Parent to Parent

POCKET PAL
GUIDE TO HEALTH INSURANCE

Coordinated by Family Faculty

Family-Centered Care

January 2012

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Welcome to Children's Specialized Hospital

Dear Parents and Caregivers,

In an effort to partner with families and caregivers to provide the best health care experience for children, this **Pocket Pal** has been prepared for your use. The goal of this **Pocket Pal** is to offer some important and practical information regarding your health insurance. Our hope is for this to be a useful resource you can refer to over and over again.

Learning about your insurance coverage and the benefits provided by your Health Insurance Carrier can be a difficult and time consuming task. It is very important that you understand how your insurance works and what you need to do to access it. The fact that you have insurance does **not guarantee** that every medical service, or piece of adaptive equipment that your child may need, will be covered. We have highlighted some information in this **Pocket Pal** that may help you understand your insurance and utilize it effectively. We hope this information will also help you to take charge of your health insurance and advocate* for your children.

**Please refer to the glossary*

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Patient Access Liaison (PAL) Telephone Numbers

For any questions or insurance concerns please do not hesitate to contact the Patient Access Liaison (PAL) at the appropriate number listed in this **Pocket Pal.**

Main Number
Children's Specialized Hospital **1-888-CHILDREN**
1-888-244-5373

For Initial Evaluations for Physical Therapy, Occupational Therapy, Speech Therapy, Audiology, Nutrition, Rehabilitation Technology, Ambulatory Care Center, Autism, Feeding Team Evaluations, and Psychology please call our Patient Access Liaison at
1-888-CHILDREN (1-888-244-5373) EXTENSION 5193.

Reports – After the day of your evaluation, you should expect to get your reports from our HIMS (Health Information Management System) department in **3 full weeks.** If you have not received the report in three weeks, please contact:

Toms River:	**732-797-3822**
Hamilton:	**609-631-2820**
New Brunswick:	**732-258-7156**
Mountainside, Bayonne, Clifton:	**908-301-5421**

For Clearance to Proceed With Treatment

After the day of your evaluation, you should expect to hear from us about your insurance clearance for treatment in **2 full weeks** from your evaluation date. *(Horizon Blue Cross and Horizon New Jersey Health typically take 3 full weeks.)* If you have not heard about your treatment authorization within two weeks, *(Horizon Blue Cross and Horizon New Jersey Health within three weeks)* please contact our Patient Access Liaison at **1-888-CHILDREN (1-888-244-5373) EXTENSION 5193.**
For Authorization and Reauthorization please contact our PAS (Patient Access Services) Liaison at **1-888-CHILDREN (1-888-244-5373) EXTENSION 5193.**

Hospital Assistance Program (HAP): Children's Specialized Hospital's program for subsidizing payment for those with financial need that has specific guidelines for eligibility. Contact Patient Access Services for more information and an application at **1-888-CHILDREN (1-888-244-5373) EXTENSION 5193.**

The orthotics/bracing companies (body jackets, braces, etc) are independent of Children's Specialized Hospital. Please contact them directly with any questions regarding insurance or coverage.

WHAT YOU NEED TO KNOW ABOUT YOUR INSURANCE CARRIER:

- Know the name of your insurance carrier and always carry your insurance card which has a member ID number, plan or group number, and customer service phone number printed on it. For a list of insurance companies that are accepted by Children's Specialized Hospital please refer to pages 29-30.
- Know if you have more than one insurance. It is important that you provide information on all insurances.
- Know if the provider* you are going to, is an in-network* or out-of-network* provider*.
- Know your child's diagnosis.
- Know if you need a referral form* for services and bring it with you to your appointment. Be sure it is valid and has not expired for the services you are receiving.
- Know if you need a prescription* for services. Prescriptions are required for outpatient physical, speech or occupational therapy.
- Know if you need prior authorization* for services.
- Know if you have a co-payment* and how much that co-payment* is.

