

NAVIGATING THE INSURANCE MAZE AFTER BRAIN INJURY



**A GUIDE FOR
PATIENTS
AND THEIR
ADVOCATES**

 **BRAIN INJURY
ASSOCIATION
OF AMERICA**

This guide provides information about private sector health insurance for individuals who have acquired brain injuries. It will help patients and their advocates understand the array of insurance products, the specialized language that insurance policies contain, and the claims process. The guide outlines the steps you can take to maximize insurance coverage for medically necessary treatment and services after injury. The guide does not discuss Medicare or Medicaid, but it includes resource listings for these and other public sector programs.

This publication is for educational purposes and is not a substitute for legal advice. It was prepared by Brain Injury Association of America (BIAA) staff and volunteers with financial support from BIAA's Business & Professional Council. The guide can be downloaded free from BIAA's website at <http://www.biausa.org>. There, you'll also find information about brain injury diagnosis, treatment, caregiving, and other important topics.

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**For individualized help and support, call BIAA's
National Brain Injury Information Center at
1-800-444-6443.**

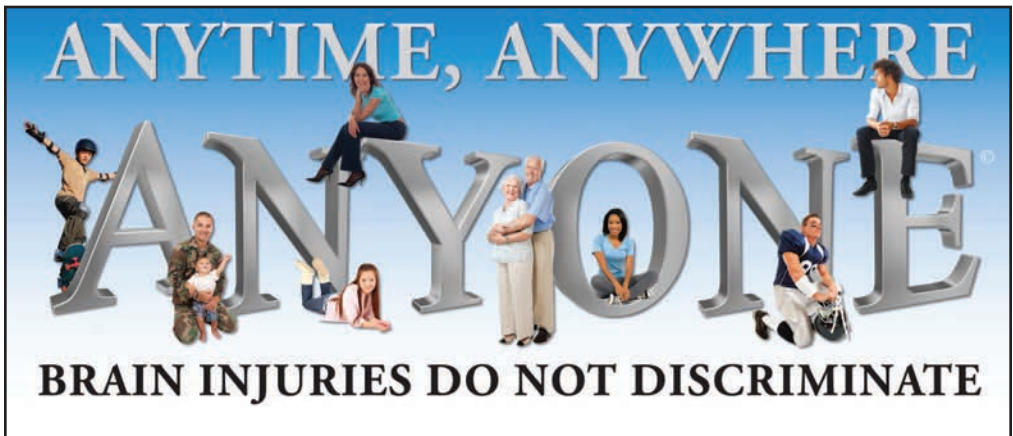
MARCH 2014

INTRODUCTION

The unthinkable has happened — you or someone you love has experienced a brain injury.

The injury may have resulted from a car crash, workplace accident, or a fall. It may have been caused by surgery, tumors, infections, or exposure to toxic substances.

Brain injuries are sometimes called by other names such as concussion, stroke, head injury, or shaken baby syndrome. You may hear a doctor or medical professional talk about a Cerebrovascular Accident or CVA. This is a stroke.



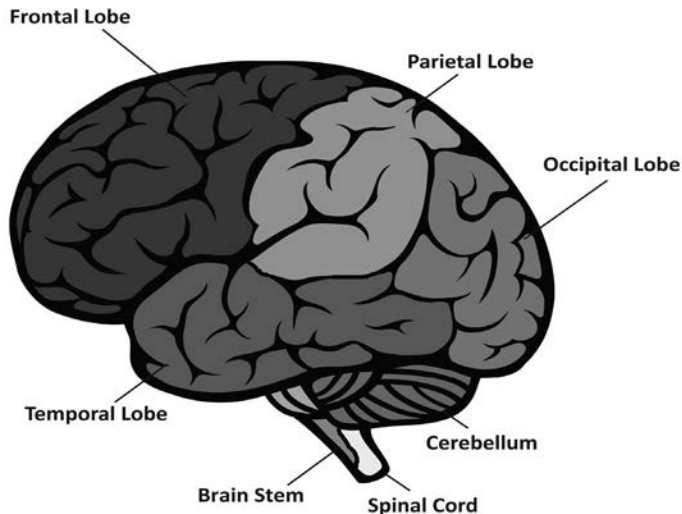
Brain injuries can happen anytime, anywhere, to anyone. A brain injury can change the way you move, think, act, and feel.

Whether the injury occurred today or many weeks or months ago, you will need to learn how to navigate through the health insurance maze as you advocate for the care, services, and supports that may be needed after a brain injury.

BEEN THERE, DONE THAT — Advice from Peers

Brain injury is a marathon, not a sprint. If your spouse or child has been injured, you may be the primary caregiver and the chief insurance advocate. Get as much rest as you can and try to stay as level-headed as possible, especially when dealing with your insurance company.

