A health plan is like a jigsaw puzzle. You start out with a jumble of pieces, scattered upside down, backward and sideways. But one by one, all the pieces eventually fit together to form a complete picture.

Rhonda Orin
Making Them Pay
KNOW YOUR PLAN

First, skim the entire plan to find important items.
- Benefits
- Exclusions
- Limitations
- Definitions

Then study each section in more detail and finally put it all together.
The Benefits Section

- There will be several benefits sections. Skim the whole benefits section.
- After you have skimmed it go back and read it more closely.
- Look for language like “all necessary…” This means that someone in the plan can decide if it is necessary.
- HMO’s set up incentive and penalty provisions to encourage physicians to control costs.
EXCLUSIONS

• Exclusions are listed in the table of contents.
• Exclusions are also listed throughout the plan.
• “medically necessary” means that someone in the plan can decide if it is necessary.
Exclusions

- Read the General Exclusions first.
- Proceed to the end of every benefits section for the What Is Not Covered. These are not exclusions but can have the power to deny a claim.
- Limitations and definitions are hidden exclusions and should be reviewed next.
Conditions are basically mistakes you can make that keep you from getting coverage. It is crucial to know all the conditions that effect your plan.

Example: Your plan may require you call before going to an emergency room. If you do not call the bill will not be covered.
Authorizations are just another name of conditions. If a policy requires authorization and you do not get one you will be responsible for the costs of the procedure.
Can’t tell if something is covered?

Call. The call will take longer than you expect. You may have to call several departments. Make sure you have a good attitude. Anger will not get you anywhere. Remember to write down who you called and what they stated.
Warning

Be careful of the term “acceptable charge or usual and customary charges.”

You should find out what your plan deems acceptable before your visit.

Example: I saw a neurologist at Mayo. The bill was $470 and my insurance paid $80 and I was left with $390 because they paid 80% of what the plan considered customary charge.
Can be limited by definition of medical necessity in the plan. The plan can limit the number of visits within a year.
How To Work With Your Plan

The best way to deal with your plan is to know their rules and follow them. Learn to make the rules work for you.
APIPA
www.myapipal.com/en/index_apipa.jsp
Mercy Care
www.mercycareplan.com
Care 1st
www.care1st.com/
Health Choice AZ
www.healthchoiceaz.com/
“IF YOU WANT TO FIGHT A COMPUTER, YOU MUST BECOME A COMPUTER: ALWAYS KEEP VERY CAREFUL RECORDS”
RHONDA
Speaking To Customer Service

- Request the representative enter into the computer that you are having a conversation including your name and date and then listen for typing!
- As the conversation takes place ask the representative to read back what they have entered into the computer
- Most calls get logged by confirmation number. You need to ask for that number so that you can use it when calling again regarding the same issue.
Catina’s Story

"Your body rejected the transplant, and your insurance company rejected your claim."
Speaking To Customer Service

- At the end of the conversation ask what action will be taken and then request that this be entered into the computer.

- Customer service representatives are not crazy about this approach. Make sure to be nice and apologize for the inconvenience.

- Make sure you record in your own records who you spoke with including last names, date and time, what phone number and extension, what geographic location they are and what you discussed.
The File System

- Make an annual insurance file with separate files for each member for the family including doctors notes from each visit. Make sure to request this from each physician at the visit.

- Keep a separate file for your notebook which contains all conversations and a policy file.

- Keep everything. Copy and file everything you send them and everything they send you.

- Remember to copy everything you send them!

- Ask your doctor for everything they send the insurance company as well.
A Trick

- Consider sending a letter to your insurance company after every important conversation and filing that with the claim.
- Ask the insurance company to write back immediately if anything in your letter is misrepresented.
Don’t assume they are right and you are wrong! Whenever you receive a denial or a bill make sure it is right before you accept it.

