

General Information to remember

* Trailer bill language enacted by California in 2009 requires parents to access their insurance for speech, occupational, or physical therapies prior to San Andreas Regional Center funding of these therapies

* You have a right to ask for an assessment if you believe that your child is showing developmental delays.

• Ask your health plan to provide the service to your child. If you are told that the services are not medically necessary, ask for your child to be assessed.

• If the health plan denies your request for an assessment or for the service, you may appeal the denial. Information about how to appeal will be included in the letter informing you of the denial.

• If the health plan denies your appeal or does not respond to your appeal within 30 days, you may request an independent medical review (IMR) from the Department of Managed Health Care. Information about the IMR process will be included in the denial letter. You can also obtain information about the process at www.healthhelp.ca.gov or by calling 888-466-2219.

• If the health plan authorizes one of these therapies for your child, it may do a periodic assessment of his or her progress to see if the treatment continues to be medically necessary.

* Generally, insurance companies should respond to your request within 30 to 45 days of the request being made.

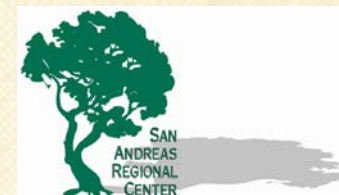
What is my recourse if my insurance company denies funding of the therapy?

If your appeal is denied or if you have not received a response to the appeal within 30 days, you may request an Independent Medical Review (IMR) from the Department of Managed Health Care. Information about the IMR process and how to get help is available at www.healthhelp.ca.gov or by calling 1-888-466-2219. The letter informing you of the denial of your appeal should also include information about the IMR process. The Department of Managed Health Care regulates all HMO plans and two PPO plans provided by Anthem Blue Cross of California and Blue Shield of California. If your health plan is a “point of service (POS),” an “exclusive provider organization (EPO),” or a “Preferred Provider Organization (PPO)” other than Anthem Blue Cross of California or Blue Shield of California, it is not regulated by DMHC. Such plans also offer an independent medical review process, but it is provided through the California Department of Insurance. You may call 800-927-4357 or visit their Web site, www.insurance.ca.gov.

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Additional information can be found at
www.sanandreasregionalcenter.org/
www.insurance.ca.gov

A PARENT'S GUIDE: HOW TO REQUEST SPEECH, OCCUPATIONAL, OR PHYSICAL THERAPY FROM YOUR INSURANCE COMPANY



NAME OF INSURANCE COMPANY

CHILD'S POLICY# _____

YOUR SERVICE COORDINATOR IS:

YOUR SERVICE COORDINATOR CAN
BE REACHED BY PHONE AT

() _____ OR BY
E-MAIL AT
_____@SARC.ORG

*“Consumers first through service,
advocacy, respect, and choice”*

How do I know if my child is recommended to receive either speech, occupational, or physical therapy?

After the comprehensive assessment is completed, you will participate in the Individual Family Service Plan (IFSP) where the assessment results and recommendations will be discussed. At that time, you will be given the recommendations under the SARC criteria.

How do I request funding for the therapy as recommended at the IFSP?

For PPO and EPO policies you can go directly to your child's pediatrician and ask for a prescription for the recommended services to take to a vendor that accepts your insurance. For HMO policies you can ask your child's pediatrician to give a referral or authorization to an in network provider for the recommended services. Or for all policies you can go directly to your insurance plan and request services. The insurance company may request to do an insurance evaluation to determine medical necessity.

What is the insurance company responsible for funding?

Insurance company health plans are generally required to cover basic health care services that are medically necessary. Speech, occupational, and physical therapies if covered are under general medical benefits and may be covered if services are medically necessary under your policy.

Is my insurance company responsible for funding recommended Speech, Occupational, or Physical therapies? Your insurance company is only required to cover what is covered under your specific policy or for fully funded plans any State or Federal Mandates. The California Department of Managed Healthcare includes all HMOs, Blue Cross and Blue Shield. The DMHC requires your health plan to provide speech, occupational and physical therapy that is deemed medically necessary under your policy.

How do I know what coverage I have?

You can find out what benefits are covered or excluded by your health plan in a document called the Evidence of Coverage, or EOC. You should receive an EOC from your employer or directly from your health plan on an annual basis. If you do not have one, you may request a copy. These documents may also be available on your health plan's Web site.

What is the time frame for insurance companies to respond to a therapy request?

Insurance companies have 30 to 45 business days to respond to your request.

What should I do if my insurance denies funding the therapy?

You may appeal the denial for services through an independent medical review (IMR). Information on how to appeal a denial of service should be included in the denial letter from your insurance company. This information is also available at www.healthhelp.ca.gov or by calling 1-888-466-2219.

What is an Independent Medical Review (IMR)?

The IMR is the process for appealing a decision. Information on how to appeal the decision is included in their letter, but you can also get information from www.healthhelp.ca.gov or by calling 1-888-466-2219.

What if my insurance company agrees to fund sessions, but the authorized sessions are less than the IFSP recommended therapy?

Please speak to your service coordinator about this issue, as San Andreas may be able to provide you with additional support.

Will San Andreas cover my co-pays or assist with my deductibles?

San Andreas may assist with co-pays or deductibles if the family income is less than 400% of the Federal Poverty Guideline (W&IC 4659.1 sec. 7). Ask your service coordinator about the process for obtaining this assistance.

What is a utilization review?

This process is when your health plan may periodically evaluate your child's progress in therapy to see if continuation of services is medically necessary.

What happens when the insurance sessions are exhausted, but your child continues to need therapy, and is still under the age of 3? San Andreas will fund the needed therapy once the insurance is exhausted, up to age 3. You should consult your service coordinator for options before the insurance sessions end.