

# Health Care

There are a variety of problems that you might encounter when dealing with a managed health care system (HMO). Some families may receive the answer that the service requested is not covered at all. Or, that the service will be covered, but only for the professionals in their 'approved' list, unless it can be shown that there is no one appropriate on the list. There can be many reasons to request a service that may not generally be covered (language therapy, occupational therapy, etc.) or to use a specialist who is not on their 'list'. But, there is also a procedure that needs to be followed to obtain what you need, and it is important to know what the procedure is for your insurance company. Be sure to read the handbook that you receive, and notice the list of what is and is not covered that they have put in writing. This is, however, not always an inclusive list, so you can call the customer service number on the back of your card and ask specific questions.

## **Some facts to know:**

- Ü Most HMOs cover strictly-medical expenses themselves, but use a contracted smaller company to cover mental health benefits. This is why you may be referred to another company when you call asking about coverage.
- Ü HMOs have a complaint or 'grievance' policy, usually handled by someone other than the customer service representative on the phone. You can ask to speak with someone who handles 'grievances'.
- Ü HMOs also usually have a team of doctors and nurses who make decisions on what is and is not covered and under what circumstances. They are the ones, ultimately, who have the power to make some coverage decisions. Company policies can vary as to whether or not you can speak with these people on the phone, but requests in writing will most likely be sent to them for decisions.
- Ü HMO customer service representatives are required to document your call on their computer in terms of what you are requesting, the date, the reasons, etc along with their response. Do not depend on their records, however; keep your own notes about ANY conversation as well as the name of whomever you spoke to and their department.
- Ü In Connecticut, there is a 'mental health parity' law that mandates coverage for "biologically-based mental nervous conditions" at least equal to coverage provided

for medical or surgical needs.

## **Some advice in obtaining coverage of questionable services:**

Ü Get the written policy information and read it thoroughly. Follow all procedures to be sure you look 'cooperative' and have covered all bases so they cannot deny coverage on technicalities.

Ü Follow the necessary hierarchy when you call the HMO, even if you have to set aside several afternoons to go through the steps and talk to everyone you need to (you will be put on hold a lot – be patient, and speak politely no matter how long it takes. They will only help you if they WANT to help you).

Ü Document every step of the way, including names, departments, dates, requests and answers, and direct phone numbers for those you may have to call back (so you don't have to go through the same menu and course of people).

Ü Do not accept no for an answer by itself. Get the reason, and check and see if it is documented anywhere in their writings. Ask where you can find such a statement in their handbook. This will help you figure out if you need to file a grievance for their not following their own policy, to obtain an exception to the policy due to circumstances, or to get the policy itself changed.

Ü When you call, follow the hierarchy. Speak to the customer service rep, and when their answer is not acceptable, ask for a supervisor. Explain your circumstances clearly, and be politely clear that their negative answer is simply not acceptable. Always ask politely what the next step would be to get this disagreement resolved. Sometimes they will give you to superiors just to be rid of you.

Ü Be prepared to be shifted between the major HMO and their contractor who handles mental health (even though, technically, developmental disabilities are not mental health related – it may work out to your benefit in the long run). Do not accept the answer that autism is not on their 'list' of covered conditions, especially if it is not on the mental health providers list either. It needs to appear on someone's list or you can argue for coverage on the basis that it is not a written excluded condition.

Ü Don't be afraid to state that Connecticut has a mental health parity law, and ask how that affects their decision.

Ü It helps to have written documentation from doctors as to the need for the service, and it should state that it is a medical need (not an educational one!). Pediatricians are usually happy to write a referral letter explaining the need, and

sometimes their word can carry more weight. Some pediatricians (or their benefits administrator) are exceptionally good at managing the system, so ask for their help.

If the service is covered, but your preferred provider is not on the approved list, you can argue for the delivery by that person because of a needed expertise that none of the providers on the list have (which you may have to prove by calling them and documenting the answers). Or, that there is no one with the expertise within a reasonable distance (they have guidelines on how many miles away 'reasonable' is – check the miles for the provider they refer you to from their list! Sometimes they will tell you they are closer in miles than they actually are. This is an acceptable dispute, as well as the need to take a child out of school in order to make a long trip).

Ü Put your request in writing if you don't get an acceptable answer within a couple of days by phone (sometimes they will need to get back to you with an answer - this can be OK, but don't wait too long – they can forget about you. Be sure they send you something in writing afterwards even with the phone agreement). Get the proper address to send the written request to during the phone conversation, and let them know you will request it in writing with appropriate background info (like notes from doctors).

Ü Get an answer from the HMO in writing, along with a detailed explanation if the answer is no.

Ü File a written 'grievance' (be sure to use that word) with the company when you have been denied, and send a copy to the State of Connecticut Insurance Department and your pediatrician or any other doctor that wrote referrals for you. Then appeal any negative decision after that as well, following their 'appeals' procedure.

Ü Don't be afraid to contact the State Insurance Department for advice, or for help with a dispute (but do so in writing including the written answer from the HMO).

Ü In Connecticut, there is a Governor-appointed State Office called the Managed Care Ombudsman. It is his/her job to assist people with their HMO questions and disputes.

Ü Be in contact with your employer's Benefits Coordinator about your experiences with the HMO they are using. They may wish to change HMO's; they may try to help you with your grievance; or they may want to add riders to the policy that might help you (riders usually cover things like glasses, eye care, dental, etc.).

**For more information, contact the State Office called the Managed Care**

**Ombudsman toll free 1-866-HMO-4446 or check their website [www.omc.state.ct.us](http://www.omc.state.ct.us), or contact the State of Connecticut Insurance Department (860) 297-3800 or 800-203-3447.**