Common mistakes—wrong CPT code or ICD9s code, data entry mistake, wrong ID number, etc.
ERISA applies to private employers (non-government) that offer employer-sponsored health insurance coverage and other benefit plans to employees. ERISA does not require employers to offer plans; it only sets rules for benefits that an employer chooses to offer.
ERISA regulates and sets standards and requirements for:

- **Conduct**: ERISA rules regulate the conduct for managed care and other fiduciaries.
- **Reporting and Accountability**: ERISA requires detailed reporting and accountability to the federal government.
- **Disclosures**: Certain disclosures must be provided to plan participants (i.e. Plan Summary clearly lists what benefits are offered, what the rules are for getting those benefits, the plan’s limitations, and other guidelines for obtaining benefits such as obtaining referrals in advance for surgery or doctor visits);
- **Procedural Safeguards**: ERISA requires that a written policy be established as to how claims should be filed, as well as a written appeal process for claims that are denied. ERISA also requires (although the language is somewhat loose) that claims appeals be conducted in a fair and timely manner.
- **Financial and Best-Interest Protection**: ERISA acts as a safeguard to assure that plan funds are protected and delivered in the best interested of the plan members. ERISA also prohibits discriminatory practices in obtaining, and the collecting on, plan benefits for qualified individuals.
Types of Plans

Fully Funded: Traditional health plan funding option. Employers pay monthly premium per employee. A plan where the employer contracts with another organization to assume financial responsibility for the enrollees’ medical claims and for all incurred administrative costs.

Self Funded: A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. Some self-insured employers contract with insurance carriers or third party administrators for claims processing and other administrative services; other self-insured plans are self-administered.
Do not apply to self insured plans. Self insured plans are governed by ERISA and federal law. These must be fully self funded.
A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person’s health care (individual limit) or for the total expenses of the employer (group limit).
Steven's Law

Steven's Law requires insurance carriers to provide coverage for medically necessary therapies for children with autism spectrum disorder including Aspergers and PDDNOS. Medically necessary therapies include speech, OT and behavioral therapy including ABA. Behavioral therapy is covered up to the following amounts:

1. Benefits up to $50,000 per year for a child age 0-9.
2. Benefits up to $25,000 per year for a child age 9-16.
Limits

- Children over the age of 16 are not covered by this mandate.

- Companies with less than 50 employees do not have to follow this mandate.

- Companies that are self funded do not have to follow this mandate.
96116- Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, i.e., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.

90804- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;

90808- 75-80 minutes of face to face behavior modifying therapy, outpatient.
97532-ABA Therapist/Instructor Code

97532 (billed in 15 minute units) Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes.

97535-Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.
Eligible For Steven's Law

- Identify the type of benefit you want
- Read your plan to see if it is covered
- Look up the state law with the statute number
- Call your human resource benefits manager
- Call your insurance plan
- Denied-ask for a detailed explanation of the basis for denial in writing.
- Contact insurance commissioner, attorney general and department of health in your state.
- Appeal the denial through the ordinary appeals process as well.
Not Eligible for Steven’s law

Apply anyway
THE APPEALS PROCESS

How To Be Effective
Always Appeal!

- First, call customer service. Write down your major points before calling. Many times you can resolve the issue with customer service. Verify denial and get reasoning. Verify diagnosis and ask what ICD9s were submitted. Verify treatment (CPT codes). Take good notes—get names, phone numbers, extensions, etc.

- If you are insured by your employer contact your employer and ask for help. Often the benefits department can resolve the issue. Remember not to complain but just ask for guidance.
Filing An Internal Grievance

- Always file a grievance in writing.
- Check your policy for the grievance policy and follow it exactly.
- Consider sending the grievance letter with UPS or FEDX.
- You will need an exact address. These services will not deliver to a PO Box.
- Call customer service for the street address.
- If customer service will not give you an address just keep trying.
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Ask for informal reconsideration. You have 2 years from health plan denial.</td>
</tr>
<tr>
<td>2.</td>
<td>Read the reconsideration decision. Health plan has 30 days to make a decision.</td>
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<tr>
<td>3.</td>
<td>Send in written appeal. You have 60 days for denial of a service and 2 years for denial of a claim.</td>
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<tr>
<td>4.</td>
<td>Read the appeal decision. Health plan has 30 days for denial of a service and 60 days for a denial of a claim.</td>
</tr>
<tr>
<td>5.</td>
<td>Ask for external independent review. You have 30 days to ask for review.</td>
</tr>
<tr>
<td>6.</td>
<td>External independent review decision.</td>
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### OVERVIEW OF AHCCCS APPEALS PROCESS