**Please refer to the glossary*

- Children's Specialized Hospital is a hospital and bills as a facility for all inpatient and outpatient services. Please check your insurance benefits related to your out of pocket obligations.
- Our Pediatric Practice is a doctor's office and you are expected to pay your co-payment when you arrive.
- Please refer to your individual insurance policy benefits to understand what your out of pocket obligation will be. For a list of insurance companies accepted by Children's Specialized Hospital please refer to pages 29-30.
- Know if you have a deductible* and co-insurance*. Know if you have a CAP* on life-time coverage*.
- Know if you need to pay your bill at the time of services or at the time you are billed.
- Know if you must submit the claim to your carrier yourself, what the process is to file a claim, and what paperwork your insurance carrier requires when filing a claim with them.
- Be aware that even if Children's Specialized Hospital is a participating facility* in your insurance plan that does not mean the particular service will be covered.

**Please refer to the glossary*

- Be aware that even if you get prior authorization* from your insurance carrier this does not mean that the service will be covered. You still need to check your individual policy.
- Conditions such as cerebral palsy*, spina bifida* as well as others that may occur at or shortly after birth may limit coverage for physical therapy, occupational therapy, or speech therapy and may need more specific diagnosis for medical necessity.*
- Check with your insurance company before receiving services to find out about exclusions* for services including *diagnosis and conditions*, number of visits, prior authorization, etc.
- If your child receives services that are not covered by your insurance plan you are responsible for payment.
- Check with your employer's Employee Benefits Representative, usually in the Human Resources Department, or your particular insurance carrier, directly using the phone number on your card to understand your benefits.

**Please refer to the glossary*

- Best practice is to get proof of benefits in writing.
- Remember, always have a pen and paper handy when talking to your insurance company. Write down everything including representative's name and request a call tracking number or reference number.
- It is your responsibility to keep your records related to your child's care. Keep all Explanation of Benefits (EOB)* to compare to your bills and have as proof of medical expenses for income tax purposes, or if trying to get other funding for your child's care. It is a good idea to put all bills and explanation of benefits matched up in a separate folder or three ring binder.

**Please refer to the glossary*

WHAT YOU NEED TO KNOW ABOUT DURABLE MEDICAL EQUIPMENT (DME)*:

- We will work closely with you through our Rehabilitation Technology clinic to connect you with an in-network supplier as Children's Specialized Hospital does not provide durable medical equipment (DME)*. Other options will be discussed at the initial evaluation.
- You will need a prescription for Rehabilitation Technology evaluation and fitting appointment for DME.*
- You will need to provide a prescription to your insurance carrier for DME* funding.
- Know if you have a CAP* on DME* coverage.
- For questions regarding DME* please contact the Rehabilitation Technology Department at **1-888-CHILDREN (1-888-244-5373) EXTENSION 5615.**

**Please refer to the glossary*

TAKING CHARGE

BECOMING YOUR CHILD'S ADVOCATE:

- When checking on insurance coverage for your child's care, **DO NOT JUST DO IT OVER THE PHONE.** If you simply call and ask about your coverage for a certain procedure or treatment, the customer service representative may give you his/her idea of what he/she thinks the policy states. **GET EVERYTHING IN WRITING!**
- You should contact your insurance company with a request that they provide you with a written pre-determination* of your exact coverage and any eligibility or requirements that must be met in order to get the service covered. If time is a factor ask to have information faxed or e-mailed to you.
- It is helpful to get any determination of benefits in **WRITING** from the insurance company. Written verification of the insurance company's intent to pay for services is a much more useful tool than anything stated by a customer service representative if you need to question the claim.
- For information regarding your benefits and requirements contact your insurance company, visit their website or work with your employer.

**Please refer to the glossary*

- Speaking with the same person at the insurance company is a good idea and may help you with getting both the information and coverage for services. If your child has complex medical needs we recommend that you request a case manager* at your insurance company. Be sure to share the case managers' name with your provider.
- Keep a log of every contact with the insurance company. Every customer service contact has a tracking/reference number. Be sure to write down the date, time of the call, name of the customer service representative, tracking number, and result of the call.
- If you need to pay your bill at the time of service for your child, you will need to submit your claim form and bill to the insurance company yourself for reimbursement*. Be organized when sending in claims to the insurance company yourself by making a copy and keeping a separate "claims submitted" folder or three ring binder. Be careful when completing claim forms and double check your work to avoid errors that will delay payment. Keep a copy of every claim form and bill sent in to protect yourself against loss of the originals and for your own use when you receive claim payments.

