Habilitative Services
Senate Bill 701

Who?
The IFSP or IEP team must present the information to the family.

When?
- Transition from ITP to preschool special education
- Initial IEP
- At least annually
- Upon the approval or denial of a parent's request for a related service to enable a child with a disability to benefit from special education

How?
- Parents are given the document, they are required to verbally informed that Caroline County Public Schools are required to share with parent/guardian that the child may be eligible to access additional habilitative services through their private insurance carrier.
- The written document is entitled: *Parents Guide to Habilitative Services*
- Parents may access the guide at the following:
- Parents may access the guide at the following:
  *http://ww.mdinsurance.state.md.us/sa/docs/documents/consumer/publicnew/parents'-guide-to-habilitative-services.pdf
  Or
  http://marylandpublicschools.org/MSDE/divisions/earlyinterv/Special ED Info.html

What are habilitative services?
- They are therapeutic services that are provided to children with genetic conditions or conditions present from birth to enhance the child's ability to function. Habilitative services are similar to rehabilitative services that are provided to adults or children who acquire a condition later in life. The difference is that rehabilitative services are geared toward reacquiring a skill that has been lost or impaired, while habilitative services are provided to help acquire a skill in the first place, such as walking or talking.
- Habilitative services include but are not limited to occupational therapy, physical therapy, and speech therapy for the treatment of a child with a congenital or genetic birth defect.

Are there limits on habilitative services?
- Under Maryland law, insurance companies and HMOs may not limit coverage for medically necessary services
- Insurance companies and HMOs may limit coverage for rehabilitative services

Are insurance companies and HMOs required to cover habilitative services?

- It depends on the type of health plan. Health plans subject to Maryland Insurance laws include:
  * A health plan purchased in Maryland from an insurance company or an HMO; or
  * A health plan that your employer purchased in Maryland
- Contact the health plan or benefits manager through employers to determine eligibility.

What health plans are required by Maryland law to cover habilitative services?

- It depends on the type of health plan. Health plans subject to Maryland Insurance laws include:
  * A health plan purchased in Maryland from an insurance company or an HMO; or
  * A health plan that your employer purchased in Maryland.
- Contact the health plan or benefits manager through employers to determine eligibility.

What health plans are not required by Maryland law to cover habilitative services?

- Group policies issued to the group's home office in another state.

For example, if a company provides a family benefits, but the company's home office is in another state, the policy may have been issued in that state.

- Federal government's employee benefit plan is not required to offer habilitative services.
- Employer self-funded and self-insured plans. The employer may be using the insurance company to process claims, but using the employer's funds to self-insure.
- Medicare or Medicaid

Could a health plan not subject to Maryland law contain habilitative services?

Contact the insurance company or HMO and ask what coverage is available for habilitative services. If the customer service representative is not helpful, ask to speak to a supervisor. It may be necessary to contact the benefits manager of the employer to find out if habilitative services are available.

How does a child qualify for habilitative benefits?

Under Maryland law, a child with a congenital or genetic birth defect, he or she qualifies for habilitative services under a health insurance or HMO contract, if the services are medically necessary. Congenital or genetic birth defect means it existed at or from birth, including a hereditary defect. "Congenital or genetic birth defect" includes, but is not limited to:

- Autism or autism spectrum disorder
- Cerebral palsy
- Intellectual disability

- Down syndrome
- Spina bifida
- Hydroencephalele

Congenital or genetic developmental disabilities

What if a child receives services through an IFSP or an IEP but the family believes the child needs more services?

- The family should contact the child's primary health care provider. The provider will examine the child and assess the child's needs.
- The primary provider may refer the child to a specialist for further assessment.
- The family should be aware that if they choose to call a private therapist directly, then the family may be responsible to pay for services if those services are not in the family's health care plan network or the services have not been approved by the health care plan.

What if a family believes that not all of their child's special needs are being addressed through the school, because some of the needs do not have "educational impact"?

- The family should contact their HMO or health insurer to determine if habilitative services are covered by the family's policy.
- If a referral is needed, then the family will need to contact the child's primary health care provider.
- The family may choose to call a private therapist directly, but the family may be responsible to pay for services if those services are not in the family's health care plan network or the services have not been approved by the health care plan.

What is a case manager?

- The case manager is a person who works for the HMO or insurance company who can assist the family to coordinate comprehensive services for the child.
- The goal of case management is for the child to receive the appropriate services and have the opportunity to function at his or her maximum potential.

Is there an age limit to receiving habilitative services?

- Under Maryland law, insurers and HMOs are required to pay benefits for habilitative services until a child turns 19.
- Some policies may provide benefits beyond 19.

What happens if the child has a congenital or genetic birth defect, but the family's health insurance company denied or limited coverage?

- The family must contact their health care plan. Contact the insurance company or HMO and ask what coverage is available for habilitative services. If the customer service representative is not helpful, ask to speak to a

supervisor. It may be necessary to contact the benefits manager of the employer to find out if habilitative services are available.

- If the child's primary health care provider states that certain health care services are needed, but the insurer or HMO disagrees, the family has the right to appeal the decision and have it reviewed by an independent medical expert.

How does the process work to apply for an independent medical expert?

1. The HMO or insurer sends a letter to the family denying services.
2. The family must follow instructions on the denial letter to ask the HMO or insurer to reconsider the decision. If the family needs help, they may contact the Health Education and Advocacy Unit in the Attorney General's Office. Additionally, a health care provider may initiate the contact.
3. If the insurer or HMO upholds the decision to deny payment for the health care service, then the case may be reviewed by an independent medical expert, who will decide if the health care service recommended by the family's doctor is medically necessary. Also, the Health Education and Advocacy Unit may assist.

Then…

- If a health plan is subject to Maryland insurance laws, the family may file a complaint with the Maryland Insurance Administration (MIA). MIA will send the case to an independent medical expert. Once the independent medical expert has rendered an opinion, the MIA will send the family notice of the decision.
- If the health plan is not subject to Maryland insurance laws, the MIA will not process the complaint. ***The health insurer or HMO will send the case to an independent medical expert.
- A letter from the insurer or HMO will be sent to tell the family if they may file a complaint with the MIA. There are time limits to the process, therefore the letter must be read for timeliness.

How and why to skip waiting?

A family may skip waiting for a letter to determine if they may file with the MIA if…

- The insurer or HMO waives the requirement that the family to first appeal to them;
- The health insurer or the HMO does not follow part of it's internal appeal process;
- You demonstrate a compelling reason, such a a delay may result in death, serious bodily impairment, serious dysfunction of a bodily organ, or cause the child to be a threat to himself or others.

What if the independent medical expert agrees that the service recommended is medically necessary?

The Insurance Commissioner, after considering all the facts of the case, may order your health insurer or HMO to pay for the health care service in accordance with your policy.