SIMPLIFIED BRAIN BEHAVIOR RELATIONSHIPS



Frontal Lobe

- Initiation
- Problem solving
- Judgment
- Inhibition of behavior
- Planning/anticipation
- Self-monitoring
- Motor planning
- Personality/emotions
- Awareness of abilities/limitations
- Organization
- Attention/concentration
- Mental flexibility
- Speaking (expressive language)

Temporal Lobe

- Memory
- Hearing
- Understanding (receptive language)
- Organizing and sequencing

Parietal Lobe

- Sense of touch
- Differentiation: size, shape, color
- Spatial perception
- Visual perception

Occipital Lobe

- Vision

Cerebellum

- Balance
- Coordination
- Skilled motor activity

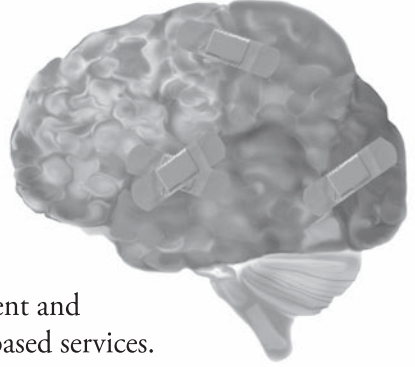
Brain Stem

- Breathing
- Heart rate
- Arousal/consciousness
- Sleep/wake functions
- Attention/concentration

CARE NEEDS

No two brain injuries are exactly the same. The effects of the injury are complex and vary greatly depending on the cause, location, and severity.

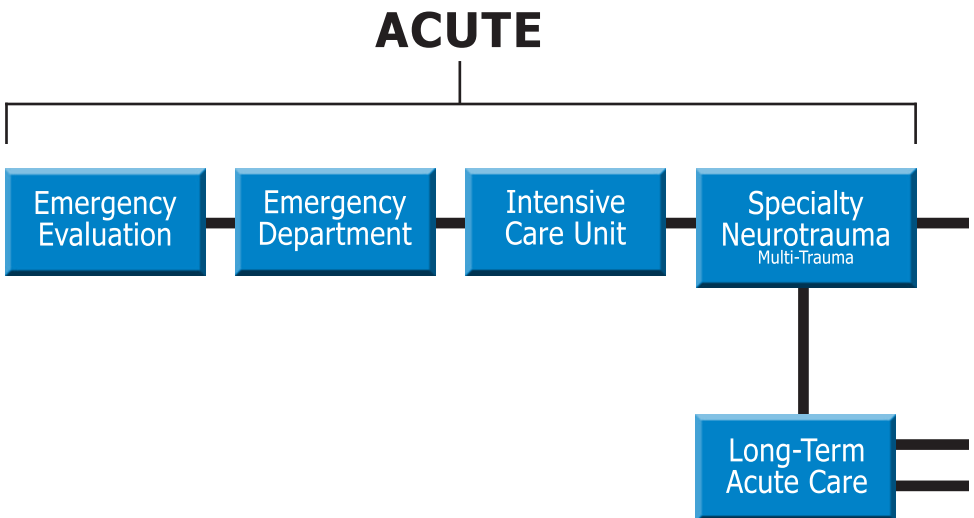
Trauma care, rehabilitation, and longer term services and supports are available from specialized providers. Brain injury care is provided through hospital and non-hospital settings, inpatient and outpatient programs, and home and community-based services.



Brain injuries can lead to physical, cognitive, and psychosocial or behavioral impairments ranging from balance and coordination problems to loss of hearing, vision, and/or speech. Fatigue, memory loss, concentration difficulty, anxiety, depression, impulsivity, and impaired judgment are also common after brain injury. Even so-called “mild” brain injuries can have serious consequences.

ACUTE CARE

An individual who sustains a serious brain injury is usually transported to a trauma center or emergency department. After completion of a work-up and determination of injuries and needs, the individual may be admitted to the hospital. A hospital may admit the individual to an intensive care unit or a regular room. Surgery and/or medical devices may be required to help maintain medical status.



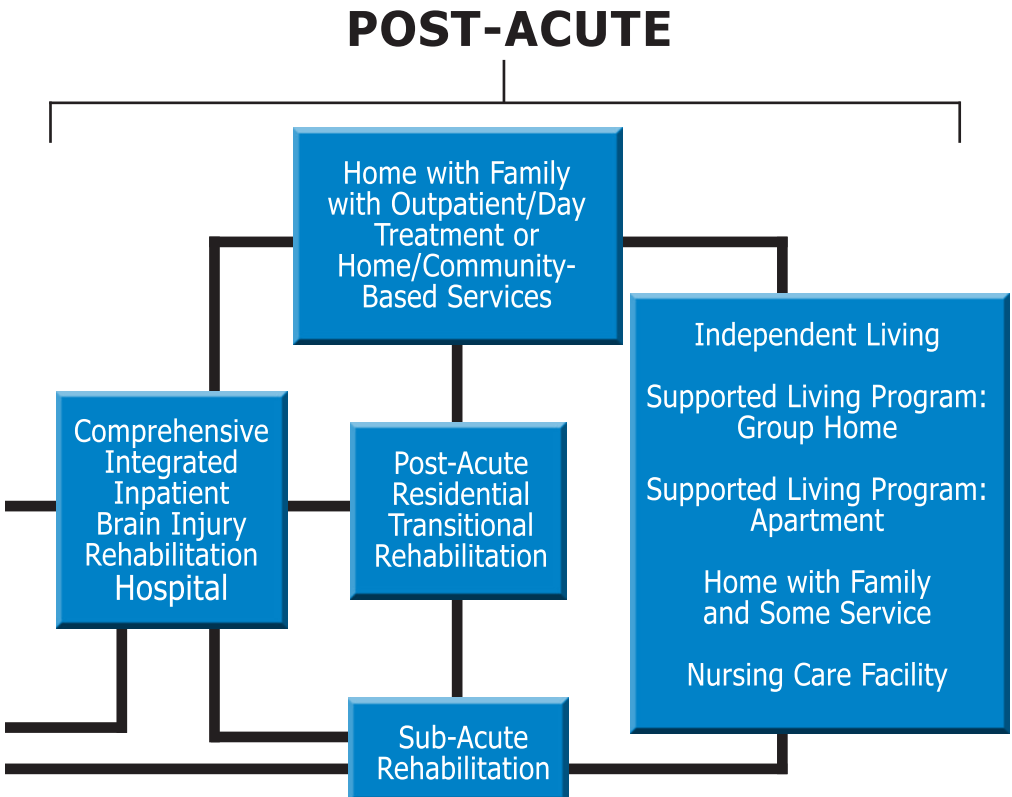
As individuals with brain injuries becomes medically stable, they are often transferred to a hospital or a hospital unit that provides comprehensive integrated rehabilitation therapies and medical services. Patients in this level of care require physician or nursing oversight 24 hours per day, seven days per week. Patients must be able to participate in 1-3 hours of rehabilitation per day and must show continued signs of improvement.

