

PRIVATE HEALTH INSURANCE

Most private health insurance companies pay for some types of assistive technology (AT) devices and services. The guidelines for purchasing such equipment vary significantly from one company to another and even one policy to another within a given insurance company. Many insurance companies do not cover some "pre-existing conditions" so, for a person with a disability, medical expenses (including AT devices and services) related to the disability may not be covered. The Patient Protection and Affordable Care Act of 2010 will eliminate most "pre-existing conditions" insurance issues.

In most cases, assistive technology must be proven to be "medically necessary" or to have an effect on limiting further loss to the insurer. A physician's determination of need is given great weight in making a decision concerning equipment.

In general, private health insurance companies are more likely to pay for specific AT devices and/or services that: a) are medically needed, b) can significantly improve a person's condition and/or prevent further injury or complications so that maintenance and health costs are reduced, or c) enables an adult to return to the workplace. Private insurance companies more readily purchase or rent/lease an AT device, if it is needed temporarily due to conditions caused by accidents or illnesses that will eventually improve.

To determine if AT devices and/or services are covered by your specific policy, answer the following questions:

1. What is the specific wording of the policy? Look for terms such as "durable medical equipment" and "prosthetic devices" used in describing services or expenses covered and read these sections carefully. If these terms exist, your policy covers AT devices and services. However, they may or may not cover the specific AT device and/or service needed.
2. How does the insurance company make decisions and determine payment for its obligations based on that policy? Read the section of your policy that describes how to file a claim and how claims are reviewed to authorize payment. Remember, you can appeal a decision.

Appeals Process

If the claim or paperwork has been filled out inadequately or incorrectly, you may not be notified by the insurance company. They will automatically deny the claim and/ or request additional information directly from the health care provider (i.e., physician), assuming all the paperwork was correct and complete, but your claim was denied. You can request an administrative review by a staff physician or nurse. However, keep in mind that a general physician employed by an insurance company may not necessarily be knowledgeable about these devices and how they can assist you in staying healthy or employed. Do not be afraid to ask that the claim be reviewed by a specialist in rehabilitation medicine. Review the information concerning "documentation of need" in Section II for suggestions on what types of support information to include when filing your claim.

Remember, there is always a chance for full or partial funding if the policy coverage does not specifically EXCLUDE an AT device or piece of equipment. It is not uncommon for the claimant to eventually learn that he or she is better informed than the personnel with the group health plan.

If, after an administrative review, you are still having problems getting the group health plan to assist with funding, then you can seek assistance from the state insurance commissioner whose office investigates consumer complaints. Should you have a specific problem with either an insurance agent or an insurance company, contact the Oklahoma Insurance Department, Claims Division toll free at (800) 522-0071.

Oklahoma Insurance Department
Five Corporate Plaza
3625 NW 56th, Ste 100
Oklahoma City, OK 73112
(405) 521-2991 OR (800) 522-0071 (In state)

www.ok.gov/oid/index.html