FAQs: Obtaining Coverage of Behavioral Health Treatment through Your Insurer

If you are having difficulty obtaining coverage through your insurance company, here are answers to some frequently asked questions that may be helpful. For bolded terms, please see the glossary for definitions.

List of Frequently Asked Questions with Answers Below

Overview: Your rights under AB88 and SB946

Under AB88 (CIC Section 10144.5), the Mental Health Parity Act of 2000 (MHPA), every health insurance policy that provides hospital, medical, or surgical coverage must also provide coverage for **medically necessary** treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child including **autism spectrum diagnosis (ASD)**.Coverage must include outpatient services, inpatient hospital services, and partial hospital services, as well as prescription drugs if the policy includes coverage for prescription drugs. ASD does not have to be the primary diagnosis and there is no age limit.

SB946 (CIC Section 10144.51) expands on the MHPA, reconfirming that health insurance must cover **behavioral health treatment (BHT)**, including **Applied Behavior Analysis** (ABA) and other **evidence-based** interventions. Some types of insurance are not subject to SB946, including Healthy Families, and CALPERS, however, they are subject to the MHPA. It is possible that your insurance will also provide physical therapy (PT), occupational therapy (OT), and speech therapy (ST). For more information, including the specific guidelines that must be followed in order for BHT to be covered, as well as a list of your rights under the law, view a Consumer Alert issued by the Department of Insurance.

How do I determine if my plan is state-regulated or self-funded?

If you are unsure, contact a Human Resources representative through your employer.

If I have a state-regulated plan, who is my regulator?

California State-regulated insurers and health plans are subject to AB88, the Mental Health Parity Law. In California, there are two state regulators: the California Department of Insurance (CDI), which regulates insurance policies issued by insurance companies, including most PPOs, and the California Department of Managed Health Care (DMHC) which generally regulates HMOs and some other types of health plans. If your insurance is issued in a state that differs from where you live, read the evidence of coverage manual for more information.

If I have a self-funded plan, will I be able to obtain coverage?

Self-funded insurers are exempt from AB88 (as of 2012). BHT treatment may or may not be covered in your plan. Consult your Plan Description or contact your insurer to determine whether or not you have coverage for treatment. Employee Retirement Income Security Act (ERISA) regulates the employer through the Employee Benefits Security Administration (EBSA) of the Department of Labor (DOL). For more information, read about filing a claim for your health or disability benefit. You may also contact your plan directly or your human resources department to get additional information. If your Plan does not specifically exclude treatment for autism, you may choose to assume that autism benefits are available and submit documentation as described in the questions and answers below.

It is important to note that individuals have successfully fought to obtain coverage under self-funded plans, as is evident by the decision in Harlick v. Blue Shield, which involved the beneficiary of a plan regulated by ERISA. Remember that if you have exhausted your appeals within the plan, you have the right to file a civil action in federal court under section 502(a) of ERISA.

Should I seek authorization for treatment first, and how?

Regardless of whether you are in a PPO, it is a good idea to seek authorization first and attempt to go through the appropriate channels to secure coverage. Requesting treatment usually means going through your Primary Care Provider (PCP) to obtain a written pre-service request.

What are the requirements for obtaining a diagnosis and developing a treatment plan?

You will need a diagnosis of autism/ASD from a **licensed physician** or psychologist and a prescription/recommendation for ABA treatment or other services. The behavioral health treatment intervention must be provided under a treatment plan administered by either a **qualified autism service provider** or a supervised **professional or paraprofessional**. Be sure the **treatment plan** has **measurable goals** over a specific timeline, reviewed every six months. Prior authorization, **copayments**, or other cost-sharing for BHT may apply.

If I obtain a referral, what else can I provide the insurer along with it as support?

You may ask your primary care provider (PCP) to write a treatment plan letter encompassing the language used in AB88 or SB946 which can then be sent, along with the referral, to the insurer.

What if my provider will not grant me a referral?

If your primary care provider (PCP) will not grant a referral for BHT services, you may be able to request a second opinion from another doctor or medical provider within the insurer's network. If you are enrolled in a PPO you will likely be able to choose providers either from within the insurer's network or by going to an out-of-network provider.

Should I contact the insurer directly, and what should I tell them?

While requesting treatment usually means first going through your PCP to obtain a referral, in other situations you may need to contact your insurance company directly. In either case, you can call your insurer and notify them that you have a child with ASD and their treating physician has prescribed BHT or other therapy for your child. Tell them that you will need a therapist skilled in treating autism, and ask them what you need to do to obtain treatment. It may be a good idea to request that a case manager be assigned to your child. If needed, speak to a supervisor. Having one person to contact in the company will provide you with consistent information. Follow up phone requests in writing, if needed. Confirm your understanding of the phone conversation. The insurer may tell you that BHT is not a covered service and deny your request. If that happens, review the questions and answers below.