*Please refer to the glossary

INSURANCE APPEALS:

- If you think that payment was denied* or processed wrong for a claim that your insurance policy clearly covers, use the appeal process* that every insurance company offers to their customers.
- A family requesting an appeal will usually get a faster response than an appeal by a provider.
- Carefully read the denial letter and follow the instructions provided. Be sure to note any time frame listed regarding the appeal process.
- If denial pertains to DME* inform Rehab Tech staff immediately as they may be able to assist with the appeal.
- If you have questions regarding the appeal process contact your insurance company and keep a written record of whom you spoke with, including dates, times, reference/tracking number.
- When preparing your written appeal be sure to attach copies of your policy to back up your claim. You may be able to obtain the wording of your policy in the policy handbook or on your insurance carrier's website.
- Be sure to save a copy of the written appeal and a record of all contacts with the insurance company.

*Please refer to the glossary

- Be assertive when using the appeal process. This is an opportunity to partner with your child's health care providers for positive results for your child.
- Be persistent in following up with the insurance company to check the status of the appeal. Keep detailed records of whom and when you spoke with time/date & status of phone call.
- Be ready to appeal the claim at least twice.
- If you are not reimbursed after the appeals and do not believe that you were given enough details about the denial, contact the Office of Insurance Claims Ombudsman at the Department of Banking and Insurance, **1-800-446-7467.** Report your problem with getting reimbursement. Send the person you talk to a written report of the problem and a copy of the section in your insurance policy that states that you are covered for the service for which you are having trouble getting reimbursed. To save time and money you may also get their fax number and fax the paperwork. Include any other information you feel would be important information in making your case as well as any information the Department of Banking and Insurance needs. Be sure to keep a copy and records of all paperwork and telephone contacts.

- Follow up on your appeal with a call two weeks after the complaint is sent to check the status.
- Contact Disability Rights NJ at **1-800-922-7233**. After hearing the facts of your case, they will let you know if they are willing to take the case. You have the option to contact a private lawyer to assist you with your appeal however, there will be fees.

*MEMBER MEDICAL APPEALS AND PROCESS FOR CONTINUATION OF BENEFITS:

- Service Denial
- Member files appeal timely *(60-90 days)*
- Member request an extension of benefits *(Must submit written request within 10 days of denial)*
- Stage 1 Appeal
- Stage 1 Appeal Denied
- Stage 2 Appeal *(Member has 60-90 days to file for Stage 2 appeal)*
- Stage 2 Appeal Denied
- Stage 3 Appeal *(Member has 60 days to file appeal)*
- Stage 3 Appeal Denied
- Member files for a Fair Hearing *(Member has 20 days to file)*
- Member requests an extension of benefits *(Must submit written request with 10 days of Stage 3 denial)*
- Fair Hearing Denial
- Discontinuation of Benefit

**Member Appeals and Continuation of Benefits Flowchart 052810.vsd*

RESOURCES FOR APPEAL PROCESS:

Disability Rights NJ
210 South Broad St., 3rd floor
Trenton, NJ 08608
Toll Free in NJ only: 1-800-922-7233
1-609-292-9742
www.drmj.org

Office of Insurance Claims Ombudsman
Department of Banking and Insurance
20 West State Street
PO Box 472
Trenton, NJ 08625-0471
1-800-446-7467
Fax: 1-609-292-2431
ombudsman@dobi.state.nj.us

ALTERNATE FUNDING RESOURCES:

CICRF
Catastrophic Illness in Children Relief Fund
NJ Dept. Human Services
PO Box 728
Trenton, NJ 08625-0728
1-800-335-3863
www.nj.gov/humanservices/cicrf/text/

If you know or suspect your child has special needs:
Special Child Health Services (SCHS)
Department of Health and Senior Services
PO Box 360
Trenton, NJ 08625-0360
1-800-367-6543
1-609-292-7837
www.nj.gov/DHSS/FamilyHealthServices

If your child has a developmental disability:
Division of Developmental Disabilities (DDD)
PO Box 726
Trenton, NJ 08628-0726
1-800-832-9173
www.state.nj.us/humanservices/ddd/index.html