Inpatient acute rehabilitation is typically the start of comprehensive rehabilitation efforts for a patient with a brain injury.

POST-ACUTE CARE

When a person with ABI is discharged from the hospital, he or she may be referred for post-acute care. Multiple factors, such as medical status, physical and cognitive needs, family support, and insurance limitations, are considered when selecting among the wide variety of programs and services available.

The post-acute programs described below are presented in order of intensity, beginning with the most intense first.



POST-ACUTE BRAIN INJURY SPECIALTY REHABILITATION

Specialty rehabilitation programs are intended for patients who are medically stable and at least minimally responsive. Allied health services are considered medically necessary and provided under physician prescription. Admission may follow acute hospitalization, acute rehabilitation, psychiatric hospitalization, skilled nursing, nursing home, long-term acute care, or home.

Services may be composed of: physician and rehabilitation nursing services; physical, occupational, speech-language, educational, cognitive, recreational, psychological, neurobehavioral, and vocational therapies; case management; social work; and other services. These services help to restore and normalize medical function, minimize or prevent medical complications and re-hospitalization, restore independent living skills function, maximize disability reduction, and enable return to work or school.

The needs of the patient determine the interdisciplinary team of specialists including: behavioral psychology, behavioral analysis, case management, physical therapy, occupational therapy, speech-language pathology, educational therapy, counseling, clinical psychology, neuropsychology, social work, nursing, neurology, neurosurgery, psychiatry, ophthalmology, neuro-ophthalmology, optometry, orthopedics, endocrinology, internal medicine, and family practice.

Inpatient Residential Rehabilitation/Transitional Residential Rehabilitation care is often prescribed for cognitively or behaviorally complex patients, or in cases where the patient's safety is at risk. Post-acute transitional residential rehabilitation provides intensive rehabilitation and patients are generally more medically stable requiring less nursing care. Care is provided 24 hours a day, seven days per week.

The high acuity level of patient needs at this level require the highest level of services and the most complex interdisciplinary treatment team to restore or normalize medical function, minimize or prevent medical complications and re-hospitalization, restore independent living skills function, maximize disability reduction, and enable return to work or school.

DAY TREATMENT

Day treatment provides 4-6 hours per day, five days per week, of allied health services for cognitive, physical, and speech related deficits. Day treatment typically follows transitional residential rehabilitation.

Patients typically receive an increased intensity of services while participating in post-acute services in comparison to acute hospital rehabilitation.

OUTPATIENT REHABILITATION

Outpatient treatment provides the least intensive treatment at 1-3 hours per day, one to five days per week. Outpatient treatment usually follows the continuum of post-acute transitional residential rehabilitation or day treatment.

Typically, outpatient treatment involves one or more of the following disciplines: physical therapy, occupational therapy, speech/language therapy, neuropsychology, medicine, and case management.

HOME AND COMMUNITY-BASED TREATMENT

These services are provided in an individual's home and/or community settings and may be delivered as a separate service or in conjunction with post-acute rehabilitation. Home and community-based services are designed to maximize the transition and generalization of skills and behaviors from facility settings to application and assimilation in the community.

Home health care services may be provided to assist the patient in his/her home. The skilled services are brief, usually not more than 4 hours a day on a regular or intermittent basis, and may include such services as nursing, aides, physical therapy, speech therapy, and/or occupational therapy.

Durable medical equipment that can withstand repeated use during a course of treatment and be used in the home to aid in a better quality of living may be prescribed. Examples of durable medical equipment include hospital beds, canes, and braces.

BEEN THERE, DONE THAT— Advice from Peers

When your loved one returns home, make sure you ask your case manager or insurance carrier if home services are covered under your plan. Ask what the insurance company will pay for in the home including assistive devices or other services you may need.

Remember, home health aides cannot dispense medications so ask if a registered nurse (RN) or licensed practical nurse (LPN) is covered under your plan.

