and durable medical equipment shall be covered in compliance with the terms of the insured's policy.

(c) *Fraudulent claim***s.** Insurers and self-insured health plans shall not be required to pay claims that have been determined to be fraudulent.

(d) *Parents of children diagnosed with autism spectrum disorders*. Insurers and self-insured health plans shall not be required to pay for treatment rendered by parents or legal guardians who are otherwise qualified providers, qualified supervising providers, qualified therapists, qualified professionals or qualified paraprofessionals for treatment rendered to their own children.

(e) *Denial of coverage*. If an insurer or self-funded health plan generally provides benefits for an illness or injury, the insurer or self-funded health plan may not deny benefits otherwise provided for treatment of that illness or injury solely because the illness or injury relates to the insured's autism spectrum disorder.

3.36 (11) Locations for Services. (a) Insurers and self-insured health plans shall cover treatments, therapies and services to an insured diagnosed with autism spectrum disorders in locations including the provider's office, clinic or in a setting conducive to the acquisition of the target skill. Treatments may be provided in schools when they are related to the goals of the treatment plan and do not duplicate services provided by a school.

(b) Insurers and self-insured health plans are not required to cover therapy, treatment or services when provided to an insured who is residing in a residential treatment center, inpatient treatment or day treatment facility.

(c) Insurers and self-insured health plans are not required to cover the cost for the facility or location or for the use of a facility or location when treatment, services or evidence-based therapy are provided outside an insured's home.

3.36 (12) Annual publication CPI adjustment. The commissioner shall publish to the office of the commissioner of insurance website on or before December 1 of each year beginning December 1, 2011, the consumer price index for urban consumers as determined by the U.S. Department of Labor and publish the adjusted dollar amount in accordance with s. 632.895 (12m) (c) 1., Stats. The adjusted dollar amount published each December shall be used by insurers and self-insured health plans when complying with s. 632.895 (12m), Stats., effective the following January 1 for newly issued policies or on the first date of a modified, extended or renewed policy or certificate after January 1.

3.36 (14) Verification of service providers. (a) Insurers and self-insured health plans are required to verify the licensure, certification and all training or other credentials of a qualified supervising or intensive-level provider, a qualified provider and a qualified therapist.

(b) Insurers and self-insured health plans shall require the following:

1. All service providers employing qualified paraprofessionals to verify the qualified paraprofessional's credentials and to document that such employee or contractee has not been

convicted of a felony or any crime involving maltreatment of a child in any jurisdiction and to periodically review and verify continuing compliance with this paragraph.

2. Certified outpatient mental health clinics employing or contracting for the services of qualified intensive-level professionals or qualified professionals to verify the credentials of a qualified intensive-level professional or qualified professional and to document that such employee or contractee has not been convicted of a felony or any crime involving maltreatment of a child in any jurisdiction and to periodically review and verify continuing compliance with this paragraph.

(c) A provider, therapist, or professional working under the supervision of a certified outpatient mental health clinic, who is approved by the department and who has a signed Medicaid provider agreement to provide services through the waiver program to individuals with autism spectrum disorders prior to November 1, 2009 shall be deemed to be a qualified intensive-level provider or qualified intensive-level professional through October 31, 2011. Beginning November 1, 2011 any provider, therapist or professional shall comply with the training and education requirements for a qualified supervising provider, qualified intensive-level provider, qualified provider, qualified intensive-level professional, qualified professional or qualified therapist.

(d) An insurer or self-insured health plans may elect to contract with certain providers, therapists and professionals who do not meet all of the requirements necessary to be considered qualified supervising providers, qualified intensive-level providers, qualified providers, qualified therapists, qualified intensive-level professionals or qualified professionals but who are approved by the department and who have a signed Medicaid provider agreement to provide services through the waiver program to individuals with autism spectrum disorders and who meet any criteria established by the insurer or self-insured health plan. The insurer or self-insured health plans shall have a verifiable and established process for rendering its determination for otherwise qualified supervising provider, qualified intensive-level provider,

qualified provider, qualified intensive-level professional, qualified professional or qualified therapist.

SECTION 2. These changes will take effect on the first day of the month after publication, as provided in s. 227.22 (2) (intro.), Stats.

SECTION 3. This section may be enforced under ss. 601.41, 601.64, 601.65, 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

Dated at Madison, Wisconsin, this _____ day of August, 2010.

_____
Sean Dilweg
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

For section Ins 3.36 relating to autism spectrum disorders treatment and affecting small business

This rule change will have no significant effect on the private sector regulated by OCI.

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 336**

Subject
autism spectrum disorders treatment and affecting small business

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):
None

Annualized Costs:	**Annualized Fiscal impact on State funds from:**	
A. State Costs by Category	**Increased Costs**	**Decreased Costs**
State Operations - Salaries and Fringes	$ 0	$ -0
(FTE Position Changes)	(0 FTE)	(-0 FTE)
State Operations - Other Costs	0	-0
Local Assistance	0	-0
Aids to Individuals or Organizations	0	-0
TOTAL State Costs by Category	$ 0	$ -0
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	$ 0	$ -0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	$ 0	$ -0
GPR Earned	0	-0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
TOTAL State Revenues	$ 0 None	$ -0 None

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ None 0	$ None 0
NET CHANGE IN REVENUES	$ None 0	$ None 0

Prepared by: Julie E. Walsh	**Telephone No.** (608) 264-8101	**Agency** Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)

Division of Executive Budget and Finance
DOA-2048 (R10/2000)

Wisconsin Department of Administration

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 336**

Subject

autism spectrum disorders treatment and affecting small business

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs
   ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs
   ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues
   ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues
   ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected:
   ☐ Towns ☐ Villages ☐ Cities
   ☐ Counties ☐ Others _____
   ☐ School Districts ☐ WTCS Districts

Fund Sources Affected

☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

Prepared by:	**Telephone No.**	**Agency**
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)