If your child has complex, expensive/extensive medical needs:
Medicaid Community Care Waiver Unit of Division of Developmental Disabilities
1-609-987-2040
www.state.nj.us/humanservices/dmahs/childrens.html

If your child needs health insurance:
New Jersey FamilyCare
1-800-701-0710
www.njfamilycare.org

If you need help meeting the basic needs of your child, such as food, housing, medical care:
New Jersey's County Boards of Social Service:
Division of Family Development
1-609-588-2400 *(request the number for your county's board)*
www.state.nj.us/humanservices/dfd/home/index.html

Social Security Administration:
1-800-772-1213
www.ssa.gov

If you need help advocating for your child in school, child care or health care:
Statewide Parent Advocacy Network (SPAN)
1-800-654-SPAN (1-800-654-7726)
www.spannj.org

You can explore Medicaid as a secondary option for health insurance coverage. Some (not all) families may be eligible for one of these benefits:

Family Care Medicaid—800-356-1561
(eligibility based on income)
SSI Medicaid—800-772-1213
(eligibility based on income and disability)

Centers for Medicare & Medicaid Services
Medicaid State Waiver Program
www.cms.gov/MedicaidStWaivProgDemoPGI/

Medically Needy Fact Sheet-State of NJ:
(May provide medical coverage to certain needy individuals who may not be able to afford health care services, and who do not qualify for the regular Medicaid program.)
http://www.nj.gov/humanservices/dmahs/clients/medicaid/medically_needy_fact_sheet.pdf

DDD Community Care Waiver
Division of Developmental Disabilities
PO Box 726
Trenton, NJ 08628-0726
1-609-631-2274
www.state.nj.us/humanservices/ddd/services/ccw/

United Health Care Children's Foundation
Provides grants to children for services not covered through commercial insurance plans.
www.uhccf.org

If you want more information about these and other resources that may be available to help your family:

Caregiver NJ
(State and Federal web-site links for Caregivers)
Department of Health and Senior Services
PO Box 360
Trenton, NJ 08625-0360
1-800-367-6543 1-609-292-7837
http://www.state.nj.us/caregivernj/resources/other.shtml

Noah's Never Ending Rainbow
(Provides national resources for support groups,
diagnosis specific, medical support, financial support,
and wish granting.)
http://noahsneverendingrainbow.org/index.php/resources/

GLOSSARY:

Advocate: A person who speaks or writes in support or defense of a person, cause, etc. A person who pleads for or on behalf of another. To argue in favor of. To push for something.

Authorization: Authorization given by a health plan for a member to get services from a health care provider. This is commonly required for doctor and hospital services. This does not mean that the services will be paid for.

CAP: CAP is a policy limitation which means the maximum benefit that will be paid under your policy for a particular service be it visits, days or dollars.

Case Manager: An individual assigned by an insurance company who has the job of coordinating care, discharge planning, and arranging for attendant and home care, etc.

Cerebral Palsy: This affects muscle tone, movement, and motor skills (the ability to move in a coordinated and purposeful way). Cerebral Palsy can also lead to other health issues, including vision, hearing and speech problems, and learning disabilities.

Co-insurance: The percentage of the charge the patient is responsible for. If a patient has 20% coinsurance, they are responsible for 20% of the charges. The insurance will pay 80%.

Co-payment: The pre-determined fee that an individual pays for health care services, in addition to what the insurance covers. For example: some HMO's require a $20.00 "co-payment" for each office visit, regardless of the type or level of services provided during the visit. Co-payments are usually due at the time of your medical visit.

Covered Services: All services for which a health insurance company has stated in a written agreement or contract that it will pay its share of the cost.

Denial: Refusal by an insurance company to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional. If a claim is denied by an insurance company that means they will not pay the claim.

Deductible: The dollar amount the patient has to satisfy before the insurance company will pay for services.

DME: Medical equipment used in the course of treatment or home care, including such things as crutches, knee braces, wheelchairs, hospital beds, prostheses, etc. DME is considered equipment that can withstand repeated use. All DME must be prescribed by a physician and is appropriate for use in the home or community setting.