Transportation may be a concern when your loved one returns home. Ask your insurance carrier if transportation to/from outpatient therapy or other medical visits is covered — especially if your loved one is using a motorized wheelchair. Most family vehicles, even vans and SUVs, cannot accommodate the size and weight of larger wheelchairs without modifications to the vehicle.

LONG-TERM SERVICES AND SUPPORTS

Individuals with very severe brain injuries may be discharged to a skilled nursing facility or a subacute rehabilitation program.

SKILLED NURSING FACILITY

A skilled nursing facility is a nursing home recognized as a facility to meet the long-term health care needs for individuals who have the potential to function independently after a limited period of care.

SUBACUTE REHABILITATION PROGRAM

Specially licensed units of a hospital or nursing home can administer subacute rehabilitation. Individuals in these programs typically are medically stable, require skilled nursing care, and have either completed comprehensive inpatient rehabilitation or are judged to not be able to benefit from inpatient rehabilitation.



BEEN THERE, DONE THAT — Advice from Peers

After my mother's stroke, our insurance company wanted to send her to a nursing home. We refused because we were told she might not get the rehabilitative care she needed. Eventually, the insurance company agreed to substitute her policy's nursing home benefit for 45 days in a specialty rehabilitation facility.

Mom regained many of her skills at the rehab center and now just has some balance problems. She's using a walker and doing great. She would not be as independent or healthy as she is now if we had sent her to the nursing home.

I'm very glad we stood our ground.

THERAPIES AND RELATED SERVICES

Individuals with brain injuries may require a broad range of therapeutic services.

OCCUPATIONAL THERAPY

Occupational therapy is the assessment and intervention of activities of daily living, including eating, dressing, and grooming, as well as assisting individuals as they reintegrate into their communities.

SPEECH THERAPY

Speech therapy encompasses services to assess and treat speech, language, cognitive-communication, and swallowing disorders in individuals of all ages.

PHYSICAL THERAPY

Physical therapy involves the assessment and use of a variety of treatment techniques to help individuals move, reduce pain, restore function, and prevent disability.

COGNITIVE THERAPY

Cognitive therapy involves services to rebuild and/or develop compensatory strategies for neurological cognitive deficits. These can be related to basic daily functioning as well as to higher level executive skills. Activities focus on comprehension, expression, reading, writing, math, and higher level activities of daily living. Goals focus on the use of everyday activities and customized interventions related to each individual.

PSYCHOTHERAPY/COUNSELING

Psychological services are aimed at increasing the individual's sense of well being and emotional adjustment to their brain injury. Counseling and education may also be provided to caregivers.

MEDICAL TESTS

Medical tests are performed to detect, diagnose, or monitor diseases, disease processes, and susceptibility, and to determine a course of treatment. Following are common medical tests often required after a brain injury.

NEUROPSYCHOLOGICAL EVALUATION

A neuropsychological exam is comprised of a battery of standardized tests to evaluate cognitive, behavioral, and emotional strengths and weaknesses and their relationship to a particular brain structure or pathway. The tests are used to measure brain behavior relationships and to assess deficits.

NEUROENDOCRINE TESTING

Neuroendocrine abnormalities following brain injury are common. The degree of neuroendocrine dysfunction may vary based on the brain injury. Systematic screening of pituitary function is recommended for all patients with moderate to severe brain injury.

SLEEP STUDIES

Sleep disturbance is a relatively common complication following a brain injury. Objective measures to determine sleep disturbance include techniques that monitor changes in select physiologic processes (heart rate, temperature, cortisol levels, blood oxygen levels, etc.) up to full polysomnography and sleep lab studies.

TYPES OF INSURANCE

When you or someone you love has an acquired brain injury, health, automobile, or workers compensation insurance may provide coverage for medically necessary treatment, including rehabilitation and other services and supports.

Unfortunately, having insurance doesn't always mean that needed services will be covered. Understanding the type of insurance and the plan benefits — what's included and what's excluded — will make advocating for coverage easier.

HEALTH INSURANCE

Health insurance is sold to individuals as well as small and large groups as one of two main types: indemnity insurance and managed care.

Indemnity, or fee-for-service, insurance is sometimes called traditional insurance because it offers greater choice of doctors and hospitals and fewer restrictions on the scope and amount of care. Indemnity insurance is more costly than managed care and may require underwriting prior to enrollment. Fewer than half of insured Americans have indemnity plans.

Managed care takes an organized approach to delivering health care by limiting the number and types of providers in a care network and restricting the amount of coverage or benefits. Managed care plans usually establish quality measures and program guidelines to control costs and minimize waste. There are many types of managed care plans, but the most common are Preferred Provider Organization (PPO) and Exclusive Provider Organization (EPO) plans.

Health Maintenance Organizations (HMOs) offer Point of Service (POS) plans, allowing members to access care directly through the HMO, through a preferred network, or from providers outside the network.

GROUP PLANS

Many Americans obtain insurance through their employer, union, or trade/professional association. Policies and benefits provided differ widely, but most are subject to the Employee Retirement Income Security Act of 1974 (ERISA).

