NAVIGATING THE INSURANCE MAZE – PART 2

About 5 years ago, I wrote an article entitled "Navigating the Insurance Maze" for the DSNMC Spring 2011 Newsletter. The article focused on selection of insurance coverage and subscriber rights with respect to habilitative services; it also touched upon obtaining in-network coverage for a non-participating provider.

My son, Jacob, who has Down Syndrome (DS), was 3 years old at the time of publication of that article, so he is now 8; during that time, his needs with respect to healthcare have changed so I have had more experience dealing with obtaining authorization and coverage for out-of-network providers and wanted to share this information with other families.

In-Network vs. Out-of-Network Providers

In-network providers are facilities (e.g., hospitals, labs, radiology offices, and pharmacies) as well as individual and group practices that have agreed to accept a contracted (agreed-upon) rate with one or more insurance companies for specific services. This rate includes both the health insurance provider's portion of the cost and the health plan member's share, which usually consists of a copay (a fixed dollar amount that the member pays for a specific service) or coinsurance (a set proportion of the total cost for a specific service, e.g., 20%) and a deductible (a set dollar amount that the member must pay before charges are considered for re-imbursement).

Out-of-network providers are facilities, individuals, and group providers that do not have a contract set up with a particular insurance company. Therefore, they may charge more because they are not restricted by an agreed-upon rate. In addition, Health Maintenance Organization (HMO) and Exclusive Provider Plans (EPO) typically require members to see only in-network providers, except for emergencies, so they do not provide any out-of-network benefits. Therefore, the member would need to pay in full were they to see a provider not covered by the plan.

If a member participates with a plan that has an out-of-network-benefit (usually referred to as a Point of Service (POS) or Preferred Provider Option (PPO) Plan), the plan may provide some coverage, but less than would be provided for an in-network or "preferred provider". Therefore, the deductible and co-pay or co-insurance might be higher for an out-of-network provider (e.g., the member would pay a $40 copay for an out-of-network provider rather than a $20 copay, or 40% coinsurance rather than 20% coinsurance). In addition, POS and PPO plans will only reimburse based on the amount they consider "reasonable and customary" (i.e., the rate that their in-network providers are contracted for) so members would also be responsible for the difference. For example, if the contracted rate was $150 and the out-of-network provider charged $200, then the member would also be responsible for an additional $50.

Many allied health professionals (physical therapists, occupational therapists, and speech pathologists) and behavioral health providers (behavioral therapists, psychologists, and psychiatrists) do not participate with any health plans due to the limited re-imbursement rate, and the amount of paperwork they would need to complete in order to get claims processed. Therefore, I have some suggestions with respect to getting services for out-of-network providers covered (at the maximum rate of reimbursement when possible).

Tips for Obtaining Maximum Coverage for Out-of-Network Providers

If you are requesting coverage for a new provider, obtain information for pre-authorization before the first appointment: Prior to seeing a new provider, check with the provider as to the Current Procedural Technology (CPT) codes that they use for billing purposes. Since, the provider will likely need to complete an initial evaluation, ask what CPT evaluation code they use and how long the evaluation typically takes (for example, to complete a 3-hour initial psychological evaluation, you would request 3 units of CPT code 90791 from your insurer). Following the evaluation, the provider typically will bill a code or set of codes specific to their discipline for each routine visit; therefore, you should also obtain the list of codes used for ongoing visits. Once you have the CPT codes, contact your insurance to determine whether pre-authorization is needed in order to see the provider.

If you are switching insurance plans and want to continue care with an existing provider request a transition period*:* When switching to another healthcare plan, many plans have what is called a "transition of care" plan. This is a method to cover the out-of-network provider as in-network for a brief period to ease the transition to an in-network provider. A transition of care plan provides the member with a few months to obtain documentation to provide a rationale for requesting that their child continue treatment with the provider in question and have them covered at the in-network rate.

Make a case for covering the out-of-network provider as in-network. Whether or not you have a plan that provides out-of-network benefits, contact your insurance company and inform them that you wish to make a non-participating provider ("non-par") request (also called a "single case exception") due to a "network deficiency" (i.e., lack of participating providers in a certain specialty area (e.g., speech pathology) within a specific radius (usually 30 miles of your home address) who has the training and skills in his/her respective field to work with a child with Down Syndrome). This places the burden on the insurer to contact in-network providers to determine whether or not they have experience working with children with Down Syndrome, practice within 30 miles of the subscriber's home, and are accepting new patients.