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<th>Step</th>
<th>Action</th>
<th>Timeline</th>
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<tr>
<td><strong>Step 1:</strong></td>
<td>ASK FOR THE SERVICE</td>
<td>Health plan has <strong>14 days</strong> to make a decision</td>
</tr>
<tr>
<td><strong>STEP 2:</strong></td>
<td>READ THE FIRST DECISION</td>
<td>You have <strong>60 days</strong> to appeal</td>
</tr>
<tr>
<td><strong>STEP 3:</strong></td>
<td>SEND IN APPEAL</td>
<td>Health plan has <strong>30 days</strong> to make a decision</td>
</tr>
<tr>
<td><strong>STEP 4:</strong></td>
<td>READ THE APPEAL DECISION</td>
<td>You have <strong>30 days</strong> to ask for fair hearing</td>
</tr>
<tr>
<td><strong>STEP 5:</strong></td>
<td>ASK FOR A FAIR HEARING</td>
<td>Hearing usually set within <strong>20-40 days</strong></td>
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<tr>
<td><strong>STEP 6:</strong></td>
<td>FAIR HEARING</td>
<td>Final decision within <strong>30 days</strong> of Judge’s decision</td>
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<tr>
<td><strong>STEP 7:</strong></td>
<td>AHCCCS FINAL DECISION (May be appealed to Superior Court)</td>
<td></td>
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Letter of Medical Necessity Should Contain:

- Your exact medical diagnosis/medical condition.
- How long your condition will last.
- Why you need the service and a description of the service.
- What health problems will occur if you don’t get the service.
- What other treatment or services were tried, if any and why they did not work.
- Included medical records that support the services requested.
Writing The Letter

- Address every reason why the coverage denial was incorrect.
- Be persuasive. Read thoroughly to make sure there is nothing in the letter that can be used against you.
- Attach documents that prove your claim. Letters of medical necessity, scripts, doctors notes, peer reviewed studies and articles.
- Try to keep the letter short. Do not vent. Be matter of fact and direct. Only 1 ½ pages!
- Include all information that supports your case. You may be excluded in raising other issues later.
File An External Grievance

- If your internal grievance fails the next step is usually the external grievance.
- Ask customer service if it offers any external review procedures.
- Insurance companies will often pretend to do an “external review.”
- States can not always mandate external grievance if the plan is governed by ERISA.
Federal and State Resources:

Arizona Department of insurance:
800-325-2548
www.id.state.az.us

Arizona Health Care Cost Containment System
800-654-8713
www.ahcccs.state.az.us

Centers For Medicare and Medicaid Services:
800-999-1118
www.cms.hhs.gov/medicare

Department of Labor:
(859) 578-4680
www.dol.gov
Universal Claim Forms

- Claim Forms and Appeal Forms can be found online on your insurance’s website in the forms section.
- It is best to use the forms from your insurance but you can use a universal claim form (CMS-1500) which you get from your doctor or insurance company.

- Universal Claim Form (CMS-1500)
  - [http://www.medical-coding.net/claimforms/claim_form_manual_v1-3_7-06.pdf](http://www.medical-coding.net/claimforms/claim_form_manual_v1-3_7-06.pdf)
- Universal Appeal Form
  - [www.id.state.az.us/publications/APPEAL_REQUEST_FORM.pdf](http://www.id.state.az.us/publications/APPEAL_REQUEST_FORM.pdf)
Additional Resources

http://www.azautisminsurance.org/facts.html

ASA-GPC “How to Navigate the Insurance Process” CD

Your doctor/referral coordinator

Your insurance website:
Cigna
www.cigna.com
Blue Cross Blue Shield
www.bcbs.com
United Health Care
www.uhc.com
Aetna
www.aetna.com