LEARN MORE ABOUT ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards to protect participants in most voluntarily established pension and health plans in private industry. ERISA does not apply to group health plans established or maintained by government agencies or religious organizations, or those plans maintained solely to comply with applicable workers compensation, unemployment, or disability laws.

The law requires plan administrators to provide participants with information about features; sets fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process; and gives participants the right to sue for benefits and breaches of fiduciary duty.

There are currently no federal mandates requiring health insurance plans to cover specific brain injury services. However, ERISA specifies that each plan administrator or fiduciary "shall discharge his duties to a plan solely in the interest of the participants and beneficiaries for the exclusive purpose of: a) providing benefits to participants and their beneficiaries and b) defraying reasonable expense of administering the plan."

This requirement, sometimes known as the "prudent man rule" requires an individual with decision-making authority to act on behalf of others as if he were acting on his own behalf.

Fully-insured plans are those in which an employer (or other sponsor, such as a union or membership association) contracts with another organization to assume financial responsibility for the enrollees' medical claims and administrative costs. Small employers that offer health insurance most often have fully insured plans. The employer does not have authority to make exceptions to a policy, but fully insured plans must follow state insurance laws controlling the benefits and services covered under the plan.

Self-insured plans are those in which an employer or other sponsor directly assumes responsibility for the health care of its employees and eligible dependents. Some self-insured plans bear the entire risk for all medical claims. Others 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; others are self-administered. Minimum Premium Plans (MPP) are included in the self-insured health plan category. Other types of plans (indemnity, PPO, EPO, HMO, POS, and PHOs) can be furnished on a self-insured basis.

Self-insured plans are not required to follow state insurance mandates for coverage. But since self-insured plans are under the direction of the employer, there is more flexibility in coverage decisions. Sometimes, employers can be persuaded to make exceptions to their health plan policies (or even make changes to the policy) to ensure that an employee or employee's dependent is able to receive medically necessary care.

WORKERS COMPENSATION

Workers compensation is a system in which an employer pays (or obtains insurance to pay) the lost wages and medical expenses of an employee who is injured on the job. Similar to health insurance policies, workers compensation plans can be fully insured or self-insured.

Workers compensation plans are controlled by state laws, but typically employees are automatically entitled to receive certain benefits when an occupational disease or injury is suffered in the course of employment. Benefits may include cash or wage loss benefits, medical and career rehabilitation benefits, and benefits for dependents in the case of accidental death of an employee.

The negligence and fault of either the employee or employer is immaterial in workers compensation claims. A worker who receives workers compensation benefits loses the right to sue the employer for that injury. Independent contractors are not entitled to workers compensation benefits.

AUTOMOBILE INSURANCE

In most states, auto insurance policies will not pay for medical services directly. Instead, the patient (or his/her health insurance carrier) is responsible for the costs of care and then seeks reimbursement from the auto policy – sometimes in a lawsuit. States with auto no-fault laws will cover services after a brain injury in accordance with established rules and regulations.



LEARN MORE ABOUT The Affordable Care Act (ACA)

As of January 2014, all individual and small group insurance plans are be required to meet or exceed the Essential Benefits Package prescribed by the Affordable Care Act (ACA). The benefits package includes several key categories of health services, such as hospitalization, physician services, prescription drugs, rehabilitative and habilitative services and devices, vision and oral services for children, mental health services, and chronic disease management services, among others.

Also starting in 2014, insurance companies are prohibited from discriminating against individual plan participants due to health status, medical history or condition, claims experience, genetic information, disability, evidence of insurability, or any other factor determined by HHS. In essence, insurers will be required to accept all applicants for individual and small group plans and to guarantee renewal. Insurers will not be allowed to impose pre-existing condition exclusions on individual and small group plans for adults, and excessive waiting periods will be prohibited.

THE FINE PRINT



An insurance policy is a binding contract between an insurance provider and an individual or his/her sponsor (e.g., an employer, union, or membership association). Most policies contain legal language and industry jargon that may be difficult for consumers to read and understand. Taking the time to become familiar with key terms now will make your advocacy efforts easier and more successful later on.

Start by obtaining a copy of your insurance policy as well as your “Certificate of Coverage,” a document that outlines your plan’s provisions and benefits. The certificate tends to be more straightforward and easier to read. It is the document most coverage decisions are based on. However, it is a good idea to compare your actual

policy with your certificate since there are sometimes slight differences between the two documents. These differences may be useful when advocating for treatment.

If you subscribe to a group policy, send a written request to the insurance company for a copy of the policy and a written request to the plan administrator (usually an employer’s human relations department) for the Certificate of Coverage. You may request the certificate by calling your insurance company’s customer service telephone number. Remember to have your ID card handy when you call.

BEEN THERE, DONE THAT — Advice from Peers

When my husband survived a severe brain injury, the hospital assigned a social worker to me and my family. The social worker helped me complete a Healthcare Power of Attorney, which gave me the authority to make medical decisions for my loved one. She also directed us to an insurance company representative who was located right in the hospital. The insurance company would not tell me anything until I had completed the power of attorney paperwork.

PLAN BENEFITS

Most insurance companies view brain injury as a medical condition. You are most likely to find coverage for the treatment and services needed after brain injury under the medical plan benefits. Be aware, however, that some benefits, especially those relating to behavioral health, may be available under the plan's mental health benefits.