Appeal the decision if it is not in your favor. Depending on the amount of work the insurance carrier puts into attempting to locate an in-network provider, and the actual availability of participating providers in your area, your request will either be approved or denied.

If your request is approved, you will still need to provide documentation from the provider, typically in the form of an evaluation and treatment plan with goals; the case will then be reviewed periodically (e.g., every 3 – 6 months).

If you receive approval for coverage of the provider as in-network, ensure that claims are processed correctly. Due to confusion on the part of our insurance carrier with respect to processing of claims for out-of-network providers who have been approved as in-network, there have been several occasions on which we have been overpaid for provider services (e.g., the claim was processed twice, once as out-of-network and then again as in-network). Then months later, either we have noted the error, or during an audit, the insurer has been notified of the error and required that I repay the amount that was overpaid because I typically pay the provider and then submit the claims to my insurance for processing.

There is a law in Maryland that prevents insurance companies from recouping payments made to a provider if the request for repayment is made more than 6 months after payment (see

"Additional Resources" below). Unfortunately, this law does not extend to the subscriber. Therefore, if your provider is willing to wait to be paid until the claim is processed by the insurer, then have claims payments made directly to provider; that way if the provider is overcompensated and more than 6 months elapse before the error is noted by the insurance company, then they are not legally required to reimburse the insurer. If the provider is not willing to wait to be reimbursed, then you could pay the provider upon receipt of their invoice and then request that they endorse the insurer's check over to you when they receive it.

If your request is denied, then you will need to file an appeal, which should include these components:

1) A cover letter that includes the following:
   - Subscriber's Name, Child's Name, Child's Date of Birth, and Member ID
   - Name and credentials of the provider you are requesting in-network coverage for
   - *For new providers*: Projected start date of treatment; *for ongoing providers*: Original start date of treatment (including length of time provider has worked with child)
   - Reason(s) for selection of provider (e.g., expertise in working with children with DS, accessibility, well-established relationships with school/aftercare providers (if child is seen in the community))
   - *If you have a traditional insurance plan:* Cite the Maryland statute mandating that the insurer provide a referral to a non-participating provider if a member is diagnosed with a condition requiring specialized care (i.e., Down Syndrome and any additional diagnoses), and the insurer does not have a participating provider with the training and expertise to treat the condition(s) (see "Additional Resources" below)
   - Repercussions in the event that the request is denied (any co-morbid diagnoses which would make it more difficult for the child to adapt, risk of regression, and need for the new provider to establish rapport with the child, all of which could ultimately increase the number of sessions needed with new provider to return to current level of functioning and therefore higher costs to the insurer)

2) A letter from one of your child's medical providers who have expertise in DS (typically a Geneticist or Developmental Pediatrician) that includes the following information:
   - Issues relevant to children with DS that make transitioning to another provider difficult (e.g., importance of structure and routine).
   - Comorbid medical and psychiatric diagnoses, such as hypotonia, reflux, oppositional behavior, etc. that make your child's situation more complex. (Insurance companies reimburse based on diagnoses, not symptoms, so include as many diagnoses as you can).

For ongoing providers only:

3) A letter from the provider that you are requesting in-network coverage for that includes the following:
   - The provider's name and any training they have received specific to DS
   - Your child's level of functioning at the beginning of treatment (refer to original treatment plan), including the original diagnosis and baseline skills.
   - Gains that your child has made during the course of treatment and current level of functioning (refer to most recent provider documentation (e.g., treatment plan or progress notes)).

4) Any medical records documenting additional diagnoses, including evaluations and psychological testing or lab work and procedure results.

Keep in mind that since most providers are very busy, they often use a form letter that doesn't meet your needs; in addition, some providers charge for writing letters. Therefore, I suggest that you draft each of the provider letters yourself, and then have the provider edit the letter, print it on letterhead, and sign it.

Note: For many insurance plans, if the initial appeal is denied, you can submit a second level appeal; often this appeal must be made by the provider. Typically, the provider either will need to submit additional clinical information or speak directly to a clinician (usually a physician) at the insurance company.

If your appeal and the provider's appeal is denied and you think the rationale for the denial is unjust, contact either the Maryland Insurance Administration or Employee Benefits Security Administration (EBSA) (see "Additional Resources" below).

If your appeal is denied because your insurance provider is able to locate an appropriate in-network provider, you may not be able to do anything further unless you can demonstrate that the provider's appeal process violated the law. For example, when appealing a claims denial, our insurer initially informed us that we had two levels of appeal but later informed us that we had only one so I contacted EBSA. In addition, if you think it is justified, you could also state that the insurer violated the Maryland law (discussed above) that requires traditional insurance plans to cover a non-participating provider in the event that they do not have a provider on their panel who specializes in working with individuals with Down Syndrome.