What if I am already receiving treatment / How do I submit claims?

If you are already receiving treatment, contact your insurer to ask what you need to do to get funding. Insurers ask for different things, but you want to make sure you ask if there is a process or procedure they would like you to follow. If you are in a situation where you are privately paying (usually in PPOs), send in claims to the address on the back of your insurance card, or call the company to obtain a fax number. Follow up all claim submissions with a phone call, to confirm that they received the claims. Send everything via certified mail and save copies to your personal file. The insurer may tell you that BHT is not a covered service and deny your claims. Should that occur, see the questions and answers below.

What do I do if my claim or request for treatment is denied / How do I file an appeal?

When you request a healthcare service from your insurer, they are legally required to process your claims or respond to your written request in writing within 30 days (Insurance Code sections 10169 and 10123.13). If your claim/request is denied by your insurance company, you may submit an appeal by contacting your insurance company's Member Services department. The appeals procedure should also be outlined in your benefits handbook. To call, check your health identification card for the Member Services phone number. You may be able to have a Member Services representative help you submit an appeal over the phone. When you call, ask if someone can help you with a problem related to autism services. Written requests can be sent to the address on the back of your health card. If there is uncertainty as to whether the request goes to the medical or behavioral plan, send to both.

When you receive a written denial from the insurer, they are supposed to state the reason for denial and make all relevant documents available to you upon request. You should request these documents in order to have adequate information to respond to their denial. Failure to provide you with the documents should be reported to the regulator when you file your grievance.

The insurer must respond to your appeal within 30 days. However, in certain cases when a person's life or long-term health is at risk you may be able to get a faster response, known as an "expedited appeal". Ask your representative if you think this should apply to your child. If your plan is regulated by the Department of Insurance, you do not have to wait 30 days after filing an appeal with the insurer to also file a grievance with the regulator.

What documentation should I include when filing an appeal?

Include supporting documentation with your appeal, such as prior evaluations, treatment plans, goals, and letters from physicians and other relevant providers specifying that the requested treatment is **medically necessary**. The insurer may need this information in order to process the claim. You should keep your own personal file with all such relevant documents.

List of some common reasons your insurer might be using to deny or delay your treatment and what you can do about it.

If your insurance plan is regulated by the California Department of Insurance and your insurer is:

- claiming that behavioral health treatment is experimental, investigational, or educational;
- claiming that the autism service provider or supervisor you are receiving treatment from is not licensed even though the individual or group is certified by a national accredited entity such as the Behavior Analyst Certification Board;
- demanding an excessive number of evaluations, or is requiring cognitive or IQ testing;

These are illegitimate practices by insurers to deny or delay covering your behavioral health treatment. Under the emergency regulations issued by the California Department of Insurance (CDI) in March of 2013, these practices are expressly prohibited for insurance plans regulated by CDI. For more information on the emergency regulations, view a Consumer Alert issued by CDI. If your insurer is claiming any of the above reasons to deny or delay your coverage, contact CDI. For health plans not regulated by CDI, contact the appropriate regulator to see if they can assist with this issue.

How do I file a grievance with the state regulator?

The following is contact information for the two state regulators in California. The regulator will review the case and try to resolve it with your insurance company or health plan. You may be asked for supporting documentation, including denials letters, other letters, bills, recommendations/evaluations/reports from the provider, and explanations of benefits.

For insurance companies regulated by the California Department of Insurance (CDI):

After contacting the insurance company, if you do not receive a satisfactory response, contact CDI. You do not need to wait 30 days after filing an appeal with your insurance company before filing a complaint with CDI.

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower

Los Angeles, CA 90013
Consumer Hotline: 1-800-927-HELP (4357) or 1-213-897-8921

For health plans regulated by the California Department of Managed Health Care (DMHC):

If your health problem is urgent, or if you already filed a complaint with your health plan and are not satisfied with your health plan's decision, you should contact the Help Center at the DMHC. An urgent problem is a serious threat to your health. You can also file a complaint with the Help Center if your HMO does not make a decision within 30 days. Consumers can file complaints with the Help Center using the DMHC's new secure, easy-to-use online form.

Department of Managed Health Care
California Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-888-466-2219

What is an Independent Medical Review?

After filing a grievance with the regulator, you may be eligible for an Independent Medical Review (IMR), which allows you to obtain an external or independent review of your case with a physician or other medical specialist that is not affiliated with your insurer. If the insurance company's denial of treatment is overturned as a result of the review, coverage must then be provided. For more information, see:

The IMR Program through CDI

The IMR Program through DMHC

What should I know about network insufficiency?