Compare the benefits in your plan with the descriptions of treatments and services discussed in this guide. Note which services are included and which are not.

LEARN MORE ABOUT Case Management

Most health plans provide case management services to enrollees with high-cost medical conditions. The case manager's goal is to assure the continuity and quality of care while controlling costs. Case managers assigned to patients with brain injury need special training and experience in working with catastrophic injuries and illnesses.

Case managers may be responsible for:

- Checking available benefits
- Negotiating rates with providers who are not part of the plan's network
- Recommending coverage exceptions where appropriate
- Coordinating referrals to specialists
- Arranging for special services
- Coordinating plan benefits with available community services

Request a case manager as soon as possible after an injury if one is not assigned. You have the right to request a change in case managers if he/she does not have the training or experience needed to handle a patient with brain injury.

EXCLUSIONS

Every insurance policy includes a list of tests, procedures, or services that are excluded from coverage. Four types of exclusions commonly impact patients with brain injury:

1. Investigative/Experimental Treatment

Any therapy, procedure, or medication considered by the insurance company to be experimental will be excluded as a covered benefit under your health plan. Many insurance companies deny cognitive rehabilitation therapy as experimental. A recent review of literature indicates cognitive rehabilitation is an effective procedure to improve cognition (*Cicerone, et. al., 2000*).



2. License Restrictions

Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of service is not required to be licensed may be excluded.

3. Training

Vocational, educational, nutritional, and other types of training, while an important part of many specialized brain injury programs, may be excluded.

4. Not Specifically Listed

Your policy or Certificate of Coverage may include a statement declaring that any items not specifically included as a covered benefit are excluded.

Make a list of all exclusions found in your policy and/or coverage documents. Compare your list with the descriptions of the treatments and services discussed in this guide. Note which benefits are included and which are not.

In general, it is more difficult to negotiate coverage for excluded items, but some health plans are flexible enough to substitute excluded benefits for other benefits covered under your policy. Ask your case manager, plan administrator, and insurance company representative if exceptions can be made.

References:

Cicerone K.D., Dahlberg C., Kalmar K., Langenbahn D.M., Malec J.F., Bergquist T.F., Felicetti T., Giacino J.T., Harley J.P., Harrington D.E., Herzog J., Kneipp S., Laatsch L., Morse P.A. (2000). Evidence-based cognitive rehabilitation: recommendations for clinical practice. *Archives of Physical Medicine and Rehabilitation*. 81(12), 1596-1615.

LEARN MORE ABOUT Facility Licensing

Post-acute brain injury specialty programs may be licensed by the state or viewed by an insurance company as Custodial/Rest Care, Residential Care, or Assistive Living; therefore, they may be excluded from major medical health benefits.

In years past, the last step of care for individuals who sustained severe brain injuries was inpatient rehabilitation or perhaps outpatient rehabilitation. Today, the survival rate has dramatically increased, and the spectrum of care available to help individuals with brain injury maximize their independence has expanded. Specialized post-acute services are now part of the normal course of recovery after brain injury.

Unfortunately, most states do not have a license for Specialized Brain Injury Intensive Post-Acute Inpatient and Transitional Residential programs. Programs of this type often fall under Assisted Living, Adult Residential, or some other license that for people who have not had a brain injury would be considered custodial. The key difference is most specialized brain injury programs provide intensive highly skilled rehabilitation, medical management, and intensive rehabilitation programming on a 24/7 basis to help individuals with brain injury maximize their recovery.

UTILIZATION REVIEW

Your health care policy will provide information regarding utilization review or how the insurance company evaluates the medical necessity and appropriateness of care and the setting in which care is provided. Medically necessary services are certified and monitored, typically through case management. The case manager typically works with the insurance company's medical director or physician to review for medical appropriateness.

Review your insurance policy to determine if there is a specific definition for medical necessity.

Typically most services associated with a brain injury require a pre-service review. Learn the pre-service guidelines and time frame requirements in your policy so that treatment is not denied based on a technicality.

LEARN MORE ABOUT **Medical Necessity**

In general medical necessity may be thought of as:

- Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms in accordance with the generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease;
- Not primarily for the convenience of the patient or physician, or other physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease;
- Recognized as standards of good medical practice within the organized medical community;
- Generally accepted forms of treatment that are less invasive and have been tried and found to be effective;
- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.

THE APPEALS PROCESS

Review the policy language to understand the level of appeals available to you in response to any denial of services. The type and number of appeals will vary based according to plan. Your plan may identify:

- Requirements for pre-service determination — time frame varies, usually less than a week
- Concurrent Request — usually within 24-48 hours of request
- Retrospective Review — within a specified time frame from receipt of information
- Peer Review (Doc to Doc)
- Initial Appeal — note if policy identifies timelines to file the appeal after a denial of services and note if policy states time frame to respond with an answer to the appeal
- Secondary Appeal
- Expedited Appeal

If your loved one has been denied necessary treatment, it is important to identify the insurance physician specialty and the state license of the physician. In some instances, you may be able to request the physician be licensed in the same state the patient is receiving care and that the physician denying services has been properly trained in brain injury as indicated by such specialties as neurology, psychiatry, and neuropsychiatry.