Explanation of Benefit (EOB): The insurance company's written explanation of a claim, showing what they paid and what the insured must pay.

In Network/Participating Provider: Any provider with whom a plan has a contractual agreement to provide care for its enrollees. Participating Providers agree not to charge enrollees more than their contracted fee. Getting services at an In Network Provider does not mean that the services will be paid for.

Medical Necessity: Services determined to be covered services required to preserve and maintain the health status of a member or eligible dependent in accordance with insurance carrier's standards of medical practice.

Out-of-Network: Doctors, hospitals and other selected providers that are not in the HMO's network. HMO members who get care Out-of-Network without getting permission from the HMO to do so may have to pay for all or most of that care themselves.

Participating Facility: Hospitals that are in your health insurance network. These hospitals have special agreements with your health care provider to provide services for your care. Payment for services received at a participating facility is not guaranteed.

Predetermination: Is when a provider submits a treatment plan to the health insurer before treatment begins. The insurer reviews the treatment plan and tells the provider of one or more of the following: Patient's eligibility, covered services, amounts payable, co-payment and deductibles and plan maximums.

Prescription: A written order, especially by a physician, for the preparation and administration of a medicine or other treatment.

Provider: A term used for health professionals who provide health care services.

Referral Form: A form that states your name, ID number, and name of the doctor or facility to whom you are being referred. It will also list the number of visits for which the referral is valid.

Reimbursement: The amount of money an insurance company will repay after a claim has been submitted and approved for payment.

Spina Bifida: This occurs when the spinal cord, surrounding nerves and/or spinal column fail to develop normally during the first 28 days of gestation. The condition can affect the nervous, urinary, muscular and skeletal system, often causing bowel and bladder complications and paralysis below the spinal defect.

SOURCES:

Romano, Joseph L., Esq., *Legal Rights of the Catastrophically Ill and Injured: A Family Guide.* Second Edition. Section XV, Managed Care, page 120.

Robinson Rosenfeld, Lyn, L.C.S.W., Ph.D., *Your Child and Health Care: A "Dollars & Sense" Guide for Families with Special Needs.* Glossary, pages 480-488.

Nemours Foundation, "Kids Health" for parents: http://www.kidshealth.org

Gillette Children's Specialty Healthcare: http://www.gillettechildrens.org

Baylor Health Care System: http://www.baylorhealth.com

Health Symphony: http://www.healthsymphony.com

Horizon BlueCross BlueShield of New Jersey: http://www.horizon-bcbsnj.com

LIST OF IN-NETWORK INSURANCE COMPANIES & PLANS ACCEPTED BY CHILDREN'S SPECIALIZED HOSPITAL:

Aetna

Amerigroup NJ

AmeriHealth

Cigna

Cigna Great West Healthcare

Consumer Health Network (CHN)

Devon Health Services Empire Blue Cross (Not the EMPIRE PLAN)

HealthCare Payers Coalition of New Jersey

Healthfirst NJ

Horizon BCBS Indemnity/PPO

Horizon BCBS Managed

Horizon Casualty Services

Horizon NJ Health

Magnacare

LIST OF IN-NETWORK INSURANCE COMPANIES & PLANS ACCEPTED BY CHILDREN'S SPECIALIZED HOSPITAL (continued):

Multiplan

New Jersey Medicaid

NY Medicaid (Inpatient Only)

Oxford

PHCS

QualCare

St Barnabas

United Health Care

United Community Plan (formerly Americhoice)

MENTAL HEALTH

Magellan Behavioral Health

Cigna Behavioral Health

MHN

Value Options

United Behavioral Health

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Children's Specialized Hospital treats children and adolescents from birth to 21 years of age with a wide variety of medical, developmental, educational and rehabilitative needs.

We invite families to visit our hospital and outpatient centers, get to know us, and learn more about our nationally recognized rehabilitative programs.

For information on additional services,
how to volunteer, or donate,
contact us at
1-888-CHILDREN (244-5373)

Or, visit our website

www.childrens-specialized.org

An affiliate member of the Robert Wood Johnson Health System, and a member of Children's Miracle Network Hospitals.