If you have a PPO or POS plan: One other thing you can do is contact your insurance company to request the maximum reasonable and customary amount that they reimburse for each CPT code should you see an out-of-network provider. Then compare the reasonable and customary amount for each code against the reasonable and customary reimbursement rates listed on FairHealth.org, a consumer website that provides estimates of the costs of healthcare by zip code (see "Additional Information" below). If there is a significant discrepancy between the reasonable and customary amount quoted by the insurance company and the rate obtained from FairHealth.org, file a complaint with either the Maryland Insurance Administration (for traditional/fully-funded plans) or EBSA (for self-funded plans) documenting the discrepancy.

Obtaining Coverage for Brand Name Medications when the Generic is Not Equivalent

Many prescription plans are now requiring that the generic form of a medication be used, rather than the brand name, because the generic form is less expensive. In many cases, the generic is equivalent to the brand name. However, in some cases the brand name and generic versions are not comparable; in such a situation, you can appeal the insurer's decision if they refuse to cover the brand name medication.

When appealing the decision, obtain the following:

1) A letter from the prescribing provider (doctor or nurse practitioner) that includes the following:

- Any medications for the same indication that have been tried already (including the generic formulation of the medication in question, if applicable) and why they are not appropriate
- The consequences of not properly treating the condition

2) Documentation from any other provider(s) that support your request for coverage of the generic form of the medication.

For example, Jake has taken Prevacid SoluTabs for chronic reflux since he was 4 years old. About 3 years ago, our insurance carrier informed us that they would no longer cover the brand name medication and that we would be required to use a generic, for which there was no solutab formulation. Jake cannot swallow whole pills, and Prevacid cannot be crushed because crushing changes the way that it is metabolized. Therefore, I appealed this decision by submitting two letters, one from Jake's gastroenterologist documenting all of the medications he had tried for reflux in the past, the fact that Jake could not swallow pills whole, and the long-term repercussions of untreated reflux; the other letter was from Jake's speech pathologist documenting the reasons that Jake was unable to swallow the pill form of Prevacid from an oral motor perspective. Within a month of submission of the appeal, our insurer approved the Prevacid SoluTab.

I know this can be a lot of work, and in some cases, it may not be worth the time to appeal (e.g., a one-time evaluation). Letters also can take some time to write. However, keep in mind that letters can be re-used or easily adapted should you need to request in-network coverage for another out-of-network provider. In addition, once you go through the appeals process once, subsequent appeals usually take far less time because you are more familiar with the process and how to navigate the system.

If you have specific issues with respect to obtaining coverage for an out-of-network-provider, brand name medication, or you have any other problems with your insurance carrier, please contact me at cjjaffe@comcast.net.

Additional Resources

Maryland Insurance Administration (for traditional plans)
Detailed procedures for filing appeals or grievances with the Maryland Insurance Administration:
http://www.mdinsurance.state.md.us/sa/consumer/file-a-complaint.html

The Employee Benefits Security Administration (EBSA) (for self-funded plans)
EBSA is responsible for administering and enforcing the fiduciary, reporting and disclosure provisions of Title I of the Employee Retirement Income Security Act of 1974 (ERISA).
To file a complaint, call 866-444-3272 or complete the online form:
https://www.askebsa.dol.gov/WebIntake/Home.aspx

Fairhealth.org is a national independent, not-for-profit organization dedicated to sharing information about healthcare prices and health insurance to help consumers manage their family's healthcare expenses. The link to the website is http://fairhealthconsumer.org/

2015 Maryland Code, Title 15 – Health Insurance, Subtitle 10 – Claims and Utilization Review, Section 15-1008 – Retroactive denial of reimbursement: "If a carrier retroactively denies reimbursement to a health care provider, the carrier …. may only retroactively deny

reimbursement during the **6-month period** after the date that the carrier paid the health care provider." Here is the link to the complete code**:** **Md. INSURANCE Code Ann. § 15-1008**

2015 Maryland Code, Title 15 – Health Insurance, Subtitle 8 – Required Heath Insurance Benefits, Section 15-830 – Referrals to specialists: "Each carrier shall establish and implement a procedure by which a member may request a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel … if the member is diagnosed with a condition of disease that requires specialized health care services or medical care and the carrier does not have in its provider panel a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease …" Here is the link to the complete code: **Md. INSURANCE Code Ann. § 15-830**