STEPS TO MAXIMIZING COVERAGE

1. Determine the type of insurance you have.
2. Request a copy of the certificate of coverage from the employer.
3. Request a copy of the full insurance policy from the employer or insurance company.
4. Obtain all paper copies or electronic copies of medical records for each treatment admission (some providers may charge a fee for this service).
5. Complete a HIPAA release to send in with all above requests.
6. Review and understand your insurance policy.
7. Research if any state health care mandates apply to brain injury services in your state.
 - a. You can check your state legislature and search for brain injury mandates.
8. Contact your insurance case manager early, and often if needed.
9. Learn key insurance supervisors and the names of your insurance plans executives, in case you need to contact them on behalf of your loved one.
 - a. Your plan will often identify key officers or you can go to the insurance web site.
10. Document your loved one's condition and progress throughout the recovery process with pictures, video, and written descriptions.
11. Document every conversation you have with any person from the insurance company including the person's name and title, the date and time, purpose for the call, and details of the conversation.
12. Save all of your claim files including any documents or records that were relied upon in making a decision to approve or deny needed treatment.
13. Understand each level of appeal available to your loved one through policy review.
14. Encourage the service provider to follow all the steps of the appeals process.
15. Write your own request to appeal any necessary treatment to benefit your loved one.
16. Include in your request: a) the reason for the denial, b) reference to the plan provision on which the denial was based, c) state specifically the type of treatment needed, d) provide written statements of support by physicians, and e) request an explanation of each level of appeal and time frames.
17. Request a copy of the claim file before the appeal is decided.

18. Exhaust all levels of appeal.
19. Consider if your loved one has been discriminated against based upon his/her ability to advocate for himself or herself.
20. Speak with your family member's employer to request their help and consideration in approving needed treatment and overriding policy language.
21. If your appeals are continuing to be denied consider:
 - a. Filing a claim with the Department of Insurance (Google)
 - b. Filing a claim with the Department of Managed Healthcare (Google)
 - c. Contacting the media with your story
 - d. Google "brain injury stories" to find press favorable toward the cause of brain injury
 - e. Contacting BIAA with your story
 - f. Contact local, state, and federal government officials and ask for letters of support and legislative action to help your loved one obtain the necessary treatment (Google local, state, and federal legislators and government officials to learn contact information)
 - g. Litigation
22. If following through with any of the considerations above consider this outline guide:
 - a. State the nature of the support and need for the support
 - b. State the history of your loved one's injury and treatment
 - c. Summarize history of appeals, documents, and prior letters of support
 - d. Point out inconsistencies, irregularities, and omissions
 - e. Conclude with specific requests

RESOURCES

Brain Injury Association of America
www.biausa.org

Centers for Medicare and Medicaid Services
www.cms.gov

Family Caregiver Alliance
www.caregiver.org/caregiver/jsp/home.jsp

National Association of Insurance Commissioners
www.naic.org

National Association of State Head Injury Administrators
www.nashia.org

GLOSSARY

Administrative Services Only (ASO)

An arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; the employer bears the risk for claims. This is common in self-insured health care plans.

Coinsurance

A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges. Individuals could also be responsible for any charges in excess of what the insurer determines to be “usual, customary, and reasonable.” Coinsurance rates may differ if services are received from an approved provider (i.e., a provider with whom the insurer has a contract or an agreement specifying payment levels and other contract requirements) or if received by providers not on the approved list. In addition to overall coinsurance rates, rates may also differ for different types of services.

Coordination of Benefits (COB)

A method of integrating benefits payable under more than one health insurance plan so that the insured’s benefits from all sources do not exceed 100% of allowable medical expenses.

Copayment

A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement. There may be separate copayments for different services. Some plans require that a deductible first be met for some specific services before a copayment applies.

Deductible

A fixed dollar amount during the benefit period — usually a year — that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both individual and family deductibles. Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. Deductibles may differ if services are received from an approved provider or if received from providers not on the approved list.

Elimination Period

A specified number of days at the beginning of each period of disability (in disability income policies) or hospital confinement (in hospital confinement indemnity policies), during which no benefits are paid.

Evidence of Coverage (EOC)

A document that summarizes the provisions and benefits of a managed care health insurance plan.

Evidence of Insurability

A statement or proof of physical condition or other information affecting a person's eligibility for insurance.

Exclusions

Specific conditions or circumstances for which the policy or plan will not provide benefits.

Exclusive Provider Organization (EPO) Plan

A plan under which patients must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.

Explanation of Benefits (EOB)

The statement sent to a participant in a health care plan listing services, amounts paid by the plan, and total amount that may be billed to the patient.

Flexible Benefits Plan (Cafeteria Plan) (IRS 125 Plan)

A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans, and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage.

Flexible Spending Accounts or Arrangements (FSA)

An account offered and administered by employers that provides a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Formulary

A list of prescription medications covered by an insurance carrier.

Fully Insured Health Benefit Plan

Employer-purchased insurance coverage from a licensed insurance carrier where the insurance carrier assumes the risk.

Gatekeeper

A gatekeeper is responsible for the administration of the patient's treatment; the gatekeeper coordinates and authorizes all medical services, laboratory studies, specialty referrals, and hospitalizations.

