HELPFUL COVERAGE TIPS FOR PARENTS OF SPECIAL NEEDS CHILDREN

Virginia Code §38.2-3418.5 requires that coverage for medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices be provided to eligible persons covered under an applicable policy.

Applicable policy includes:
Policies and contracts issued in the Commonwealth of Virginia to groups and individuals by health insurers and HMOs, including Managed Care Health Insurance Plans, (hereinafter referred to collectively as "health plans").

Policies exempt from this requirement:
Short-term travel, accident only, limited or specified disease policies, policies or contracts designed for issuance to persons eligible for coverage under Medicare, short-term nonrenewable policies of not more than six months' duration, policies issued and insured by a single employer (self-funded employer), or policies issued to a group, individual, trust, or association located outside the Commonwealth of Virginia.

Requirements for eligibility:
A covered child must be certified by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) as eligible for services under Part C of the federal Individuals with Disabilities Education Act (IDEA) (20 U.S.C. § 1431 et seq.), formerly known as Part H of IDEA (20 U.S.C. §1471 et seq). Services under this benefit are only available until the child reaches the age of 3 years. You can find out more about this process and eligibility requirements by contacting the Infant & Toddler Connection of Virginia, which is part of DMHMRSAS, toll-free at 1-800-234-1448, or on the Internet at www.infantva.org

Cost of services:
Federal funds, state general funds, or local government funds appropriated to implement these services may be used to pay an eligible member's copayment, coinsurance or deductible if the cost of care would prohibit the family's use of the early intervention services. Health plans cannot charge a higher copayment, deductible or coinsurance for this benefit than for physical illness in general. The benefit is limited to $5,000 per covered person per contract or calendar year. The cost of the services to the member cannot be subject to the member's lifetime maximum benefit.

What happens at age three and beyond:

The insurance coverage requirement for early intervention services for your child ends at the age of 3 years. You, your child's health care provider, DMHMRSAS, and possibly your child's school district can be involved in coming up with a transition plan for your child. You might be able to obtain additional therapy services through your health plan. These services, however, may be excluded for your child's condition or limited to a short-term benefit as described below. You should read your health plan's coverage document to determine your benefits.

Listed below are examples of *Exclusions* (services not covered) under some health plans' coverage documents. Each health plan will have its own exclusions. Your health plan's exclusions may vary:

- Therapy services for delayed or abnormal speech.
- Maintenance therapy services.
- Group speech and physical therapy.
- Speech therapy performed to correct impairment resulting from a functional nervous disorder.

- Educational or teacher services.
- Services or devices deemed not medically necessary, or experimental/investigational as determined in your health plan's sole discretion.

Listed below are examples of ***Limitations*** (services covered on a limited basis) under some health plans' coverage documents. Each health plan will have its own limitations. Your health plan's limitations may vary:

- Services for short-term physical, occupational, and speech therapy only to the extent that significant improvement can be expected to result within a period of 90 consecutive days.
- Rehabilitation services only to the extent that they restore the individual to a pre-trauma, pre-illness or pre-condition level.

Your health plan's appeal process:

The complaint/appeal systems vary somewhat among health plans, however, the following tips should be applicable to most plans.

- *Decide whether you should appeal:* If the service or device you are requesting is clearly and specifically excluded in your health plan's coverage document, an appeal most likely will not change your health plan's determination. If, however, your plan's denial was based on a medical determination that the service or device is not medically necessary or is experimental/ investigational, and you or your provider can obtain information to the contrary, your appeal may be successful.
- *Call your plan*: If you receive a denial from your plan or if you have a question, you or your health care provider may contact your plan by phone at the number listed on the Member ID card. This is usually a good starting point. It is important that you accurately record this contact. Keep a record of the person's name with whom you spoke, the date and time of your call, and the outcome of your call.
- *Send a written appeal*: If a further appeal is needed, you will need to submit a written appeal to the health plan. In your appeal, clearly state what you are appealing, include the date of service, provider name, and claim number, if applicable, and the desired outcome. Also include any medical information from either your or your provider's records, a provider's letter, or articles from peer-reviewed literature to support your request. You may or may not be able to present your case in person to a committee.

Contacting the Office of the Managed Care Ombudsman:

We invite you to contact our office if you have any questions or at any point during the appeal process. If you have not begun your appeal process, our office can discuss the mechanics of an appeal with you. When you submit your written appeal to your health plan, you may send our office a copy and we will forward to you our Inquiry Form, then we will be able to formally assist you in the appeal process. You can contact us toll-free at 1-877-310-6560, or on the Internet at www.scc.virginia.gov

Additional options for appeal:

If your appeal for a service or device remains denied after you have exhausted your health plan's internal process, you may file a complaint with the Virginia Department of Health, or you may be eligible to submit an external appeal through the Virginia State Corporation Commission Bureau of Insurance. You should receive the necessary contact information and forms needed for external appeal following your health plan's final decision.