Under SB946, every insurer must maintain an adequate network that includes qualified autism service providers who provide behavioral health treatment. However, the insurer is able to selectively contract with providers within these requirements. Usually, insurers have lists of in-network providers in your area that you may be able to find online. You can contact the insurer for lists of appropriate providers with autism expertise. For mental health services, the insurer cannot require you to drive more than 30 minutes or 15 miles from your home. You may call to verify that the providers have experience treating people with autism, and also verify that they have current availability. If they don't have experience and regular availability, contact the insurer about their network being insufficient. If the insurer's network is insufficient, the insurer may be required to do a single case agreement to use an appropriate provider. If the insurer is not responsive, you may contact your regulator for more help.

What if I am already a regional center client and have insurance? How do I transition from receiving state funded services to insurance covered services?

Regional centers are considered the funding source of last resort; therefore, families need to take the initiative ASAP in researching their current health insurance benefits to ensure a smooth continuation of treatment services. Here are the steps to follow to get started: Find out if your current health insurance policy covers Behavioral Health Treatment (BHT) Services. If yes, start the treatment authorization process with assistance from your regional center service coordinator or current behavioral services

vendor. It is important for families to contact their insurance company to better understand the specific benefits of their health plan and their financial responsibilities towards co-payments and/or deductibles. If treatment is not a covered benefit under your plan, a denial letter will be sent to you. This denial letter may be helpful for the purposes of obtaining or maintaining regional center funded services.

Can my insurer impose a visit limit or dollar limit on speech or occupational therapy?

For insurance plans regulated by the California Department of Insurance (CDI), new emergency regulations went into effect on March 11, 2013, prohibiting insurers from placing visit limits on coverage for behavioral, speech, or occupational therapy. Also, insurers cannot place dollar limits on coverage unless the limit applies equally to all benefits under the policy. If you believe your insurer is wrongly placing limits, contact CDI. For health plans not regulated by CDI, contact the appropriate state regulator to see if they can assist with this issue.

General Tips

- If you are told that you cannot get the care you need, ask for the reason in writing.
- Talk to your doctor about your problem.
- When you make a phone call, take notes. Write down the date of your call, the name of the person you talk to, and what the person says.
- If you send anything by mail, make copies for your own records. If you communicate via e-mail, print and save each one. Create a file folder or binder for this topic and keep it organized.
- Have someone with you for extra support. Remain calm and stick to the facts.
- Act soon. If you wait longer than 6 months, you may lose the right to file a complaint, ask for an IMR, or take other action against your insurer.
- Follow your insurer's rules when seeking services.
- Contact your state regulator if you have questions.

Glossary

Applied Behavior Analysis (ABA): ABA is frequently used to address behavioral issues and improve symptoms related to autism. It is the science of learning about behaviors and factors that contribute to behavior. Once factors that affect behavior are identified, ABA techniques can be used to help caregivers adjust these factors in an effort to change certain behaviors. Then new skills are taught to the person to replace undesirable behaviors.

Autism spectrum disorders: Generally include autism, pervasive developmental disorder, pervasive developmental disorder – not otherwise specified (PDD-NOS) and Asperger's syndrome.

Behavioral health treatment: Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Copayment: A flat fee that you may pay when you see the doctor or obtain a prescription or other health care services.

Evidence-based: Treatments that scientific research has shown are effective for children who have ASD.

Licensed physician: Under SB946, treatment must be prescribed by a physician or surgeon licensed pursuant to Chapter 5 (commencing with Section 2000), or developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.

Measurable goals: Refers to standards the provider uses to gauge progress toward the treatment objectives.

Medically necessary: In reviewing whether treatment denied by an insurer is medically necessary for the patient, CDI's medical reviewers use the standards contained in Insurance Code Section 10169.3(b).

Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the insured and any of the following:

(A) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
(B) Nationally recognized professional standards.
(C) Expert opinion.
(D) Generally accepted standards of medical practice.
(E) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

Insurers must maintain detailed documentation demonstrating the basis of their decision to deny treatment consistent with the above standards.

Treatment plan: Under SB946 the treatment plan must: 1)Have measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated; 2) Describe the patient's behavioral health impairments to be treated; 2) Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported; 3) Provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism; 4) Discontinue intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan must also not be used for purposes of providing or for the reimbursement of respite, day care, or educational services.

Qualified autism service provider: Refers to a person or group that is certified by a national accredited entity, for example, a provider certified by the Behavior Analyst Certification Board, or a physician, psychologist or other licensed practitioner provided the services are within the experience and competence of the licensee.

A **qualified autism service professional** means an individual who meets all of the following criteria: a) provides BHT; b) is employed and supervised by a qualified autism service provider; c) provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider; d) is a behavioral service provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations; e) has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 9500) of the Government Code.

A **qualified autism service paraprofessional** means an unlicensed and uncertified individual who meets all of the following criteria: a) is employed and supervised by a qualified autism service provider; b) provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider; c) meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code; d) has adequate education, training, and experience, as certified by a qualified autism service provider.