Grace Period

A specified time period (usually 31 days) following the premium due date during which insurance remains in force and a policyholder may pay the premium without penalty.

Group Certificate

The document provided to each member of a group health benefit plan. It describes the benefits provided under the group plan.

Guaranteed Renewable Contract

A contract under which an insured has the right, commonly up to a certain age or for a specified number of years, to continue the policy by the timely payment of premiums. Under guaranteed renewable contracts, the insurer reserves the right to change premium rates by policy class, not just for one or a few members.

Health Maintenance Organization (HMO)

A health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.

Group Model HMO

An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated, per capita rate, which the group distributes among its physicians, usually on a salaried basis.

Staff Model HMO

A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The physicians see patients in the HMO's own facilities.

Network Model HMO

An HMO model that contracts with multiple physician groups to provide services to HMO members and may involve large single and multispecialty groups. The physician groups may provide services to both HMO and non-HMO plan participants.

Individual Practice Association (IPA) HMO

A type of health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs. An IPA may contract with and provide services to both HMO and non-HMO plan participants.

Indemnity Plan

A type of medical plan that reimburses the patient and/or provider as expenses are incurred.

Maximum Plan Dollar Limit

The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while covered under the health plan. Plans can have a yearly and/or a lifetime maximum dollar limit. The most typical maximum is a lifetime amount of \$1 million per individual.

Medical Savings Account (MSA)

A savings account designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and a Medical Savings Account (MSA) is the ability under an MSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most MSAs allow unused balances and earnings to accumulate. Unlike FSAs, most MSAs are combined with a high deductible or catastrophic health insurance plan.

Minimum Premium Plan (MPP)

A plan where the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services.

Out-of-Network Care

Medical services obtained by managed care health insurance plan members from non-participating or non-preferred providers. In many plans, such care will not be reimbursed unless previous authorization for such care was obtained.

Out-of-Pocket Costs

Health care costs the covered person must pay out of his or her own pocket, including such things as coinsurance, copayments, deductibles, etc. Most plans and policies contain a maximum out-of-pocket limit that is applicable on a policy year or calendar year basis. Please be aware that only those costs the member incurs related to covered benefits count toward any out-of-pocket maximum. The member may have

considerable out-of-pocket costs related to non-covered benefits, to include amounts in excess of the allowable charge. In addition, some copayments, coinsurance, and deductibles may not apply to the out-of-pocket maximum.

Point-of-Service (POS) Plan

An “HMO/PPO” hybrid; sometimes referred to as an “open-ended” HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary, and reasonable charges).

Physician-Hospital Organization (PHO)

An alliance between physicians and hospitals to help providers attain market share, improve bargaining power, and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers.

Pre-Admission or Pre-Certification Authorization

A requirement that the health care plan must approve, in advance, certain hospital admissions or certain procedures.

Pre-Existing Condition Exclusion

Generally, a limitation or exclusion of health benefits based on the fact that a physical or mental condition was present before the first day of coverage. HIPAA, the ACA, and state laws limit the extent to which a health plan or issuer can apply a pre-existing condition exclusion in certain instances.

Premium

Agreed upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, or employees, or shared by both the insured individual and the plan sponsor.

Premium Equivalent

For self-insured plans, the cost per covered employee, or the amount the firm would expect to reflect the cost of claims paid, administrative costs, and stop-loss premiums.

Preferred Provider Organization (PPO) Plan

An indemnity plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.

Rescission

To nullify or make void a policy or coverage. In many cases, when and if a carrier rescinds a policy, premiums are refunded. Current law requires that your coverage can

be rescinded only for fraud or intentional misrepresentation of material fact on your application.

Reinsurance

The acceptance by one or more insurers, called reinsurers or assuming companies, of a portion of the risk underwritten by another insurer that has contracted with an employer for the entire coverage.

Self Funded or Self-Insured Health Benefit Plan

A group health benefit plan offered by an employer to employees under which the employer chooses to assume the financial risk of paying health care claims instead of contracting with an insurance carrier to underwrite the risk. This type of plan is usually not evident to the enrollee because the employer generally will contract with an insurance carrier to administer the plan.

Stop-Loss Coverage

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).

Third Party Administrator (TPA)

An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

Usual, Customary, and Reasonable (UCR) Charges

Conventional indemnity plans operate based on usual, customary, and reasonable (UCR) charges. UCR charges mean that the charge is the provider's usual fee for a service, does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognizes charges for covered services up to a negotiated fixed dollar amount.

Underwriting

A process by which an insurer determines whether or not, and on what basis, it will accept and classify the risks associated with an application for coverage.

REFERENCES:

<http://www.dol.gov/dol/topic/health-plans/erisa.htm>

<http://www.bls.gov/ncs/ebs/sp/healthterms.pdf>

<http://legal-dictionary.thefreedictionary.com/Workers'+Compensation>

<http://www.healthinsurance.info/plans/Managed-Care.HTM>

<http://www.scc.virginia.gov/boi/pubs/healthguide.pdf>

<http://www.cbs.state.or.us/ins/publications/consumer/4618.pdf>

<http://www.dhs.wisconsin.gov/guide/spec/probins.htm>





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